VIETNAM VETERANS
ASSOCIATION OF AUSTRALIA

SUBMISSION TO THE REVIEW COMMITTEE OF THE VETERANS' ENTITLEMENT ACT

Part 8

STANDARD OF PROOF

AND

STATEMENT OF PRINCIPLES

19 April 2002

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"…we say to them 'You go and fight, and when you come back we will look after your welfare" '

Prime Minister Billy Hughes 1916

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Introduction

Aim

This paper will focus upon issues and anomalies arising from the Veterans' Entitlements Act 1986 (Cth.)("the Act"), Part II – Pensions, Other Than Service Pensions, For Veterans And Their Dependants, Section 120A.

Organisation

The VVAA submission considers these issues under the following headings

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Origin of the Standard of Proof

The situation prior to 1 June 1994

Prior to the introduction of Section 120A of the Act, a veteran who made a claim for the acceptance of a medical condition as being war caused, was (and still is) required to satisfy a number of specific Sections of the Act. These include requirements as to eligibility[1], the existence of an injury or disease[2] and when an injury/disease shall be taken to be war caused[3].

History of the Standard of Proof

Section 9(1)(b) of the Act states that an injury/disease suffered by a veteran shall be taken to be a war caused injury/disease, if: *'the injury suffered or disease contracted, by the veteran arose out of, or was attributable to, any eligible war service rendered by the veteran;'.*

Section 120 of the Act refers to the requisite [reverse criminal] Standard of Proof for claims under Part II of the Act, in that the Repatriation Commission shall determine that the injury/disease/death was war caused '*unless it is satisfied beyond reasonable doubt, that there is no sufficient ground for making that determination'.*

The concept of the Standard of Proof was first introduced into the area of veteran's claims in 1935 at the level of appeal[4]. Section 39B of the Australian Soldiers' Repatriation Act 1920 (Cth), required the Commission to '*give the appellant the benefit of any reasonable doubt in hearing appeals from the Board,*'[5]. In 1943 that Section of the then Act amended and extended the '*benefit of any reasonable doubt*' wording through an attenuation of its scope and as to '*all reasonable inferences in favour of the claimant*'[6]. The reverse criminal '*beyond reasonable doubt*' standard of proof was introduced in 1977 pursuant to Section 47(2).

In the early 1980's the Federal Court made a number of decisions interpreting Section 47(2)[7] and legislative amendments were introduced in 1985 and re-enacted in the 1986 Act. The '*reasonable hypothesis'* concept was introduced as a distortion of the '*beyond reasonable doubt*' wording and it undoubtedly represents a significant tightening of the concept, particularly when viewed in the light of the original '*benefit of any reasonable doubt*' standard.

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Introduction of Statements of Principle (SoP)

Bushell v Repatriation Commission

The 1992 High Court of Australia decision in 'Bushell'[8], provided some guidance as to the interpretation of the '*reasonable hypothesis*' standard of proof, however the Government of the day was not content to leave the rules as they were and appointed a Committee to look into the legislation[9].

The Baume Committee

The 'Baume Committee' made a number of suggestions including the replacement of '*reasonable hypothesis*' by a modified form of the civil, '*balance of probabilities*' or '*reasonable satisfaction*' standard. A further degradation of the '*reasonable'* part of the '*reasonable hypothesis'* occurred when it was decided to implement refinements aimed directly at the medical and scientific element in an hypothesis.

The Repatriation Medical Authority

The Repatriation Medical Authority (RMA) was established to create Statements of Principle whose function is to provide rules as to both the diagnosis of a condition and as to those factors that must exist to establish the causal connection between an injury/disease/death and eligible service. SoPs are '*disallowable instruments*'[10].

Section 120A of the Act 'Reasonableness of Hypothesis to be Assessed by reference to Statement of Principle ("SoP")'was enacted with effect from 1 June 1994.

Appeals

As the intention was to make SoP's binding on decision makers at all levels, the legal avenues for appeal are limited and usually made on those points where the Courts have provided some specific interpretations of the application of an SoP. Requests may be made for the RMA to investigate or re-investigate any SoP[11] and there is a right to request a further review of the decision of the RMA to the Specialist Medical Review Council[12].

SoPs as an alternative to removal of the "reasonable hypothesis"

The SoP system was introduced as the preferred alternative to the removal of the '*reasonable hypothesis*' Standard of Proof and on the basis that the Government of the day believed that 'rorting' of the system was taking place. It was felt that the decision in 'Bushell' would lead to too much 'doctor shopping' by veterans.

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Introduction of Statements of Principle (SoP), Continued

Ethics in the claims environment

The Vietnam Veterans Association of Australia has been concerned for some time that on the anecdotal evidence and advice of Government, a few advocates and veteran representatives were manipulating claims to achieve outcomes that were well beyond what should reasonably have been expected.

The ethical pursuit of just outcomes has been a core principle of the VVAA, and this is reflected in our methodology of approach to all issues and particularly the input and contribution made by the Association to the Training and Information Program, the Veterans Indemnity and Training Association and the Statement of Ethics established as a result.

The VVAA philosophy is that benefits are provided for those who have suffered genuine injury, illness or death as a result of their service, and that those making false claims not only make it more difficult for the genuine veteran to obtain proper support, but also reduce the funds available to provide for those in need.

Practical outcomes

Instructions from the Association to its veteran representatives requires that those representatives act responsibly and ethically, that they properly represent the veteran and that they decline to act for any individual who knowingly falsifies or misrepresents their situation.

Reported rorting not acted upon by DVA

On more than one occasion, however, the VVAA has made Departmental officers aware of situations where it believes that veterans and their representatives have grossly distorted the facts to obtain greater benefit from the public purse. Evidence and statements have been provided.

Investigative action by the Department has appeared to the VVAA to be half-hearted at best, and without any apparent will by DVA to seek the truth or to deal with those who have apparently assisted with, lied or distorted the facts.

The VVAA perception

The divergence between the policies of the Department in this regard, and its actions, makes it difficult for genuine veterans and organisations who support ethical behaviour, to understand why other means are sought to correct perceived 'rorting'. The VVAA sees the failure to properly pursue the rogues as a break-down in standards within the Department of Veterans' Affairs.

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Analysis of SoPs

Sound scientific, but very mainstream medical standards	It has been argued by the Department that the provision of a guide to the basis of a claim, predictability, improved consistency and other efficiency-based outcomes are key advantages of SoP's. The RMA's 'sound medical and scientific' investigative focus also implies the inclusion of the most up to date medical and scientific expertise and knowledge. On the other can be argued that the requirement of a sound medical / scientific basis for the establishment of both the diagnostic and causal requirements of each SoP, necessarily limits the scope of the SoP system to reliance upon mainstream theory.
Single medical opinion subject to the judgement of the RMA	The Minister of the day suggested that the opinion of a single medical expert could still be maintained, subject to its having a sound medical-scientific base[13]. The sound medical-scientific definition is to be found at Section 5AB(2) of the Act and whether it is met is dependant upon the available evidence. As that decision is left to the judgment of the RMA itself, it is therefore not subject to scrutiny in terms of the Standard of Proof legislated requirements, although once a SoP is passed into law it is enforced pursuant to S120A.
Construction of the SoPs reduces the scope and coverage of the standard of proof	An example is the decision previously made concerning the non-acceptance of obesity in its own right as a medical condition, based upon the opinion of the RMA. There is evidence available to the contrary and again the sound medical / scientific test is an internal RMA decision only able to be appealed to a further medical panel and neither of these panels being formally subject to the beneficial standard of proof requirements that apply thereafter. The construction of SoP's is therefore a less obvious way of further reducing the scope and coverage of the Standard of Proof.

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Analysis of SoPs, Continued

Intellectual integrity of the instruments

An important criticism of these instruments is that they are lacking in intellectual integrity. The basis of a claim is a medical matter, the medical professions are the most eminent experts in the field and the subjugation of medical opinion to strict and binding legal rules is therefore not justifiable.

Illustrative examples of the absurdity of the system are:

- if there are two veterans whose 'trauma' evidence is the same, apart from there only being one days difference in onset of the initial symptoms , then one may succeed and one may fail to meet the requirements of the SoP definition; and
- the acceptance of the existence of a psychiatric condition pursuant to an SoP, is predicated upon **objectively** establishing the real threat associated with the stressor. Two good illustrations are situations where a soldier on patrol is surprised by the sudden emergence of a number of Vietnamese wearing in black pyjamas who turn out to be 'friendlies' or a where a soldier who is woken suddenly by noises in the dark that turn out to be a monkey inside his tent. Clearly these events have an objective basis, but to determine matters on the 'objective' basis of the threat itself is hair splitting and plainly stupid. .

Veteran problems often fall outside mainstream medical knowledge and opinion

The VVAA notes that it was only the dogged actions of veterans themselves that initiated further research into and recognition of the effects of Post Traumatic Stress Disorder – despite the huge body of knowledge gathered from World War One and World War Two about this issue. The outcomes of exposure to dioxins and herbicides were steadfastly denied by the establishment for years, again despite the overwhelming evidence.

The fact is that many of the problems faced by veterans fall not within the mainstream of medical opinion, but on the periphery. Perhaps this is because so few medical specialists have actually seen or under-gone the traumatic events. There are two further significant contributors. Experiments and activities conducted within the context of a war or war zone are often undocumented. Their existence may be deliberately masked, veiled or hidden from view. Medical records within the military are fragmentary and incomplete at best, and the evidence available to the veteran community indicates that this standard is not improving – it may well have declined.

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Analysis of SoPs, Continued

Veteran problems often fall outside mainstream medical knowledge and opinion, continued

The VVAA has been attempting for years to have multiple micro-traumata accepted as a causal factor in injuries such as lumbar spondylosis and degradation of lower limb joints.

We believe that carrying loads of up to 40kg, running in boots, climbing up and down steel ladders, moving stores and equipment and flying in service aircraft which vibrate heavily are all examples of activity that are common within the services and they are examples of activities that cause damage to the individual.

Yet because there is only a limited body of current medical or scientific MMT knowledge, any claim based on these factors will fail because there is no single traumatic event as required within the SoPs.

The RMA and the Commission have declined to investigate on the basis that there is no evidence or that any evidence that does exist is inconclusive – a circular argument at best. It also defies the evidence overseas and in Australia accumulated by the military in training units such as the Recruit Training Battalion at KAPOOKA and which has led to major changes in the conduct of physical training tests because of the trainee attrition rates. This evidence is not available to the veteran community but may be available to the Review Committee.

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SoPs In Practice

Introduction

In the period leading up to and since the introduction of the SoP system in 1994, there has been considerable debate about its effect in practice and including a review conducted by Professor Pearce into whether the objectives of the 1994 amendments to the Act had been achieved.

VVAA contends that anomalies exist

It is the submission of the VVAA that the system itself contains a number of anomalies that result in inequities between a pre and post SoP claimant, one who is not subject to an SoP as compared with one who is, and as between different claimants.

Conflict between medical and legal principles

A key problem also identified by the Commonwealth Administrative Appeals Tribunal is the apparent conflict between the application and use of medical principles by medical experts, as compared with the legal principles in respect of the SoP's.

Example of the medico/legal dichotomy

An example of this is the application of the phrase '*witnessed, experienced, confronted*' a part of the definitional requirements for psychiatric disorder SoP's.

On the one hand the phrase has been interpreted as limited to the situation where a veteran is '*present, directly observed, was faced with*' etc, whereas from a medical perspective such a narrow intent has been disputed, i.e. the phrase contemplates '*hearing about events from others or on the radio*'; which are proximate rather than absolute associations.

Replacing "malevolent environment" with an object-ive test disadvantages the disadvantaged

A DSM-1V[15] sub-committee was involved in the development of the diagnostic criteria for psychiatric disorders and particularly PTSD. An RMA 'Consensus Conference' was held in 1998 to further discuss the definitional issues.

The '*general milieu of a harsh or malevolent environment*' war stress factor was recommended but not included in the PTSD or any other psychiatric disorder SoP on the grounds that there was insufficient '*sound medical or scientific evidence*' available to warrant its inclusion.

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SoPs In Practice, Continued

Replacing "malevolent environment" with an objective test disadvantages the disadvantaged, continued

The inclusion of an **objectivity** test for the existence of a 'stressor' was intended to avoid reliance solely upon perception (or subjectivity), although the result is that it has placed an obligation on the veteran to identify, validate and define the existence of, and the adverse nature of the stressor.

The limited nature and inadequacy of Defence Force records is a pointer to the difficulties a veteran has in attempting to meet the requirement. Generally low levels of education and intellectual achievement may also act against the common soldier, sailor or airman in being able to identify and articulate specific stressors, even though such stressors may well exist.

Dichotomy between "normal" medical diagnosis and the diagnostic requirements of the SoPs

Whether a medical diagnosis is limited to the terms set down by an SoP has also been a matter of much legal debate, although in recent times the Courts have given some more detailed guidance on this issue[14]. The crux of this issue is about the difference between medical diagnosis and the diagnostic requirements of an SoP.

The claim for the acceptance of a psychiatric condition requires a diagnosis and a medical expert is relied upon in all cases for confirmation. The medical profession uses a number of tools to assist with this task. The following discussion is drawn from excerpts of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM) website and the extensive experience of the VVAA panel in the obtaining of diagnosis under the DSM IV and applying it within the existing legislative framework.

DSM IV defined

DSM IV is the standard classification of mental disorders used by mental health professionals. The DSM consists of three major components: the diagnostic classification, the diagnostic criteria sets, and the descriptive text. DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition), published in 1994 was the last major revision of the DSM.

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SoPs In Practice, Continued

Diagnostic label and code

Associated with each diagnostic label is a diagnostic code, which is typically used by institutions and agencies for data collection and billing purposes. These diagnostic codes are derived from the coding system used by all health care professionals in the United States, known as the ICD-9-CM.

Diagnostic, inclusive and exclusive criteria provide consistency of diagnosis

For each disorder included in the DSM, there is a set of **diagnostic criteria** that indicate what symptoms must be present (and for how long) in order to qualify for a diagnosis (called '*inclusion criteria'*) as well as those symptoms that must not be present (called '*exclusion criteria*') in order for an individual to qualify for a particular diagnosis.

Many users of the DSM find these diagnostic criteria particularly useful because they provide a compact encapsulated description of each disorder. Furthermore, use of diagnostic criteria has been shown to increase diagnostic reliability (i.e., likelihood that different users will assign the same diagnosis). However, it is important to remember that these criteria are meant to be used as guidelines to be informed by clinical judgment and are not meant to be used in a cookbook fashion.

Diagnostic classification

The diagnostic classification is the list of the mental disorders that are officially part of the DSM system.

Making a DSM diagnosis

Making a DSM diagnosis consists of **selecting those disorders from the classification that best reflect the signs and symptoms that are afflicting the individual being evaluated**.

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SoPs In Practice, Continued

Descriptive text

Finally, the third component of the DSM is the **descriptive text** that accompanies each disorder. The text of DSM-IV systematically describes each disorder under the following headings:

- Diagnostic Features;
- Subtypes and/or Specifiers;
- Recording Procedures'
- Associated Features and Disorders;
- Specific Culture, Age, and Gender Features;
- Prevalence;
- Course;
- Familial Pattern; and
- Differential Diagnosis.

Medical diagnostic guidance is now black letter law

DSM-1V wording is also incorporated in the SoP's for psychiatric disorders, however **legal decision-making has turned what was intended to be a medical guideline into inflexible hard and fast rules**. The result is that an anomalous situation often exists between the opinion of medical experts and the requirements of SoP's.

Effect upon the veteran causes welfare issues

A significant welfare issue is the effect upon a veteran of the resulting difficulties arising from the gap between the medicine and the law. Medical professionals who are often also treating doctors have reported that the SoP system itself can be responsible for the worsening of a patient's condition.

The situation can arise where more than one expert agree that a condition is diagnosable, but the requirements of the relevant SoP do not allow for its existence. Not surprisingly the veteran is at a loss to understand why his treating doctor's opinion is not acceptable and he thereby loses faith in the determining system itself.

Diagnosis accepted, but not the link to service

Different problems also occur because the DSM 1V criteria are repeated as part of the definitional requirements for the causal factors. A number of decisions have been made accepting the diagnosis of a condition but refusing the link with service.

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SoPs In Practice, Continued

Summary

Whilst the decision in 'Benjamin'[16] has given decision makers greater flexibility in terms of diagnosis, the conflict between the application of the medicine and its reduction to law will inevitably lead to further and continuing argument.

Conclusions

Introduction

This section of the paper draws together the conclusions that should be drawn from the previous discussion.

Degradation of the standard of proof

The standard of proof has been degraded from the original concept in the following ways:

- introduction of the '*reasonable hypothesis*' into the 1986 Act;
- further refinement as a result of the Baume Committee introducing '*balance of probabilities*' or '*reasonable satisfaction*' standard; and
- implementation of the Statements of Principle;

Limiting avenues of appeal

The binding nature of the SoPs limits appeal, despite the fact that the courts have provided some interpretation and there is a right to request a non-legal review from the RMA to the Specialist Medical Review Council.

SoPs are effectively a 'group punishment'

The government of the day introduced the SoPs as a reaction to the perception that some veterans were rorting the system. This is effectively a 'group punishment', or a situation where the many are disadvantaged because of the acts of a few.

The VVAA has provided evidence of rorting that has been followed up only half-heartedly by the Department, and there is a very real feeling within the VVAA that there is no will to court political disfavour by being seen to punish a few specific veterans. It is perhaps seen as more politically acceptable to introduce rigorous administrative measures that are generic in nature.

What is more galling to the ethical organisations is that those individuals and organisations, which systematically bend the rules, are not sanctioned in any way.

Single medical opinion discounted

Single medical opinion is subject to the judgement of the RMA, and not supported at any level under 'sound medical and scientific' criteria as currently defined.

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Conclusions, Continued

SoPs reduce the scope and coverage of the standard of proof	The construction of the SoPs is such that it reduces the scope and coverage of the standard of proof, as non-legal appeals to specialist medical panels are not subject to an expressed standard of proof let alone the beneficial standard of proof.
Arbitrary standards act against the standard of proof	The introduction of arbitrary standards acts against those who may have only one day's difference in display of symptoms and the objective application of the presence of stressors and responses.
Some veteran experience outside the mainstream	The VVAA has demonstrated very clearly over a number of years that many of the exposures and subsequent symptoms of veterans extend far beyond the experience of the medical profession. Indeed, as a group of laypersons, the VVAA has contributed much to the professional body of knowledge concerning the symptoms, effects and treatment of PTSD, and of exposure to chemicals. The provisions within the Act and its administration through the SoPs provide little if any opportunity for the veteran community to operate within the arena of '*reasonable hypothesis'* as it was first defined.
Medico-legal dichotomy	In practice there are significant anomalies created by the application of legal standards to medical diagnosis. These acts both against the standard of proof, and against the veteran who expects to be fairly treated.
Medical diagnosis	The medical diagnosis provided by a medical professional (who also is taken to be an expert witness and whose opinion must fit within the construct of the SoPs, particularly for the quasi-legal definition of objective tests.

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Conclusions, Continued

Summary

The VVAA has shown here that there are a significant number of elements, which contribute to the veterans' inability to have his, or her war or Defence-caused injuries or illnesses appropriately dealt with using the '*reasonable hypothesis*', being the supposed legal interpretation of the beneficial basis for subsequent treatment and compensation.

This is a sad reflection of the words of Prime Minister Hughes, cited in the opening page of this document.

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Recommendations

Recommend-ations

8. The VVAA recommends that the Veterans Entitlements Review Committee acknowledge within its Report the historical changes to the standard of proof for veterans and assess the degree to which the beneficial nature of the legislation has been reduced.

9. The VVAA recommends that the Veterans Entitlements Review Committee document within its Report shortcomings in the practical use of SoP's and particularly the anomalies arising from such things as:

(a) the RMA's decision-making process outside the application of the VEA veteran standard of proof;

(b) a narrow interpretation of the wording in SoP's

(c) the practical difficulties associated with the employment of an objective test for the existence of a stressor for psychiatric disorder SoP's;

(d) failure to recognise the validity of single or less than mainstream medical opinion or limited medical/scientific research

10. The VVAA recommends that the Veterans Entitlements Review Committee propose that government:

(a) recognise and correct the erosion of the beneficial nature of the legislation governing veterans; in that

(i) there has been a steady erosion over time in the generosity of the Standard of Proof applicable to veterans; and that

(ii) Statements of Principle in particular represent a further reduction and restriction;

(iii) the practical use of the SoP system has lead to anomalies in decision making, disregard for the process of making claims and for review and has fostered the distrust of the veteran community.

(b) acknowledge and correct the significant detrimental effect upon the well being of some veterans caused in whole or in part by the application of the SoP's or the obtaining of particular expertise, given rise to by the extra evidentiary requirements.

11. The VVAA recommends that the Veterans Entitlements Review Committee:

(a) provide the Commonwealth Administrative Appeals Tribunal, as a significant and senior level decision maker in veteran's matters, with copies of relevant submissions and request its comments; and

(b) express real concern that a consensus arrived at from time to time by a chosen group of doctors is used to create a legal standard; thus turning a medical opinion into a rule of law.

Notes

1. VEA Section 7 and see VVAA submission Part 2, Eligibility
2. VEA Section 5D
3. VEA Section 9
4. Veterans' Entitlements Law – Creyke and Sutherland, The Federation Press 2000, page 402
5. *Ibid*, p. 402
6. *Ibid*
7. *Ibid*, p. 403
8. *Ibid*
9. Veterans' Compensation Review Committee 1994 (The 'Baume' inquiry)
10. VEA Section 196D
11. VEA Section 196E
12. VEA Section 196Z
13. Minister's Second reading Speech, Veterans' Affairs (1994-95 Budget Measures) Legislation Amendment Bill 1994, *Hansard* , 9th June 1994, page 1808
14. Diagnostic Statistical Manual Edition Four, American Psychiatric Association 1994
15. Benjamin v Repatriation Commission [2001] FCA 1879
16. *Ibid*