Can a Psychiatrist Be Held Responsible When a Patient Commits Murder?

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When a former psychiatric patient killed two people on the streets of Chapel Hill, North Carolina, and then sued the psychiatrist who had treated him for failing to prevent the murders, the mental health world dismissed the suit as frivolous. But when a jury agreed with the killer and awarded him $500,000 in damages, bewilderment was the order of the day (1). Can it be true, psychiatrists asked, that murder pays—as long as you can blame your psychiatrist for your deed?

This strange story began when Wendall Williamson, a second-year law student at the University of North Carolina, stood up in class to announce that he was telepathic and had a videotape that could prove it (2). Although he initially refused treatment at the student counseling service, he acquiesced after a dean suggested that the school might not otherwise recommend him to sit for the bar examination. This was not Williamson's first contact with the mental health system. He had been hospitalized briefly 18 months earlier after being picked up at a campus gathering spot, yelling at passersby and striking himself repeatedly.

Williamson was assigned to a senior psychiatrist at the service, Dr. Myron Liptzin. Dr. Liptzin learned that Williamson had believed for two years that he could hear other people's thoughts as a consequence of his special powers. Sitting for hours in local bars, he would drink and silently "telepath" with other patrons. Recognizing that Williamson, who had declined medication during his previous hospitalization, would be a difficult patient to engage, Dr. Liptzin took a pragmatic approach. "He insists that I review the evidence of the videotape, and I tell him it's immaterial," wrote Liptzin in the patient's medical record. "Whether or not he's experiencing these things, he needs to make a decision about priorities, and if it's important to him to finish law school . . . he must try to suppress these other experiences." Persuaded by this argument, Williamson agreed to take modest dosages of an antipsychotic and to attend outpatient sessions.

Over the next ten weeks, Williamson saw Dr. Liptzin six times. He took his medication faithfully, stopping only once for a few days but resuming as soon as the voices returned. His psychotic symptoms gradually resolved. By the end of the semester, Williamson had successfully completed all his law school courses, an apparent therapeutic triumph. However, with summer vacation looming and the patient planning to return to his home in a distant part of the state, treatment was about to be interrupted. A further complication was Dr. Liptzin's long-planned retirement at the end of the academic year. At their final session, Dr. Liptzin wrote a prescription for a month's supply of medication, advised Williamson that he should obtain a refill from his primary care physician or the local mental health center, and told him to return in the fall to see the psychiatrist who would be taking Dr. Liptzin's place.

Unfortunately, Williamson stopped taking his medication shortly after arriving home, and he never contacted the counseling service on his return to campus. Eight months after his last session with Dr. Liptzin, Williamson, whose psychosis had returned during the fall, stalked and killed two strangers with an M-1 rifle on the streets of Chapel Hill and wounded a police officer before being shot by the police himself. At trial, Williamson was found not guilty by reason of insanity after he explained that his motive had been to stop people from projecting their thoughts into his head (3). From the state hospital in which he was confined, Williamson hatched the idea of a suit alleging that Dr. Liptzin's negligence in treating him was the sole cause of his murderous acts and thus that he was entitled to compensation for the trauma he had suffered in the wake of the murders.

When the malpractice suit came to trial, Williamson found expert witnesses who pointed to several alleged flaws in Dr. Liptzin's treatment (2). These included failure to obtain and read the full record of the patient's prior hospitalization, misdiagnosis—Dr. Liptzin had said the patient had a delusional disorder, rather than schizophrenia—and allowing the patient to leave treatment without a specific follow-up appointment.

In rebuttal, Dr. Liptzin's expert witnesses described his care of a difficult-to-engage patient as exemplary and noted that the lack of a specific referral was in keeping with the standard of care provided by a student health service, especially for an intelligent patient who was no longer psychotic at that time. Liptzin himself seemed to suggest that he chose a less stigmatizing diagnosis because he did not want to damage his patient's career prospects and that his treatment would have been the same regardless of which diagnosis he selected. Conflicting accounts were given of

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whether Dr. Liptzin had indicated to the patient that he could stop taking his medication, as long as he told someone he had done so, or whether he had been instructed to continue taking it indefinitely.

After three days of deliberations, the jury returned a $500,000 judgment against Dr. Liptzin (4). The jurors reported that what had persuaded them the most was Dr. Liptzin's failure to emphasize to the patient the severity of his disorder and its likely persistence, along with the need for lifelong use of medications, as well as the absence of a specific referral to another psychiatrist (5). The verdict was hailed by the North Carolina branch of the National Alliance for the Mentally Ill as an endorsement of the need for seamless treatment for persons with serious mental disorders (6). In contrast, psychiatrists warned that their resulting fear of liability in the event that patients stop taking prescribed medications might lead them to decline to accept patients who are severely ill (7).

Although lawsuits ending in damage awards to the victims of patients' violence have become a common concern of psychiatric practice since the *Tarasoff* decision in the mid-1970s (8), legal judgments that require psychiatrists to compensate patients for the consequences of their criminal acts had previously been unheard of. Indeed, a similar claim was rejected in one state—Iowa—on the grounds that state law precluded people from profiting from their own illegal behavior (9). Thus it is understandable that the verdict was met with such consternation.

Moreover, the jury's decision seemed to turn on several problematic propositions. First, the jurors apparently believed that psychiatrists must tell patients their precise diagnosis and likely lifetime prognosis at an early stage of treatment. Dr. Liptzin, sensing that his paranoid and treatment-averse patient might flee from therapy if forced to confront this information, had elected not to share it explicitly with him. Many skilled psychiatrists would probably have used a similar approach. However, the jury was clearly disturbed that Williamson was not told up front that he might need to take medication for the rest of his life.

In addition, the jurors accepted a broad characterization of psychiatrists' responsibilities to ensure follow-up care, even for competent adult patients. Many of Dr. Liptzin's colleagues in college mental health services indicated that general suggestions for students to seek follow-up treatment are the norm in that setting (10), as they probably are in many other settings. For patients who are more impaired, or when immediate follow-up is urgent, psychiatrists typically adjust their efforts to their patients' needs, including arranging specific appointments with identified clinicians if warranted.

Williamson, however, was no longer psychotic and had just successfully completed his second year of law school. That Dr. Liptzin should have found a psychiatrist for him in a distant part of the state or given him the name of a person to contact on his return to campus would probably have exceeded the standard of care. And, given that Williamson stopped taking his medication shortly after he returned home, it is unlikely that having a specific appointment would have changed the subsequent events in any way.

A further peculiarity of the verdict relates to North Carolina's status as one of the few remaining states to embrace the doctrine of contributory negligence. Under this doctrine, if a plaintiff's negligence contributed in any way to the outcome—even if only 1 percent of the causation can be attributed to the plaintiff's actions—the defendant cannot be held liable. In this case, in which Williamson made a series of decisions while nonpsychotic that may have led directly to the outcome, including stopping his medications and failing to seek follow-up care, it seems odd that the jury nevertheless bought Williamson's argument that Dr. Liptzin bore sole responsibility for the murders.

One final questionable aspect of the jury's verdict relates to the legal requirement that before a judgment of malpractice can be reached, any departures from the standard of care must be shown to have been the proximate cause of the resulting harms. The most common test for whether an act or omission constitutes a proximate cause is whether it was reasonably foreseeable at the time that the negligent act occurred that would result in the consequent harms. Williamson had no history of violent behavior and had never revealed a violent impulse during treatment. It is impossible to conclude that he was foreseeably dangerous at the time he was seen by Dr. Liptzin.

In the end, when this case was appealed to the North Carolina Court of Appeals, it was precisely the question of foreseeability on which the court chose to base its analysis (2). Throwing out the verdict in favor of the plaintiff, the court held that "given the very specific and novel factual scenario presented by this case, defendant's alleged negligence was not the proximate cause of plaintiff's injuries."

In support, the court noted that even the plaintiff's expert witnesses had been unwilling to say that Dr. Liptzin should have known that Williamson was dangerous during his treatment. The court also expressed concern that a contrary ruling in this case might lead mental health professionals to overuse involuntary commitment "to protect themselves against possible medical malpractice liability." Having resolved the case on that basis, the court did not need to address Dr. Liptzin's other challenges to the jury's verdict. The North Carolina Supreme Court refused to hear the plaintiff's appeal of this ruling, leaving the appellate court's decision as the final word in the case (11).

On occasion, a jury's decision in a malpractice case appears so anomalous that considerable caution must be exercised in drawing conclusions from it. Nonetheless, although the judgment against Dr. Liptzin ultimately was overturned, it is not unreasonable to ask what might be learned from the case. The answer, in part, is that prudent psychiatrists and other therapists will want to be thoughtful about how they arrange follow-up care for patients whom they can no longer see.

Sometimes a general suggestion that a patient seek follow-up care will be adequate. However, as the patient's condition warrants, clinicians might choose, in ascending order of time commitment, to provide the pa-

tient with the name of a particular practitioner or facility, to contact the facility to ascertain that a clinician is willing to see the patient, to help the patient make an appointment, or, with the patient's permission, to make an appointment on the patient's behalf. In some cases, it may be appropriate to ask for the patient's permission to contact his or her family to indicate a need for follow-up and to encourage the family to make sure that follow-up takes place. But of these approaches, no specific one will always be indicated, and the degree of assistance rendered the patient should be calibrated to his or her individual needs. ♦

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