

Editor:

Dr. Alan Stone subjected the role of forensic psychiatrists as expert witnesses in malpractice cases to critical analysis. He did so against the background of *Wendell Williamson v. Dr. Myron Liptzin* (Cal., Orange County Sup. Ct. Dkt. 97CVS690), a North Carolina case. Dr. Stone, at the time he wrote the article published in the *Journal* (27:451-61, 1999), had no access to the transcript of the case. He relied on newspaper accounts, his contact with Dr. Liptzin, and information generated at a plenary session of the Group for the Advancement of Psychiatry, which took place in November 1998. My only source of information is Dr. Stone's article.

In 1994, Dr. Liptzin saw Wendell Williamson, a 26-year-old student at the University of North Carolina Law School, at the Student Health Service. The contact was brought about by the intervention of the Dean of Students. Mr. Williamson "disrupted the law school class proclaiming that he had telepathic powers." The Dean of Students escorted Williamson to Dr. Liptzin's office for an emergency appointment. This was the second psychotic episode in two years. On the earlier occasion, Williamson was subjected to "emergency civil commitment." Dr. Liptzin placed Williamson on antipsychotic medication and saw the patient on six separate occasions "over the next several weeks." After the sixth session, Dr. Liptzin informed Williamson that he would be retiring and "gave him a prescription for one month's supply of medication and referred him either to his family doctor or to someone at the community mental health center near his home to get the prescription refilled." However, Williamson stopped taking the medication and began to make plans "about violent retaliation against his persecutors." Eight months after he had last seen Dr. Liptzin, Williamson acted on a plan he had rehearsed by shooting at trees on his grandparents' abandoned farm. Armed with a rifle and dressed in military camouflage, he went into the streets of Chapel Hill, North Carolina, and shot to death two people and seriously wounded a policeman before he could be stopped and arrested. Wil-

liamson was charged with 15 counts, including murder, but was found by a jury not guilty by reason of insanity. While in the state hospital, Williamson filed a malpractice lawsuit against Dr. Liptzin.

Two psychiatrists testified in the civil lawsuit on behalf of Williamson. One of them is referred to by Dr. Stone as a forensic psychiatrist, and he is the focus of Dr. Stone's essay. We are not told the basis for calling this particular physician a forensic psychiatrist and distinguishing him from the other expert, who was employed by a student health service. Neither one of the physicians is identified by name. I shall refer to the "forensic psychiatrist" as Dr. "X". The two expert witnesses who testified on behalf of Wendell Williamson identified, according to Dr. Stone, the following departures from standard of practice: (1) negligent diagnosis; (2) negligent failure to inform the patient about the actual diagnosis which was paranoid schizophrenia; (3) failure to read the entire record of the patient's earlier involuntary hospitalization; (4) failure to recognize risk factors for violence; (5) failure to refer the patient to a specific psychiatrist for further treatment.

Dr. Stone reached a variety of conclusions about forensic psychiatry based upon the involvement of Dr. X in this case. It should be noted that Dr. X was the same psychiatrist who testified on behalf of Williamson in the criminal trial.

Dr. Stone wrote that there was "a small cottage industry offering remunerative opportunities to expert witnesses." He described a segment of the discipline that is "selling [its] services to the legal market." He claimed that forensic psychiatrists have "inadvertently accepted the lawyer's view that the adversarial system of law requires experts for both sides (i.e., professionals who are prepared to take either side of the argument). . . . malpractice litigation involves the forensic psychiatrist in the web of self interest, billable hours, reputation, and ego. . . . the growth of forensic psychiatry demonstrates that the conspiracy of silence has been replaced by experts competing to sell their expertise to either side of the case." Dr. Stone did not use the pejorative term "hired guns," but his descriptions of forensic psychiatry were consistent with this label. He implied that Dr. X and other forensic psychiatrists would, for a fee, agree to testify for either side in a controversy. Dr. Stone told us that considerations of "economics loom large for the increasingly numerous and competitive suppliers of marketable expertise."

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Dr. Stone reported that two psychiatrists testified that Dr. Liptzin committed malpractice in his care of Williamson. However, Dr. Stone took umbrage at the testimony of the expert witness whom he designated as a forensic psychiatrist. He wrote: "The adversarial system requires lawyers and experts for both sides, and as the number of qualified forensic psychiatrists have increased there is a buyer's market for experts." He pointed out how forensic psychiatrists earn their living: "that means if they want to work, they have to say something that the lawyer believes will help his side."

Dr. Stone made no critical reference to the testimony of Dr. X in the criminal trial. Why not? After all, in civil litigation only money is at stake; in a criminal trial, justice and freedom are at issue. There was no outcry of protest in the psychiatric community when Williamson was acquitted by a North Carolina jury for killing two people and seriously injuring a policeman.

Dr. Stone stated that both sides had as their expert a forensic psychiatrist and a Student Health Service psychiatrist. He made no critical references to the defense psychiatrist. Using Dr. Stone's criteria of the corrupting influence of money, the index of suspicion should be greater when dealing with defense experts. They are often paid more and are less likely to have difficulty in collecting their fees from the insurance companies. It is equally puzzling that Dr. Stone did not cast any aspersions on the non-forensic psychiatrist who testified that Dr. Liptzin committed malpractice. Presumably, that psychiatrist also received remuneration for his services. Is there any evidence that forensic psychiatrists are more likely to be corrupted by money than non-forensic psychiatrists? I am not aware of any evidence that forensic psychiatry is particularly attractive to unethical psychiatrists. On the contrary, my 45 years of experience in all phases of psychiatry lead me to the conclusion that corrupt psychiatrists are least likely to be successful in this field. It is may be easier to be unethical in the privacy of one's office, free of the scrutiny of the adversarial process.

Dr. Stone pointed out that the standard of care in psychiatric treatment is by no means the "natural" province of the subspecialty of forensic psychiatrists . . . . They are certainly more expert than their colleagues about law, testimony in court, and the legal process, but there is nothing in the professional training or experience of a forensic psychiatrist that

would make him particularly qualified to establish professional standards of care for the general psychiatrists or for other subspecialties in psychiatry. Indeed, one might assume that as in any other medical subspecialty, the successful practitioner of forensic psychiatry would lose touch with the current standards of care in clinical settings in which he no longer works or has had no substantial experience."

This view is contradicted by reality. Less than a handful of American psychiatrists practice full-time forensic psychiatry. Most members of the American Academy of Psychiatry and the Law devote less than 20 percent of their practice to forensic matters. Last, but not least, at issue in most malpractice cases are matters that are common knowledge to anyone who is a psychiatrist. One need not be an expert, in the usual sense of the term, on diagnosis to provide expert witness testimony that there is a difference between delusional disorder and paranoid schizophrenia. Incidentally, Dr. Stone did not disagree with Dr. X, who diagnosed Mr. Williamson as a paranoid schizophrenic. Dr. Liptzin made the diagnosis of delusional disorder. Evidently, what troubled Dr. Stone was not the substance of the testimony but the source of it. Should competent psychiatrists be excluded from giving testimony on the standard of care because they are contaminated by exposure to forensic psychiatry? Such a restriction cannot be justified on logical or empirical grounds; it makes good sense, however, as a tactical move on the part of the defense in civil litigation and is to the advantage of the prosecution in criminal trials. Forensic psychiatrists are less likely to be manipulated in the courtroom setting than their colleagues who have no knowledge about the legal system. Dr. X was "guilty" of being effective. His view prevailed in the criminal trial of Mr. Williamson and carried the day in civil litigation.

Dr. Stone used a mixture of inductive and deductive approaches. Based upon the population of one forensic psychiatrist, he generalized about the entire subspecialty. He then shifted and used a deductive approach by starting with the axiom that forensic psychiatry has no place in "establishing" a standard of care, therefore Dr. X, by definition, should not have testified. Thus, Dr. Stone killed two birds with one blank shot.

Dr. Stone stated that Dr. Liptzin was expected to predict that Mr. Williamson would become dangerous. In reality, Mr. Williamson was dangerous by

virtue of the fact that he was suffering from an acute paranoid schizophrenic episode.

Let us assume that Dr. X testified for all the wrong reasons that Dr. Stone eloquently enumerated. This assumption still would not justify the collective indictment of forensic psychiatry that Dr. Stone offered in the pages of the Journal.

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Editor:

In his well-articulated discussion of the *Williamson v. Liptzin* lawsuit, Dr. Stone<sup>1</sup> has critiqued the alleged breaches of ordinary prudent treatment suffered by the plaintiff at the hands of Dr. Liptzin. These included a claim of wrongful diagnosis. Mr. Williamson's psychiatric expert testified that Dr. Liptzin erroneously diagnosed Delusional Disorder instead of a correct diagnosis of Paranoid Schizophrenia.

It becomes difficult to conceptualize how a patient with a *bona fide* diagnosis of Paranoid Schizophrenia can function, study and pass into his third year at a university law school. A study of 141 schizophrenic patients followed at a university outpatient clinic, monthly, demonstrated that schizophrenia cripples patients' ability to function at any but sheltered vocational activities.<sup>2</sup> Based upon preservation of intellect, lack of information concerning formal thought disorder, absence of hallucinations or personality dilapidation and Mr. Williamson's apparent insight and acuity of judgement in proceeding with a lawsuit against Dr. Liptzin, a diagnosis of schizophrenic illness remains very much in doubt. On the contrary, Dr. Liptzin's diagnosis of Delusional Disorder more definitively correlates with the information that Williamson progressively developed systematized persecutory, grandiose and somatic delusions as discussed by Dr. Stone.<sup>1</sup>

The time-honored case study of Delusional Disorder is Freud's analysis of the paranoia affecting Daniel P. Schreber, the late nineteenth century presiding judge of the Appeals Court in Dresden, Austria.<sup>3</sup> The research literature on Delusional Disorder is rudimentary compared to the vast accumulation of knowledge that schizophrenia, including paranoid schizophrenia is a genetically predisposed bio-psy-

chosocial disease. Contrary to schizophrenia, the causes of Delusional Disorder are postulated to be essentially psychological, including ambitious but frustrated strivings, a need for defense of the personality against undesirable tendencies, repudiated impulses, feelings of insecurity, guilt or other anxiety-provoking factors.<sup>4</sup> There is no research evidence supporting the efficacy of anti-psychotic medication in cases of Delusional Disorder as opposed to Schizophrenia.

In the reported treatment of Mr. Williamson by Dr. Liptzin, Dr. Stone has pointed out the excellent therapist-patient alliance established, which contributed to a rapid social recovery while Mr. Williamson was under Dr. Liptzin's care. Recognizing that psychological illnesses like Delusional Disorder are likely to be more responsive to interpersonal psychotherapy than anti-psychotic management, it is reasonable to theorize that the inevitable severance of the unique doctor-patient relationship, when Dr. Liptzin went into retirement, caused Mr. Williamson's violent psychotic breakdown. Cited "breaches" of standardly acceptable treatment, such as failure to advise Mr. Williamson that he had a very serious mental illness, failure to refer to a specific psychiatrist and Mr. Williamson's unsupervised discontinuation of antipsychotic medication during the interim period when he was not under psychiatric care, represent the well known fallacy (*post hoc ergo propter hoc*) when contemporaneous events are simplistically linked.

As Dr. Stone has elucidated, Dr. Liptzin's deviation from ordinary prudent care was that he provided an extraordinary level of interpersonal psychotherapy, which temporarily abated Delusional Disorder, but which was regrettably unsustainable once Dr. Liptzin went into retirement.

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