*Michael Fordham was admitted as a barrister in 1996. He was appointed silk in 2012. Michael's primary areas of practice are medical matters for hospitals, local health districts, medical practitioners and allied health practitioners. He has appeared as counsel assisting in both coronial and ICAC matters. Much of his work involves complex psychiatric issues. These include not only liability questions arising out of care and treatment but also complex questions of causation and damage arising out of treatment for bullying and assaults. Michael has been the Course Director of the Bar Readers Course since October 2007 and has an extensive interest in and involvement in advocacy training. Michael currently sits on the Education Committee of the NSW Bar Association.*

I was quite pleased to see that Professor Parker finished with the rider that he did, as it is the approach I have taken to my analysis of DSM-5. It is a day of my life I will never get back. The only upside is that I borrowed Richard Weinstein's copy and did not waste any money.

Professor Frances of Duke University opened a paper on DSM-5 in The Conversation with a quote from Alice in Wonderland: “We're all mad here”. An article by Claudine Ryan on the ABC Health and Wellbeing webpage ‘the Pulse’ noted that if you read DSM-5 and apply it literally, 50 per cent of western population would now qualify for a diagnosis of mental disorder. Our first speaker was quoted in the same article as suggesting that this strains credulity.

The lead up to the publication of DSM-5 saw much comment in the specialised medical and legal press amounting to widespread hysteria. You only have to put DSM-5 into a search engine and read the various notes that come up. Some of this filtered through into mainstream media where the popular press of course focussed on the trivialities in order to downgrade some of the good work that had been done. There were headlines referring to things such as child onset fluency disorder which was previously known as stuttering. On the other hand some commentators have described as great steps forward removing terms such as mental retardation and replacing it with intellectual development disorder. As recently as this Monday (11 November 2013) MJA Insight delved into the vexed question of over-diagnosis and treatment of ADHD (now known as autism spectrum disorder) in the broadened scope as set out in DSM-5. With the exception of those matters, there has been very little serious analysis in the popular press. Meanwhile the specialised press has, and it is there for you to read, worked a great deal in trying to deconstruct, but probably not as fluently as we have just heard, some of the myths that surround DSM-5.

There has been little, if any, judicial comment. As far as I can ascertain, there are two cases in the Family Law Court in relation to gender dysphoria, which was formerly gender identity disorder, a bail application in Victoria and one appeal on sentence in Tasmania. Although a great deal of my practice is psychiatrically based I am yet to do a case in which DSM-5 actually gets a mention. However I am sure it is coming.

The preparation for this presentation gave me some insight into how it is that the two questions that I have been asked to discuss this evening should be answered.

The first question that I was asked by Mr Took to pose and answer was “is everyone diagnosable?” The answer to that question is clearly yes. The second question was “does it change the approach for lawyers?” For reasons I will come to, the answer to that question is clearly no.

However, in researching and preparing for this particular presentation, I realised that I was suffering something called a social anxiety disorder (social phobia). I have a marked fear and anxiety about the social situation in which I now find myself. I am fearful of being exposed to scrutiny by others such as yourselves. I fear that I will act in a way that shows anxiety symptoms, like the tremor in my voice, and I will be negatively evaluated by yourselves again. DSM-5 does however require that I move to one of the specifiers because my anxiety is related to speaking in public. Whilst my position this early in the evening cannot be explained by the physiological effects of a substance, it is necessary that I exclude that.

The makings of this particular presentation came out of a coronial inquest at Glebe about 12 years ago. The case involved significant psychiatric issues and I, like all diligent juniors, immediately went and bought a copy of DSM-IV. Having given myself a hernia carrying it back to my chambers, I made the mistake of reading it. I made the bigger mistake of trying to understand it and then just to add insult to injury, I sat down with Professor Parker's reports and I started to analyse them - criteria by criteria, specifier by specifier. That then led me to what I thought was going to be a killer cross examination. Nonchalantly I leaned on the lectern: “I take it you have heard of DSM-IV?” “Well, yes” said the Professor. We then went to the diagnosis, which I will not go into here, and I started going through the criteria and the sub-criteria and the various elements that were required. Having sucked him in so far I thought I was on a bit of a winner until I landed what I thought was the killer blow about just what was missing. He looked at me and I will never forget what he said: “so what?” As I picked myself up off the floor, the Professor then engaged in a very meaningful dialogue with the coroner about how that was all very interesting but it was just a guide and what we really need to look at is pattern recognition and proper clinical diagnostics. I lost.

The other way this presentation came about was because of a Senior Counsel who appeared for a drug company in this particular inquest. As drug companies do, they arrived over-armed, making noise, creating havoc etc. After that settled down, the SC became bored and took my copy of DSM-IV. He then started handing out diagnoses to various members of the bar, the experts and the coroner.

I had planned to do something similar here this evening. My original plan was to get a large sheet of paper and put on it photos of some of the more prominent members of the Medico-Legal Society. On the other side of the paper I had a list of diagnoses from DSM-5 and the plan was to have everyone draw a line between the individuals so that we could tally up the scores at the end. The Thought Police on the Medico-Legal Society committee put the kibosh on that one. The other problem was that there are only so many times you can write narcissistic personality disorder with aspects of autism and just a hint of antisocial personality disorder.

I have also been directed to mention at least one case so that the lawyers in the audience can obtain their requisite CLE point. Rogers v Whitaker (1992) 175 CLR 479 has nothing to do with this topic but since everybody who speaks here mentions it, I thought I would too.

Having had my creative output curbed by the Thought Police, I then thought I had to come up with a way of trying to discuss, from a lawyer's perspective, some of the changes in DSM-5 that might be relevant to how it is we go about our business. It occurred to me that the life cycle of a typical defendant's medical negligence brief may provide a useful template.

It is best that I start with the cautionary tale that has already been told by Professor Parker. That is; the authors, having put no doubt years of work into what is a large and bulky item, basically then say well, if you are not trained to use it, do not read it. The authors said that non-clinical decision-makers, and by that I assume they mean judges, need to be cautioned that a diagnosis does not carry the necessary implications regarding courts. Clearly, they had trial judges in mind when they wrote that one. In a criminal context they put in quite an important rider which was that the presence or absence of a disorder says nothing about a person's ability to control behaviour at the time of the given offence. Having read the cautionary statements about the way I am not to use DSM-5, I am going to ignore them.

The brief arrived. My junior, keen as he was, immediately accused the plaintiff of hypochondriasis. I had to politely explain that this has now been subsumed into a somatoform disorder in DSM-5 and that the plaintiff did not have one. That said, the plaintiff did appear to be suffering from an illness, namely anxiety disorder arising out of her preoccupation with having acquired a serious illness. One of the sub-specifiers is that you have to be performing excessive health related behaviours. It occurred to me that these were largely at the behest of her lawyers, but were probably good enough. I was however hopeful of a reasonable prognosis with the award of damages that was surely coming her way. The plaintiff was the only person who was

more or less upfront about her condition, having pleaded a post-traumatic stress disorder. For the lawyers in the room, it is quite arguable that what qualifies as a traumatic experience has in fact been tightened in DSM-5 as compared to DSM-IV. In fact, it looks just a little bit like the test for Nervous Shock under the Civil Liability Act 2002 where it is limited to largely direct experience or learning about events in relation to a close family member. DSM-5 of course extends it to friends, which will not get you there for the CLA, but most importantly for a lot of the work I do involving the military and the police, people in those positions are now included where it is they are investigating, even after the event. Subjective reaction has been excluded, but most importantly for another and somewhat sad area of my practice where I deal extensively in the abuse of children, the PTSD has been conceptually altered to take into account the developmental diagnostic thresholds for children and adolescents. But I digress.

In my analysis of DSM-5 for the purposes of the case it became necessary to assess the defendant. Going a little off piste I soon came to the view DSM-5 could be used to diagnose a hospital. Up to that point I thought only neurosurgeons suffered from histrionic personality disorder. Like many neurosurgeons, the hospital was certainly uncomfortable in a situation where it was not the centre of attention. Like many hospitals, its interactions were often inappropriate and/or provocative and the hospital displayed rapidly shifting and shallow expressions of emotion. Need I go on?

The claims officer was a little easier to diagnose. Gambling disorder has now been included in the chapter on substance related and addictive disorders. My usual somewhat pessimistic advice in relation to prospects was duly prepared and sent. Whilst not the traditional way of instructing senior counsel, the email that returned from the claims officer read: “Suck it up Princess”, and suggested to me that I ought to prepare for trial in the District Court. It is true there is a jurisdictional cap, but as the evidence came in the claims officer was compelled to gamble with increasingly larger amounts of money in order to just try and get that one last piece of excitement - the verdict for the defendant. All attempts to dissuade the claims officer failed. Efforts by the Court in the past to curb this desire had also been unsuccessful. As the trial date drew nearer, the intensity lifted. But perhaps most importantly for this diagnosis as is now set out in DSM-5, the claims officer was relying on others to provide the money with which he gambled.

The matter was referred to mediation. Now, half the room probably has not been to a mediation and it is a little hard to describe, but criteria A from delusional disorder no longer requires the delusions to be non-bizarre. Whether bizarre or not, the idea that retired judges who have not run a case of this type for some years and certainly have not bothered to read the papers, can somehow apply their 'special powers' to achieve settlement, suggests delusional disorder grandiose type.
Those who have been around as long as I have can remember when that particular delusion was also accompanied by the erotomanic variant.

The day of trial, always a stressful one, led to a number of elections between competing diagnoses. My opponent displayed all the signs of a paranoid personality disorder. True it was I who was out to get him but every move I made was greeted with pervasive distrust and suspicion. Everybody, including the judge, was suspected. My opponent was reluctant to confide in anyone, particularly the judge, about what his case was for fear that information could be used against him. He read hidden meaning into every remark.

I then turned to assessing the judge and my initial diagnosis, provisional as it was, was intermittent explosive disorder. That was based on the judge's reaction to my defence. That provisional diagnosis had to be abandoned due to some comment I read in DSM-5 that highlights the difficulty in distinguishing such outbursts from the normal temper tantrums of a child.

Closer analysis led to a different conclusion. The conclusion that I came to was subsequently vindicated on a number of occasions in the Court of Appeal. The judge in question lost his temper, was touchy, easily annoyed, often angry and resentful. He continued to argue with authority figures in the form of the List Judge and the Court of Appeal. He refused to comply with

any of their requests. It was as though he was out to deliberately annoy them. Finally, he had become quite spiteful and vindictive and blamed everybody, including me, for the errors that he made. For those of you who read DSM-5, you will know that his Honour was suffering from oppositional defiance disorder. Fortunately the case was adjourned and transferred to the Supreme Court. Panic disorder as defined in DSM-5 without reference to the presence or absence of agoraphobia, descended on my claims officer, who was now exposed to an unlimited verdict.

Moving up the road to the Supreme Court had me reaching for DSM-5 again when asked to update my advice on prospects. I had to take into account the differing personalities and peculiarities of the Supreme Court bench. That task has led me to write to the authors of DSM-5 proposing further research. For many years we have been familiar with clustering in the form of different diseases, particularly cancer. I suspect that I am the first person to have ever identified and documented a cluster of narcissistic personality disorder. My research proposal has received favourable comment because you do not need expensive research. All you need is a copy of the Supreme Court Rules, the NSW Law Reports and the directions that are made on any Friday by the List Judge.

Having recently chaired an expert conclave of colo-rectal surgeons I am pleased to announce that the research can be expanded and that clusters are not necessarily confined to the legal fraternity. I understand that similar research is now taking place in relation to the Medical Board and certain hospital management.

The judge we drew had the necessary sense of entitlement. That entitlement extended to expecting me to comply with directions. The sense of entitlement was piggybacked on the fact that he or she, because I am not naming names, thought they were very special and they required excessive admiration. There was a pre-occupation with fantasies of unlimited power and a certain sense of grandiosity. It was all there. It was completely text book. I lost.

Having been summarily monstered in the trial the claim officer's gambling addiction re-emerged and we went to the Court of Appeal. Those of you who have been to my chambers will know of my latent obsessive compulsive disorder. The submissions were drafted with just one folder on my desk at a time.

For those of you who have not been to the Court of Appeal, I can tell you that it is about as close as you can get to a dry run for a disorder from the schizophrenia spectrum. For a month or so beforehand I was deluded into thinking I had a chance. I also thought the judges might be nice to me, even if they did not agree with me. Whilst in that delusion my functioning was not markedly impaired as I produced what passed for submissions and lists of authorities.

The appearance itself in the Court of Appeal was characterised by disorganised thinking and speech as I desperately tried to put what passed for an argument. As I did so I could hear the voices - all three of them. For a moment the hallucination deepened to the point where I truly believed one of the judges was actually trying to help me. My speech became yet more disorganised and as the last killer blow landed, I verged on catatonia.

Through it all I could not help wondering how one would diagnose the Court of Appeal. I initially went with dissociative identity disorder. The reasoning behind that is that those of us who have appeared there can tell you that the transitions in identity usually occur about half way through your first sentence and it all goes downhill from there. Criteria B is also catered for because the Judges of Appeal have gaps in their recall of the events which explains why they are quite pleasant to you when you meet them in the street.

After much thinking I actually ended up settling on a social pragmatic communication disorder. As impossible question after impossible question rained down on me from above, it occurred to me that there was a clear deficit in using communication for social purposes and sharing in a manner appropriate for the social context. There was a complete inability to change

communication to match the context of the needs of the listener, me. The rules of conversation were thrown out as each Judge competed for the opportunity to humiliate me. Finally there was extreme difficulty understanding what was not explicitly stated, that is I did not want to be there and I was just doing my best with a crap case.

The Court of Appeal on the other hand quickly expressed the view that I was suffering a variant of the newly conglomerated specific learning disorder. They said mine was in the law of tort.

Judgment came down and needless to say I lost. As I left the Court room the court officer came over and politely asked if I had Tourettes, to which I responded, no, that is just what I think of the judgment.

Everybody is diagnosable and most of all me.

Does DSM-5 change the way we run cases? The answer to that has to be no. The caution by the authors to DSM-5 as expressed by Professor Parker is in fact paramount in the way psychiatric cases should be run. You have got to be very careful about using tools you are not trained to use and that you do not fully understand. As an aside I can I say it occurred to me reading DSM-5 that it had been written by the same people who act as Parliamentary draftsmen and having heard what Professor Parker had to say, it now all makes sense.

In the world of the Civil Liability Act we talk about persons of normal fortitude. What does that mean in this day and age? If you accept what Professor Parker has told us on the definitions, only 40 to 50 per cent of people qualify. The forensic psychiatric community has noted, to my detriment, that just because you do not fit the formula, it does not exclude a recognised psychiatric illness and that has to be right.

Before coming here this evening I spoke to a number of clinical psychiatrists, whom I am not going to name for obvious reasons, and they have all said they largely ignore DSM-5.

The greater problem is in causation because of the literal interpretation that the Courts now force on us in relation to section 5D. Psychiatrists, or at least the ones I cross examine, continually tell me that people are the sum total of their existence. How does that work in a 5D context?

Just to finish, and in relation to how we are going to run these cases, we are going to run them in the way we always run them.

Plaintiffs have to be aware they have the onus of proof. Defendants have to be very careful when they try and unscramble the psychiatric egg.

When I run these cases I look to clusters of symptomatology, history and effect. The best results you get are when you concede everything that does not matter and you are prepared to pour money into treatment, necessary treatment in the hope that the person, the victim, gets the best outcome. A number of my clients will pay money upfront, pre-trial in order to do that. Often that is pastoral but it has a specific benefit when it comes to running the case.

In reality, you can try and cross examine on DSM-5, DSM IV or anything else by criteria but you will lose. Drilling down to diagnosis and trying to exclude stress related event diagnoses in favour of the so-called constitutional conditions that emerge usually ends in tears. Just ask yourself this question as lawyers, how many people who are seriously bullied, sexually abused as children or are the relatives of people who die from a tort are going to go home empty handed as a result of a technical difference in diagnosis or attribution? The answer is none.

One of the difficulties that emerges with the interplay between the diagnoses is that the onset of so-called constitutional or personality based issues are often temporally linked to tortious events. As I have said, you work with onset, severity, duration and symptomatology and analyse that.

With all that in mind, I will leave you with one last thought for those who practise in the coronial jurisdiction and work at the coalface of mental health. Suicidality and the assessment of it are dealt with in greater detail in DSM-5. However it does not add anything for the people trying to work at the coalface with desperately ill people and it does nothing for the lawyers trying to pick up the pieces in the coronial jurisdiction. The short point of all this is DSM-5, like the Jesuitical view of the Bible, might be an interesting document, but it is only a starting point.

One really has to ask this question: Is everyone diagnosable? Well they probably are. Does it change what we are going to do running cases? The answer is no. It will have influence on the availability of funding for children and education and medicine. It will not have any appreciable effect on civil liability and damages.

Thank you.