NO. COA99-813 DISTRICT 15B

NORTH CAROLINA COURT OF APPEALS

* *

WENDELL JUSTIN WILLIAMSON,	)	
	)	
Plaintiff-Appellee,	)	From Orange County
	)	No. 97 CVS 690
vs.	)	
	)	
	)	
MYRON B. LIPTZIN, M.D.,	)	
	)	
Defendant-Appellant.	)	
	)	

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OF NORTH CAROLINA

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BRIEF OF AMICUS CURIAE NORTH CAROLINA PSYCHIATRIC ASSOCIATION, AMERICAN PSYCHIATRIC ASSOCIATION, AMERICAN MEDICAL ASSOCIATION, NORTH CAROLINA MEDICAL SOCIETY, AND NORTH CAROLINA PSYCHOLOGICAL ASSOCIATION

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BRIEF OF AMICUS CURIAE NORTH CAROLINA PSYCHIATRIC ASSOCIATION, AMERICAN PSYCHIATRIC ASSOCIATION, AMERICAN MEDICAL ASSOCIATION, NORTH CAROLINA MEDICAL SOCIETY, AND NORTH CAROLINA PSYCHOLOGICAL ASSOCIATION

* *

Pursuant to Rules 26 and 28(i) of the North Carolina Rules of Appellate Procedure, and with leave of this Court, the North Carolina Psychiatric Association; the American Psychiatric Association; the American Medical Association, its Litigation Center and its forty-nine constituent state medical societies; the North Carolina Medical Society; and the North Carolina Psychological Association (collectively, "Amici"), respectfully submit this amicus curiae brief in support of the position advanced by defendant-appellant Myron B. Liptzin, M.D., ("Dr. Liptzin") and in opposition to the arguments of plaintiff-appellee Wendell Justin Williamson ("Plaintiff"). Simultaneously with this brief, the North Carolina Hospital Association and the

American Psychological Association have filed a motion requesting to join in and adopt this amicus curiae brief.

QUESTION PRESENTED

WHETHER PUBLIC POLICY SUPPORTS THE EXTENSION OF THE LAW OF PROXIMATE CAUSATION TO ALLOW LIABILITY IN THIS CASE?

ARGUMENT

PUBLIC POLICY DOES NOT SUPPORT THE EXTENSION OF THE LAW OF PROXIMATE CAUSATION TO ALLOW LIABILITY IN THIS CASE

Regardless of the Court's resolution of the issues relating to Dr. Liptzin's alleged negligence, public policy considerations preclude an expansion of the law of proximate causation to allow liability in this case. North Carolina's leading case on proximate cause states:

> If the connection between negligence and the injury appears unnatural, unreasonable and improbable in the light of common experience, the negligence, if deemed a cause of the injury at all, is to be considered a remote rather than a proximate cause. It imposes too heavy a responsibility for negligence to hold the tortfeasor responsible for what is unusual and unlikely to happen or for what was only remote and slightly probable.

Hairston v. Alexander Tank and Equip. Co., 310 N.C. 227, 237-38, 311 S.E.2d 559, 567 (1984) (quoting Phelps v. Winston-Salem, 272 N.C. 24, 30, 157 S.E.2d 719, 724 (1967)). See also Batts v. Faggart, 260 N.C. 641, 645, 133 S.E.2d 504, 507 (1963) ("it must appear that the injury was the natural and probable consequence of the negligence"). It strains logic and the bounds of sound public policy to contend that Plaintiff's injuries--his wounds from being shot by the police, the trauma of being arrested and

put on trial for murder, and his loss of freedom--were a "probable" consequence of Dr. Liptzin's alleged negligence.

Dr. Liptzin instructed Plaintiff to seek follow-up treatment in the town in which he eventually decided to reside in the summer of 1994 (either Chapel Hill or Clyde) and provided him with a thirty-day supply of medication. No one can reasonably contend that, at that time, it was "probable" that Plaintiff would suffer such unusual injuries so many months later. In fact, when asked if Plaintiff's violence was foreseeable, Plaintiff's own experts testified that "I'm not sure I can go that far with it" and "[N]obody's crystal ball is that good." (T pp. 107, 242-43). Because Plaintiff's injuries were, at best, only a possibility, the judgment below has improperly expanded negligence liability to injuries that were "remote" or only "slightly probable." As explained so well in defendant-appellant's brief, Dr. Liptzin's alleged negligence did not, as a matter of law, proximately cause Plaintiff's unusual and improbable injuries. Moreover, the public interests in promoting patient autonomy and access to health care strongly militate against such an expansion of the doctrine of proximate causation.

I. THE JUDGMENT BELOW UNDERMINES PATIENT AUTONOMY AND RESPONSIBILITY AND WILL IMPEDE THE ABILITY OF HEALTH CARE PROFESSIONALS TO PROVIDE EFFECTIVE PATIENT CARE

In the last thirty years alone we have made great strides in erasing the historic stigma and lack of dignity associated with mental illness and the lack of civil rights accorded the mentally

ill. Historically, involuntary civil commitment was controlled almost entirely by the medical profession. Miller & Fiddleman, Involuntary Civil Commitment in North Carolina: The Result of the 1979 Statutory Changes, 60 N.C. L. Rev. 985, 985-86 (1982). In 1970, 31 states allowed civil commitment based on the certification of a single physician that the individual suffered from a mental illness and needed treatment. Gary B. Melton, *et. al.*, Psychological Evaluations for the Courts 300 (2nd ed. 1997). North Carolina's statutes prior to 1973 allowed commitment based on a certification by two physicians of mental illness and need for treatment and provided no counsel or court hearing. Miller, supra, at 993. One of the results of the civil rights movement of the 1960s was the transformation of civil commitment from essentially a clinical procedure to a legal process which recognizes the due process and liberty interests of the mentally ill. Id. at 985-86. These legal reforms helped contribute to a dramatic reduction in the number of patients confined to public institutions due to mental illness--a 65% decrease from 1955 to 1975, from over 550,000 to less than 200,000. Melton, supra, at 300.

Today North Carolina's mental health policy is clear:

> The policy of the State is to assist individuals with mental illness . . . in ways consistent with the dignity, rights, and responsibilities of all North Carolina citizens . . . through a service delivery system designed to meet the needs of clients in the least restrictive available setting . . . and to maximize their quality of life.

N.C.G.S. § 122C-2 (1999) (emphasis added). Our courts and legislature have established that our mental health policy should promote dignity, liberty, and responsibility. The judgment below threatens to undermine these achievements by elevating paternalism over autonomy and blame-shifting over personal responsibility.

The judgment below tells physicians and other mental health professionals that, even when a patient is not a candidate for civil commitment, they must revert to paternalistic practices to protect against the possibility of medical malpractice liability. Even with a patient as competent as Plaintiff was at the end of his treatment (a patient who functioned in the competitive environment of a top law school and who was able to tend to all of his daily affairs), the judgment tells mental health professionals they must take responsibility for the actions of their patients--and even former patients. But how much autonomy must be sacrificed is an open question. Must a health care professional make appointments on behalf of his former patient, act as a secretary coordinating the schedules of the new health care professional and the former patient, check in with the new health care professional on a periodic basis, phone the former patient to see if he has been complying with medical advice, follow up with the former patient's family members and friends on the patient's progress, or pay unannounced visits to the former patient's home? Under the judgment below, no mental health

professional can know how much is required. As a result of this uncertainty, there will be an increase in referrals for involuntary commitment evaluations, along with the infringement of patient privacy such referrals will entail. Thus, the judgment below undermines our achievements in promoting mentally ill patients' dignity and liberty, because the natural response will be to err on the side of sacrificing patient autonomy and confidentiality to avoid career-threatening liability.

The paternalistic standard of care mandated by the judgment below is also destructive to the relationship between mental health professionals and their patients, especially the often delicate therapeutic alliances formed with mentally ill patients. In order to promote a patient's best interest effectively, the mental health professional and patient must develop a level of mutual trust. When mental health professionals become more paternalistic and intrusive, this trust is undermined, with the result that patients become more reluctant to seek or continue necessary treatment. As such paternalism disrupts fragile provider-patient relationships, patient care suffers.

In addition, the judgment eviscerates any notion of personal responsibility by the patient. North Carolina's policy is to "assist individuals with mental illness . . . in ways consistent with the . . . responsibilities of all North Carolina citizens." N.C.G.S. § 122C-2 (emphasis added). Personal responsibility for one's conduct is part and parcel of autonomy; the price of

liberty is responsibility for one's actions. To place the blame for Plaintiff's tragic and unexpected injuries on Dr. Liptzin not only ignores the traditional law of proximate causation, but also undermines the proper role of individual responsibility.

In Cobo v. Raba, 347 N.C. 541, 495 S.E.2d 362 (1998), our Supreme Court rejected the argument that personal responsibility vanishes with the onset of mental illness. Mental health patients, like patients in general, have "an active responsibility" for their own well being. Id. at 546, 495 S.E.2d at 366 (citing McGill v. French, 333 N.C. 209, 217, 424 S.E.2d 108, 115 (1993)). See also Stephen J. Morse, A Preference for Liberty: The Case Against Involuntary Commitment of the Mentally Disordered, 70 Cal. L. Rev. 54, 61-62 (1982) (empirical evidence indicates that there is "little support for the proposition that the mentally disordered, in contrast with normal persons, lack the ability to control their behavior").

At the time Plaintiff's short-term, outpatient treatment with Dr. Liptzin ended, he was a highly-functioning individual, fully competent to make all of his own decisions, including decisions about his health care. Because of his competence, Plaintiff was fully autonomous and Dr. Liptzin had no right to control him. When Plaintiff exercised his autonomy by not following Dr. Liptzin's medical advice to seek follow-up care and continue his medication, Plaintiff accepted responsibility for

this decision. He should not now be allowed to shift this responsibility to Dr. Liptzin.

As described above, our mental health law has evolved greatly during the past century. As a result of this evolution, our General Assembly has determined that the appropriate point at which to draw the line against one's autonomy is when an individual is (1) mentally ill, and (2) either an imminent danger to himself, an imminent danger to others, or in need of treatment to prevent further deterioration that would predictably result in dangerousness. N.C.G.S. § 122C-261(a). It is at this point that autonomy--and therefore responsibility--can be taken away from an individual.

The "right to control" cases reinforce the significance of the public-policy line drawn by the criteria for civil commitment. These cases hold that "an individual is not liable for the conduct of a third person unless he has the ability and the right to control the conduct of that person." Cantrell v. United States, 735 F. Supp. 670, 673 (E.D.N.C. 1988). It is not until an individual loses his right to autonomy, such as by involuntary commitment, that responsibility for his actions can be shifted to the person with the right to control him. As explained by this Court in King v. Durham County Mental Health Auth., 113 N.C. App. 341, 345-47, 439 S.E.2d 771, 774-75 (1994), responsibility for a patient's violence can only be shifted from the patient to another individual when (1) the individual has the

ability and the right to control the patient (such as when a patient has been involuntarily committed), and (2) the individual is aware of the patient's propensity for violence. 113 N.C. App. 341, 345-47, 439 S.E.2d 771, 774-75 (1994).

Not only did Plaintiff in this case not exhibit a propensity for violence while under the care of Dr. Liptzin, but Dr. Liptzin never had any right to control him. Indeed, even Plaintiff's experts did not contend that Plaintiff was ever a candidate for civil commitment while under the care of Dr. Liptzin. Because Plaintiff at all times maintained his right to personal liberty and autonomy and Dr. Liptzin never had the right to control him, responsibility for the results of Plaintiff's violence cannot now be shifted to Dr. Liptzin.

The judgment below is contrary to the public policy of North Carolina because it undermines patient autonomy and responsibility and encourages paternalism and improper blame-shifting. Moreover, the paternalism mandated by this judgment is injurious to the provider-patient relationship and impedes the ability of health care professionals to provide effective care. For these reasons, this judgment should be overturned.

II. THE JUDGMENT BELOW ESTABLISHES A DANGEROUS PRECEDENT THAT WILL ADVERSELY IMPACT OTHER OUTPATIENT HEALTH CARE SERVICES AND HARM THOSE PATIENTS MOST IN NEED

One of the most menacing implications of this judgment, though perhaps not the most obvious, is its inevitable impact in other outpatient settings. If this Court upholds liability when

proximate cause has been stretched to these lengths, then it will be an easy transition from this student health service setting to other short-term, outpatient services. Urgent care centers, ambulatory surgical facilities, community mental health clinics, outpatient clinics for indigent patients, and perhaps most significantly, hospital emergency rooms (which all too often serve as primary care clinics for indigent patients) will all be adversely affected.

The potential liability posed by this judgment can be illustrated by the following hypothetical situation. A hospital emergency department ("ER") is staffed by physicians who specialize in emergency medicine and have no practice outside the ER. An out-of-town, diabetic patient presents at the ER with diabetic ketoacidosis ("DKA"), an acute complication that occurs when insulin levels are too low and which, in severe cases, can result in coma and possibly death. Similar to many mental illnesses, diabetes is generally a long-term condition with varying symptoms and outcomes that requires diligent compliance with medical direction. The patient's DKA is stabilized over a series of ER visits. The physician-patient relationship ends with the ER physician advising the patient to alter his diet, exercise regularly, and make a follow-up appointment with a family practice physician in his hometown. Additionally, the ER physician provides the patient with a thirty-day supply of insulin to cover the period until he can see another physician.

The ER physician does not attempt to make an appointment with a physician in the patient's hometown, nor does he call or visit the patient to see if he is following medical advice.

Unfortunately, in this hypothetical situation the patient neglects to make a follow-up appointment and discontinues his medication. As a result of that noncompliance, eight months later the patient loses consciousness while driving, crashes, and kills two people, injures two others, and is himself injured.

The foregoing hypothetical facts almost exactly parallel those in the present case, only in a different medical context. Under the judgment below, with its incredible expansion of what is considered proximate causation, the hypothetical ER physician would be liable for such a totally improbable and unforeseeable result.

The same scenario can be played out with any of a number of conditions, such as epilepsy, alcoholism, and depression. For example, a physician treating Timothy Blackwell for substance abuse prior to his 1997 intoxicated-driving collision in which four-year-old Megan Dail was killed could be held liable for the damages he has suffered as a result of that tragedy. See Amanda Garrett & Dan Kane, Jury Finds Blackwell Guilty of Murder in DWI Case, Raleigh News & Observer, Apr. 17, 1998, at A1.

Where, then, should we draw the line? Our jurisprudence draws the line at proximate causation. As quoted above:

> If the connection between negligence and the injury appears unnatural, unreasonable and

> improbable in the light of common experience, the negligence, if deemed a cause of the injury at all, is to be considered a remote rather than a proximate cause.

Hairston at 237, 311 S.E.2d at 567. The scenarios described above raise eyebrows for the very reason that they are "unreasonable and improbable in the light of common experience." As with those cases, proximate cause is lacking in the case at bar.

In the mental health context, our courts have also drawn a line at control. As described above, it is only when a mental health professional has a right to control a patient that he or she may be held liable for the patient's destructive conduct. See King at 345-47, 439 S.E.2d at 774-75. Without such a right to control, responsibility for these types of injuries cannot properly be shifted to the mental health professional.

Approval by this Court of the judgment below will encourage more lawsuits in a myriad of outpatient settings that stretch proximate causation beyond all recognition. Such a result is not in the interest of North Carolina's health care professionals or the citizens they serve.

In addition, this judgment will result in less care for those mentally ill patients who are most in need. The mentally ill are currently one of the most medically underserved segments of the population. See Mental Health: A Report of the Surgeon General, Dept. Health and Human Services (1999) ("[L]ess than one-third of adults with a diagnosable mental disorder receive

treatment in one year. In short, a substantial majority of those with specific mental disorders do not receive treatment."). This is so for a variety of reasons, including historical stigma, reluctance to seek treatment, financial barriers, and a shortage of mental health professionals. See, e.g., Mental Health: A Report of the Surgeon General, supra, ("The supply of well-trained mental health physicians . . . is inadequate in many areas of the country."); Mental Health Parity--Its Time Has Come, Am. Psychiatric Ass'n., Public Policy Advocacy, May 1999 ("[N]early 98% of private health insurance plans discriminate against patients seeking treatment for mental illness by requiring higher copayments, allowing fewer doctor visits or days in the hospital, or higher deductibles than imposed on other medical illnesses.").

Although Amici submit that the great majority of mental health professionals will continue to care for all patients whom they can reasonably serve, it is easy to see how an expansion of liability to include the unexpected deterioration of a model outpatient such as Plaintiff so many months after treatment will serve to steer badly-needed mental health professionals away from the most "risky" mentally ill individuals--those who most desperately need mental health care. Mental health professionals will wonder how they can possibly take enough precautions with such patients if Dr. Liptzin can be held liable in this case in which Plaintiff:

- was in short-term, voluntary, outpatient therapy;
- was competent enough to succeed at a top-ranked law school, complied with his therapy, never missed an appointment, never met the criteria for civil commitment, had no thoughts of violence until months after the physician-patient relationship had ended and indicated he would continue to comply with the instructions of the physician; and
- was instructed by the physician to follow up with the local mental health center when he decided where he would be residing, and was provided with a thirty-day supply of medication for the interim period.

As this case is discussed at professional conferences and in clinics and private practices around the country, mental health professionals have already begun asking how they can possibly do enough to protect against liability if this situation can be grounds for liability. See, e.g., Alan A. Stone, M.D., Commentary: The Verdict Against Myron Liptzin--Who Sets the Standard of Care?, Psychiatric Times, Apr. 1999 ("[M]embers of the Group for the Advancement of Psychiatry . . . crowded into a special plenary session [on the Liptzin verdict]. . . . There was a sense of collective disbelief . . . in this room full of distinguished psychiatrists . . . . Many of them spoke to me afterward and they all had the same concern: This could happen to them."). Unfortunately, many mental health professionals will

not be able to find a satisfactory answer to this question; they will decide that treating such patients is just not worth the risk.

Were the Court to stretch the law of proximate causation to encompass the situation at bar, it would only further exacerbate the plight of the chronically mentally ill. The judgment below does this vulnerable population a disservice and should be overturned.

CONCLUSION

Amici cannot say if Plaintiff himself, his parents, or someone else who observed him daily during his deterioration so many months after his last visit with Dr. Liptzin should have acted differently; if they should have taken steps to make sure he received proper treatment. Amici cannot say who, if anyone, should be held responsible for Plaintiff's violent decomposition. But Amici do submit that it would be a tragedy for North Carolina's patients and health care professionals alike if this Court were to agree that Dr. Liptzin should be held liable under these circumstances. Without question, that is not the answer to the problem. Rather, that would be the cure that killed the patient.

The decision below is contrary to both law and public policy, and this Court should reverse it.

Respectfully submitted this the 7th day of February, 2000.

KILPATRICK STOCKTON LLP

Noah H. Huffstetler, III
N.C. State Bar No. 7170
Sharon L. McConnell
N.C. State Bar No. 15983
Wallace C. Hollowell, III
N.C. State Bar No. 24304

By: Noah H. Huffstetler III
Noah H. Huffstetler III
Post Office Box 300004
Raleigh, NC 27622
Telephone: (919) 420-1700

ATTORNEYS FOR NORTH CAROLINA PSYCHIATRIC ASSOCIATION, AMERICAN PSYCHIATRIC ASSOCIATION, AMERICAN MEDICAL ASSOCIATION, NORTH CAROLINA MEDICAL SOCIETY and NORTH CAROLINA PSYCHOLOGICAL ASSOCIATION

OF COUNSEL:
Michael L. Ile
Anne M. Murphy
Leonard A. Nelson
Office of General Counsel
American Medical Association
515 N. State Street
Chicago, Illinois 60610
(312) 464-5532

CERTIFICATE OF SERVICE

This is to certify that the foregoing Brief of Amicus Curiae North Carolina Psychiatric Association, American Psychiatric Association, American Medical Association, North Carolina Medical Society and North Carolina Psychological Association was duly served on counsel for all parties by depositing a copy thereof in the United States mail, first-class, postage paid, addressed as follows:

L.G. Gordon, Jr.
Gordon & Nesbitt, P.L.L.C.
2000 West First Street, Suite 512
Winston-Salem, NC 27104

Seth R. Cohen
Smith, James, Rowlett & Cohen, L.L.P.
P.O. Box 990
Greensboro, NC 27402-0990

Bruce W. Berger
Pipkin, Knott, Clark & Berger, L.L.P.
3101 Glenwood Avenue, Suite 250
Raleigh, NC 27612

James G. Exum, Jr.
Smith Helms Mulliss & Moore, L.L.P.
P.O. Box 21927
Greensboro, NC 27420

Matthew W. Sawchak
Smith Helms Mulliss & Moore, L.L.P.
2800 Two Hannover Square
Raleigh, NC 27601

This the 7th day of February, 2000

Noah H. Huffstetler, III

RALLIB01:535628.05