

The Forensic Psychiatrist as Expert Witness in Malpractice Cases

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This essay is a discussion of the role of the forensic psychiatrist in malpractice cases as an expert witness establishing the standards of care for the psychiatric profession. The occasion for these comments, which hopefully will lead to constructive dialogue and response, is the much discussed malpractice case of *Wendell Williamson v. Doctor Myron Liptzin* (Cal., Orange County Sup. Ct., Dkt. No. 97CVS690). The case achieved public notoriety when it was a featured segment of the CBS television program "60 Minutes," and it has also produced controversy about standards of care within psychiatry.¹

The professional controversy* might be stated as follows: how can most of his professional peers who work in university mental health services believe that Dr. Liptzin did a superb job in his care of Williamson and that quite unforeseeably

a tragedy occurred, whereas the psychiatric experts who testified against him in court "honestly" believed that Dr. Liptzin was negligent on several grounds and should be held liable for the tragic result?

This controversy demonstrates that there are major disagreements about the applicable standards of care in psychiatry and that psychiatrists who testify in court, particularly forensic psychiatrists, may reach substantially different judgments and have different values than their colleagues. I am not making the simplistic argument that all forensic psychiatrists think alike on substantive matters. If that were the case, then either Dr. Liptzin or his patient would have been unable to secure a forensic expert. My thesis is more subtle and perhaps more difficult to defend. Nonetheless, this essay will argue that the controversy in the Liptzin case is in part the result both of changes in the law and climate of malpractice litigation and of the altered professional values of forensic psychiatrists and others who testify as expert witnesses.

Malpractice litigation was almost nonexistent in psychiatry until the last 30

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* The case was the basis for a plenary session at the November 1998 meeting of the Group for the Advancement of Psychiatry (GAP). Most of the GAP members who spoke supported Dr. Liptzin.

years. It is now a small cottage industry offering remunerative opportunities to the expert witnesses who consult with lawyers, review medical records, offer opinions, and testify at depositions and in court.² There is now a market for experts in which the purchasers are lawyers and the mental health professionals are the suppliers competing for a niche. As is true everywhere else in the mental health arena, psychiatrists find themselves increasingly forced to compete with forensic psychologists, forensic social workers, and nurses. The potential economic rewards are substantial, and many psychiatrists find forensic work more stimulating than clinical practice or at least a welcome variation in their professional routine. There is nothing unique about the growth of forensic mental health professionals; every discipline that has relevant expertise to offer is selling its services in the legal market, a market that is much wider than malpractice. Considerations of reputation and economics loom large for the increasingly numerous and competitive suppliers of marketable expertise.

The standard of care in psychiatric treatment, which is the central question in malpractice cases, 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 psychiatrist 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. One would not refer an acutely psychotic university student for evaluation or consultation about treatment to a colleague because he is a forensic psychiatrist. Yet, if something goes wrong in treatment, a forensic psychiatrist may well appear, as in the Liptzin case, and testify about how such a student should have been treated (i.e., the applicable standards of care and the breach of those standards by the psychiatrist who does specialize in the care of acutely psychotic young adults). Although forensic psychiatrists by no means have a monopoly on the role of expert witness in malpractice litigation, they have been major players³ and have had a significant and I believe problematic impact. It is not my argument that forensic psychiatrists are the only problem in this area. Elsewhere I have described how partisan practitioners have used the legal process to impose their own standards of care on their colleagues or to advance their own special interests.⁴ Nonetheless, I believe that forensic psychiatry merits particular scrutiny.

I have not identified any of the expert witnesses in the Liptzin case by name, and my analysis and criticisms are directed at what I take to be general practices and not at the plaintiff's experts or at some unusual departure in their testimony. My understanding is that each side used a forensic psychiatrist *and* a psychiatrist with experience in a university men-

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tal health center.[†] As in an earlier paper discussing the ethics of forensic psychiatry, it should be noted that mine is "a view from the Ivory Tower."⁵ I do not claim to have done an empirical survey; these are no more than my thoughts, reflections, and opinions.

Dr. Myron Liptzin is a respected psychiatrist who specialized in the treatment of university students. Five years ago he retired as chief of psychiatry at the student health center, University of North Carolina, Chapel Hill, where he had earned a reputation as a skillful clinician who was particularly adept at crisis intervention. If Dr. Liptzin had hoped to go on to a less hectic and stressful life, his expectations were shattered when he found himself accused of negligence in one of the more unusual cases of psychiatric malpractice in this decade. A former patient went on a rampage, killing two people and then blaming Dr. Liptzin, suing him for negligence. The verdict against the psychiatrist was front page news and the CBS program "60 Minutes" came to North Carolina to do a story that aired in mid-November of 1998.

It was the spring of 1994 when Dr. Liptzin first encountered Wendell Williamson. The 26-year-old man was a second-year student at the University of North Carolina Law School and was in the throes of a psychotic episode. He had disrupted a law school class proclaiming that he had telepathic powers. This occurrence brought him to the attention of the

dean of students, who set up an emergency appointment and escorted Williamson to Dr. Liptzin's office.

It was not the first psychotic break for the young man; two years earlier he had a similar episode, which had led to an emergency civil commitment. He fought that hospitalization tooth and nail. His psychiatrists were unable to establish a therapeutic alliance, and their attempts to impose involuntary treatment on him failed when at his hearing a judge ruled on the information then available that he could not be involuntarily treated. He was therefore released. Williamson supposedly had made verbal promises to the judge that he would accept outpatient care, but he had failed to do so. During this hospitalization the psychiatrists followed all of the relevant procedures that Dr. Liptzin allegedly breached.

Despite this daunting past history and the patient's almost total lack of insight into his mental disorder, Dr. Liptzin not only avoided a confrontation when the young man was brought to his office, he was also able to establish a therapeutic alliance and achieve compliance in a regimen of appropriate antipsychotic medication in the very first session. In six visits over the next several weeks, Wendell Williamson made a rapid social recovery. Dr. Liptzin was able to maintain a therapeutic alliance by using his psychodynamic and interpersonal skills to avoid a confrontation with his patient's delusional grandiosity. The patient went from his acute psychotic and disruptive condition to being stable enough to get through the stressful spring semester at law school.

[†] Dr. Liptzin presented his thoughts about the case to a meeting of the Group for the Advancement of Psychiatry in November 1998, where the present writer gave a preliminary version of this essay.

Judged by that result, most psychiatrists would conclude that Dr. Liptzin was a superb clinician. Dr. Paul Appelbaum, who reportedly looked into this case for the American Psychiatric Association,¹ stated on "60 Minutes" that Dr. Liptzin "did an exceptional job." Most of Dr. Liptzin's colleagues in university mental health who make up the Group for the Advancement of Psychiatry (GAP) Committee on the College Student concur with this judgment. Thus, there is a "respectable majority" of the profession who would agree that far from negligent psychiatric care, the substance of Dr. Liptzin's actual treatment of his patient was superb—beyond what most of us could do.

However, things did start to go wrong after Williamson completed that semester and his treatment with Dr. Liptzin had ended. Dr. Liptzin had informed Williamson along with his other patients that he would be retiring. The accepted practice at the university clinic was to assign patients in rotation to the available staff; Dr. Liptzin therefore advised Williamson that when he (Williamson) returned in the fall for his third year of law school, he would need to come to the clinic to be assigned a new therapist. Since Williamson's plans over the summer were uncertain, Dr. Liptzin 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. Dr. Liptzin said that these discharge arrangements followed the standards of care in the university mental health center over which he presided. This nonspecific referral and other "pro-

cedural matters" became the major issues in the subsequent malpractice case. The patient, in fact, never had his prescription filled or sought further psychiatric care.

Williamson stopped taking his medication shortly after leaving Dr. Liptzin, and over the next several months grandiose, paranoid, and somatic delusions proliferated and became entrenched. He began for the first time to think about violent retaliation against his persecutors. Eight months after he had last seen Dr. Liptzin, he 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 out into the streets of Chapel Hill, North Carolina, and shot and killed two people and seriously wounded a policeman before he could be stopped and arrested. He acknowledged subsequently that he had never told Dr. Liptzin about this violent plan because it never occurred to him until after he had left treatment. This seems to confirm Dr. Liptzin's own statement that when he evaluated Williamson there was no salient risk factor to indicate dangerousness and no way he could have foreseen his patient's violence. The state of North Carolina charged Williamson with 15 counts, including murder, but a jury found him not guilty by reason of insanity—not blameworthy on all counts.

Williamson was confined to a state facility where he apparently began to ponder the question of who was to blame. The onetime law student resolved to bring a malpractice suit against Dr. Liptzin on the premise that his psychiatrist, and not he, was responsible for the tragedy of these murders that had ruined his life. He

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contacted a lawyer who was willing to press his lawsuit and was able without difficulty to retain two psychiatrists who were prepared to testify that Dr. Liptzin had in fact been negligent. One of these experts was a forensic psychiatrist who had testified on behalf of Williamson at his criminal trial and who reportedly thought that there were grounds for a malpractice suit. This is not a *Tarasoff* case in which the victims of violence sue the perpetrator's psychiatrist. Here, the perpetrator himself was claiming to be the victim of negligence.

Williamson's lawyer had a very difficult case to make. He not only would have to convince a jury that Dr. Liptzin was negligent, he would need to persuade them that none of the actions Williamson took contributed "as a legal cause to the harm he [had] suffered."⁶ North Carolina is one of only five states that still adheres to the traditional doctrine of Contributory Negligence. Briefly, the case law theory of Contributory Negligence, as summarized by Prosser⁶ is "... that the plaintiff's negligence is an intervening, or insulating, cause between the defendant's negligence and the result" (p. 417). Dr. Liptzin's lawyers went into the case assuming that many of the actions taken by Williamson would constitute intervening causes that would provide a defense for the psychiatrist even in the unlikely event he was deemed negligent. Furthermore, North Carolina has resisted the general trend toward a national standard for medical specialties such as psychiatry. North Carolina General Statutes, 590-21.12, provides that the standards to be applied in malpractice cases are "the standards of

practice among members of the same health care profession with similar training and experience situated in the same or similar communities." The case law indicates that this statute allows variations in resources to have an impact on standards of care.

Much to the astonishment of most experienced observers, the case was not dismissed. *Williamson v. Liptzin* went to trial, and despite the same or similar community standards for malpractice and the doctrine of Contributory Negligence, a North Carolina jury found that Dr. Liptzin was negligent and that his negligence was the proximate cause of the tragedy and awarded Mr. Williamson \$500,000 in damages. No legal precedent was established in the trial, but the verdict seemed to stretch the envelope of legal liability and common sense. Many psychiatrists shared Dr. Appelbaum's assessment of the case, given on "60 Minutes," where he stated that it was unprecedented to reward the "perpetrator of two murders" and hold a psychiatrist responsible for something "that couldn't possibly have been foreseen." Dr. Appelbaum also commented: "I think the jurors made a mistake in this case." He may be right; jurors, according to some observers, seem more willing to ignore the law and come to their own mistaken conclusions.⁷ But the jurors were provided with expert psychiatric opinion on the standards of care; and in this case, given the legal obstacle of contributory negligence, the experts who testified against Dr. Liptzin must have been quite persuasive. Because of the controversy and the "60 Minutes" coverage, some of the jurors came forward and

made public statements. It seems clear that they were deeply influenced by the plaintiff's experts' testimony that Dr. Liptzin had negligently failed to make the right DSM-IV diagnosis and failed to inform his patient about the gravity of his illness as was supposedly required by the same or similar community standards of care. They seemed to accept without question the proposition that if Dr. Liptzin had recorded the diagnosis of schizophrenia, paranoid type, and told his patient that he had this very serious mental disorder, the patient would have taken his medication. There is nothing in my clinical experience that would substantiate their view; indeed, during his earlier hospitalization he was told how sick he was, and it led to a total therapeutic impasse.

Although Dr. Liptzin provided me with a brief summary of the case, most of the facts I have reported above and shall elaborate below are from various additional public and nonconfidential sources. There are doubtless many different versions of the facts, and I make no claim that my description is definitive. Others who have access to the trial transcript (not available at this writing) may come to quite another perhaps better and more detailed understanding. The forensic psychiatrist and the other expert witness who testified on behalf of Wendell Williamson identified several breaches of the same or similar community standards of care, among which were the following: (1) negligent diagnosis (Liptzin's recorded diagnosis was delusional disorder rather than schizophrenic disorder, paranoid type); (2) negligent failure to inform the patient about the actual diagnosis and the life-

time, disabling severity of such a schizophrenic disorder, and thus, he failed to make the patient realize the dangers of not taking his medication; Dr. Liptzin told his patient he was "wired differently than other people"; (3) negligent failure to read the entire record of the patient's earlier involuntary hospitalization—he read only the discharge summary; (4) failure to recognize risk factors for violence; and 5) failure to refer the patient to a specific psychiatrist for further treatment.

These "breaches" of the standard of care consist of what can legitimately be described as procedural rather than substantive failings that, if corrected, would not have actually changed the outcome. For example, Dr. Liptzin stated that the treatment of delusional disorder in his clinic was identical to that for schizophrenic disorder, paranoid type (i.e., crisis intervention, a therapeutic alliance, and efficacious levels of antipsychotic medication). Thus, the patient received exactly the substantive treatment he required, and the crucial consideration was to have him accept treatment, not to convince him that he suffered from a schizophrenic disorder.[‡] Neither in my own experience, as I noted previously, nor in the scientific literature is there any empirical basis for believing that when patients like Mr. Williamson are informed that they have a very serious schizophrenic disorder they are more likely to comply with a regimen of antipsychotic medication. Again that seems to have been the proce-

[‡] It also should be emphasized that university mental health centers have traditionally erred on the side of giving students the less serious and less damaging diagnosis.

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cedure followed by his physicians when he was involuntarily confined and he refused to take the prescribed medication. There is also no reason to believe that reading the entire record of the patient's earlier unsuccessful treatment, or identifying periodic substance abuse and the patient's age as risk factors in a clinical risk assessment, would have led Dr. Liptzin or any other psychiatrists to recognize how very dangerous Williamson would become. The final issue, not referring the patient to a specific psychiatrist, caused me the greatest concern. That is my own standard of care in dealing with a very small private practice, and I believe that the lack of continuity of care is the greatest failing in psychiatry and modern medicine generally.

However, Dr. Liptzin asserts that under the time constraints of the university mental health center, it was standard practice to handle patient referrals as he did Williamson's. His colleagues on the GAP Committee on College Students confirmed this statement. There is therefore a factual dispute about the applicable standards of care, whether one assumes a national standard or one based on North Carolina law. My own opinion, however, is that the patient's experts stressed procedural failings that have little to do with the actual substantive practice of psychiatry in North Carolina or any other state.

Over the past 50 years, forensic psychiatry has not only moved into a competitive market, it has developed as a subspecialty whose practitioners are increasingly sophisticated in matters of law. This may be the most striking feature of contemporary forensic psychiatrists—

they sound like lawyers. Some of them seem to know more about certain areas of law than the lawyers who retain them. Rather than being coached by the lawyers, they are doing the coaching. The forensic psychiatrists of an earlier generation saw their task as doing in the legal setting what they did in their offices.⁸ The current generation increasingly accepts the idea that they are doing something quite different.² Theirs is a discourse meant to anticipate the tactical manipulations of opposing counsel, and by investing themselves in such a discourse they become more lawyer-like both by intention and inadvertently. Eventually they think and speak differently from their clinical colleagues as they adapt to the adversarial forum. The leaders of forensic psychiatry also see themselves as recognizing a different set of ethics from what applies in their traditional role as physicians.⁸ Their basic axiom is honesty. Elsewhere I have commented on this special ethics. On the one hand it seems superfluous, since all witnesses are sworn to tell the truth. On the other hand it seems to have had little effect in limiting "junk" testimony.

In fact, despite aspiring to an ethic of honesty, I believe forensic psychiatrists have succumbed to the rules of adversarial combat. They have inadvertently accepted the lawyers' 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). This is a paradigmatic shift in their professional outlook, which has significant consequences.

Perhaps the most important axiom to

be learned in legal academia is that professional self-interests influence policy, judgment, and ethics more than they should. Nowhere is this axiom more manifest than in the legal profession itself. Law firms and lawyers with market power have found ways to justify levels of reimbursement that would shock the conscience of the law's own "reasonable person." Nor is there anything in the lawyers' elaborate principles of ethics that bars such self-interested profiteering. Their code of ethics calls for a lawyer to be a zealous advocate in the pursuit of justice. But under the sheep's clothing of zealous advocacy there is hidden a den of wolfish self-interests: billable hours, contingency fees, reputation, and pure ego to mention only a few. Although no profession is more aware of potential conflicts of interest and the dangers of self-interested actions, there is none more able to rationalize them. Zealous advocacy is often the most useful rationalization of self-interested motives because it contains an undeniable kernel of truth about the requirements of our adversarial system.

Malpractice litigation involves the forensic psychiatrist in this web of self-interest, billable hours, reputation, and ego. Because the law in malpractice cases ordinarily requires the plaintiff to produce an expert witness to establish negligence, the plaintiff's lawyer cannot proceed without a helpful professional expert. Plaintiff's lawyers often complained in the past that physicians engaged in a conspiracy of silence. Indeed, within hospitals and small communities of physicians there existed an almost tribal solidarity. But those customs and traditions have

been eroding, and 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. Thus, a forensic psychiatrist asked to evaluate the Liptzin case for a plaintiff's lawyer who is seeking to retain him as an expert might begin with a lawyer-like perspective, "What within the bounds of honesty can be said against Dr. Liptzin's standards of care in the treatment of Mr. Williamson?" This attitude is quite different from asking oneself, "Is this a good psychiatrist to whom I would gladly refer a patient?" As recent empirical studies have shown, malpractice litigation now deals with every shade of gray, and in some specialties (e.g., obstetrics) virtually every physician, no matter how proficient his clinical skills may be, can expect to be sued in the course of his career. And lawyers certainly no longer have difficulty finding expert witnesses willing to make a case against their colleagues.⁹

This is not to suggest that all forensic psychiatrists or other experts think alike in such cases. There is a wide spectrum of opinion; nonetheless, being retained as an expert witness is 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. Gutheil,² a leading authority in the field, has discussed the percentage of cases in which, in his experience, the forensic psychiatrist will turn down a retaining attorney's request for his services on the grounds that the case cannot be supported.¹⁰ This is a matter in which the "ethics of honesty" is sure to be tested.

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Gutheil is himself a busy and respected forensic psychiatrist who can afford to turn down as many as 20 to 30 percent of requests. A novice may have an altogether different kind of pressure to establish his or her practice and reputation with trial lawyers. A recent reviewer of Dr. Gutheil's book¹¹ makes this point, questioning the significance of the percentage of cases and suggesting other extenuating considerations that might allow an honest forensic psychiatrist to participate in cases that might not seem supportable. As the reviewer points out, whether one can testify honestly in a particular case depends very much on what the opposing experts have said.

Forensic psychiatry's allegiance to the ethos of honesty as opposed to the medical ethos of *primum non nocere* (first of all do no harm) is a clear recognition of the different contexts in which they serve and the adversarial challenges and pitfalls of the expert witness. The adversarial system is the hallmark of the Anglo-American system of justice, and lawyers are bound by their ethics to be zealous advocates. Although Gutheil may turn down 20 to 30 percent of the attorneys who request his services, trial lawyers do not experience great difficulty in finding experts willing to testify. 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. Furthermore, as forensic psychiatrists have become increasingly sophisticated in legal matters, they tend to think more like lawyers than like physicians. Lawyers typically put great weight on the impor-

tance of procedures, and in my opinion that emphasis has made its way into forensic psychiatry and to expert testimony in malpractice cases. As noted above, I believe the *Williamson v. Liptzin* case deals with procedural matters rather than substantive failings, and it thus reflects this legalistic approach.

Many clinicians who work in university clinics were puzzled by the fact that expert psychiatric witnesses in the Liptzin case seemed to apply uniform standards of care in malpractice cases that do not take into account local practices. Their question is particularly pertinent in the Liptzin case, because the North Carolina legislature had passed a statute specifically intending to exclude national or other uniform standards. That in fact is one of the more important developments in the law of malpractice. Over the past few decades most jurisdictions have moved toward national standards for the medical specialties like psychiatry.¹²

Plaintiff's lawyers see this as a progressive development. Along with other legal changes it has destroyed the so-called "conspiracy of silence," which made it difficult for plaintiffs to obtain expert witnesses from the same locality who would be willing to testify against their colleagues. North Carolina's "same or similar locality" standard rejects this "progressive direction." Moreover the expert from a similar location must testify that he knows what the standards of care are in North Carolina where the alleged negligence took place. North Carolina's rules would therefore limit the pool of potential expert witnesses including most of those

with national reputations who are associated with teaching hospitals.

The legal rules, however, control only certain parameters; the courts rely on the experts to establish the standards of care. Unfortunately there are no agreed upon professional standards for many of the things psychiatrists do in different settings and in periods of change. Often the expert witnesses have very little they can point to or rely on in their testimony. Consider the standard of care that so impressed the jurors—that Williamson should have been told that he had a very serious and chronic psychiatric illness, schizophrenia, paranoid type. This is one of the most difficult and complicated matters a caring psychiatrist faces. The issue is even more vexing in a university mental health setting where there is appropriate concern that such a diagnosis will follow the young adult the rest of his life, limiting his personal and professional opportunities even when there is a good treatment result. At the core of the clinical management problem is the patient's lack of insight into his illness and the fact that he may either experience the diagnosis as an insult, provoking his rage, or as a defeat, leading to despair. As noted earlier, I know of no good scientific evidence that telling such a patient his diagnosis leads to greater treatment compliance. Arguably one has an obligation to tell a patient his diagnosis as a matter of informed consent. But this is a situation in which a therapeutic exception can and should apply.

Many forensic psychiatrists and other expert witnesses are painfully aware of the limitations of their testimony about

standards of care. Therefore, published standards of care are increasingly important and relied upon by forensic psychiatrists. Although many clinicians are unaware of this literature, it may be relevant if a legal conflict arises. The late Dr. Gerald Klerman¹³ in a published exchange with this writer set out as the standard of care very specific requirements for the initiation of treatment. He tied his requirements to informed consent, thus entangling ethics and standards of care.

It would seem that part of the grounds on which Dr. Liptzin was found negligent were taken from the Klerman standards. His first two standards were to make a DSM-IV diagnosis and to inform the patient. Dr. Klerman made no allowance for a therapeutic exception or the negative consequences involved in informing a patient of his schizophrenia when he has no insight into the fact that he is mentally ill. Klerman made a hard and fast rule for his proffered standards of care, and these have been accepted by some experts.

Klerman's thesis¹³ at the time was that psychiatrists were providing inefficacious treatments, particularly psychoanalytic therapy, to patients who could benefit from other kinds of treatments. Since that time his general views about substantive treatment have overwhelmingly prevailed. However, he also set down a procedural approach that, as the Liptzin case indicates, has become an issue in adversarial testimony in malpractice cases. I believe that the late Dr. Klerman would agree that Dr. Liptzin gave his patient efficacious care, and that was the underlying goal of the approach he proposed.

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The shift in emphasis to Klerman's procedure over Klerman's substance demonstrates how expert witnesses transform clinical wisdom into adversarial discourse.

Note Added in Proof

Since the submission of this article, more information about the expert testimony against Dr. Liptzin has been made available to me. It gives the other side of the story and demonstrates that the plaintiff's experts had "honest" criticisms of the care provided the patient. I expected and assumed nothing different. The basic premise of my essay remains unchanged. I believe that Dr. Liptzin provided enviable care, that any failings were procedural rather than substantive, and that the tragic outcome was unforeseeable. Like many of his colleagues at GAP, I had the impression that, if Dr. Liptzin had rigidly followed the "procedures" that are the proposed standards of care, the patient would have refused treatment.

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