The Worried Well

Psychiatric Injury, Iatrogenic Transmission of Disease and Iatrogenic Transmission of Post Traumatic Stress Disorder.

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The worried well is the title by which the Group B plaintiffs are known in the CJD litigation. It is perhaps an unfortunate title in that being "worried" does not provide a cause of action in English law. This is a commonly held position in all similar legal systems where damages may only be recovered for what is termed in the English system, a recognised psychiatric disorder[1]. This litigation is being parralled all over the world and to date no country has accepted that fear of contracting a particular illness, even as it is in this case a fatal one, is grounds for an action.
It is clear that the plaintiffs must establish a condition that goes well beyond worry[2].

What is a psychiatric injury?
The established heading in law for psychiatric injury is nervous shock although this is now being replaced by simply calling it psychiatric injury. The most common type of psychiatric illness giving grounds for action is post traumatic stress disorder PTSD but it is by no means the only injury that can be precipitated by exposure to a traumatic event. The syndrome is the subject of some scepticism by many and for that reason has caused the courts to take a long time to admit this type of damage into the wider range of injuries for which one can sue, this will be dealt with in more detail below . It is first necessary to define the type of injury for which nervous shock is perhaps an inadequate description. Starting with a brief history of externally inflicted psychiatric injury.

With the development of railways in the early decades of the nineteenth century the medical profession began to consider the appearance of new medical disorders to correspond with the new technology. The first of these became known as railway spine[3]. This condition was thought to be caused by the increased speeds and abrupt stops that people were routinely beginning to experience and had it not been subsequently shown to be a myth it would in today's terminology be described as a post traumatic disorder. The American Civil War, which was the first modern war, in the 1860's saw the description of a syndrome which fifty years later came to be called "shell shock". These conditions were thought to be organic in nature in the case of shell shock the symptoms were thought to be

[1] *Hinz v. Berry* [1970] 2 QB 42.
[2] Grief, fear anxiety, vexation and distress will not suffice; *Alcock v. Chief Constable of South Yorkshire Police* [1992] 1 AC 310. 401
[3] Ericksen et al.

precipitated by changes in atmospheric pressure or exposure to chemical poisoning[4]. The medical authorities wanted to avoid the concept of a purely psychological disorder found them selves more comfortable with the idea of a physical cause of the condition. The symptoms of shell shock were amnesia, sight loss, aphonia, and paralysis, as well as a range of anxiety neuroses[5]. The medical authorities at the time were prepared to accept a physiological cause for the condition known as shell shock because they had seen strange affects on soldiers who had been killed by nearby shell bursts that had left hardly any mark on the body. When these bodies were examined there were found to be small lesions in the brain and spinal membranes that were thought to precipitate the mental symptoms of the condition. It was even thought that close misses from machine gun bullet's could cause a diachisis[6] which was the supposed alteration of physiological connections in the brain. There were any number of explanations for psychological disorder but they all had to have a physical "cause". The only other option which the authorities would consider at the time of the First World War was that the shell shock case was a malingerer. The consequences of that could be court martial and firing squad. Even after more than seventy years there are still those who would maintain this view. Later in the century with the development of psychology as a science it was realised that symptoms and illnesses could arise out of the experiences themselves and that no accompanying somatic condition was necessary (although these commonly did occur). The first mention of a disease precipitated by shock came in 1889 when Pierre Janet described a syndrome where intense emotional reactions make events traumatic by interfering with the integration of the experience into existing memory[7]. By the second world war post traumatic stress was described in detail by Abraham Kardiner[8] and E Lindeman[9] considered the possibility of a disorder arising out of long term stress in 1944.

There are now more scientific and conveniently for legal purposes more standardised forms of definition and diagnosis. In 1980 The American Psychiatric Association laid down the definition of Post Traumatic Stress Disorder[10] and it was classified in their diagnostic and statistical manual. It was the first recognised psychiatric disorder that was capable of being caused entirely by extrinsic events and broke new ground not only in psychiatric circles but also in the law. The most used of the standardised manuals of psychiatric classification is the DSM series of manuals of which DSM IV is the latest. While they are

[4] Trimble MR. Post Traumatic Neurosis : From Railway Spine to the Whiplash. New York, John Wiley & Sons 1981.
[5] Da Costa's syndrome
[6] Healy D. *Images of Trauma*, p.93. Faber and Faber London
[7] Janet P. *L'Automatisme Psychologique*. Paris. Alcan [1889]
[8] The Traumatic Stress of War. New York. Hoeber [1941]
[9] Symptomatlogy and Management of Acute Grief. Am. Journal Psychiatry. [1944] 101, 141-148
[10] Davis Healy. *Images of Trauma*, p. xiii . Faber & Faber, Boston

specifically medical manuals and cautions are given in DSM III[11] about using them for other purposes[12]

DSM IV the diagnostic and statistical manual of the American Psychiatric Association lists PTSD as disorder number 309.81 and describes the characteristics as follows:

> A. The person has been exposed to a traumatic event in which both of the following were present:
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> (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 the self or others;
>
> (2) the person's response involved intense fear, helplessness or horror. note: in children this may be expressed instead by disorganised or agitated behaviour.
>
> B. The traumatic event is persistently re-experienced in one (or more) of the following ways:
>
> (1) recurrent and intrusive distressing recollections of the events including images, thoughts or perceptions. Note: in young children repetitive play may occur in which themes or aspects of the drama are expressed;
>
> (2) recurrent distressing dreams of the event. Note: in children, there may be frightening dreams without recognisable content;
>
> (3) acting or feeling as if the trauma were recurring (including a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes including those that occur on awakening and while intoxicated) Note: in children trauma specific re-enactment may occur;
>
> (4) intense psychological distress at exposure to internal or external cues that symbolise or resemble an aspect of the traumatic event;

[11] Shuman DW; *The Diagnostic and Statistical Manual of Mental Disorders in the Courts*. Bull Am Acad. Psychiatry Law 17:25 - 32. 1989

[12] DSM III R states specifically that the manual is for clinical and research purposes only and that a specific diagnostic category does not necessarily meet legal and other non medical criteria for mental disease, mental disorder or mental disability. They *are* necessarily of importance when defining an illness to the courts and in determining whether or not it may be trauma induced.

(5) physiological reactivity on exposure to internal or external cues that symbolise or resemble an aspect of the traumatic event;

C. Persistent avoidance of stimuli associated with the trauma and numbing of the 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) marked diminished interest or participation in significant activities;

(5) feeling of detachment or estrangement from others;

(6) restricted range of affect[13]

(7) sense of foreshortened future;

D. 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) hyper-vigilance;

(5) exaggerated startle response.

E. The duration of symptoms in criteria B,C and D. is more than one month

[13] Flattening of emotional response with inability to show, love anger etc.

F. The disturbance causes clinically significant distress or impairment in social, occupational or other important areas of functioning.

If the condition is of a duration of up to three months then it is considered acute. If it persists for more than three months then it is chronic. It is possible for the first symptoms to manifest themselves up to six months after the traumatic event in which case the condition is referred to as delayed onset post traumatic stress disorder . The diagnosis is summed up in précis by Schoppert, Graber and Bernstein[14] as "a pattern of adverse reactions following a traumatic event". The Disorder may appear immediately or weeks to years after the event . Symptoms include anxiety, irritability, jumpiness, inability to concentrate or work, sexual dysfunction and difficulty in interpersonal relationships" These commentators suggest however that flashbacks are a rare occurrence while others consider, particularly the authors of *DSM IV*, that the intrusive flashbacks are a consistent and particular feature of the disorder. Schoppert, Graber and Bernstein pay a great deal of attention to the functioning of the sympatho-adreno- medullary system in the stress response and the damage that this prolonged exposure may cause should be considered when assessing the damage suffered by a patient who has been exposed to a severe stress inducing situation.

This as can be seen is a comprehensive list of criteria, which must be satisfied by psychiatric examination if it is to be established that the plaintiff is actually "damaged". It goes without saying of course that the event must have been set in train by negligence if this is to be applied in law. It is by no means the only type of psychiatric injury recognised by the courts and other categories have been described as "anxiety neurosis" [15] or reactive depression[16]

The latter category was the diagnosis in *Brice v Brown* and its manifestation was particularly severe. Mrs Brice had been travelling as a passenger in a taxi with her daughter when it was involved in a collision with a bus. Mrs Brice received only minor injuries but her daughter suffered a severe laceration to the head . Despite the fact that the daughter made a rapid recovery from this injury, Mrs Brice suffered shock that deteriorated into a state better described as psychotic. She was diagnosed as suffering a reactive depression as a result of the accident but the symptoms steadily grew worse with delusional

[14] Psychology. 3rd Ed. 1994. Houghton Mifflin Corp. Boston.
[15] *McLouglin v. O'Brian* (1983) 1 AC 410 Per Lord Bridge.
[16] *Brice v. Brown* [1984] 1 All ER 997.

states and paranoia. the patient made attempts at suicide and was admitted to hospital on several occasions under the provisions of the Mental Health Act[17].

Mrs Brice has never made a full recovery and it is not difficult to imagine the devastating effect that this episode has had on her, not to mention that of her family. The defendant in this case attempted to establish in their defence that this illness was in fact an endogenous depression[18] and that the accident was not responsible for its onset.

This was rejected by Stuart-Smith J. on consideration of the medical evidence. While Mrs Brice had been subject to an hysterical personality the judge was convinced that the illness was an exacerbation of a personality disorder and did not arise out of purely internal factors.

Clearly psychiatric injury can range in severity just as widely as physical injury but it has taken the courts quite some time to get used to the idea. This is to some extent due to sociological factors, the famous “stiff upper lip” and “smiling in the face of adversity” traditions, and also because it is seen as a convenient area for false claims. There is no doubt that the traditional views have influenced the development of the law in this area. The phraseology used includes such expressions as "persons of normal fortitude"[19] when setting a standard to work by. This legal "ideal" is badly flawed in its subjectivity and while one might with some difficulty perhaps be able to describe a "reasonable person," many more complex factors and widely varying opinions would influence the description of normal fortitude. In the history of the development of compensable psychiatric damage the first clearly identifiable action for nervous shock did not involve negligence. The injury was in fact inflicted wilfully when the defendant told a lie to the plaintiff which caused her "serious and permanent physical consequences at one time threatening her reason" *Wilkinson v. Downton*[20]. In this case the court recognised that mental harm is as serious as physical injury and was willing to compensate accordingly. Negligently inflicted nervous

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[17] S.2(2) b Mental Health Act 1983 provides that a patient may be detained in hospital if:
he ought to be detained in the interests of his health or safety or with a view to the protection of others;

s.3 (2) a, that: he is suffering from a mental illness, severe mental impairment, psychopathic disorder or mental impairment and his mental disorder is of a nature or degree which makes it appropriate for him to receive treatment in a hospital.

[18] This is described as a condition arising out of internal physiological factors sometimes, but not in every case, complicated by psychological difficulties. A depressive episode does not require outside stimuli and can appear "out of the blue", so to speak

[19] The trauma must be such to have induced injury in those considered to be normally balanced individuals. If the victim was injured by an event that would not damage those with the ”Customary Phlegm” they would have no claim.

[20] [1897} 2 QB 57. per Wright J

shock came before the courts for the first time in England in the case of *Dulieu v. White & Sons*[21]. In this case the plaintiff who was pregnant was behind the bar of the public house, of which her husband was the licensee. A horse drawn vehicle was negligently driven into the front of the pub causing Mrs Dulieu to suffer shock which precipitated a premature birth. Mrs Dulieu was awarded damages not only for the brain damaged child she gave birth to but also for her own condition which arose from the traumatic event. Kennedy J. considered the term nervous shock appropriate as it suggested a somatic bodily response to a shocking event and avoided the possibility that the distress caused could be solely mental in nature. It established the idea that for the mental distress to be actionable it must be accompanied by some form of physical effects. This falls short of accepting psychiatric injury, as understood today, as being actionable. The shock had also to occur as a result of fear for oneself it was later in 1925 that it was expanded to include fear for the safety of loved ones in *Hambrook v. Stokes Brothers*[22]. This still did not allow a bystander to recover compensation for shock that they may have suffered in witnessing a negligently caused horrific accident when neither they themselves or their loved ones were at risk . The term the "customary phlegm" is used in dismissing such a case in *Hay (or Bourhill) v. Young*[23], where Lord Porter said:

> "The driver of a car or vehicle, even though careless, is entitled to assume that the ordinary frequenter of the streets has sufficient fortitude to endure such incidents as may from time to time be expected to occur to them including the noise of a collision and the sight of injury to others and is not to be considered negligent to one who does not possess the customary phlegm".

This very well demonstrates the idea that mental injury is different from a physical injury in that those with this fortitude or phlegm may somehow be invulnerable to such damage. It is not a sentiment confined to judges and even today those suffering from mental disorders inflicted or otherwise are seen as blameworthy, weak, malingerers or "working a fiddle"

perhaps benefit of the doubt can be extended to Lord Porter as this case occurred in wartime. The principle of ordinary fortitude if employed in such a way to physical injury would lead to a very interesting defence when considering Egg Shell Skull cases. Is the ordinary assailant similarly entitled to expect that all his victims should have a "normally thick skull"?. While it is applicable only to bystanders, as secondary victims, and even the ruling in *Bourhill v. Young* could appear to establish this, the concept of normal fortitude is still topical even where primary victims have been concerned. In some of the States of The

[21] [1901] 2 KB 669.
[22] (1925) 1 KB 141.
[23] (1943) AC 92.

United States a "fireman's rule" as it is known is still the basis of a defence against claims by professional rescuers. It suggests that such rescuers should possess a fortitude over and above the "normal". It is a view that is held by many in this country and outraged articles accompany press reports where rescuers from the emergency services have been compensated for psychiatric injury, *Piggot v. London Underground*[24] and *Frost v. Chief Constable of the South Yorkshire Police*[25]came down firmly on the point that where the rescuer was injured by the negligence of another they would recover damages. It is fundamentally important that it is made clear that the recovery is for injury arising out of negligence not injury arising out of "just doing their job".

The next landmark came with *McLoughlin v. O Brian* [26]. Prior to this case it had been necessary for the victim to be directly threatened by the event or to have seen loved ones similarly threatened. What is known as proximity in space and time the plaintiff had failed at the court of first instance and at the court of appeal because though her husband and children had been involved in a serious accident she had herself been threatened and had not witnessed it with her own eyes. In fact she had gone to the hospital on hearing of the accident and witnessed her loved ones in a distressed state and still being treated for their injuries. In the House of Lords it was decided that this was within the necessary proximity of time and space as long as the distressing scene was witnessed by the plaintiffs own eyes at the scene of the immediate aftermath. The claim had been threatened also because of another common fear where nervous shock / psychiatric injury cases are concerned that of the floodgates issue. This matter will be dealt with at a later stage of the text.

To summarise the law as it stands at the moment, the plaintiff, if he or she is to succeed must establish all the principle features of an action in negligence involving all other injuries or loss. The duty of care, the negligent breach, that the negligence caused the injury that the injury is not too remote and that all the common defences such as *volenti*, *ex turpi causa* and contributory negligence[27] are absent. That happy position being established they must go on to demonstrate that:

(1) The plaintiff must have suffered a recognised psychiatric condition that, at least where the plaintiff is a secondary victim, is shock induced.

(2) That it must have been reasonable foreseeable that they might have suffered a psychiatric injury as a result of the defendant's negligence.

[24] [1990] FTLR 19.12.90
[25] [1996] TLR 6.11.96 QBENF 95/0658/C
[26] (1983) 1AC 410

[27] Contributory negligence will not of course necessarily bar an action

(3) The plaintiff can recover if the foreseeable psychiatric injury arose from a reasonable fear of immediate physical injury to himself or herself.

(4) That the defendant has negligently injured or imperilled someone other than the plaintiff (but probably excluding the defendant himself or herself) and the plaintiff, as a result, has foreseeably suffered a shock induced psychiatric illness, the plaintiff can recover if he or she can establish the requisite degree of proximity in terms of:

(a) the class of persons whose claims should be recognised

(b) the closeness of the plaintiff to the accident in time and space, and

(c) the means by which the shock is caused.

(5) Where the defendant has negligently damaged or imperilled property belonging to the plaintiff or a third party, and the plaintiff, as a result, has suffered a psychiatric injury, it would appear that, in certain circumstances, the plaintiff can recover for that injury but the necessary criteria for recovery are unclear.

(6) It is unclear whether there can be a liability for the negligent communication of news to the plaintiff which has foreseeably caused him or her to suffer psychiatric illness.

(7) There are miscellaneous instances (that is other than those covered by propositions (3), (5) and (6) above where a primary victim probably can recover for a psychiatric injury foreseeably caused by the defendant's negligence.

In the next chapter each proposition will be analysed against the background of decided cases and later in the text examination will be made as to how these principles may apply to the case of *Plaintiffs v. The United Kingdom Medical Research Council and The Secretary of State for Health* and how such principles along with established case law applied in the case of *APQ v .Commonwealth Serum Laboratories Ltd and Commonwealth of Australia.*

A Recognised Psychiatric Condition

In addition to the common rules concerning negligently inflicted injury, duty of care, breach and consequent damage with the additional elements of causation, foreseeability and remoteness, where the injury is one to the mental health of the victim there are extra criterion to be followed. As mentioned above these rules have arisen as the law attempted to keep up with the emerging science of psychiatry and involved difficult adaptations of old principles as well as the adoption of completely new ones. The legal and medical establishments took a long time to adapt to the new understanding of how the mind worked and this is still in the stages of evolution today. When it is difficult to understand what causes a particular condition it is understandable that causation in the legal sense may need a difficult adaptation of the rules.

The additional criteria which must be in place for an action to succeed can be baffling and, as will be illustrated below, can certainly be unfair. The possible remedies for this will be considered later in the text, for now it is necessary to describe the rules and comment on the cases that have developed them.

Any person taking action for negligently inflicted nervous shock is required to demonstrate that they:

> have suffered a recognised psychiatric condition that, at least where the plaintiff is a secondary victim , is shock induced.[28]

The first part of this condition is clearly a matter for medical experts to determine and the courts will need to see evidence of the effect of such an injury on the patient's ability to function and its long term prognosis in order to evaluate appropriate damages should the plaintiff succeed in his action.

Psychiatric illness is in general terms divided into two distinct areas, although in practice the distinction is often blurred, those of neurotic conditions and those of psychotic conditions.

Neuroses encompass a broad spectrum of conditions including phobias, hysterical conditions, morbidity, obsessional states, post traumatic stress disorder, and some forms of depression. In very general terms the conditions are characterised by unusual behaviour, and varying levels of distress against a background of clear consciousness with the patient

[28] *ibid.* above p48.

retaining an insight into their own condition. Most neurotics will, despite their illness, lead ordinary lives, holding down jobs and maintaining a family life. Neurotic disorders precipitated by a shocking event are the most likely conditions to come before the court, with PTSD and reactive depression being the most common. However, as was seen in *Brice v. Brown*[29] injury amounting to a psychotic state can be caused or at least exacerbated by exposure to negligently inflicted shock.

Psychosis is generally thought to be a more serious form of mental illness and is usually associated with an internal element, either a genetic or organic predisposition. The condition encompasses schizophrenia and unipolar or endogenous depression. The illnesses are characterised by a loss of insight and in most cases a complete inability to function within a normal environment[30]. These general descriptions illustrate the type of condition which must be satisfied if an action is to be sustained in the courts. What is made clear by case law, indeed it is rather hammered home, is that anything less than such a recognised psychiatric injury, *Hinz v. Berry*[31], per Lord Denning and *McLoughlin v. O'Brien*[32] per Lord Wilberforce and Lord Bridge, will not support an action. In the language of the bench anything less than the recognised psychiatric injury is described as "lesser mental harm". This includes grief, fear, anxiety, vexation and distress and none of these are compensable, see: *Alcock v. Chief Constable of South Yorkshire Police*[33], per Lord Ackner and Lord Oliver; *Hinz v. Berry*[34]; and *McLoughlin v. O'Brian*[35] per Lord Bridge at 431. Fear, of whatever degree will not be sufficient, see: *Hicks v. Chief Constable of South Yorkshire Police*[36], per Lord Bridge: *Nichols v. Rushton*[37], no question of damages in negligence for severe shock and shaking up falling short of an identifiable psychiatric injury where no physical illness or trauma, *Calvely v. Chief Constable of the Merseyside Police*[38], Lord Bridge again, "no claim in negligence for mere anxiety, vexation and injury to reputation". This is an interesting observation by Lord Bridge in that injury to reputation is precisely what is actionable in defamation. *Kerby v. Redbridge Health Authority*[39], "no damages recoverable in negligence for dashed hopes". This makes the position clear as to what the courts must be convinced of in any negligently inflicted nervous shock case. It has been recognised that this "lesser mental harm" can evolve into a recognised illness in *Mount Isa*

[29] [1984] 1 All ER 997
[30] The development of psychotropic medication since the early fifties has greatly altered the prognosis for the psychotic patient. Those who were once condemned to a lifetime in an institution can with adequate medication and support lead relatively normal lives within the community.
[31] [1970] 2 QB 40.
[32] (1983) 1 AC 410.
[33] [1992] 1 AC 310.
[34] *ibid.* above.
[35] *ibid.* above.
[36] (1992) 2 All ER 65.
[37] [1984] 1 All ER 997.
[38] [1989] AC 1228.
[39] [1994] PIQR Q1.

Mines Ltd v. Pusey [40]. There has also been one case where this "lesser mental harm" was compensated, *Whitmore v. Euroways Express Coaches Ltd*[41]. Here a woman received damages for simple shock on witnessing an injury to her husband. The decision is almost certainly wrong in law.

Diagnosis of classic psychiatric conditions now, in nearly all cases, follows the definitions of the American Psychiatric Associations Diagnostic and Statistical Manual currently at Edition IV. While, as mentioned earlier, this manual is really meant for clinical diagnosis only, its rôle in supportive evidence is clear.

In the early days there was a great reluctance to accept the idea of mental injury, not only for the purposes of compensation, but at all. This owes more to social attitudes to mental health than any other factor and it has to be noted that when the early cases first appeared there was an ambivalent attitude to the mentally ill to say the least. The first significant cases came to the courts at a time when the concepts of mental illness were in their infancy and when psychology and psychiatry were just beginning to appear in the world of science. Most sufferers of mental illness in these times were incarcerated in the great Victorian asylums that were features of the outskirts of most cities until very recently. The public at large held strong beliefs about the mentally ill which ranged from fear to the notions that these were simply people lacking in moral fibre or malingerers. Some of these beliefs persist today in some part thanks to the tabloid press which paints a picture of patients released into the community as a threat to everyone's well being and takes the view that those compensated for any such injuries inflicted upon them are in some way the lucky recipient of a windfall. Against this background it is easier to understand the legal rulings in the early cases which are some times over criticised by commentators.

At the beginning there was an out and out rejection of nervous shock. In the Australian case of *Victorian Railways Commissioner v. Coultas*[42] finally decided by the Privy Council, the plaintiff had been a passenger on a train which was the subject of a near miss on a crossing. The court ruled that there was no cause of action in nervous shock where the mental injury was unaccompanied by physical injury. The reasoning behind this was that it was contrary to established precedent but most interestingly it was feared that to allow such an action to succeed would open the floodgates. This is a constantly recurring theme throughout the history of the issue. In 1897 the courts accepted in principle that nervous shock could be inflicted, *Wilkinson v. Downton*[43] where the infliction had been intentional

[40] (1970) 125 CLR 383.
[41] The Times 4.5.84
[42] (1888) 13 App Cas 222
[43] [1897] 2 QB 57

and deliberate, by means of a "practical joke". In *Dulieu v. White & Sons*[44] Kennedy J. allowed the concept in a negligence case. The judgement considered that a plaintiff may have suffered nervous shock where she had been placed in fear of physical injury even though she had been spared any actual "impact". While this was contrary to the finding in *Coultas* a great deal of emphasis was placed on physical symptoms manifesting themselves as a result of the shock. Mrs Dulieu had suffered a miscarriage as a result of the shock inflicted by the defendants negligence. Kennedy J. stated in his judgement that "nervous" was a better epithet than "mental" for it implied a system whereby the psychological shock had worked through bodily systems to produce a physical injury. This is one of the judgements often criticised as being too narrow in its application but it demonstrates a remarkable degree of insight for the period. The type of injury Mrs Dulieu suffered would today be referred to as psychosomatic and the systems by which such injuries occur has only begun to be understood in the past couple of decades. How shock affects the endocrine system is the subject of much study and scientists now understand the systems which contribute to the cause of many illnesses thought simply functional. The judgement laid the foundation on which nervous shock as a head of damage would be built. While there was an undoubtedly strong emphasis on the need for physical symptoms such as the judges statement at p 672:

> "The use of the epithet mental requires caution in view of the undoubted rule that mere mental pain unaccompanied by injury to the person cannot sustain an action of this kind"

and further down at p. 675, that the shocking event:

> " is proved to have naturally and directly produced physical effects."
> The first step had been taken towards establishing nervous shock as a cause of action. The injury while still being a necessary element in the action now arose out of the shock, not the shock out of the injury.

This is an interesting observation and even has the appearance at first glance of being prophetic. It is today well recognised that exposure to stress is the major cause of many modern illnesses. Heart disease in particular is commonly seen in people with stressful lives and it is now well understood that there is a relationship between the immune system and stress. The science of psychoneuroimmunology studies how the immune system is affected by stressors. In particular the immune system is suppressed by stress and this has

[44] [1901] 2 KB 669

the obvious consequence of making the sufferer more likely to succumb to infection[45]. Applying the philosophy of *conditio sine qua non*, if a patient is stricken by an infectious disease that has occurred because stress has weakened his immune system then the causer of the stress must be responsible for the infectious disease. While it might be argued that the exposure to the agent causing the disease is *novus actus interveniens* evidence adduced by the expert medical witnesses should be able to rebut this successfully. As far as an intervening act by nature is concerned reference is made to *Carslogie Steamship Co. v. Royal Norwegian Government*[46] where the plaintiffs ship suffered damage as a result of a collision caused by the defendants negligence. After temporary repairs had been carried out the ship sailed to America and suffered extensive damage in a storm. The defendants were held not liable for the damage because the damage was caused as a result of a "supervening event in the course of a normal voyage". It would not have been the case where the defendants had left the ship unseaworthy and applying such a principle to a person whose immune system has been damaged by the direct result of another's negligence it would be reasonable to argue that the disease had occurred as a result of the original negligent act and that the appearance of the infective agent was not a new intervention. In *Smith v. Leech Brain*[47] the plaintiff's husband had died as a result of contracting cancer as a result of being burned on the lip by molten metal. This burn had been treated and healed but due to the predisposition of the victim to cancer he had succumbed and died form a tumour. Lord Parker CJ held the defendants liable for the death saying:

> "The test is not whether these defendants could reasonably have foreseen that a burn would cause cancer and that Mr Smith would die. The question is whether these defendants could reasonably foresee that type of injury he suffered, namely the burn. What, in the particular case, is the amount of damage which he suffers as a result of that burn depends upon the characteristics of the victim".

This is clearly an eggshell skull rule case but comments made by Lord Parker in classifying the injury as the "burn" and the cause of death as the "cancer" caused by the burn differentiate it slightly and significantly in that it is recognised that the cause of death is unforeseeable but none the less a result of the harm. A person whose immune system is significantly damaged as a result of negligently inflicted nervous shock who later dies of an infection exacerbated by the weakened immune system is in effect as the ship left in an unseaworthy condition by the defendants. The principle was further recognised in *Jaench*

[45] This issue is very well documented in Dr Robert Sapolsky's book "Why Zebra's don't get ulcers, a guide to stress, stress related diseases and coping".
[46] [1952] AC 292.
[47] [1962] 2 QB 405

v. Coffey[48], where it was stated that foreseeability of any recognised psychiatric illness induced by shock should be sufficient, and the defendant need not foresee the particular illness developed by the plaintiff. The "cause in fact" approach has been described as a social policy issue based on who to blame, or more likely on who should pay compensation. This is over cynical and in error the cause in fact arises out of logical, even common sense approaches to liability and its overt simplicity is not sufficient ground for dismissing it. Clear to most people is the concept that "B" happened as a result of "A's" act or failure to act and allocating blame and subsequent penalty should not be avoided by philosophical argument or even public policy. Where there is culpability it must be addressed and the victims compensated.

The next significant case, *Hambrook v. Stokes Bros.*[49], took a step further, in establishing the principle that the sufferer of the shock need not have been the one directly threatened with death or injury. Although the physical manifestation of the shock was still a major factor in this case. Lord Porter in *Hay (or Bourhill) v. Young*[50] took the opposite view and coined a phrase which still applies as an element of today's thinking. The learned judge thought no person could be held negligent, indeed that he owed no duty of care, to those who did not possess the "customary phlegm". This exists today in the ordinary fortitude rule where a person may only have cause of action if the shocking event is of a severity that it would have acted upon the senses of those of ordinary fortitude. This is a throw back to the "British Bulldog stiff upper lip mentality" and such a rule owes far to much to the subjective to be commended as a test. The test for reasonableness, The man on the Clapham omnibus allows some leeway in its interpretation but while most would find it easy to agree on what is reasonable, at least in a populist way. Where the boundaries of ordinary fortitude begin and end is likely to involve widely varying views. This could be good reason to construct entirely new tests based solely on expert opinion and may mean that cases where the verdict is heavily reliant on expert testimony should perhaps also be decided by experts. Similar ideas are being mooted for fraud cases where the complexity of the evidence and the law is seen by many commentators to be too complex for the ordinary juror the ubiquitous reasonable man. This concept is in itself too complex to be entered into at this stage of the thesis and will be returned to at a later stage when considering future reforms.

To the present. The definitive case today on negligently inflicted psychiatric injury is *Page v. Smith*[51]. The facts of the case were as follows. On the 24th July 1987 Mr Page was

[48] (1984) 54 ALR 417.
[49] (1925) 1 KB 141.
[50] (1943) AC 92.
[51] [1995] 2 All ER 736. [1995] 2 WLR 644

driving his car in Bury St Edmunds when Mr Smith cut across his path in order to enter a side road. This action resulted in a collision between the two vehicles. Mr Page and his wife and child who were with him in the car suffered no injuries but both vehicles were extensively damaged. Despite the damage Mr Page was able to drive the car home but three hours later was overcome by fatigue which grew progressively worse and up until the case was heard in the House of Lords had not recovered. Mr Page had suffered from the controversial illness Myalgic Encephalomyelitis[52] prior to the accident but it was said to have been in remission and he was looking forward to returning to work as a schoolteacher it was asserted that the relapse was caused as a result of the accident.

In the court of first instance the judge Otton J. had held that it was not necessary for the defendant to have foreseen that his negligence could cause psychiatric injury and that all that was necessary was that some injury could be foreseeable. In a unanimous decision the Court of Appeal overturned this view and asserted that indeed it was necessary for the defendant to have foreseen the possibility of psychiatric injury. In addition to the finding Ralph Gibson LJ was not convinced that the plaintiff had proved that the relapse was caused by the accident.

The House of Lords reversed the decision of the Court of Appeal while supporting the following propositions:

(1) In cases involving nervous shock, it is essential to distinguish the difference between primary and secondary victims.

The principle was maintained that where the victim was classed as secondary i.e. that of a bystander he still needed to prove that shock would foreseeable cause psychiatric injury in a person of normal fortitude. The issue therefore would be in future cases extricating one type of plaintiff from the other.

(2) In claims by secondary victims the law insists on certain control mechanisms, in order as a matter of policy to limit the number of claimants.

The policy decision is formulated around the observation that in any incident the number of bystanders could and would be likely to outnumber the participants. This alerts the judges to the floodgates concept again.

[52] This condition is not recognised by many in the medical profession and is looked on with some scepticism by the public who know it as yuppie flu. There is some debate as to whether the illness is precipitated by physical causes such as the after effects of viral infection or whether it is a manifestation of a psychiatric affective disorder. In any case it was accepted as a genuine illness by the courts.

> (3) In claims by secondary victims, it may be legitimate to use hindsight in order to be able to apply the test of reasonable foreseeability at all Hindsight however has no part to play where the plaintiff is a primary victim.

Lord Lloyd referred to Ralph Gibson LJ in the Court of Appeal using hindsight to conclude that the lack of physical injury established that the accident was of moderate severity.

He concluded that this was in error referring further to Lord Bridge in *McLoughlin v. O'Brian:*

> "…an Acute emotional trauma, like a physical trauma, can well causes a psychiatric illness in a wide range of circumstances and in a wide range of individuals whom it would be wrong to regard as having any abnormal psychological make up".

> (4) Subject to the above qualifications, the approach in all cases should be the same, namely whether the defendant can reasonably foresee his conduct will exposes the plaintiff to the risk of personal injury, whether physical or psychiatric. If the answer is yes then the duty of care is established, even though physical injury does not in fact, occur. There is no justification for regarding physical and psychiatric injury as different 'kinds of damage'

This point hits the nail on the head and it can only be hoped it will now be driven home.

It is incredible that there ever has been a distinction between the 'two' types of injury. There has never been a period of history where psychiatric injury has been recognised at all that it has not been seen as debilitating. To draw such a distinction is absurd, it might just as well be argued that in an accident while it was foreseeable that a broken arm would occur it was not foreseeable that the victim might suffer a fractured skull and suffer its consequences. By the flawed logic of foreseeablity of psychiatric injury the victim of the fractured skull would have to prove the defendant foresaw this consequence or have the attendant broken arm to accompany his fractured skull before recovering damages.

> (5) A Defendant who is under a duty of care to the plaintiff, whether as primary or secondary victim, is not liable for damages

> for nervous shock unless the shock results in some recognised psychiatric illness. It is no answer that the plaintiff was predisposed to psychiatric illness Nor is it relevant that the illness take s a rare form or is of unusual severity, The defendant must take his victim as he finds him.

As the noble and learned Lord pointed out these propositions did not involve any radical departure form the law as it was left by Kennedy J in *Dulieu v. White*[53]. He said that it was important that the law should not take a step Backward as it would if it allowed the ruling in the Court of Appeal to stand.

Psychiatric injury as an injury in its own right, not just as an adjunct to physical trauma had come of age, albeit grudgingly where some were concerned.

This principle of "The Recognised Psychiatric Condition" as a prerequisite to any action for negligently inflicted nervous shock is further reinforced by the almost universal acceptance of it in all jurisdictions. Even in the litigious United States the courts expect to see more than anxiety, distress, fear and vexation. The courts there do not employ at least on the face of it the same rigid definitions of psychiatric illness preferring a seriousness threshold. While this in principle would not exclude a claim for something less than psychiatric injury as a rule a plaintiff would have to demonstrate some "damage" rather than just distress. Indeed in some jurisdictions in The United States the courts still prefer to see physical manifestations of the
shock *Champion v. Gray* [54], Florida; *Payton v. Abbott Labs*.[55], Massachusetts; *Corso v. Merrill*[56], New Hampshire; *Ramirez v. Armstrong*[57] , New Mexico; *Curtis v. State Department for Children and Their Families*[58], Rhode Island; This stance effectively putting these states of the United States back in the time of *Dulieu v. White*[59]. A more relaxed view has been adopted in California after the case of *Molien v. Kaiser Foundation Hospitals*[60] where the court required only proof of serious mental distress but the position with regard to worried well remains the same as it is here and the United States has so far shown reluctance to accept that its victims of the hGH treatment who have not actually contracted CJD and eligible for compensation. It is possible in California to recover

[53] [1901] 2 KB 669
[54] (1985) 478 So 2d 17
[55] [1982] 437 NE 2d 171
[56] (1979) 406 A 2d 300
[57] [1983] 673 P 2d 822
[58] [1987] 522 A 2d 203
[59] [1901] 2 KB 669
[60] (1980) 616 P 2d 813

damages for fear of contracting an illness, (*Potter v. Firestone Tyres & Rubber Co.*[61]) where the defendant had exposed the plaintiff to a potential source of a fatal illness, in this case a carcinogen, dumped on the land in violation of the law and company policy.

The plaintiff only has to demonstrate that:

> ..they have been exposed to the danger and that their fear stems from knowledge corroborated by scientific opinion, that it is more likely than not that they will develop cancer.....

That second requirement is not necessary where the defendant has acted maliciously.

In Australia where the parallel case of *APQ v. Commonwealth Laboratories and the Commonwealth of Australia* is being heard the principle is the same as in England as decided in *Bunyan v. Jordan* [62]. The plaintiff must have suffered a recognised psychiatric illness and the legal officer of The Commonwealth Department of Health and Family Services, Mr Brendan Jacomb has stated that the Commonwealth Government will be defending the action on the grounds that there is no cause of action in Australian law for nervous shock where the person is in fear of contracting a possibly fatal disease[63].

In New Zealand where there are two cases of iatrogenically transmitted CJD, a no fault insurance scheme is in operation which removes the need for litigation in a large number of cases. This, the Accident Rehabilitation and Compensation Scheme through its medical misadventure unit compensates the victims of medical accidents but their spokesperson, Corporate Secretary Barry Davis, has stated the organisations position on such cases[64]:

> "I am unaware of any situation where people "worried about the prospect of developing the illness have been compensated. Certainly the ACC would not have provided compensation where no physical injury occurred"

Dr G R Boyd of the Therapeutics section of the New Zealand Ministry of Health confirmed that no recipients of hGH/hGnH therapy had been compensated[65]. The plaintiffs here would have to meet the requirements of the rarity test in which there must be no more than one in a hundred chance of the illness occurring but more importantly the ACC will not

[61] [1994] Lloyd list, 4.3.94
[62] (1937) 57 CLR 1
[63] Commonwealth Department of Health and Family Services. 30.5.1996
[64] In a letter to the author Feb. 1996
[65] ACC. 27 Feb. 1996

consider a claim where a patient has been exposed to faulty treatment likely to cause illness (such as a blood product) unless and until some injury occurs. What is interesting in this statement is the implied old presumption that any psychiatric injury is an accompaniment to a physical one.

In France the Civil Code under Article 1382 provides that a person who causes damage to another through fault is liable to compensate that person[66]. The provisions of the French Civil Code do allow for a person suffering less than psychiatric injury *dommage moral* allows claims to be made for grief and anxiety while *dommage moraux*, allows a plaintiff to be compensated for "emotional distress", for the loss or injury to another to be compensated including in cases where the person has suffered no concomitant physical injury[67]. This on the face of it seems enlightened and progressive when compared to the other jurisdictions but in practice the requirement that an injury must be direct and certain[68] mitigates against any successful action by the worried well in France. Indeed while the French have compensated the recipients of the hGH treatment in France it is without prejudice and does not imply acceptance of liability. Germany follows the pattern common to most jurisdictions and uses the same terminology Under article 823(1) of the German Civil Code Injury to health must be a recognised psychiatric injury mere fright, anguish, distress or grief will not suffice. This is the extremely well established principle in *Hinz v. Berry* and *Alcock* et al and the matter was affirmed in an appeal case in the *Bundesgerichtshof* [69] in 1989[70] this case involved a family who had lost their son just before commencing a holiday. They claimed against the defendant for the loss of the holiday but failed as the court held that while they had suffered "grief and psychological pressure" the symptoms did not display the pathology required to constitute an injury under article 823(1)[71].

In Scotland the principle was established in *Wallace v. Kennedy* [72] that the pursuer must have suffered an injury that goes beyond "mere emotional reaction" this accords with the principles in English law and needs no more elaboration at this stage.

All the foreign jurisdictions will be returned to in the next chapter which considers the next test applied to psychiatric injury, that of shock suffered by secondary victims.

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[66] This includes damage caused by deliberate actions, negligence and carelessness
[67] Droit Civil, Obligations. 2nd Ed 1985. vol. 1, paras. 123, 146-159
[68] Article 1151, applicable to both contract and tort cases
[69] German Federal Supreme Court
[70] [1989] NJW 2317.
[71] BS Markensis. *The German Law of Tort.* 3rd Ed, pp.114-118.
[72] [1908] 16 SLT 485

The approach of the courts in most of the world to the problem of plaintiffs who fear the contracting of a fatal disease looks ominous to those under the head of worried well. There have been cases where a plaintiff has recovered damages for psychiatric injury arising out of a fear of contracting a disease. In *Vance v. Cripps Bakery Pty Ltd*[73] damages were recovered where the plaintiff contracted a phobic illness after consuming bread contaminated with mouse remains and in Canada in the similar case of, *Curll v. Robin Hood Multifoods Ltd*[74], where the dead mouse was in a bag of flour used by the plaintiff. The fears of these plaintiffs are unlikely to have been addressed in English law and as things stand the worried well in the hGH/CJD case may also never recover. Had the contamination of the growth serum been a part of the traumatic event then it might be different. The general rule for awarding damages for fear of contacting an illness laid down in *Potter v Firestone Tire and Rubber Company*[75]
made some logical sense although its preoccupation with cancer could give rises to problems:

> First the plaintiffs must establish that they have been exposed to toxic substance which threatens cancer.
>
> Second it must be shown that the plaintiffs fear stems from the knowledge, corroborated by reliable medical or scientific opinion , that it is more likely than not that they will develop cancer in the future due to toxic exposure.
>
> The more likely than not condition does not apply where the exposure was as a result of the defendants malice or fraud.

Where there are "worried well" plaintiffs this would make a fine general rule and could apply to more than simply cancer risks. Clearly the expert witness would play an ever increasing role in such cases. In the case of *The Plaintiffs v. The Medical Research Council et al* establishing the likely hood of developing the full blown CJD would rely on some highly specialised epidemiologists in degenerative brain disorders. The nature of the illness[76] could cause some problems in medical and scientific corroboration but from the point of view of the fear, the publicly known characteristics of the illness[77] certainly give grounds for this.

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[73] [1984] Aust. Tort Rep 80-668.
[74] (1974) 56 DLR (3d) 129
[75] [1994] Lloyds List 4.3.94
[76] Long incubation and unusual transmissible agent characteristics. Dr RG Will of the Creutzfeldt Jakob Disease Surveillance Unit at Edinburgh said " an assessment of the degree of risk is extraordinarily difficult" BSE and The Spongiform Encephalopathies. Churchill Livingstone. London 1992.
[77] Arising mainly from BSE coverage in the media.

The second part of the condition requiring secondary victims to have suffered injury as a result of or "induced by the shock" will form the subject of the next chapter. In the cases involving hGH/CJD this is of course the families, who in the case of group A have endured the extremely traumatic events of the development of the illness in their loved ones . For the group B plaintiffs their families are now faced with the distressing possibility of this terrifying disease hitting them in the future. These are justifiable fears considering the background history of the treatment and a rule such as that applying in *Potter v. Firestone Tyres & Rubber Co.*[78], should perhaps be adopted for such cases. For now it seems correct to conclude that the law is not likely to develop further without a different approach being taken to the idea of psychiatric injury itself. The public who can be vocal in their opposition to compensation for psychiatric injury need to drop some of the preconceived biases and see that injury to the mind can lead to just the same pain and suffering, and loss that physical injury can. Damages need to be explained better to make it clear that they are meant to compensate and that they are not a reward. Sadly the prognosis is poor. It is argued by many that the reason for the caution in developing the law further is that psychiatric diagnoses vary to widely anyway and that many health professionals will extend the diagnosis of conditions such as post traumatic stress disorder too far.

There are many that fear the floodgates opening if damages were to be awarded for anything other than a serious, and probably crippling psychiatric illness. On top of all this is the widely held view of the public at large that many of the claims are fraudulent with the plaintiffs milking the system and that should a less serious form of distress be actionable then there would be further encouragement of this. These concerns should be addressed as they are not all without merit. The problem with them is that they tend to make for an entrenched opposition to any development rather that contributing to any beneficial debate. This is undoubtedly an area where the expertise of the medical profession should combine with that of the lawyers to attempt to break some new ground. Otherwise there will always be those that suffer undeniable pains as a result of someone else negligence, but because they fall short of the recognised psychiatric injury, will never recover damages.

As a general rule for damages to be recoverable for psychiatric injury the injury must have been shock induced. That is to say that it must have been caused by a specific singular event that amounted to a "sudden assault on the nervous system", or..... "the sudden appreciation of a horrifying event which violently agitates the mind"[79] his has been the

[78] *ibid*. above
[79] *Alcock v. Chief Constable of the South Yorkshire Police* [1992] 1 AC 310.

position for most of the time that nervous shock has been a recognised head of damage. Gradual or continual stressors acting to cause psychiatric illness have until very recently not been considered to be actionable. This position is now in the process of changing and the accumulative effects of long periods of stress are now being compensated. In *Walker v. Northumberland CC*[80] a senior social worker Mr John Walker was awarded damages, later settled out of court, at £175,000 for stress he had suffered at work. He had been working on child abuse cases and was undoubtedly subjected to harrowing accounts of such practice day in a and day out at work His case load had increased from fifteen cases to eighty eight and despite requests that he be given assistance with them or that his case load be reduced he was left to cope alone. In November 1986 he suffered a nervous breakdown and despite this when he returned to work four months later his employer still failed to reduce his work load. In May 1988 Mr Walker had his second nervous breakdown which left him weeping uncontrollably, with insomnia, unable to think coherently and with attacks of anxiety. The court accepted the case made by Mr Walker's union UNISON that the illness was caused by stress and effectively accepted that the stress need not arise from a single event but may be the result of a continuing situation. The Unison spokesman later warned that all employers would now be responsible for subjecting their employees to stress that resulted in them becoming ill. On June the 12th a second social worker, this time in South Lanarkshire[81] was paid £66,000 in an out of court settlement after she had alleged that her employer had humiliated her and ignored her requests for help while she was deputy head of a home for the elderly in 1991 and 1992.

It remains to be seen whether such liabilities will rest with employers alone and undoubtedly cases will occur where other parties have been responsible for subjecting the victim to long periods of stress While there are very obvious dangers in such decisions it must be stated that while it has long been the position that defendant can be held liable for causing a physical illness to the plaintiff it would be absurd that allowing circumstances to continue which cause an eventual mental illness could not be actionable. To sustain the position that only shock induced mental illnesses were actionable would be the same as insisting that physical injury was only actionable if the result of a single impact on the body.

Primary victims of medical negligence who suffer a psychiatric illness as a result of the negligence will usually be able to recover damages without a great deal of difficulty. The only real issue in such cases will be causation. Secondary victims however, being close family usually but not in all cases necessarily, have a more daunting problem, which in the

[80] (1994) 144 NLJ 1659
[81] "Second social worker wins damages for stress related illness". The Independent, 12.6.96

case of the worried well's families will most likely exclude them from recovery. Secondary victims must pass three tests to succeed in an action for damages. The first of these tests are the two proximity tests and the first of these refers to who may be considered "relationship proximate". It is accepted in law that close family members would pass this test and for the purposes of this litigation it is only likely to be such people who would come forward as secondary victims of the admitted negligence. However the category is not strictly limited to close family members and those with emotional relationships. A rescuer such as a fellow worker in a works accident can fit the required degree of proximity. It is only however likely that such a person would succeed if they had been directly involved and were "event proximate" as well as having a commercial relationship. In any other set of circumstances they are likely to be held to be the mere bystander. In a recent case, *McFarlane v. E.E.Caledonia Ltd*[82] the courts took the view that a worker who was 500 meters away from an accident he witnessed could not succeed in an action for nervous shock because he himself was not in any danger nor were any of his loved ones. Stuart Smith LJ took the view that the plaintiff was a mere bystander and that the defendant owed no duty of care to such a class of person.

The Other Worried Well

This section is really a continuation of the previous one in that it is still concerned with the first principle of liability, that the plaintiff must have suffered a recognised psychiatric illness that, at least where the plaintiff is a secondary victim, is shock induced. However since the principle, while it is one in a list of seven, needs to be split for the purposes of analysis. This is because it clearly identifies two separate potential plaintiffs and separates them further by giving the secondary victim more hoops to jump through than the primary victim.

The boundary between primary and secondary victims is often indistinct and while some attempts were made to clarify this distinction in *Alcock v. The Chief Constable of The South Yorkshire Police, w*here the plaintiffs were secondary and *Page v. Smith* where the plaintiff was undoubtedly primary, the issue is still very much a live one. See conceptual opposition below.

The first principle is to a large extent repeated within the fourth principle section **c**[83] , "the means by which the shock is caused", and ties in with two other sub principles of relationship and event proximity. The principles are in the main inseparable in application. and seem to have been formulated as a safeguard against the veer present threat of the

[82] [1994] 2 All ER 1
[83] Law Commission Report 137

floodgates. They raise some formidable barriers to both types of plaintiff but in the case of the secondary victim seem at times almost totally exclusionary. How they will apply to the worried well and their relatives will now be looked at through the case histories in this area.

The recipients of the treatment with human growth hormone, as has already been mentioned fall into two categories. Group A who have contracted the disease and their relatives and Group B those in fear of its contraction. The court has already found in favour of the first
group mainly because the MRC and Department of Health did admit to a limited degree of negligence themselves. Damages are yet to be arrived at for this group and are expected in the late autumn. Those in group B are face with number of difficulties with regard to their own claims as has been described above. What is likely to be of more difficulty is the position of their relatives. They also are subject to a great deal of worry about the health of their loved ones and what the future may hold for them. Should they develop a psychiatric illness as a result of this worry they will have other problems to overcome. Anyone in this position is referred to as a secondary victim and their first problem is that the illness should have been shock induced. That is caused by a:

> "sudden assault on the nervous system or .....the sudden appreciation of a horrifying event which violently agitates the mind"[84].

The families of the worried well can have had no such shock to the system, not in legal terms anyway. There is no event as such to have caused the effect. This is yet another example of the law's need to keep up to date with the developments in psychology and psychiatry. The trauma induced injury is no longer seen a simply a response to one shocking event so it is not logical to have a law in place that treats it as such *Disorder of Extreme Stress*[85] is a disorder now being recognised. It is characterised by a long exposure to a series of stressors[86] usually of an interpersonal variety in many cases prolonged child abuse. Like PTSD its symptoms include Chronic affect dysregulation, Aggression towards self and others, Dissociative symptoms, Somatism and alterations of perception of self and others. General Adaptation Syndrome, described by Hans Selye of Montreal, is another condition brought about by exposure to a series of, some times unspecific, stresses. This illness which is divided for classification purposes into three distinct stages. The alarm reaction, the stage of resistance and the stage of exhaustion can have fatal consequences as

[84] *Alcock v. Chief Constable of The South Yorkshire Police*[1992] 1 AC 310.
[85] Van Der Kolk BA. Psychological Trauma. Washington DC. [1992] Am. Psychiatric Press.
[86] Herman JL. A Syndrome of Survivors of Prolonged Stress. Journal of Traumatic Stress [1992] 5: 377-391

the extended periods of stress can cause somatic effects disturbing homeostasis which may precipitate fatal diseases, that are known as diseases of adaptation.

In requiring a secondary victim to have been exposed to a sudden assault of the senses the law seems to adopt the position that such diseases do not exist. If these diseases, recognised diseases, are caused by the defendant's negligence, and they are foreseeable as a consequence
of the negligence, excluding them because of a possibly outdated test seems very unfair. In *Sion v. Hampstead Health Authority*[87] the plaintiff spent fourteen days attending his son's bedside he had been injured in a road accident but the action was in medical negligence. The plaintiff watched as his sons condition got worse and as a result suffered a psychiatric illness.

The fourteen days spent at the bedside were not considered to be sufficiently shocking compared with the events in *Tredget and Tredget v. Bexley Health Authority*[88] where the parents recovered damages for psychiatric injury when their child was killed as a result of medical negligence. The parents were at the scene of the negligence and suffered the immediate consequences so to speak satisfying the sometime bizarre rules applying to how psychiatric injury occurs, or at least is perceived by some to occur. In *Sion* the father as a secondary victim to the alleged negligence the plaintiff could not demonstrate that the illness was shock induced. While Sir Thomas Bingham MR had reached a conclusion in *Newham v London Borough Council*[89] that a plaintiff's case should not be struck out because the condition was not caused by any such sudden shock. In *Sion* the Court of Appeal interpreted the victim in *Newham* to be a primary victim and the father in *Sion* to be secondary victim and therefore subject to the ruling. Unfortunately this meant that the courts should continue, until the House of Lords thought otherwise, to follow the ruling that any secondary victim suffering from a negligently inflicted psychiatric injury must have had that injury inflicted by a shock. Since in this case the illness arose from a continuing awareness on an inevitable event and not from a sudden appreciation by unaided senses the action failed. In *Taylor v. Somerset Health Authority*[90] the plaintiff was a secondary victim. She had suffered a psychiatric illness a result of the health authorities negligent treatment of her husband who had died of a heart attack. Mrs Taylor did not witness the actual attack and was informed of her husbands death when she arrived at the hospital later. She had failed the event proximity test and because of the ruling that the communication of bad news could not give rise to a cause of action she failed to recover damages. The

[87] [1994] 5 Med. LR 170
[88] [1994] 5 Med. LR 178
[89] [1994] 2 WLR 554
[90] [1993] PIQR 262

negligence for which the Department of Health accepted liability was in the treatment with the growth hormone on children and their relatives are unlikely to pass the event proximity test. They were not involved directly in the treatment. A more important factor is that they only became aware of the dangers of the treatment by the defendants themselves informing them. An obvious paradox arises here. The health authority cannot as a matter of policy be liable for giving bad news[91]. In this case they are giving bad news about an event for which they are responsible. The court has found in the first part of this action that they were liable in negligence for the illness contracted by the group A plaintiffs.

If the worried well or plaintiffs in Group B have grounds for any action here it cannot be fair that their relatives, persons with a tie of love and affection to these primary victims, should not also have any grounds for action. Unfair or not, the recovery of damages by those who suffer psychiatric injury as secondary victims looks unlikely. In *McLoughlin* Lord Wilberforce was stated that the victim must have received the shock through sight or hearing of the event or its immediate aftermath. His Lordship also made it clear that the plaintiff could not recover where this shock had arisen from being told of the event. This decision was the one accepted in *Alcock* although there had been two earlier decisions in *Hevican v. Ruane*[92] and *Ravenscroft v. Rederiaktiebølaget Transatlantic* where damages were awarded because the injury sustained, although relayed by a third party, fitted the time honoured principles of causation and foreseeability. This looked like a move in the right direction and one based on sound established law but the decision in *Ravenscroft* was later reversed by the Court of Appeal[93].

The relatives of the worried well, if they do sustain psychiatric injury will not have been present at the event or its immediate aftermath and will fall foul of the third party informer rule. This is yet another rule which seems to have arisen out of a fear of opening floodgates. It makes no sense in practice as can clearly be seen in the case of *Schneider v. Eisovitch*[94]

In this case the plaintiff was allowed to recover for psychiatric injury as well as her physical injuries sustained in a car crash. Her psychiatric injury was precipitated by being informed of her husband's death. She had been unconscious immediately after the accident and would have to have been told of the death by a third party as her unconsciousness prevented her from seeing or hearing the event or its immediate aftermath. The court held that the plaintiff being informed by a third party to be a natural consequence flowing from the defendants breach of duty. But for the negligence of the defendant she would not have

[91] *Alcock v. Chief Constable of South Yorkshire Police* [1992] 1 AC 310
[92] [1991] 3All ER 65
[93] (1992) 2 All ER 470
[94] [1960] 2 QB 430

had to be told of her husbands death. A secondary victim, a person with a tie of love and affection, in *The*
Plaintiffs v. The Medical Research Council of The United Kingdom and the Secretary of State for Health [1996] is likely to have years of stress arising out of the understandable worry for their loved one and perhaps the provider for the home. As has already been mentioned the worry arises out of the threat of contracting a very unpleasant disease. If this causes an illness such as *General Adaptation Syndrome* or *Disorder of Extreme Stress* then the person or organisation that brought that threat into being should not escape liability because of this event proximity rule.

In other jurisdictions compensation is recoverable by the primary victims relatives. In Germany a relative who suffers psychiatric illness as a result of being told of an accident involving a loved one may recover. The courts decide the case on whether the chain of causation can be established and that the damage would be foreseeable. This ruling goes back to 1931[95] and must have been very progressive for its time. This court recognised, what could be said to be the obvious, that a mother would suffer great emotional stress as a result of the death of her children in an accident and that it would be entirely reasonable that she may suffer a nervous breakdown as a result of such emotional distress. The decision was upheld in 1971 in the *Bundesgerichthof*[96] when it was decided that an award of damages would not be confined to a relative who had witnessed the accident, what in England would be event proximity, but that a relative informed later should also recover if the nexus between the negligent event and the plaintiffs psychiatric injury was established. In 1985 a plaintiff who was unborn at the time of the negligence recovered damages for physical injury because her birth was adversely affected by her mothers psychological state which had been brought about by being informed of her husband's death in a traffic accident[97].

The German courts have made it plain that if a person's death is their own fault then no claim could succeed. It would not be practical to require that a person took care to avoid injury solely to prevent a loved one suffering psychiatric injury as a result of their death.

In France a secondary victim may be compensated under the principle of *dommage par ricochet*. This is a category of the *dommage moraux*[98] and allows damages to be recovered for grief. Again causation rules temper the actions.

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[95] *Reichsgericht* [1931] 133 RGZ 270
[96] [1971] BGHZ 163
[97] [1985] 93 BGHZ 351
[98] Starck B. *Droit Civil, Obligations* (2nd Ed 1985). vol. 1 para. 123, 146 -149

In the United States provision is made in principle to compensate a secondary victim in a case such as the hGH/CJD litigation, that is where the fear or apprehension of the harm to another causes psychiatric injury in a secondary victim. Such cases involve a well defined category of relative who may recover and a close analysis of both the foreseeability of the damage and of its severity[99].

The Commonwealth countries in the main take the same view as the English Courts that the secondary victims injury must be shock induced and that the proximity rules must be applied. When a Canadian court of first instance attempted to break new ground in *Rhodes v. Canadian National Railway Co.*[100] by allowing damages to a mother who had been subject to hours of anxiety following a train crash which involved her son and who was later informed by a third party of his death, the decision was forcefully rejected by the British Columbia Court of Appeal where Wallace JA restated the position that the event and relationship proximity test was the correct test to be applied.
In Ireland the aftermath has been extended beyond the "immediate" and allows for a secondary victim to recover when they have been informed by a third party[101], and *Kelly v. Hennessey*[102]

The possible lessons for English judges to learn are readily seen in other jurisdictions and there are many areas where an updating and redefining of any tests to be applied to a plaintiff is needed. These issues involve complex argument and a more thorough understanding of the types of damage encompassed in psychiatric injury. They will be dealt with in more detail at a later stage in the thesis when future developments and possible reforms are considered.

Other Developments in PTSD Litigation

The Court of Appeal in *Frost and Others v. The Chief Constable of South Yorkshire Police and Others*[103] considered the relationship between employees and employers and between rescuers and bystanders again and found in favour of the appellants who were four police officers whose original claim for psychiatric injury had failed in the court of first instance. In the Court of Appeal Rose LJ and Henry LJ agreed that a duty of care was owed to the officers as employees and rescuers with Judge LJ dissenting. The basic principle was that the officers were either owed a duty of care because of the master and servant principle

[99] *Hunsley v. Giard* (1976) 553 P 2d 1096 (Washington)
[100] [1989] 49 CCLT 64
[101] *Mullally v. Bus Eireann* [1992] ILRM 722
[102] [1993] ILRM 530
[103] TLR 6.11.96 QBENF 95/0658/C.

which would make them primary victims of the disaster or that if they were to be regarded as secondary victims in that they were not in immediate fear of their lives then in the case of three of them at least they were rescuers. There is some considerable resistance to the idea that professional rescuers should be able to recover damages while the family members in the related case of *Alcock v. Chief Constable of South Yorkshire Police* had failed. In *Piggot v. London Underground*[104] four firemen had recovered a total of £34,000 for suffering psychiatric injury as result of the Kings Cross fire. The newspapers and in particular the Daily Telegraph expressed strong disapproval at the concept of compensating firemen who's job it was to encounter such disasters. Its article stated:

> The concept of seeking damages for stress incurred in the course of professional duties seems to us unworthy and distasteful. Indeed we would argue that men and women who find the stresses of dangerous but respected and rewarding jobs too much to bear should simply seek different employment....[105]

Again the argument arises that exposure to a severe stress inducing illness is best dealt with by a brisk application of the stiff upper lip. The Princess Royal in one of her recent speeches said:

> "Most people were sufficiently intelligent to cope with stress without counselling"[106]

She further suggested that Post Traumatic Stress disorder might be no more than a convenient label for a common problem. It is a fascinating opinion. What it, along with other knee jerk
reactions to stress injuries fails to address, is that no emergency worker is seeking this "reward" for their ordinary duties but is seeking redress for their employers negligence. There would be no need to compensate any of these workers if it had not been established first that the person who owed them a duty of care had been below standard when delivering that care. Rose LJ in *Frost and Others v. The Chief Constable of the South Yorkshire Police* stated the principle clearly:

> " The scope of duty owed by the employer is the same whatever the nature of the employment, namely to take reasonable care to avoid exposing the

[104] (1990) FTLR 19.12.90
[105] Daily Telegraph. Leader Article. 20 December 1990
[106] Press release extract from the European Conference on Traumatic Stress in Emergency Services, Peacekeeping Operations, and Humanitarian Aid Organisations. Sheffield. 17th 20th March 1996

> employee to unnecessary risk of physical or psychiatric injury. The normal working of stevedores and steel erectors, like that of police officers exposes them to the risk of death or serious injury. This is part of the hazard of the job, but it does not exonerate the employer from the need to take reasonable care towards his employees".

Another consequence of the quaint line of thought that these people are only doing their job is that the adoption of the stiff upper lip is actually a contributory factor to stress related illness. Studies done of returning Vietnam veterans put the high rate of alcoholism and suicide down to attempts at inappropriate coping strategies and lack of adequate care[107]. While the *Plaintiffs v. Medical Research Council of The United Kingdom and The Secretary of State for Health*[108] is not a case involving employees or rescuers it is not difficult to apply the same principle where the defence of acceptable risks and development risks in medical treatment are concerned. All medical treatments especially experimental and revolutionary ones involve an element of risk indeed so do long established ones which is why there is an issue of informed consent at all but what would be unacceptable is if this risk was applied as a built in catch all defence to exonerate practices which fell below the expected standard of care of health professionals. Perhaps the best solution to the problem of inconvenient legal actions for psychiatric injury is for the prospective defendants simply not to be negligent in the first place.

The accident at Hillsborough was a national disaster and is by definition thought to convey much more horror, fear and sadness than a much more localised and personalised "disaster". In principle this can be broadly agreed with although it may be much harder for a victim of an individual tragedy to see this. The contamination of a tissue product by an invariably fatal and devastating disease, not only to its victims but their families, should surely be seen in the same light as Hillsborough. Ninety five people died at Hillsborough because the standard of care that the public expect of the police was not delivered. A further seven hundred and thirty were injured. In the hGH treatment more than eighteen hundred patients were treated for restricted growth alone with many more having been exposed to a similar threat from fertility treatments employing hGH and hGnH tissue extracts. The potential for disaster is very real. In *Frost v. Chief Constable* the expert witness Professor Sims described the circumstances of all the plaintiffs as such:

(They)

> "were all among those who were intimately involved with one

[107] Sparr L. Pankratz L. Factitious Post Traumatic Stress Disorder Bull Am Acad. Psych. Law
[108] QBD 1994 N-05086 Trial transcript

> or more aspects of the disaster itself and were therefore exposed to the psychological trauma of that occasion to a varying but significant extent"

The recipients of the hGH treatment could also be described in similar fashion.

Lord Justice Henry said of the plaintiffs in that case:

> "That so many were affected reflects the nature of events sufficiently potent in their horror to cause PTSD"

The possibility of contracting a disease, even a fatal one, may not in the normal course of events be outside what is considered outside the range of human experience[109]. That so many may have been infected, with a disease of this ones horrific characteristics, by a defective treatment is.

Another of Professor Sims' points in relation to the plaintiffs in *Frost* is that the nature of the trauma is not instantaneous horror but rather prolonged exposure to horrifying and uncontrollable circumstances. Professor Sims is of the opinion that :

> "The longer the exposure to a traumatic situation the greater the degree of psychological distress subsequently"....

The differences are clear between the two disasters. Hillsborough is seen as a disaster with all the attendant characteristics, ambulances, police, bodies seen lying around relatives in distress at the information points and sensational news reporting, The hGH treatment is not. It is quiet and its effects are isolated with the individuals. They are not perceived as a sprawling mass of humanity they were absorbed into the community by the time the damage was known.

The similarities are largely ignored. A duty of care owed to the injured a breach of that duty by a failing in acceptable standards, many casualties, many traumatised, a lack of adequate explanation by those responsible and the feeling of betrayal that occurs when a trusted body of individuals, in *Frost*, the Police, in *The Plaintiffs*, the Health Service, fails. While the worry about serious illness and even death are obviously part of "life's rich pageant" it

[109] In "Tort Liability for Psychiatric Damage" Mullany and Handford (1st Ed. 1993 p.35) the event is described so: The American literature currently defines PTSD as requiring exposure to a psychologically distressing experience that is outside the range of usual human experience (so common experiences such as simple bereavement , serious illness business and financial loss and marital conflict will not suffice) This is a reference to *DSM IIIR* and this requirement is no longer necessary since the publication of *DSM IV*

seems incredible that, should they arise by the negligence of one who owes a duty of care , that there should be any question of limiting access to redress and compensation.

In final points made by Judge LJ there was a reflection on the apparent injustice of the case suggested by newspapers and the like that it was grossly unfair that paid rescuers may recover while the families could not, Judge LJ, saying:

> "Finally I am aware that many people regard it as fundamentally unjust that the police should recover damages for PTSD sustained on that terrible day while the relatives claiming in *Alcock* failed.
> While respecting their feelings of disappointment that the relatives failed, we in this court can only consider whether these plaintiffs should recover on the different principles of law that apply to them. In my judgement they should, and that conclusion cannot properly be affected by my sympathy for the relatives.

Could this be a backhanded concession that the rules on relatives recovery were perhaps wrong?

The Factor Eight Affair

While other issues are considered it seems a suitable time to take a brief look at a case involving iatrogenic transmission of a fatal illness by what appears, at least on the face of it, of a lower standard of care than should be expected of the Department of Health. During the nineteen eighties a blood product known as factor eight was imported from the United States for the treatment of Haemophilia. The period during which this treatment was carried out coincided with the health scares about the newly perceived danger of a relatively new disease, Acquired Immune Deficiency Syndrome, AIDS. It is not intended to examine culpability for this series of incidents within the body of this text but some comparisons can be made about the Health departments attitudes to these events. From the very beginning the Department sought to deny any responsibility for the accident and more interestingly to distance itself from the events. The usual cry of alarm as heard that to settle the claims would result in a floodgate opening. Months of campaigning were required before the government would concede any compensation payment to the victims and even then the compensation was paid without accepting liability. This compensation was offered in amounts considered derisory by the victims and their families and increased incrementally as pressure was put on. When the compensation deal reached a figure of £21,000 for a child to £60,000 for an adult with a family of two children it involved agreement from the victims that all further legal action would be dropped. William

Waldegrave, the Secretary of State for Health at the time, said that the compensation was a fair amount based on discussions with the victims lawyers but the Secretary of The Haemophiliac society rejected this saying the figure were derisory. While the case was eventually settled out of Court the Ministry of Health still went ahead with unnecessary proceedings based on the opinion of Kenneth Clarke that the department had a duty to care for the citizens of the United Kingdom, as well as a legal prerogative, to deny responsibility for medical accidents. Mr Clarke again suggested the floodgates argument was relevant saying that the would be grave consequences of a settlement establishing a precedent of paying compensation where no blame attached. Mr Justice Ognall stated in reply that:

> "......The haemophiliacs are a special case. All are entirely blameless.
>
> .....Compromise does not necessarily betoken any admission of blameworthiness....."

This view was endorsed by lawyers who equated the case to the Herald of Free Enterprise and the Kings Cross fire where out of court settlement were reached without any concessions of liability. As stated above the case was eventually settled this way but only after protracted legal wranglings which cost the very people Kenneth Clarke had a "moral duty to protect" a very great deal of money. The floodgates argument, dangerous precedent argument, public policy argument or whatever else it is described as is a very poor excuse for a defence and where the state is negligent provision should be made out of public funds to compensate the victims. This view may be out of fashion in a society where the public are encouraged to look after their own affairs through private health insurance and prudent management of their money but hiding behind a facade of "moral duty" or legal prerogative is hardly a moral position, or in the end a politically expedient one. During the Factor Eight litigation the Secretary of State attempted to use the issue of Public Interest in order to prevent disclosure to the plaintiffs lawyers of documents relating to the issues in contention[110]. This sort of thing is entirely wrong and as it is in the government's view for a defendant in criminal trial to withhold information on which he may later rely on in his defence. Perhaps the judge in a civil trial should apply the same logic and infer guilt where there is failure to answer any question. Public interest immunity where national security is concerned is one thing and it is easy to understand it being a necessary condition in some circumstances, where perhaps it is to protect the identity of some one at grave risk. It is extremely difficult however to imagine that it is meant to be used as a method of avoiding responsibility for negligence. the government and not just the present incumbents have always sought to avoid the issue in all cases of disasters that in some way involve their

[110] The Guardian 28.9.90. HIV, Haemophiliac Litigation

departments this avoidance takes several forms from the refusal to hold a public enquiry through ministerial abrogation of duty and even to the extreme cases of a cover up. It is clearly a state of affairs that no government anywhere could be proud of.