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Jacob M. Appel

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# CAPITAL PUNISHMENT, PSYCHIATRISTS AND THE POTENTIAL “BOTTLENECK” OF COMPETENCE

JACOB M. APPEL

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## I. INTRODUCTION

Michael Owen Perry of Lake Arthur, Louisiana, an unemployed oil-field roustabout with a history of repeated hospitalizations for mental illness and an obsessive interest in singer Olivia Newton-John, was an unlikely individual to call into question many of the fundamental underpinnings of modern forensic psychiatry.<sup>1</sup> However, after his arrest in 1983 for murdering his parents, his 2-year-old nephew and two cousins at point-blank range with a shotgun, the delusional 28-year-old Perry became the center of a seven-year court battle over the appropriate role for psychiatrists in the administration of capital punishment.<sup>2</sup> Although at various times Perry, who suffered from schizoaffective disorder, expressed his belief that he was God and that Ms. Newton-John was “a Greek goddess living under a nearby lake,” he was nonetheless found competent to stand trial and subsequently convicted of first-degree murder—despite a plea of innocent by reason of insanity.<sup>3</sup>

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<sup>1</sup> John Mintz & Alfred E. Lewis, *Man Arrested Here is Suspect in Five Slayings*, WASH. Post, Aug. 2, 1983, at A1.

<sup>2</sup> *State v. Perry*, 610 So. 2d 746, 748 (La. 1992).

<sup>3</sup> Ruth Marcus, *Justices Order State to Review Medicating Death-Row Insane; Louisiana Wants Inmate Competent for Execution*, WASH. Post, Nov. 14, 1990, at A2; *see also Man Accused of Killing Family Goes on Trial*, THE ASSOCIATED PRESS, Oct. 21, 1985.

The jury also found Perry responsible for “committing murders with the intent to inflict great bodily harm to one or more persons” in a manner “especially heinous, atrocious or cruel” and recommended a death sentence.<sup>4</sup> Judge Cecil Cutrer formally imposed this penalty on December 19, 1985.<sup>5</sup> By that time, however, no psychiatrist could be found to declare Perry competent—a requirement for execution under the United States Supreme Court’s 1986 ruling in *Ford v. Wainwright*—and the question arose whether the anti-psychotic drug haloperidol might be administered, over the patient’s objections, to treat his active psychosis and render him fit for execution.<sup>6</sup>

Perry’s predicament created a challenge for both his psychiatrists and the legal system. If he were forced to take anti-psychotic medication—a demand his lawyers termed “Orwellian”—the psychiatrists who evaluated him stated that he might indeed be rendered sane enough to meet the level of competence required for execution.<sup>7</sup> On the other hand, if Perry was permitted to refuse anti-psychotic medication, he would continue to live in a state of nearly perpetual psychosis in which, to offer just one example of his delusions, he believed that he had to shave his eyebrows to “let his brain breathe.”<sup>8</sup> The question for the legal system was whether, under standards outlined in the 1990 Supreme Court decision in *Harper v. Washington*, Perry might be forcibly medicated without violating his rights under the Constitution’s guarantee of due process.<sup>9</sup> Psychiatrists faced an equally challenging dilemma: Did medicating Perry, and thus indirectly making his execution possible, violate the canons of their profession’s ethics?<sup>10</sup> More broadly, how complicit or entangled might psychiatrists become in the apparatus of capital punishment before such conduct became a censurable offense? Judge L. J. Hymel of the Louisiana Criminal Court had initially ruled in 1988, prior to the Supreme Court’s *Harper* decision, that Perry might be forcibly medicated and executed.<sup>11</sup> Perry appealed his own case all the way up to the United States Supreme Court—which sidestepped the issue and instructed the Louisiana State Supreme Court to review the case in light of the *Harper* ruling, even though the state’s highest court was already made in light of the *Harper* decision.<sup>12</sup> The judges in Louisiana clearly recognized the message from

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<sup>4</sup> *Man Faces Death Penalty in Slaying of Five Relatives*, THE ASSOCIATED PRESS, November 1, 1985.

<sup>5</sup> *State v. Perry*, 502 So. 2d 543, 545 (La. 1992).

<sup>6</sup> Adam Nossiter, *Paradox: Healing to Execute; Insane Man to Get Louisiana Rehearing*, THE ATLANTA J. AND CONST., Mar. 17, 1991, at A1.

<sup>7</sup> *Id.*

<sup>8</sup> *An Insane Remedy*, USA TODAY, Sept. 24, 1991, at 10A.

<sup>9</sup> *Washington v. Harper*, 494 U.S. 210, 223-227 (1990).

<sup>10</sup> David L. Katz, Note, *Perry v. Louisiana: Medical Ethics on Death Row – Is Judicial Intervention Warranted?*, 4 GEO. J. LEGAL ETHICS 707, 713-714 (1991).

<sup>11</sup> *The Cure That Could Kill*, SAINT LOUIS POST-DISPATCH, May 3, 1991, at 2C.

<sup>12</sup> *Perry v. Louisiana*, 498 U.S. 38 (1990). One likely explanation for the court’s one-sentence remand in this case may be that recently-appointed Justice Souter had not heard oral argument and could not take part in the decision and that the court was deadlocked 4-4 on the issue and wanted a later vehicle to address the underlying issues once the court was functioning at full capacity.

above: Caught between their own past interpretation of *Harper* and the U. S. Supreme Court's new order, they ruled that Perry had a right *not* to be forcibly medicated for execution under the "cruel and unusual punishment" clause of the *state* constitution, thereby avoiding the larger question of the rights of defendants under federal law.<sup>13</sup> As a result, Perry's sentence was to be stayed indefinitely until the government could demonstrate that the prisoner had "achieved or regained his sanity and competence for execution independent of the effects or influence of antipsychotic drugs."<sup>14</sup> This disposition fell short of that called for by the American Psychiatric Association in its amicus brief—namely, that Perry's sentence be formally commuted to life imprisonment so that he might receive appropriate psychiatric care without any risk of placing his life in future jeopardy.<sup>15</sup> At the same time, it opened the door for medicating Perry in the short term, and thereby spared both physicians and the state from grappling with the bind posed by his case.<sup>16</sup> However, the questions that had prompted the initial lawsuit remained unresolved.

Three distinct sets of questions arose surrounding the *Perry* case, itself the product of simultaneous changes in the technology of capital punishment and in attitudes toward the death penalty that have increasingly placed the exigencies of the legal system on a collision course with the consensus opinion of the medical community. The first of these questions was whether the United States Constitution protected condemned inmates from unwanted medical treatment—either corporeal or psychiatric—if receiving such care made them fit to be lethally injected. The second question was the degree to which, under the canons of medical ethics, psychiatrists might participate in capital punishment. While the specific issue in *Perry* was forcible medication, this represents just one of many points in the chain of complicity where a psychiatrist might be called upon to facilitate the process. Even the act of testifying that a prisoner is competent and thereby executable under the *Ford v. Wainwright* standard is a form of participation, albeit remote, and the professional debate surrounding *Perry* left the ethics of various degrees of participation largely unresolved.<sup>17</sup> (Another matter still unresolved is whether one might medicate a *willing* inmate to render him competent for execution—or whether doing so would actually be abetting a suicide—but that is a question beyond the

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<sup>13</sup> *State v. Perry*, 610 So. 2d 746, 747-749 (La. 1992); Kristen Wenstrup Crosby, Comment, *State v. Perry: Louisiana's Cure-to-Kill Scheme Forces Death Row Inmates to Choose Between a Life Sentence of Untreated Insanity and Execution*, 77 MINN. L. REV. 1193, 1209 (1993); *Court Says Killer Cannot Be Forced to Take Drugs for Sanity*, N.Y. Times, Oct.21, 1992, at A21.

<sup>14</sup> *State v. Perry*, 610 So. 2d at 747 (La. 1992).

<sup>15</sup> Brief for the American Psychiatric Association et al. as Amici Curiae Supporting Petitioner, *Perry v. Louisiana*, 498 U.S. 1075 (1990)(No. 89-5120), 1990 U.S. S. Ct. Briefs LEXIS 1053.

<sup>16</sup> *State v. Perry*, 610 So. 2d at 747 (La. 1992); Kristen Wenstrup Crosby, Comment, *State v. Perry: Louisiana's Cure-to-Kill Scheme Forces Death Row Inmates to Choose Between a Life Sentence of Untreated Insanity and Execution*, 77 MINN. L. REV. 1193, 1209 (1993); see also Lindsay A. Horstman, Comment, *Commuting Death Sentences of the Insane: A Solution for a Better, More Compassionate Society*, 36 U.S.F. L. REV. 823 (2002)

<sup>17</sup> See Paul S. Appelbaum, *A Theory of Ethics for Forensic Psychiatry*, 25 J. AM. ACAD. OF PSYCHIATRY AND LAW 233 (1997).

scope of this essay.) Finally, the truncated resolution of the *Perry* case left entirely open the question of the impact that legal codes and social context might have on ethical norms in this area: If a certain degree of medical or psychiatric acquiescence in the execution process might be necessary to reduce a patient's suffering, once execution had been unequivocally decided upon by the state, was such limited participation excusable or even desirable? For example, might a physician ethically re-infuse an anesthetic or sedative during the execution process, after initial attempts by ancillary staff had failed, if a patient appeared to be in acute discomfort? In short, this question asks to what degree existing practices and the existing legal regime may allow for exceptions to general ethical principles that govern the conduct of physicians in the area of capital punishment.

The purpose of this paper is to merge two largely separate bodies of writing on the subject of psychiatric participation in capital punishment. Much has already been written from the perspective of legal academics regarding the rights of prisoners to be free from unwanted medical care if the purpose of providing such care is to render them fit for execution.<sup>18</sup> Medical ethicists have also written much on the degree to which physicians, and specifically psychiatrists, may participate in facilitating the death penalty before they become so complicit as to violate accepted standards of professional ethics.<sup>19</sup> Surprisingly, these two fields of inquiry have developed in relative isolation. What this essay seeks to do is to examine the relationship between these two bodies of thought and to explore the following question: What impact do the ethical limits of psychiatric practice have on the application of capital punishment? Two other questions naturally follow: 1) Do ethical limitations on psychiatric participation create a "bottleneck" that will, in practice, make executions impossible; and 2) Are there ways of meeting the constitutional rights of condemned defendants that would allow for execution *without* the participation of medical professionals? In order to answer these

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<sup>18</sup> See, e.g., Kelly A. Gabos, Note and Comment, *The Perils of Singleton v. Norris: Ethics and Beyond*, 32 AM. J.L. & MED. 117 (2006); Rebecca A. Miller, Comment, *The "Insane" Contradiction of Singleton v. Norris: Forced Medication in a Death Row Inmate's Medical Interest Which Happens to Facilitate His Execution*, 22 U. ARK. LITTLE ROCK L. REV. 659 (2000); Sarah F. DePanfilis, Note, *Singleton v. Norris: Exploring the Insanity of Forcibly medicating, then Eliminating the Insane*, 4 CONN. PUB. INT. L.J. 68 (2004); Ronald J. Tabak, *Executing People with Mental Disabilities: How We Can Mitigate an Aggravating Situation*, 25 ST. LOUIS U. PUB. L. REV. 283 (2006); Holland Sargent, Comment, *Can Death Row Inmates Just Say No?: The Forced Administration of Drugs to Render Inmates Competent for Execution in the United States and Texas*, 35 TEX. TECH. L. REV. 1299 (2004); Amir Vonsover, Comment, *No Reason for Exemption: Singleton v. Norris and Involuntary Medication of Mentally Ill Capital Murderers for the Purpose of Execution*, 7 U. PA. J. CONST. L. 311 (2004).

<sup>19</sup> See, e.g., Charles P. Ewing, "Dr. Death" and the Case for an Ethical Ban on Psychiatric and Psychological Predictions of Dangerousness in Capital Sentencing Proceedings, 8 AM. J.L. & MED. 407 (1983); Michael L. Radelet & George W. Barnard, *Ethics and the Psychiatric Determination of Competency to be Executed*, 14 BULL. AM. ACAD. PSYCHIATRY AND LAW 37 (1986); Douglas A. Sargent, *Treating the Condemned to Death*, 16 HASTINGS CENTER REP. 5 (1986); Marianne Kastrop, *Psychiatry and the Death Penalty*, 14 J. MED. ETHICS 179 (1988); Alfred M. Freedman & Abraham L. Halpern, *The Psychiatrist's Dilemma: A Conflict of Roles in legal Executions*, 33 AUSTL. & N.Z. J. PSYCHIATRY 629 (1999).

questions, a brief exploration of evolving medical attitudes toward capital punishment is necessary.

## II. PHYSICIANS & CAPITAL PUNISHMENT

The controversy surrounding the role of physicians in capital punishment dates back to at least the 18<sup>th</sup> century Enlightenment, when French physician and death-penalty opponent Joseph-Ignace Guillotin proposed a more humane method of execution, “a machine that beheads painlessly,” to replace the torture of the condemned upon the breaking wheel.<sup>20</sup> In the years following American independence from Great Britain, Dr. Benjamin Rush became the public face and voice of opposition to capital punishment in the United States.<sup>21</sup> His campaign to end executions as “contrary to reason,” launched from Benjamin Franklin’s front porch in 1787 and supported by many of his medical brethren, convinced the Pennsylvania legislature to prohibit executions for all crimes except first degree murder.<sup>22</sup> By the late 19th century, physicians had become active participants in the national debate over which methods of execution were most humane. For example, notable physicians dominated the New York State commission that in 1887 recommended the prohibition of hanging as a method of killing.<sup>23</sup> Three years later, New York State asked three nationally prominent medical men—Carlos F. MacDonald, the President of the State Board of Lunacy; George F. Shrady, editor of the *Medical Record*; and alienist Edward Charles Spitzka—to witness the electrocution of murderer William Kemmler and to ascertain that the first use of the electric chair proceeded smoothly.<sup>24</sup> Yet Kemmler’s execution devolved into chaos when the condemned man started to breathe again after MacDonald and Spitzka had already declared him dead.<sup>25</sup> Soon thereafter, Dr. Shrady spoke out publicly against the death penalty, writing that, “Although science had triumphed, the question of the humanity of the act is still an open one....We venture to predict that public opinion will soon banish the death chair...and that imprisonment for life will be the only proper punishment meted out to a murderer.”<sup>26</sup> The debate over the merits of

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<sup>20</sup> STEVEN MILES, *THE HIPPOCRATIC OATH AND THE ETHICS OF MEDICINE* 72 (Oxford University Press Inc., 2004); see also Arthur Isak Applebaum, *Professional Detachment: The Executioner of Paris*, 109 HARV. L. REV. 458 (1995).

<sup>21</sup> DAGOBERT D. RUNES, *THE SELECTED WRITINGS OF BENJAMIN RUSH* 35-37 (Philosophical Library, 1947).

<sup>22</sup> James R. Archer, *Capital Crimes*, in *THE ENCYCLOPEDIA OF CRIME AND PUNISHMENT* 153 (David Levinson ed., 2002).

<sup>23</sup> *Death by Electricity: The Substitute Recommended for Hanging*, N.Y. TIMES, Jan. 17, 1988; *Reform in Executions*, WASH. POST, Jan. 19, 1888.

<sup>24</sup> Kenneth Baum, “*To Comfort Always*”: *Physician Participation in Executions*, 5 N.Y.U.J. LEGIS. & PUB. POL’Y 47 (2001); *Dr. C.E. Spitzka, Alienist, Is Dead*, N.Y. TIMES, Jan. 14, 1914; *The Kemmler Execution: Dr. C. E. Spitzka Tells Doctors and Lawyers All About It*, N.Y. TIMES, Nov. 11, 1890; *Dr. Shrady Dead*, N.Y. TIMES, Dec. 1, 1907.

<sup>25</sup> John G. Leyden, *A Century of Executions*, WASH. POST, Aug. 15, 1990, at D5.

<sup>26</sup> *Says It Is Barbarous: Dr. Shrady Doesn’t Like the Way Kemmler was Executed*, CHI. TRIB., Aug. 8, 1890, at P2.

execution, and the appropriate role for physicians in the process, brewed for months after the Kemmler execution before the uproar abated.<sup>27</sup>

During the first half of the 20<sup>th</sup> century, a handful of physicians gained widespread attention for campaigning against capital punishment, and the role of physicians in the process, most notably psychiatrist Lloyd Briggs, but it was not until the 1960s that Dr. William F. Graves returned the controversy to the center stage of professional and public opinion.<sup>28</sup> Graves, a former physician at San Quentin Penitentiary from 1942 to 1954 who had participated in the executions of notorious killers Barbara Graham and William Charles Cook, refused to take part in any further executions after the death of Cook because he had concluded that doing so violated the ethical canons of his profession—making his the first documented case of an American prison physician refusing to participate in the administration of capital punishment.<sup>29</sup> After his change of heart, Graves toured the country warning the public about the horrors of the death penalty.<sup>30</sup> The ideas of men like Briggs and Graves paved the way for a second debate over the role of the medical profession in capital punishment, beginning in the late 1970s, which stemmed largely from changes in the material aspects of the punishment process.<sup>31</sup>

The role of physicians in the administration of capital punishment in the United States was rather limited until the late 1970s. Ironically, efforts to abolish the death penalty led indirectly to an *increased* role for medical professionals. At the time of the Supreme Court's ruling in *Furman v. Georgia* (1972), which declared the existing regime governing the death penalty unconstitutional and ultimately led to a four year moratorium on the practice, the thirty-seven states that sanctioned executions relied upon four methods: hanging, electrocution, lethal gassing and firing squad.<sup>32</sup> Although several states required physician involvement in these processes, and all mandated a physician to confirm that death had in fact occurred, none of these methods of execution inherently demand a significant role for healthcare professionals.<sup>33</sup> It was the shift toward lethal injection—a method first introduced in Oklahoma and Texas in 1977 because it was considered “less painful

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<sup>27</sup> *The Kemmler Execution: Dr. C. E. Spitzka Tells Doctors and Lawyers All About It*, N.Y. TIMES, Nov. 11, 1890

<sup>28</sup> *Dr. Lloyd Briggs, Psychiatrist, 77: Reformer of Massachusetts Insane Asylum System Dies in Tucson Home*, N.Y. TIMES, Mar. 1, 1941

<sup>29</sup> Dan L. Thrapp, *Death Penalty Hit By Church Groups*, L.A. TIMES, Feb. 20, 1955, at A4.

<sup>30</sup> Ron Einstoss, *Former Prison Doctor Decries Death Penalty*, L.A. TIMES, Nov. 4, 1967, at P3; Paul Coates, *The Death Penalty: Our Society's Indictment*, L.A. TIMES, Feb. 21, 1968, at B6.

<sup>31</sup> This paper argues that changes in technology led to increased debate over the role of psychiatrists in capital punishment. For an alternate approach, arguing that increased visibility of psychiatric discretion led to this increased attention. See Gregg M. Bloche, *Psychiatry, Capital Punishment, and the Purposes of Medicine*, 16 INT'L J.L. & PSYCHIATRY 301, 301-357 (1993).

<sup>32</sup> *Execution Facilities Put to Unuse*, THE HARTFORD COURANT, Oct. 2, 1972, at D33.

<sup>33</sup> Arif Kahn & Robyn M. Leventhal, *Medical Aspects of Capital Punishment Executions*, 47 J. FORENSIC SCI. 847, (2002).

and thus more humane”—that opened the door to a closer entanglement between physicians and the death apparatus of the states.<sup>34</sup>

The preferred method of lethal injection in the thirty-eight states that eventually adopted this method of execution is administration of a three-drug cocktail containing sodium thiopental (to render the prisoner unconscious), pancuronium bromide (to paralyze the prisoner) and potassium chloride (to induce cardiac arrest). Dosing of these substances may prove challenging, and errors in dosing can cause severe suffering on the part of the inmate.<sup>35</sup> Selecting an injection site, and ensuring that the cocktail is injected into a vein, as opposed to muscle tissue, is also essential if the suffering of the condemned is to be minimized.<sup>36</sup> While lethal injection might theoretically be administered and supervised by a layperson, non-medical efforts have often led to unpalatable complications for the inmate and bad publicity for the state. As a result, many states require the participation of doctors in the process.<sup>37</sup> Oklahoma’s pioneering statute, for example, initially required a licensed physician to inspect the equipment to make sure that it would flow into the prisoner’s veins and for a physician to pronounce the inmate dead.<sup>38</sup> A “trained medical employee” was permitted to administer the lethal dose.<sup>39</sup> Other states have also opted to have physicians train lay executioners, such as physician’s assistants, to conduct the injections.

As states introduced lethal injection statutes in the late 1970s and early 1980s, American physicians for the first time argued that a collective stand against their participation in the process might be necessary. When Texas passed its lethal injection statute in 1977, the state’s medical association became the first in the nation to restrict the role of physicians in executions, issuing a policy statement which warned that the only role an ethical physician might play in the process was to certify the death of the inmate.<sup>40</sup> Soon afterward, Dr. Louis J. West of the University of California at Los Angeles called for a “national medical declaration that it would be unethical for a physician to lend his presence to an execution, even as an official examiner to certify the fact and time of death.”<sup>41</sup> In 1980, attorney William J. Curran and cardiologist Ward Casscells published a “Sounding Board” article in the *New England Journal of Medicine* that threw down the gauntlet on the subject of lethal injection. After a thorough investigation of the moral dangers of physician

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<sup>34</sup> William Curran & Ward Casscells, *Ethics of Medical Participation in Capital Punishment By Intravenous Drug Injection*, 302 *NEW ENG. J. MED.* 226 (1980).

<sup>35</sup> *Baze v. Rees*, 553 U.S. 35, 53 (2008); Linda Greenhouse, *Justices To Enter the Debate Over Lethal Injection*, *N.Y. TIMES*, Sept. 26, 2007.

<sup>36</sup> David Waisel, Commentary, *Physician Participation in Capital Punishment*, 82 *MAYO CLINIC PROC.* 1073, (2007).

<sup>37</sup> See, e.g., Nathan Crabbe, *Executioner’s Qualifications Still in Doubt*, *GAINESVILLE SUN*, Mar. 1, 2007.

<sup>38</sup> William Hines, *Ethics of Injection Killing Debated*, *WASH. POST*, Feb. 28, 1980, at N4.

<sup>39</sup> *Id.*

<sup>40</sup> See, e.g., Philip Boffey, *Experts Debate Ethics of Doctor’s Execution Role*, *N.Y. TIMES*, Dec. 8, 1982, at A28.

<sup>41</sup> Altman, Lawrence K. *Dead by Drugs for Criminals*, *The Times-News*, Henderson, NC, March 13, 1980.

involvement in this process, they concluded: "The medical profession in the United States should formally condemn all forms of medical participation in this method of capital punishment."<sup>42</sup> Within months, both the American Medical Association and the American Psychiatric Association, while noting that they were not taking a stand upon the morality of capital punishment, declared participation by physicians in the process to be unethical.<sup>43</sup> According to the A.M.A. resolution, which relied upon the Hippocratic Oath's dictum to do no harm, "A physician as a member of a profession dedicated to preserving life when there is hope of doing so should not be a participant in a legally authorized execution."<sup>44</sup> The A.P.A. position statement, drawing a direct comparison to medical practice in Nazi Germany, stated that the organization "strongly opposes any participation by psychiatrists in capital punishment, that is, in activities leading directly or indirectly to the death of a condemned person as a legitimate medical procedure."<sup>45</sup> The following year, the 45-nation World Medical Association called upon American physicians to refuse collectively to participate in the process.<sup>46</sup> By 1982, when Texas executed Charles Brooks Jr. via lethal injection, the first actual use of this novel method, many of the medical profession's leading bodies, institutions and individuals had spoken out against a role for their colleagues in the process. However, no consensus existed in the medical community as to the *degree* of involvement that was permissible (*e.g.* Could a physician sign a death certificate?) or as to the appropriate sanction for participation. Whether Dr. Ralph Gray, who had supplied the drugs for Brooks' execution and examined him after his death, had violated the ethical standards of medicine was hotly debated—with the American Medical Association *defending* his limited role in the process.<sup>47</sup> By the early 1990s, several states attempted to avoid any conflict with the medical establishment by reducing, as much as possible, the role that medical professionals played in executions.<sup>48</sup> Oklahoma repealed its requirement that physicians supervise the process. Texas enacted a rule that the death-certifying physician might wait outside the execution chamber until the warden has already pronounced the condemned prisoner to be dead.<sup>49</sup> Other states, such as Illinois, continued to permit willing physicians to participate, but relied upon

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<sup>42</sup> William Curran & Ward Casscells, *The Ethics of Medical Participation in Capital Punishment By Intravenous Drug Injection*, 302 NEW ENG. J. MED., 236, 230 (1980).

<sup>43</sup> Ronald Kotulak, *Execution by Injection: The Doctor's Dilemma*, CHIC. TRIB., Dec. 12, 1982, § 2, at 4; *Position Statement on Medical Participation in Capital Punishment*, 137 AM. J. PSYCHIATRY 1487, 1487 (1980).

<sup>44</sup> Betsy Glennon, Editorial, *A Physician Is Not an Executioner: The Case Against Lethal Injection in Virginia*, WASH. POST, Feb. 21, 1988, at B8.

<sup>45</sup> *Position Statement on Medical Participation in Capital Punishment*, 137 AM. J. PSYCHIATRY 1487, 1487 (1980).

<sup>46</sup> *Doctors Oppose Execution by Injection*, L.A. TIMES, Sept. 13, 1981, at 15.

<sup>47</sup> Boffey, *supra* note 40.

<sup>48</sup> Don Colburn, *Lethal Injection: Why Doctors are Uneasy About the Newest Method of Capital Punishment*, WASH. POST, Dec. 11, 1990, at Z12.

<sup>49</sup> *Id.*

registered nurses or “physician extenders” (i.e. specially trained technicians) in the absence of medical professionals.<sup>50</sup>

A small minority of physicians continues to express support for the involvement of medical professionals in executions. Some have argued that doing so makes the procedure as painless as possible for the condemned and avoids unnecessary suffering.<sup>51</sup> As Dr. Carl Musso, an internist who assisted with executions in Georgia explained,

We, as doctors, are not the ones deciding the fate of this individual...this is an end-of-life issue, just as with any other terminal disease. It just happens that it involves a legal process instead of a medical process. When we have a patient who can no longer survive his illness, we as physicians must ensure he has comfort.”<sup>52</sup>

Other physicians have argued that a duty to the public safety outweighs any harm done to the individual patient under these circumstances.<sup>53</sup> Recently, Michael Keane has done studies showing that failure to execute condemned murderers actually causes measurable brain damage in the surviving relatives of crime victims, suggesting that medicine may have a public health related duty to participate in executions.<sup>54</sup> However, doctors who will agree to participate in executions are few. Those who are willing to advocate in the public forum for physician participation are even fewer. State legislatures have not been quick to recognize this emerging consensus—and the result has often been conflict between the demands of the penal system and the ethical canons of the medical profession.

This debate over the appropriate role for physicians in the lethal injection process came to a head in North Carolina in 2006. The controversy originated in the case of *Brown v. Beck*, a prisoner’s challenge to that state’s execution protocol.<sup>55</sup> The inmate in the case feared that the lethal cocktail might not ensure that he remained unconscious throughout the process. In ruling against the prisoner, the United States District Court for the Eastern District of North Carolina relied upon a state statute that required the presence of a licensed physician to monitor the inmate’s level of consciousness during the procedure and the belief that “the questions raised could be resolved by the presence of medical personnel.”<sup>56</sup> In response to this ruling, and inquiries from member physicians, the state medical board issued a statement that physicians may not participate in any aspect of executions, and that doing so would

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<sup>50</sup> *Id.*

<sup>51</sup> Emma Marris, *Will Medics’ Qualms Kill the Death Penalty?*, 44 NATURE 8, 9 (2006).

<sup>52</sup> Atul Gawande, *When Law and Ethics Collide: Why Physicians Participate in Executions*, 354 NEW ENG. J. MED. 1221, 1228 (2006).

<sup>53</sup> Neil Farber et al., *Physicians’ Willingness to Participate in the Process of Lethal Injection for Capital Punishment*, 135 ANNALS INTERNAL MED. 884, (2001); Robert D. Troug & Troyen A. Brennan, *Participation of Physicians in Capital Punishment*, 329 NEW ENG. J. MED. 1346, 1346 (1993).

<sup>54</sup> Michael Keane, *The Ethical “Elephant” in the Death Penalty “Room”*, 8 AM. J. BIOETHICS 45 (2008).

<sup>55</sup> *Brown v. Beck*, No. 5:06-CT-3018-H, 2006 U.S. Dist. WL 3914717 (E.D.N.C. 2006).

<sup>56</sup> *Id.* at 8.

subject them to disciplinary action.<sup>57</sup> The result was a series of suits and countersuits between the medical licensing board and the state Department of Corrections, the ultimate results of which are still pending.<sup>58</sup> Brown, however, will not benefit from the results as he was executed on April 21, 2006.<sup>59</sup> Far more significant than the ultimate resolution of this case is the strong statement on the part of a medical licensing authority, in a conservative state with a lengthy history of support for capital punishment, that physician participation in the process amounts to an ethical breach worthy of license revocation. The conflict is also significant because it suggests an indirect path to compete abolition of capital punishment: If federal courts require physician participation for executions to proceed within the protective principles of the 8<sup>th</sup> and/or 14<sup>th</sup> Amendments, and state licensing boards refuse to permit doctors to do so, the result will be an impasse that prevents executions from taking place.

What is clear is that a broad consensus has emerged over the preceding two decades that physicians should not participate actively in the administration of the death penalty.<sup>60</sup> Bioethicist Arthur Caplan stood on solid ground when he recently wrote that nearly every major medical organization in the world has made clear its opposition to such participation.<sup>61</sup> However, the degree to which physicians may be complicit in the process without transgressing ethical boundaries still remains uncertain. Is training another individual in the basic principles of dosing and/or infusing, knowing that he will subsequently perform executions, itself a violation of ethical norms? May physicians record vital data before or sign death certificates after lethal injections are administered? The state medical licensing board of Kentucky investigated Governor Ernie Fletcher, a physician, in 2004 for merely approving death warrants in his capacity as governor.<sup>62</sup> A group of physicians led by Dr. Arthur Zitrin of New York, who spearheaded the effort to revoke Fletcher's license, has since filed complaints with numerous state licensing boards against physicians associated with the execution process in the hope of having the licenses revoked.<sup>63</sup> The Moratorium Campaign, an abolitionist organization founded by Sister Helen Prejean of "Dead Man Walking" fame, has also made convincing state

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<sup>57</sup> Guy Loranger, *North Carolina Supreme Court Contemplates Doctors' Role in Executions*, N.C. LAWYERS WEEKLY, NOV. 24, 2008.

<sup>58</sup> Daniel Lerman, *Second Opinion: Inconsistent Deference to Medical Ethics in Death Penalty Jurisprudence*, 95 GEO. L.J. 1941 (2007).

<sup>59</sup> *North Carolina, Using Medical Monitoring Device, Executes Killer*, N.Y. TIMES, Apr. 22, 2006, at A13.

<sup>60</sup> See Neil Farber et al., *Physicians' Willingness to Participate in the Process of Lethal Injection for Capital Punishment*, 135 ANNALS INTERNAL MED. 884, (2001) (for a comprehensive survey of physician attitudes towards participation in capital punishment).

<sup>61</sup> Arthur Caplan, *Should Physicians Participate in Capital Punishment?*, 82 MAYO CLIN. PROC. 1047, 1047 (2007).

<sup>62</sup> Brett Barrouquere, *Governor's Execution Role Risks MD License*, CHI. TRIB., Nov. 19, 2004, at 19.

<sup>63</sup> Carlos Campos, *Doctors' Role in Executions Debated: Death Penalty Foes Go After Licenses*, ATL. J. CONST., Feb. 1, 2005, at 1A.

medical boards both to prohibit physicians from taking part in executions and to revoke the licenses of those who do so one of their top priorities.<sup>64</sup>

Among the most controversial debates in the evolving relationship between physicians and capital punishment is the degree to which physicians may use their healing powers on inmates in order to improve their health—even if doing so *also* makes them fit for execution. At one extreme are cases where the state forcibly treats an inmate who has attempted suicide in order to preserve his life for the execution.<sup>65</sup> In a particularly glaring instance, Robert Brecheen intentionally overdosed on sleeping pills within hours of his scheduled execution, and Oklahoma prison officials insisted that doctors pump his stomach to render him fit for his lethal injection.<sup>66</sup> In another case, death row inmate David Martin Long attempted an overdose with pills two days before he was scheduled to die, and Texas prison authorities had the prisoner flown from the intensive care unit in Galveston—on a ventilator and accompanied by a full medical team—to carry out his execution in Huntsville.<sup>67</sup> More complicated are the cases of inmates whose execution may be months or years away. No court has yet resolved the question of whether the state has a legitimate interest in reviving a condemned prisoner in spite of an otherwise valid “do not resuscitate” order or whether states may impose a simple course of antibiotics on a death row inmates.<sup>68</sup> Similarly, no state licensing authority or major medical organization has staked out ground on these questions. The difficulty in these cases, of course, is that the physician is not actually harming the patient physically, and may even be helping them under a narrow or short term understanding of the meaning of beneficence. While the patient’s autonomy is certainly being overridden, since the state has apparently carved out a specific exception to generally-held notions of patient autonomy, much as it does with minors or the incompetent, it is not entirely clear that physicians who offer such “care” operate beyond the bounds of acceptable practice.

The conflict becomes particularly challenging to negotiate where psychiatric care is concerned. As Yale psychiatrist Howard Zonana, chairman of the American Psychiatric Association’s Commission on Judicial Action, has argued, “If the prisoner needed an emergency appendectomy [in order to keep him alive for execution]...probably no doctor would have qualms about treating him, even against his will.” However, the same reasoning does not necessarily apply to administering psychiatric medication.<sup>69</sup> Moreover, even if the medical community could arrive at a consensus regarding the corporeal medical treatment of condemned inmates

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<sup>64</sup> Nancy Fraizer, *Doctors’ Role in Executions Part of New Tactic Against Death Penalty*, CATH. NEWS SERV., Feb. 4, 2009.

<sup>65</sup> *A Doomed Inmate Drugs Himself, Is Revived and Then Executed*, N.Y. TIMES, Aug. 12, 1995.

<sup>66</sup> *Death Row Inmate is Saved, Then Executed*, L.A. TIMES, Aug. 13, 1995.

<sup>67</sup> Yardley, Jim. *Texan Who Took Overdose is Executed*. *The New York Times*, December 9, 1999. See also Jacob M. Appel, *The Forcible Treatment of Criminal Defendants*, 86 MED. HEALTH R.I. 367, available at 2003 WLNR 13329586.

<sup>68</sup> *Id.*

<sup>69</sup> Don Colburn, *Catch 22 on Death Row: The Case of Michael Owen Perry*, WASH. POST, Dec. 11, 1990, at Z15.

against their wishes, in cases where the state had a vested interest in preserving their lives for future execution, it is not at all apparent that such a general rule should be applied to the forcible treatment of *psychiatric illness* in condemned prisoners, a subset of cases with its own unique and troublesome history. In short, the appropriate and ethical role for psychiatrists in this field remains undetermined.

### III. FORCIBLE MEDICATION: FROM HARPER TO SELL AND BEYOND

The question of forcibly medicating prisoners to meet the exigencies of the legal system, like the relationship of physicians to capital punishment, is one that emerged principally as a result of advances in technology—in this case psychiatric pharmacology.<sup>70</sup> As early as 1960, the Supreme Court in *Dusky v. United States* held that competence was required by the Constitution as a prerequisite for trying a criminal defendant.<sup>71</sup> However, the development of more effective anti-psychotic medications over the subsequent decades was a necessary prerequisite for genuine controversy to arise as to whether treatment might be forced upon an inmate to render him or her fit for trial. These cases compelled the courts—and the psychiatric profession—to assess what precisely was meant by serving the medical interests of prisoners.<sup>72</sup> In a series of cases starting with *Harper v. Washington*, the Supreme Court has attempted to answer the question of when and how a prisoner may be medicated against his wishes.<sup>73</sup>

The inmate at the center of the first major case to address these issues, Walter Harper, had a long history of both violence and mental illness.<sup>74</sup> He had been convicted of robbery by a Washington state court in 1976 and served four years in the mental health unit of the state penitentiary, where he was treated with anti-psychotic medication.<sup>75</sup> After his release on parole in 1980, he was civilly committed to a state mental facility.<sup>76</sup> When he attacked two nurses at Saint Cabrini Hospital in 1981, his parole was revoked.<sup>77</sup> Harper then initially agreed to return to his regimen of antipsychotic medication, but changed his mind in November 1982, when he expressed a belief that the medication, which included perphenazine, haloperidol and fluphenazine, was “poisoning his brain” and causing other side effects.<sup>78</sup> From 1982 to 1985, Harper received such medication involuntarily.<sup>79</sup> In

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<sup>70</sup> Jami Floyd, *The Administration of Psychotropic Drugs to Prisoners: State of the Law and Beyond*, 78 CALIF. L. REV. 1243 (1990).

<sup>71</sup> *Dusky v. United States*, 362 U.S. 402, 403 (1960).

<sup>72</sup> See generally Amanda Lee, *Protecting the Inmate's Right to Refuse Anti-Psychotic Drugs*, 64 WASH. L. REV. 459 (1989).

<sup>73</sup> See generally *Washington v. Harper*, 494 U.S. 210 (1990).

<sup>74</sup> James H. Rubin, *Court to Decide Inmate Rights on Anti-Psychotic Drugs in Washington State Case*, ASSOCIATED PRESS, Mar. 6, 1989.

<sup>75</sup> *Washington v. Harper*, 494 U.S. 210, 213 (1990).

<sup>76</sup> *Id.* at 214.

<sup>77</sup> Rubin, *supra* note 74.

<sup>78</sup> *Court OKs Involuntary Medication*, SEATTLE TIMES, Feb 27, 1990.

<sup>79</sup> Dawn Weyrich, *Court OKs Forced Medication of Mentally Ill Prisoners*, WASH. TIMES, Feb. 28, 1990, at A3; *Harper v. State*, 759 P.2d 358, 360 (Wash. 1988).

February 1985, he brought suit in state court claiming a Constitutional right to be free from such involuntary medication and that, at a minimum, he was entitled to a judicial hearing (rather than a mere administrative hearing) to determine whether such medication was necessary.<sup>80</sup> After losing at trial, Harper appealed directly to the Washington State Supreme Court.<sup>81</sup> Harper argued that the state could not “override his choice to refuse antipsychotic drugs unless he ha[d] been found incompetent” and also if the fact-finder had made “a substituted judgment that he, if competent, would [have] consent[ed] to drug treatment.”<sup>82</sup> The state high court agreed with Harper and held that psychiatric medication implicated a liberty interest under the Fourteenth Amendment of the United States Constitution.<sup>83</sup> According to the state’s high court, the prison authorities had to demonstrate both “a compelling state interest” in medicating Harper and also show that the administration of the drugs was “necessary and effective for furthering that interest”—what amounted to a strict scrutiny standard.<sup>84</sup> (Legal scholars have also suggested a first amendment right to freedom of conscience may be implicated in such cases, but this issue was not raised by Harper on appeal.<sup>85</sup>) As significant federal questions were implicated by the case, the state of Washington then appealed the state court’s decision to the United States Supreme Court.

Mental health professionals were sharply divided over the state court’s ruling.<sup>86</sup> The American Psychiatric Association supported Washington’s appeal in an amicus brief that argued the benefits of the drugs far outweighed their dangers.<sup>87</sup> In contrast, the American Psychological Association expressed its concerns over drugs that may “disfigure” and “disable” a prisoner long after he has been released.<sup>88</sup> Their brief also noted that alternative interventions, such as psychotherapy, might be able to treat Harper effectively—without exposing him to the risks and side effects of antipsychotics.<sup>89</sup> All parties conceded that the side effects of the drug regime to which Harper was subjected could be severe—including akathisia, parkinsonism, tardive dyskinesia, and sexual dysfunctions.<sup>90</sup> On the other hand, such medications are widely used in psychiatric practice, and are viewed by many psychiatrists as far

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<sup>80</sup> Harper v. State, 759 P.2d 358, 360-61 (Wash. 1988), *rev’d*, 494 U.S. 210 (1990).

<sup>81</sup> *Id.*

<sup>82</sup> *Id.*

<sup>83</sup> *Id.*

<sup>84</sup> *Id.*

<sup>85</sup> See Bruce J. Winick, *The Right to Refuse Mental Health Treatment: A First Amendment Perspective*, 44 U. MIAMI L. REV. 1, 26 (1989).

<sup>86</sup> Linda Greenhouse, *Court Upholds Forced Treatment Of Mentally Ill by Prison Officials*, N.Y. TIMES, Feb. 28, 1990, at A1.

<sup>87</sup> Brief for the Am. Psychiatric Ass’n et al. as Amici Curiae Supporting Petitioners, at 29-30, Washington v. Harper, 494 U.S. 210 (1990)(No. 88-599).

<sup>88</sup> *Id.* at 7.

<sup>89</sup> *Id.* at 23-24, 48.

<sup>90</sup> Amanda E. Lee, Note, *Protecting the Inmate’s Right to Refuse Anti-Psychotic Drugs*, 64 WASH. L. REV. 459, 462-63 (1989), *see also* Harper v. State, 494 U.S. at 229-30.

more humane than continuous mechanical restraint or seclusion.<sup>91</sup> Also at stake, of course, was the competing interest that the state had in maintaining order within its prison system.<sup>92</sup> Implicit in such a need is an additional concern for the welfare of other inmates, many of whom fell under the care of the same psychiatrists charged with treating Harper. The web of conflicting and parallel interests was complex. What should be apparent is that the controversy raised questions for both the courts and the treating physicians.

The Supreme Court decided the legal questions on February 27, 1990.<sup>93</sup> In writing for a five-member majority, Justice Kennedy upheld Washington State's forced-treatment policy under a far looser standard than that demanded by the state's high court. According to Kennedy, "the extent of a prisoner's right under the [Due Process] Clause to avoid the unwanted administration of antipsychotic drugs must be defined in the context of the inmate's confinement" and such requirements as the "medical finding" that "a mental disorder exists which is likely to cause harm if not treated," and that two psychiatrists must concur on the need for treatment, were enough to meet such standards.<sup>94</sup> Furthermore, an administrative review was acceptable to make such determinations; the Constitution did not require a formal judicial hearing to determine competence, once the prisoner was already legally incarcerated. Two specific aspects of Kennedy's decision are worthy of emphasis. First, Kennedy denied Harper the right to a formal judicial hearing in part because he feared that "expanding the rights of prisoners to a full judicial hearing" might "divert scarce prison resources, both money and the staff's time, from the care and treatment of mentally ill inmates."<sup>95</sup> Second, he relied heavily on previous Supreme Court rulings in the area of prison safety, such as *Turner v. Safley* (1987) and *O'Lone v. Estate of Shabazz* (1987) that had determined "the proper standard for determining the validity of a prison regulation claimed to infringe on an inmate's constitutional rights" was to inquire "whether the regulation is 'reasonably related to legitimate penological interests'."<sup>96</sup> Kennedy held this to be true even when "the constitutional right claimed to have been infringed is fundamental."<sup>97</sup> The expansive nature of this finding seemed to suggest that, even if such medication were not found to be in the inmate's personal or medical interest, it still might have been Constitutionally permissible to medicate an inmate forcibly. In other words, while all of the safeguards offered by the state of Washington in Harper's case helped to assure that the inmate was receiving care that complied with acceptable medical standards, Kennedy's opinion opened the door to forcing care upon inmates under circumstances that did not meet such standards, if a "legitimate penological interest" were served as a result. The precise parameters of this ruling were left unsettled. However, one has to suspect that no "legitimate penological interest" might have

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<sup>91</sup> Lee, *supra* note 90, at 460-61.

<sup>92</sup> *Washington v. Harper*, 494 U.S. at 223 (1990).

<sup>93</sup> *Id.* at 213.

<sup>94</sup> *Id.* at 222-23.

<sup>95</sup> *Id.* at 232.

<sup>96</sup> *Id.* at 223.

<sup>97</sup> *Washington v. Harper*, 494 U.S. at 223 (1990).

justified medical interventions that would place a prisoner's life or health severely at risk, but even this is not clear under *Harper*.

The legal case, of course, is only half of Harper's story. Equally significant are the questions regarding psychiatric ethics raised by his suit. While treating a psychotic prisoner with anti-psychotic medication is certainly not an ethical dilemma for the vast majority of psychiatrists, with the exception of anti-medication zealots such as Thomas Szasz, a more difficult quandary arises where the primary purposes of medicating prisoners serves the interests of prison security and order.<sup>98</sup> While a full exploration of this difficult topic is beyond the scope of this paper, the question is worth noting, as it suggests that there are areas other than capital punishment where the penal system may permit forcible medication that may not serve the welfare of individual inmates. For example, whether psychiatrists are ethically prevented from sedating prisoners for the sole purpose of transporting them from one prison facility to another, raises similar questions to those raised by complicity in capital punishment, only the stakes are far lower and the possible justifications far more reasonable.

Returning to a legal analysis, it is important to note that one of the distinguishing features of the *Harper* case—in fact, one specifically noted by Justice Kennedy—was that the prisoner had already been convicted.<sup>99</sup> The *Harper* Court left open the question of whether forced medication was permissible when the state's primary purpose was to render the prisoner fit to stand trial. In such a case, of course, the inmate might have a competing interest in remaining psychotic—if doing so rendered in perpetually unable to face a jury.<sup>100</sup> The Court eventually confronted precisely this quandary two years later in *Riggins v. Nevada*.<sup>101</sup>

David Riggins was charged with the 1987 murder of Paul Wade in his Las Vegas apartment.<sup>102</sup> Shortly after his arrest, the defendant informed the jail psychiatrist, Dr. R. Edward Quass, that he was hearing voices and having difficulty sleeping.<sup>103</sup> He also informed Quass that he had suffered similar symptoms in the past that had been successfully treated with the antipsychotic thioridazine.<sup>104</sup> The psychiatrist responded by placing Riggins on a notably high daily dose of 800 mg of the drug.<sup>105</sup> Riggins symptoms then abated and, shortly thereafter, two of three court-appointed psychiatrists found him competent to stand trial.<sup>106</sup> At this point, Riggins decided that he wanted to plead not guilty by reason of insanity and requested discontinuation of the anti-psychotic medication. His intention was not to render

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<sup>98</sup> For a critique of the entire process of forced treatment, see THOMAS SZASZ, *FAITH IN FREEDOM: LIBERTARIAN PRINCIPLES AND PSYCHIATRIC PRACTICES* (Transaction Books 2004).

<sup>99</sup> *Washington v. Harper*, 494 U.S. at 219 n.6.

<sup>100</sup> Brenda Likavec, Note, *Unforeseen Side Effects: The Impact of Forcibly Medicating Criminal Defendants on Sixth Amendment Rights*, 41 VAL. U.L. REV. 455, 488-89 (2006).

<sup>101</sup> *Riggins v. Nevada*, 504 U.S. 127, 129 (1992).

<sup>102</sup> *Id.*

<sup>103</sup> *Id.*

<sup>104</sup> *Id.*

<sup>105</sup> *Id.*

<sup>106</sup> *Riggins v. Nevada*, 504 U.S. at 129-130 (1992).

himself unfit for trial. Rather, he wished the jury to witness first-hand the psychiatric condition that he was in at the time of the murder.<sup>107</sup> The trial court refused this request without explanation in a one-page order. A Nevada jury subsequently found Riggins guilty of murder with a deadly weapon and sentenced him to die by lethal injection.<sup>108</sup> The Nevada Supreme Court rejected Riggins' appeal, and the United States Supreme Court then granted *certiorari* on the question of whether forcibly medicating a criminal defendant at trial violated his Constitutional rights.<sup>109</sup>

Justice O'Connor, writing for the majority, chose not to answer the larger question of whether forcibly medicating a criminal defendant *for the purposes of rendering him fit for trial* passed constitutional muster. Instead, she wrote that since Riggins "did not contend that he had a right to be tried without Mellaril if its discontinuation rendered him incompetent," the question of "whether a competent criminal defendant may refuse antipsychotic medication if cessation of medication would render him unfit to stand trial" need not be addressed by the Court.<sup>110</sup> The case tread significant new Constitutional ground, however, as O'Connor held that a 14<sup>th</sup> Amendment right to due process *did* apply at the trial stage, as well as after conviction, she also wrote that the state did not have to meet a "strict scrutiny standard" to forcibly medicate a defendant. Rather, showing that "medical appropriateness" justified such treatment was enough.<sup>111</sup> Such appropriateness might mean that the forced medication was necessary for the "sake of Riggins' own safety or the safety of others" and that no lesser means of achieving this end was possible.<sup>112</sup> O'Connor also noted that the state "might have been able to justify medically appropriate, involuntary treatment with the drug by establishing that it could not obtain an adjudication of Riggins' guilt or innocence by using less intrusive means."<sup>113</sup> Note the use of the word "might." Fortunately for Riggins, the state had not attempted to make either of these claims, so the Court remanded for further fact-finding and adjudication under its newly announced standard. The Nevada Supreme Court subsequently overturned Riggins' conviction.<sup>114</sup>

The question left unanswered in *Riggins*—namely, whether treatment might be imposed if the primary purpose of treatment was to render the defendant fit for trial—was finally addressed by the Court in *Sell v. United States*.<sup>115</sup> Charles Thomas Sell, a St. Louis dentist, did not have the track record of violent or criminal conduct displayed by Harper and Riggins. His initial indictment in 1997 was for mail fraud,

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<sup>107</sup> *Id.* at 130.

<sup>108</sup> *Id.* at 131

<sup>109</sup> *See generally id.*

<sup>110</sup> *Id.* at 136.

<sup>111</sup> *Riggins v. Nevada*, 504 U.S. at 135-36 (1992).

<sup>112</sup> *Id.* a 135.

<sup>113</sup> *Id.*

<sup>114</sup> *Riggins v. State*, 860 P.2d 705 (Nev. 1993).

<sup>115</sup> Braden Borger, Comment, *Sell v. United States: The Appropriate Standard for Involuntarily Administering Antipsychotic Drugs to Dangerous Detainees for Trial*, 35 SETON HALL L. REV. 1099, 1099 (2005).

money-laundering and cheating Medicaid. However, Sell had a long history of delusions, and his psychiatric state deteriorated while he was out on bail.<sup>116</sup> After his bail was revoked in 1998, he was indicted for attempting to hire a hit man to murder the FBI officer who had initially arrested him and was charged with attempted murder.<sup>117</sup> At this point, Sell petitioned the federal courts to reconsider his competency to stand trial and the presiding magistrate sent Sell to the United States Medical Center for Federal Prisoners in Springfield, Missouri, for examination.<sup>118</sup> The magistrate subsequently found Sell unfit to stand trial.<sup>119</sup> Two months later, Sell objected to staff efforts to medicate him on the grounds that it might render him competent for trial.<sup>120</sup> Unlike in *Riggins*' case, Sell's goal here, at least in part, was to avoid adjudication.<sup>121</sup> Both the reviewing district court and the Eighth Circuit Court of Appeals found that the state's interest in medicating Sell outweighed Sell's objections.<sup>122</sup> As the district judge explained, the antipsychotic drugs were "medically appropriate" and represented "the only viable hope of rendering the defendant competent to stand trial" and thus the only opportunity "to serve the government's compelling interest in obtaining an adjudication of defendant's guilt or innocence of numerous and serious charges."<sup>123</sup> Sell appealed to the Supreme Court and *certiorari* was granted on the specific question of whether "the Constitution permits the Government to administer antipsychotic drugs involuntarily to a mentally ill criminal defendant—in order to render that defendant competent to stand trial for serious, but nonviolent crimes."<sup>124</sup>

The Court used *Sell* as the vehicle to answer definitely the questions that the Court had sidestepped in *Riggins* and to establish a rubric for deciding similar cases in the future. Writing for the six members of the Court willing to examine the substantive issues in the case, Justice Breyer set up four requirements for forcible medication.<sup>125</sup> These prerequisites were that "important government[] interests [be] at stake," that the forcible medication would "significantly further [these]... interests," that the medication was "necessary" to further these interests, and that such medication be "medically appropriate."<sup>126</sup> Several issues, however, remain

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<sup>116</sup> *Sell v. United States*, 539 U.S. 166, 169-70 (2003).

<sup>117</sup> *Id.* at 170.

<sup>118</sup> *Id.* at 170-71.

<sup>119</sup> *Id.* at 171 (citing to internal appendix 323).

<sup>120</sup> *Id.* at 171, 174 (citing U.S. CONST. amend. V).

<sup>121</sup> *See generally* *Sell v. United States*, 539 U.S. 166 (2003).

<sup>122</sup> *Id.* at 174 (citing *United States v. Sell*, 282 F.3d 560, 586 (8th Cir. 2002), *vacated*, 539 U.S. 166).

<sup>123</sup> *United States v. Sell*, No. 4:97CR290-DJS, 4:98CR177-DJS, 2004 U.S. Dist. LEXIS 26009, at \*22-23 (E.D. Mo. April 4, 2001), *aff'd* 282 F.3d 560 (8th Cir. 2002).

<sup>124</sup> *Sell v. United States*, 539 U.S. at 169.

<sup>125</sup> *See, id.* at 168, 180-81. Justices O'Connor, Scalia, and Thomas did not believe that a discussion of the substantive issues was merited, as they did not believe the case was ripe under the "final decisions of the district courts" standard of 28 U.S.C. § 1291. *See id.* at 186-87 (Scalia, J., dissenting).

<sup>126</sup> *Id.* at 180-81.

unclear. First, what constitutes an offense serious enough to meet an important government interest is not spelled out; one of the circuit court judges, for example, did not feel that the fraud charges against Sell rose to this standard.<sup>127</sup> In fact, Kennedy himself noted that courts “must consider the facts of the individual case in evaluating the Government’s interest in prosecution.”<sup>128</sup> In Sell’s case, for example, the accused had already spent more than four years in a government psychiatric ward—a longer period of time than he would likely have faced on the fraud charges. Unfortunately, whether this fact increases or decreases the case for forcible medication is not clear.<sup>129</sup> Another concern is the difficulty of predicting whether a particular treatment is “significantly likely” to restore a defendant to competence, a determination that might be made with far more confidence after the fact.<sup>130</sup> Moreover, Kennedy does not translate “significantly likely” into a meaningful legal concept such as “more likely than not” or “beyond a reasonable doubt”—in short, leaving enough latitude to largely swallow the principle.

The most significant puzzle left unsolved by the *Sell* ruling is the meaning of the requirement that treatment be “medically appropriate.” One might assume that this was merely shorthand for serving the best medical interests of the patient. However, Kennedy seemed to suggest in *Sell* that he intended a broader definition of medically appropriate—one that might include the duty of an ethical physician to serve his patient’s larger social interests, rather than merely his physical health. Kennedy explained that the *Sell* test should be used as a last resort, when the Harper requirement of rendering an individual “nondangerous” was not relevant—because determining dangerousness is easier than determining the medical appropriateness of treatment.<sup>131</sup> Kennedy wrote: “The medical expert may find it easier to provide an informed opinion about whether, given the risk of side effects, particular drugs are medically appropriate and necessary to control a patient’s potentially dangerous behavior (or to avoid serious harm to the patient himself) than to try to balance harms and benefits related to the more quintessentially legal question of trial fairness and competence.”<sup>132</sup> What Kennedy appeared to be stating was that physicians are expected to make a determination regarding their patient’s interests based on the *gestalt* of the situation—and that this weighing of therapeutic, legal and social factors combined is what is meant by “medically appropriate.” If this was Kennedy’s intention—and only further adjudication is likely to clarify the matter—the test reflects a prescient recognition of the evolving relationship between the

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<sup>127</sup> *United States v. Sell*, 282 F.3d at 572-74 (Bye, J., dissenting).

<sup>128</sup> *Sell v. United States*, 539 U.S. at 168, 169, 180.

<sup>129</sup> On the one hand, forcible medication might be justified on the grounds that adjudication would likely lead to release whether or not Sell was convicted. On the other hand, since the state achieves little by convicting Sell other than the formality of a verdict, he might have a stronger claim to be free from such intervention. See Paul S. Appelbaum, *Treating Incompetent Defendants: The Supreme Court’s Decision is a Tough Sell*, 54 *PSYCHIATRY SERVICES* 1335, 1336, 1341 (2003).

<sup>130</sup> *Id.* at 1336, 1341.

<sup>131</sup> *Sell v. United States*, 539 U.S. at 182 (Kennedy, J., concurring) (citing *Riggins v. Nevada*, 504 U.S. 127, 140).

<sup>132</sup> *Id.* (Kennedy, J., concurring).

medical community and the courts. However, it offers psychiatrists no guidance as to what degree of drugging, and under what circumstances, actually does serve the interests of a patient like Sell. For example, how one should weigh intermittent psychosis versus trial for fraud is a question that calls for a highly subjective answer that weighs multiple variables and values from various disciplines—everything from the odds of conviction at trial to the likelihood of recovery on antipsychotics. Even an “expert” trained in criminal law, psychiatry, and moral philosophy would likely be at sea when faced with such a calculus. At the same time, a decision regarding the disposition of cases like Charles Sell’s cannot be avoided.

*Sell* explicitly left open the question of whether the Court’s ruling applied to cases where an inmate might be forcibly medicated for the purposes of execution. A related question—also left unanswered, if not explicitly noted—was whether *Sell*’s findings applied to capital cases, in regard to competence *for trial*, where the Courts have historically exacted higher standards of process and certainty. There are two separate yet related questions: 1) May a prisoner be forcibly treated for the purposes of trial in capital cases?; and 2) If convicted of capital murder, may such a prisoner be forcibly treated for the purposes of execution? Yet if these are two distinct questions for the legal system, they also raise two separate sets of concerns for the psychiatric community. While A.M.A. and A.P.A. guidelines are quite explicit on the subject of forcibly medicating prisoners for execution, the guidelines have not prohibited other aspects of participation in the trial phase of a capital case—including, somewhat paradoxically, forcible medication for the purposes of adjudication.<sup>133</sup> At the same time, it is not entirely clear that the determination of competence or even the rendering of the opinion in such cases that medication is psychiatrically appropriate, *if the outcome may be execution*, does not defy the professional duty of non-maleficence. Of course, before the medical community ever faces these questions, the legal system must determine whether such treatment meets Constitutional standards.

#### IV. FORCIBLE MEDICATION MEETS CAPITAL PUNISHMENT

The forcible treatment of convicted criminals, like that of criminal defendants, obviously becomes a higher-stakes issue when the prisoner has been sentenced to death. This is particularly the case since the Supreme Court’s ruling in *Ford v. Wainwright* (1986), which upheld the common law doctrine that the insane may not be executed.<sup>134</sup> The rule itself had been well established by the reign of Henry VIII, when Sir Edward Coke spoke of it as a cardinal principle of criminal law.<sup>135</sup> According to Coke, “By intendment of law the execution of the offender is for example...but so it is not when a mad man is executed, but should be a miserable spectacle, both against law, and of extream [sic] inhumanity and cruelty, and can be no example to others.”<sup>136</sup> Two centuries later, William Blackstone explained the rationale for the common law approach:

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<sup>133</sup> See generally *Sell v. United States*, 539 U.S. 166.

<sup>134</sup> *Ford v. Wainwright*, 477 U.S. 399, 435 (1986).

<sup>135</sup> John L. Farringer IV, Note, *The Competency Conundrum: Problems Courts Have Faced in Applying Different Standards for Competency to Be Executed*, 54 VAND. L. REV. 2441, 2444 & n.13 (2001).

<sup>136</sup> *Id.* at 2444 & n.13.

[I]diots and lunatics are not chargeable for their own acts, if committed when under these incapacities: no, not even for treason itself. Also, if a man in his sound memory commits a capital offence, and before arraignment for it, he becomes mad, he ought not to be arraigned for it: because he is not able to plead to it with that advice and caution that he ought. And if, after he has pleaded, the prisoner becomes mad, he shall not be tried: for how can he make his defence [sic]? If, after he be tried and found guilty, he loses his senses before judgment, judgment shall not be pronounced; and if, after judgment, he becomes of nonsane memory, execution shall be stayed: for peradventure, says the humanity of the English law, had the prisoner been of sound memory, he might have alleged something in stay of judgment or execution.<sup>137</sup>

Whether these principles still applied in the United States, after much of American criminal law had been codified, remained an open question when the Supreme Court ended its moratorium on executions in 1977.<sup>138</sup> While several individual justices had stated in *dicta* that these principles did apply under the Eighth and Fourteenth Amendments, as early as the 1950s, it was not until 1986 that *Ford v. Wainwright* finally answered the question in the affirmative. However, in doing so, the Court may have actually *increased* uncertainty surrounding the competency requirement for execution.<sup>139</sup>

In many respects, the facts underlying *Ford* were not unusual for a death row case. In 1974, at the age of twenty-one, Alvin Bernard Ford and three accomplices detoured en route to a cocaine-buy to rob a Red Lobster restaurant in Fort Lauderdale, Florida; during his escape, Ford gunned down policeman Walter Ilyankoff.<sup>140</sup> Ford was convicted of murder in 1974 and sentenced to death.<sup>141</sup> Shortly after receiving his first stay of execution in 1982, which was granted twenty-four hours before he was scheduled to die in the state's electric chair, Ford appeared to suffer a psychotic break.<sup>142</sup> By the time he had exhausted his state appeals nearly two years later, Ford's psychiatric health had deteriorated to a state of perpetual psychosis.<sup>143</sup> The inmate informed his jailers that he had "sent his mother, brothers and sisters to another planet on one of his space ships to ensure their safety."<sup>144</sup> At other times, Ford claimed that he had appointed nine new justices to the Florida

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<sup>137</sup> 2 WILLIAM BLACKSTONE, COMMENTARIES, \*24-25 (citation omitted).

<sup>138</sup> *Ford v. Wainwright*, 477 U.S. 399, Powell (concurring). See also *State v. Pastet*, 169 Conn. 13.

<sup>139</sup> See *Solesbee v. Balkcom*, 339 U.S. 9, 15-32 (1950) (Frankfurter, J., dissenting); see also *Caritativo v. California*, 357 U.S. 549, 550-52 (1958) (Harlan, J., concurring).

<sup>140</sup> Mary Thornton, *Death Row Said to Drive Killer Insane; Supreme Court Asked to Rule on Pending Execution of Florida Inmate*, WASH. POST., Nov. 11, 1985, at A6.

<sup>141</sup> *Death Row Inmate Asks to Be Executed as Soon as Possible*, ASSOCIATED PRESS, April 30, 1983.

<sup>142</sup> James Bone, *Languishing on Death Row*, INTERNATIONAL PRESS SERVICE, July 28, 1984.

<sup>143</sup> Thornton, *supra* note 140.

<sup>144</sup> Thornton, *supra* note 140.

Supreme Court, bragged of having foiled a vast Ku Klux Klan conspiracy that involved taking 135 of his relatives and Senator Edward Kennedy hostage, and signed his letters to public officials “Pope John Paul III.”<sup>145</sup> Neither Ford nor his state-appointed attorneys, who pursued his appeals even after he began demanding immediate execution in 1983, argued that Ford had been insane at the time of the murder or at his trial.<sup>146</sup> Rather, they argued that his years on death row had rendered him insane and therefore unfit for execution.<sup>147</sup>

The devil in the *Ford* case lurked in the details of Florida’s criminal procedure. State law did not permit executing insane prisoners and, in fact, had specific guidelines for addressing the question of the condemned inmate’s sanity.<sup>148</sup> These guidelines instructed the governor to appoint a panel of three independent psychiatrists to evaluate the competence of the condemned and to report back to the chief executive—but did not allow for a judicial hearing on the question of sanity.<sup>149</sup> The standard to be used under Florida law was a determination whether “the convicted person has the mental capacity to understand the nature of the death penalty and the reasons why it was imposed on him.”<sup>150</sup> In Ford’s case, all three examiners concluded that Ford was indeed mentally ill, but that he was nonetheless capable of understanding the causes and consequences of his impending electrocution.<sup>151</sup> Ford’s legal team, whose own psychiatric expert disagreed with these findings, demanded to present its evidence to a judge.<sup>152</sup> So the question in *Ford* became not merely whether the federal constitution prevented the execution of the insane, but if it did so, what standard of due process was required to determine competence.

Writing for a four-member plurality in *Ford*, Justice Marshall announced a sweeping rule that, without qualification, “the Eighth Amendment prohibits the State from inflicting the penalty of death upon a prisoner who is insane.”<sup>153</sup> He also

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<sup>145</sup> *Ford v. Wainwright*, 477 U.S. 399, 402 (1986).

<sup>146</sup> *Death Row Inmate Asks to Be Executed as Soon as Possible*, ASSOCIATED PRESS, April 30, 1983.

<sup>147</sup> Thornton, *supra* note 140.

<sup>148</sup> FLA. STAT. ANN. § 922.07 (LexisNexis 2010).

<sup>149</sup> *Id.*; see also *Ford v. Wainwright*, 477 U.S. at 403.

<sup>150</sup> FLA. STAT. ANN. § 922.07 (LexisNexis 2010).

<sup>151</sup> *Ford v. Wainwright*, 477 U.S. at 404.

<sup>152</sup> *Id.* at 413.

<sup>153</sup> *Ford v. Wainwright*, 477 U.S. at 401, 410. Marshall’s majority was joined in entirety by Brennan, Blackmun and Stevens. *Id.* at 401. Powell, concurring, agreed that the 8<sup>th</sup> Amendment prohibited executing the insane and that due process was required, but believed that such due process could be met by an impartial board housed within the executive branch. *Id.* at 418, 424-25 (Powell, J., concurring). O’Connor and White, dissenting in part, did not believe that the 8<sup>th</sup> Amendment prohibited executing the insane per se, but did argue that once Florida established a right for the insane not to be executed, they had to establish meaningful due process. *Id.* at 427, 43 (O’Connor, J., & White, J., dissenting). Burger and Rehnquist, dissenting, refused to recognize an 8<sup>th</sup> Amendment right and argued that due process was met by the existing executive branch procedure. *Id.* at 431-34 (Burger, C.J., & Rehnquist, J., dissenting).

affirmed, for the first time, that the United States Constitution guaranteed condemned inmates a right to full due process to determine their sanity prior to the implementation of the death sentence.<sup>154</sup> According to Marshall, this right entailed not only the opportunity to offer and impeach evidence, such as the presentation of testimony from psychiatrists other than the examiners appointed by the governor, but also a hearing *within the judicial branch* to determine sanity.<sup>155</sup> Previously upheld state regimes that placed such determinations entirely within the hands of the executive branch, such as the one the court had sanctioned in *Solesbee v. Balkcom*, no longer sufficed.<sup>156</sup> However, as Marshall could not find a fifth vote for this final portion of the opinion, the Court did leave a door open, per Justice Powell's concurring opinion, for an "impartial officer or board" housed within the executive branch to make the determination.<sup>157</sup> As Florida's statute did not even approach this standard, Ford's case was remanded to the lower courts for further adjudication.<sup>158</sup> Ford received treatment for his psychosis and was eventually declared sane by a federal judge in 1989.<sup>159</sup> He died of respiratory failure on Florida's death row in 1991 at the age of thirty-seven.<sup>160</sup>

While *Ford* resolved one significant question, it raised several others. The first of these was the threshold at which the right to a sanity hearing arose. Marshall acknowledged that every condemned prisoner was not entitled to *pro forma* due process on the question of competence.<sup>161</sup> He wrote: "It may be that some high threshold showing on behalf of the prisoner will be found a necessary means to control the number of non-meritorious or repetitive claims of insanity."<sup>162</sup> Yet both the quality and quantity of evidence required to surmount such a threshold—which has previously been left unresolved by the Court in *Pate v. Robinson* (1966)—remained entirely unclear.<sup>163</sup> For example, could the evidence of lay people trigger the right to such a hearing or was expert psychiatric testimony required? Moreover, if psychiatrists refused to examine the condemned prisoner because doing so in a capital case might violate a perceived ethical duty of non-maleficence, did the unavailability of experts shift the burden to prove sanity onto the state? Also unclear was the permissible timeframe between the sanity hearing and the execution: For example, would six months of additional appeals or a brief stay pending review by the executive branch then trigger the need for a repeat evaluation? Yet by far the most important question left unresolved by the Court was precisely how much understanding the condemned prisoner had to have to meet the Constitutional

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<sup>154</sup> *Ford v. Wainwright*, 477 U.S. at 410-18.

<sup>155</sup> *Id.* at 414-16.

<sup>156</sup> *Id.* at 405.

<sup>157</sup> *Id.* at 418, 427 (Powell, J., concurring).

<sup>158</sup> *Id.* at 413-18.

<sup>159</sup> *Alvin Ford, 37, Dies: Stricken on Death Row*, N.Y. TIMES, Mar. 9, 1991, A11.

<sup>160</sup> *Id.*

<sup>161</sup> *Ford v. Wainwright*, 477 U.S. at 418.

<sup>162</sup> *Id.* at 417 (citing *Pate v. Robinson*, 383 U.S. 375, 387 (1966)).

<sup>163</sup> *See generally* *Pate v. Robinson*, 383 U.S. 375, 376-87 (1966).

threshold for execution. Justice Marshall's standard—namely, that the defendant understood why he was to be executed—had not drawn a fifth vote from Justice Powell, who relied on a lower threshold of understanding the nature of the punishment and the state's rationale for imposing it, so the Court did not speak with one voice on the subject.<sup>164</sup> Moreover, even Marshall's standard of "rational understanding" is rather amorphous. It was not until two decades after the *Ford* decision, in *Panetti v. Quarterman*, 551 U.S. 930 (1997), that the Court sought to bring clarity to these areas of inquiry, and to offer the lower courts guidance regarding what specific rights it had intended to establish under the prior ruling.

The sequence of events leading to the *Panetti* decision started in 1992 when a thirty-four year old unemployed veteran with a long history of mental illness, Scott Panetti, killed his in-laws and held his wife and three-year-old daughter hostage until being forced out of his cabin by a SWAT team.<sup>165</sup> When Texas tried Panetti for capital murder in 1995, he sought to represent himself.<sup>166</sup> The trial court ordered a psychiatric examination, which concluded that the defendant suffered from "a fragmented personality, delusions, and hallucinations," but was nonetheless capable of mounting his own defense.<sup>167</sup> Panetti was subsequently convicted, at a trial where standby counsel described his behavior as "scary," "bizarre" and "trance-like," and sentenced to death.<sup>168</sup> Over the next nine years, his efforts to gain appellate review in the Texas state courts and at the United States Supreme Court proved unsuccessful, as did his claims for state habeas relief, and the trial court set an execution date of February 5, 2004.<sup>169</sup> Only then did Panetti's legal team assert that he was not competent to be executed under the standards established in *Ford v. Wainwright*.<sup>170</sup> The Supreme Court accepted the case and used it to clarify three large gaps left by *Ford*—namely: 1) *when* a claim of incompetence for execution had to be raised; and 2) *how extensive* an assessment had to be conducted to meet due process standards, and 3) *what level of understanding* what required in order to carry out a death sentence.

At first glance, the *Panetti* decision appears to have resolved much of the doubt left in the wake of *Ford*. Writing for the "liberal" five-member majority on a highly divided court, Justice Kennedy first tackled the question of the timing of the incompetence claim.<sup>171</sup> As a practical matter, he was compelled to address the question by the Antiterrorism and Effective Death Penalty Act of 1996, which barred "second or successive" habeas claims.<sup>172</sup> In other words, all habeas claims not raised in a defendant's initial federal appeal were considered waived. However, Kennedy

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<sup>164</sup> *Ford v. Wainwright*, 477 U.S. at 419-421 (Powell, J., concurring).

<sup>165</sup> *Man Suspected in Double Killing in Texas Holds Off Police*, ASSOCIATED PRESS, Sept. 8, 1992.

<sup>166</sup> *Panetti v. Quarterman*, 551 U.S. 930, 936 (1997).

<sup>167</sup> *Id.*

<sup>168</sup> *Id.* at 936-37.

<sup>169</sup> *Id.* at 937.

<sup>170</sup> *Id.* at 938.

<sup>171</sup> *Panetti v. Quarterman*, 551 U.S. at 948-49.

<sup>172</sup> *Id.* at 963-64.

noted that competence for execution did not fall under this standard, as a condemned defendant's claim might not be "ripe" at the time of his first appeal. To rule otherwise, he pointed out, would create a legal catch-22 for prisoners like Panetti. As "all prisoners are at risk of deteriorations in their mental state," at a first *habeas* hearing a prisoner would have either to "forgo the opportunity to raise a *Ford* claim in federal court; or raise the claim ...even though it is premature." What Kennedy did not resolve was how close in time to the actual execution date such a claim might be raised and whether successive claims were permissible. Similarly, the court left open several key questions regarding the extent of the hearing to which a defendant was entitled in order to meet the Constitution's due process requirements. Justice Kennedy interpreted *Ford* in such a way that Justice Powell's concurrence was controlling. As Kennedy paraphrased Powell's standard, "Once a prisoner seeking a stay of execution has made 'a substantial threshold showing of insanity,' the protection afforded by procedural due process includes a 'fair hearing' in accord with fundamental fairness." At a minimum, this "fair hearing" requires "an opportunity to be heard" and to "submit evidence and argument from the prisoner's counsel, including expert psychiatric evidence that may differ from the State's own psychiatric examination."<sup>173</sup>

The crucial holding of Powell in *Ford*, now described by the Court as "clearly established" law, is that the state could not rely solely on the evidence of its own experts to render a decision on the condemned prisoner's competency. However, Kennedy still left open the question of whether such a hearing required "opportunity for discovery or for the cross-examination of witnesses."<sup>174</sup> He also entirely ignored the possibility that psychiatrists sympathetic to *Ford's* claim might also prove unwilling to evaluate him for fear of complicity in the apparatus of execution, a possible violation of ethical norms of their profession.

The third and most important aspect of the *Panetti* case was that it sought to clarify the standard by which competency for execution was to be evaluated. The defendant in this case acknowledged that he had committed the murders and also that the state intended to execute him; he even conceded that the state claimed that it intended to execute him *for the murders*. However, he viewed this claim as a "sham" and believed that the state actually intended to execute him in order to prevent him from preaching. The Fifth Circuit interpreted *Ford* to require merely that the defendant have an awareness of the state's motive for executing him, not an understanding of it. In other words, according to the appellate court, the delusional belief system of a schizophrenic patient like Panetti is not relevant as long as "the prisoner knows that the state has identified his crimes as the reason for the execution."<sup>175</sup> Justice Kennedy strongly rejected this standard as too narrow. Instead, what was required of the defendant was not merely a prisoner's "awareness of the state's rationale for an execution" but also a "rational understanding of it."<sup>176</sup> However, as Kennedy conceded, "rational understanding" is a highly imprecise term. He noted that "some prisoners, whose cases are not implicated by this decision, will fail to understand why they are to be punished on account of reasons other than those

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<sup>173</sup> *Id.* at 949-50 (citing *Ford v. Wainwright*, 477 U.S. 399, 424, 427 (1986)).

<sup>174</sup> *Id.* at 952.

<sup>175</sup> *Id.* at 958.

<sup>176</sup> *Panetti v. Quarterman*, 551 U.S. at 959.

stemming from a severe mental illness.”<sup>177</sup> While good reason might exist to distinguish psychotic patients from sociopathic patients or those with “amoral character,” as Kennedy did, that the Court did so without explaining its reasoning for this distinction lent less, rather than more, clarity to its standard. Kennedy also stated that his ruling did not cover prisoners “so adept in transferring blame to others as to be considered, at least in the colloquial sense, to be out of touch with reality.”<sup>178</sup> Why such patients are different from psychotic patients, with regard to the ethics and policy basis of execution, remains entirely unclear. In short, *Panetti* has left the lower courts with even less guidance on what exactly constitutes competence for execution. As Paul Appelbaum saliently noted in the wake of the *Panetti* decision, “there seems little question that in the future the issue of when a prisoner is incompetent to be executed will again make its way to the Supreme Court for a definitive ruling.”<sup>179</sup>

The need for clarity acquires added importance when the issues of competence for execution raised by *Ford* and *Panetti* meet the issues of forcible medication addressed in *Sell*. After the Court chose not to resolve question at the nexus of these cases (namely, the forcible treatment of psychiatric defendants to render them fit for execution) in *Perry*, a series of similar quandaries emerged in various states. The dilemma was not merely whether forcibly medicating for the purpose of execution was constitutional, but also, if it were not, what the appropriate remedy might be. On the one hand, the trial courts might allow the condemned to remain in a state of psychosis. Alternatively, the state might commute or vacate the inmate’s death sentence and then medicate him—the position favored by the American Psychiatric Association. As is not surprising, jurisdictions varied in their approaches. For example, South Carolina’s Supreme Court established a right *not* to be forcibly medicated for execution under the state constitution in *Singleton v. State*, but overtly rejected a lower court judge’s effort to permanently commute the defendant’s sentence.<sup>180</sup> Writing for a unanimous state court, Justice Toal noted that the trial judge was mistaken in his belief that no cure for Singleton’s illness was possible. As Toal explained, “Perhaps under the scope of our current psychological knowledge, this is true; but there is always a potential for change. To carve out a remedy which ignores the ebb and flow of medical science is to create a rule which potentially could be impossible to live with in years to come.”<sup>181</sup> In contrast, the Maryland legislature annotated its penal code to automatically commute the death sentence of anyone found incompetent for execution, thus ensuring that such prisoners might receive appropriate treatment for their illnesses.<sup>182</sup> These various approaches, and the forceful objection of the A.P.A. to medication for execution, meant that it was only a matter of time before a case arose that forced the federal courts to address the

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<sup>177</sup> *Id.*

<sup>178</sup> *Id.* at 960.

<sup>179</sup> Paul S. Appelbaum, *Death Row Delusions: When is a Prisoner Competent to be Executed?*, LAW & PSYCHIATRY, Oct. 2007, at 1258-60.

<sup>180</sup> *Singleton v. State*, 437 S.E.2d 53, 59 (S.C. 1993); *Hughes v. State*, 626 S.E.2d 805, 809 (S.C. 2006).

<sup>181</sup> *Singleton v. State*, 437 S.E.2d at 59 (S.C. 1993).

<sup>182</sup> 1999 Md. Laws 54.

issues at the nexus of forcible treatment and capital punishment, which the Supreme Court had skirted in *Perry*. The vehicle for potentially resolving these issues was the Arkansas case of *Singleton v. Norris*—a case that shared nothing except a similar name and a similar fact pattern to South Carolina's *Singleton v. State*.

Charles Laverne Singleton was convicted of stabbing to death Mary Lou York during a robbery of her Hamburg, Arkansas, grocery store in 1979.<sup>183</sup> The evidence against Singleton was “overwhelming,” including positive identification by the dying woman, and several witnesses who knew both the defendant and victim.<sup>184</sup> He later confessed to the crime.<sup>185</sup> However, after his conviction, Singleton was diagnosed with schizophrenia. The catch in Singleton's case was that his psychotic symptoms abated after the state had deemed him a threat to himself and others and had placed him on anti-psychotic medication in 1997. Singleton accepted that forcibly medicating him was permissible under previous Supreme Court rulings, such as *Harper v. Washington*, as long as it was in his “best medical interests.” However, he claimed that “it becomes illegal once an execution date is set” because it no longer serves such purposes. Unfortunately for Singleton, the Eighth Circuit, sitting *en banc*, adopted a very constricted view of the “best medical interests” standards. Chief Judge Roger Wollman distinguished between Singleton's short-term medical interests, which favored the drug regime, from his long-term interests, which, as they rendered him fit for execution, might not. According to Wollman, if the forced treatment served Singleton's short-term medical interests, then that would be enough to meet the *Harper* standard.

Many court watchers believed that the Supreme Court would use *Singleton* to address the question that they had explicitly left unanswered in *Sell*, where Justice Breyer had noted that, unlike in most forcible medication cases, an entirely different case is presented when the government wishes to medicate a prisoner in order to render him competent for execution.<sup>186</sup> Inexplicably, the Supreme Court refused to grant *certiorari*. Governor Mike Huckabee of Arkansas subsequently denied clemency and Singleton, his appeals exhausted, was executed by lethal injection on January 6, 2004.<sup>187</sup> As of 2009, no other circuit court has yet to address this question. As a result, the law of the land regarding forcible medication for execution, left open by the Court in *Sell*, remains unclear. However, the questions of Constitutionality should not be conflated with those of medical ethics. It does not follow that, just because the state may legally impose medication upon a prisoner to render him fit for execution, a medical professional may facilitate the administration of the drug regime. Much like in the sixties protest mantra captured in the title of a Tony Curtis movie, “Suppose They Gave a War and Nobody Came,” one must consider what would happen to the state capital punishment regimes if all medical professionals, including psychiatrists, refused to address issues of competency, at

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<sup>183</sup> Emmett George, *Death Row Inmate Apologizes for Slaying*, ARK. DEMOCRAT-GAZETTE, Feb. 6 1999, at B8.

<sup>184</sup> *Singleton v. State*, 437 S.E.2d at 181.

<sup>185</sup> George, *supra* note 183.

<sup>186</sup> Linda Skatter, *Supreme Court refuses appeal of Arkansas death-row inmate*, ARK. DEMOCRAT-GAZETTE, Oct. 7, 2003; *Sell v. United States*, 539 U.S. 166 (2003).

<sup>187</sup> Traci Shurley, *Singleton Dies*, ARK. DEMOCRAT-GAZETTE, Jan. 7, 2004.

any stage of the proceedings, on ethical grounds. As with nearly all questions under our federal system, the practical result of such collective action would differ significantly by state.

#### V. PSYCHIATRISTS, CAPITAL PUNISHMENT AND THE STATES

The states vary greatly in the degree to which they require the participation of physicians and psychiatrists to conduct their capital punishment regimes. However, the rules of the states can be broadly divided into three categories: those whose statutes specify a role for physicians and/or psychiatrists, those whose statutes seem to require a role for physicians and/or psychiatrists without explicitly stating so, and those states that overtly exclude a role for physicians and/or psychiatrists to the degree that such exclusion is Constitutionally permissible. Ironically, the three state cases that this paper has examined in depth—*Riggins*, *Harper*, and *Perry*—offer paradigmatic examples of these three possible approaches. Most other states use variations upon these regimes. A detailed comparison of the various state regimes, both between *and within* these general models, would be highly informative, but requires a focus well beyond the scope of this paper.

##### A. Nevada

The sections of Nevada's criminal code dealing with capital punishment rely upon the participation of medical professionals in numerous ways. For example, the Director of the Department of Corrections must invite both "a competent physician" and a "psychiatrist" (the statute makes a distinction between the two that seems to suggest that these are mutually exclusive) to witness the execution.<sup>188</sup> The statute guarantees an opportunity for DNA analysis that may require the employment of a medically trained professional to remove and later examine a biological sample.<sup>189</sup> The statute also requires the participation of physicians to determine whether the condemned inmate is pregnant.<sup>190</sup> One should note that a determination of pregnancy is not inherently a medical determination—a midwife, a technician or even a layperson could likely make such determination—but Nevada has chosen to require three physicians to take part in the evaluation.

The Nevada statute also specifies a role for psychiatrists in the evaluation of a condemned inmate's sanity. If the Director of the Department of Corrections has "a good reason to believe" that the prisoner has become insane prior to execution, a judge shall arrange a hearing before two psychiatrists, two psychologists or a psychiatrist and a psychologist.<sup>191</sup> The threshold for invoking such a hearing is unclear. The statute makes no provision for circumstances in which no mental health professional can be found to conduct the evaluation. However, one can reasonably assume that once the Director has expressed to the trial court a belief that a prisoner has crossed such a threshold, the unavailability of psychiatric evaluators would place a *de facto* hold on the death penalty process. In this regard, Nevada relies heavily on the complicity of medical professionals in conducting executions.

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<sup>188</sup> NEV. REV. STAT. ANN. § 176.355 (Lexis-Nexis 2010).

<sup>189</sup> NEV. REV. STAT. ANN. §§ 176.0911-0919 (Lexis-Nexis 2010).

<sup>190</sup> NEV. REV. STAT. ANN. § 176.465 (Lexis-Nexis 2010).

<sup>191</sup> NEV. REV. STAT. ANN. § 176.425 (Lexis-Nexis 2010).

### B. Washington

Washington state's capital punishment regime appears to depend on the use of physicians in a limited way, but not nearly as extensively as does Nevada's. For example, there is no provision in the Washington penal code for physicians or psychiatrists to witness executions.<sup>192</sup> The only overt mention of a role for physicians in the Washington code appears to be the requirement that "death shall be pronounced by a licensed physician."<sup>193</sup> However, the state of Washington does have provisions for determining competency at trial—rules that, in the wake of *Ford v. Wainwright*, appear to apply to competence for execution as well. What is most striking about Washington's rules governing competency trials is that they call for the appointment of "two qualified experts or professional persons" to make determinations of competence.<sup>194</sup> Nowhere in the statute is there any requirement that these be medical or even mental health professionals, so in theory, a social worker or even a legal expert trained in such matters might pass muster. It is true that Washington's courts have consistently assumed that these individuals will be medically trained—without every formally imposing such a requirement.<sup>195</sup> At the same time, the courts have left trial judges with broad discretion in matters of competence—far more so than in most states, including Nevada—so it is not at all clear that a trial judge might not qualify a non-medically trained individual as an expert under Washington law.<sup>196</sup> The bottom line is that while Washington law does depend upon physicians and psychiatrists in its capital punishment regime, its statutory law is constructed in such a way as to leave the door open to the continued operation of the system even if medical professionals refused to take part.

### C. Louisiana

Louisiana appears to exclude physicians and psychiatrists, as much as is feasibly and constitutionally possible, from its capital punishment regime. For example, the Louisiana statute overtly states that a physician need not be present for the execution. Similarly, with regard to female prisoners, the code states that the "execution of a female who has been clinically diagnosed as being pregnant shall be suspended"—but does not require that a physician make such a determination.<sup>197</sup> The only obligation with regard to competence, beyond those imposed by the federal Constitution, is the provision that the trial court "shall order a mental examination of the defendant when it has reasonable ground to doubt the defendant's mental capacity to proceed."<sup>198</sup> It is not at all clear that any experts—medical or otherwise—are required under the statute. Louisiana appears to be one of the few states where questions of competence, in theory, might be determined entirely by the trial judge. As a result, it is possible that even without the participation of medical professionals, the state's capital punishment system might

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<sup>192</sup> WASH. REV. CODE ANN. § 10.95.185 (Lexis-Nexis 2010).

<sup>193</sup> WASH. REV. CODE ANN. § 10.95.180 (Lexis-Nexis 2010).

<sup>194</sup> WASH. REV. CODE ANN. § 10.77.060 (Lexis-Nexis 2010).

<sup>195</sup> See e.g., *State v. Wicklund*, 638 P.2d 1241 (Wash. 1982).

<sup>196</sup> Compare *State v. Wicklund*, 638 P.2d 1241 (Wash. 1982), with *Seattle v. Gordon*, 693 P.2d 741 (Wash. Ct. App. 1985).

<sup>197</sup> LA. REV. STAT. ANN. § 15:567(D) (2010).

<sup>198</sup> LA. CODE CRIM. PROC. ANN. art. 643 (2010).

be able to function. Of course, whether or not such a system would meet the standards of the federal Constitution without the participation of physicians is an entirely different matter.

#### *F. Implications*

If evolving standards of medical ethics compelled medical professionals, including psychiatrists, to opt out of the capital punishment system, the impact would be felt immediately in states like Nevada and California, which rely heavily upon their participation, while the statutory regimes in states like Louisiana and Oklahoma might survive—at least until confronted with the federal constitutional issues raised in *Ford* and *Harper*. Of course, it is not clear that psychiatrists *should* remove themselves from the system in such a manner. The degree to which participation by psychiatrists in the various aspects of these state capital punishment regimes is ethical depends in part on the theoretical underpinnings of the opposition to participation voiced by various professional associations and opinion leaders. While a complete survey of the reasons favoring and opposing such participation is available elsewhere, and is unlikely to clarify the relationship between legal and medical thinking on these issues, a brief analysis of the controversy as it relates to the question of how much entanglement is too much entanglement may be helpful at this juncture.

### VI. A ROLE FOR PSYCHIATRISTS?

#### *A. Philosophical Underpinnings to Opposition*

There are at least three sets of distinct reasons advanced by opponents of psychiatric involvement in capital punishment. The first of these stems largely from duties toward the specific patient who faces execution. The second set of objections arise in the context of the medical profession and the public consequences of entangling the practice of medicine with the machinery of execution. Finally, a third set of objections arises regarding the possible moral duty of physicians and psychiatrists to object to practices that increasingly defy international norms regarding human rights. Each of these objections merits discussion, as the underlying reason one opposes physician involvement in capital punishment may help clarify the degree to which psychiatrists may participate in the process.

The most frequent objection raised to physician participation in capital punishment is that medical professionals have a duty to serve the medical needs of their patients. Several questions immediately arise: 1) Are the individuals being evaluated by forensic psychiatrists in capital cases truly “patients” in the traditional sense of the doctor-patient relationship? 2) Does an ethical approach to these cases require the psychiatrist to take a broad view of harm that encompasses the social consequences of treatment (i.e. execution) or only a narrow view of harm that restricts itself to the medical aspects of care? These questions, which reflect many of the fundamental debates underpinning forensic psychiatry, have been explored extensively in the literature of psychiatric ethics.<sup>199</sup> Some commentators, such as

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<sup>199</sup> See Appelbaum, *supra* note 17, at 233-247; James C. Beck, *Psychiatry and the Death Penalty*, HARV. REV. OF PSYCHOLOGY 225, 225-9 (1996); Marianne Kastrup, *Psychiatry and the Death Penalty*, J. OF MED. ETHICS 179, 179-83 (1988); Ebrahim J. Kermani & Sanford L. Drob, *Psychiatry and the Death Penalty: Dilemma for Mental Health Professionals*, PSYCHIATRY QUARTERLY 193, 193-212 (1988).

Alan Stone, have argued that treating forensic patients as distinct from other patients or interpreting the principle of non-maleficence narrowly undermines the basic tenets of ethical medical practice.<sup>200</sup> Others, notably M. Gregg Bloche, have noted that Stone's seemingly rigid take on psychiatric ethics ignores the "awkward reality that adverse extra-clinical consequences of clinical work are pervasive in contemporary life" and that these objections do not merely challenge forensic practice, but are largely unworkable in the context of modern medical practice.<sup>201</sup> It is important to note that *if* one accepts the "do not harm principle" as the reason for opposition to physician participation in capital punishment, then it logically follows that the more likely a physician's actions are to increase the likelihood of execution, the more difficult they become to defend. However, even this principle may provoke more questions than it answers. For example, an individual physician testifying *on behalf of* a capital defendant might, on first glance, appear to be acting in an ethical manner because such conduct reduces the likelihood of execution. However, if *all* physicians opted out of the process, the machinery of capital punishment might grind to a halt, so such participation on the behalf of the defendant might actually have the paradoxical effect of increasing the likelihood of execution—not merely at a systemic level, but for the specific defendant as well. Needless to say, the application of "do no harm" in such cases is not intuitive—even to the most well-intentioned physician and *even to the physician who opposes capital punishment*.

A second set of objections argues that the challenges of physician involvement in capital punishment extend far beyond any conflicts of interest in the physician's relationship with his or her individual patients. Instead, the concern here is that a perceived conflict of interest will undermine the confidence of both individual patients and the general public in mental health professionals. An analogy can be drawn to the debate over physician-assisted suicide, in which some commentators argue that whether the practice is legalized, medical professionals should not be involved—because the involvement of physicians compromises the trust that patients may have in them.<sup>202</sup> The damage here is systematic or structural, rather than to any specific criminal defendant. Rather, all criminal defendants—and maybe other psychiatric patients—will doubt the loyalties of their mental healthcare providers. Of course, psychiatrists have been participating in capital punishment regimes in limited and indirect ways for many years, and it is not clear that doing so has undermined trust in the profession. What is significant about this objection to physician involvement in capital punishment is that it does allow for gradations of participation. If the concern is the appearance of entanglement, rather than the specific effect on death row inmates, then the judgment becomes one of degree rather than an all-or-none proposition.

Finally, the third set of objections to physician involvement in capital punishment relies upon the principle that the death penalty is a violation of evolving

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<sup>200</sup> See, e.g. ALAN STONE, *LAW, SOCIETY, & MORALITY* (American Psychiatric Publishing 1994).

<sup>201</sup> Gregg M. Bloche, *Psychiatry, Capital Punishment and the Purposes of Medicine*, INT'L J. OF PSYCHIATRY 301, 318 (1993).

<sup>202</sup> See *Assisted Suicide? Maybe. Doctors Providing the Assistance? Never.* (Feb. 26, 2009), <http://news.scotsman.com/comment/Assisted-suicide-Maybe-Doctors-providing.5017197.jp?CommentPage=1&CommentPageLength=1000>.

standards of international human rights.<sup>203</sup> The United States remains one of only a handful of Western democracies that permits state-sanctioned executions; the European Convention on Human Rights speaks unequivocally on the subject.<sup>204</sup> Unlike objections on either non-maleficence or professional welfare grounds, this set of objections does not oppose only physician involvement in capital punishment, but presumably the practice as a whole. If an ethical duty to work toward abolition—or at least not to stand in the way of abolition—is the reason for such a proscription, then the consequences for the degree of permissible involvement are far more drastic. When bearing witnesses is the goal, it is not even clear that participation that reduces the likelihood of particular executions is permissible. A reasonable comparison might be drawn to a jurist in an oppressive state who continues in his duties in order to meet out more lenient punishments than his believing colleagues. To phrase the matter candidly: If one truly believes that capital punishment is a violation of basic human rights, then any participation in a system that utilizes it—possibly even any work as a forensic psychiatrist in the American legal system—might be unethical. Leaving that question unanswered, it remains safe to state that the reasons one opposes physician participation in capital punishment are inextricably linked to the degree of involvement that one will ethically tolerate.

#### *B. How Complicit is Too Complicit?*

There are multiple places along the path to execution that psychiatrists may be called upon to participate in the legal process.<sup>205</sup> While the A.P.A. and many other professional organizations have issued policy statements on the subject, the psychiatric community is highly divided over what stage, if any, such participation is appropriate.<sup>206</sup> Among those ways in which a psychiatrists might be called upon to participate are: 1) in determining that an inmate is fit to stand trial in a potential capital case; 2) in medicating an inmate to stand trial in a potential capital case; 3) in offering testimony at the trial phase in a capital case; 4) in offering testimony at the sentencing phase in a capital case; 5) in finding an inmate competent to be executed; 6) in medicating an inmate for execution; and 7) in determining that a prisoner has indeed died and/or in signing a death certificate. Many other incidental ways inevitably exist, too varied to enumerate, in which a psychiatrist might also become tangentially involved in the mechanism of execution—everything from sedating a prisoner for transportation to a capital trial to certifying that the presence of the defendant in the courtroom does not pose a safety hazard. Finally, although not unique to psychiatrists, the participation of any medical professional in a supervisory role might also raise ethical concerns. One Washington state physician, Marc F. Stern, recently resigned from his position as medical director of the state's corrections department, where he supervised more than seven hundred health professionals, when he discovered that medication from the facility's dispensary had

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<sup>203</sup> Bloche, *supra* note 201, at 301-357.

<sup>204</sup> Protocol No. 6 to the Convention for the Protection of Human Rights and Fundamental Freedoms Concerning the Abolition of the Death Penalty, April 28, 1983, *available at* <http://conventions.coe.int/treaty/en/treaties/html/114.htm>.

<sup>205</sup> Bloche, *supra* note 201, at 301-357.

<sup>206</sup> Charles L. Scott, *Psychiatry and the Death Penalty*, PSYCHIATRIC CLINICS OF N. AM. 791, 791-804 (2006).

been used in an execution.<sup>207</sup> Obviously, such an approach can be advocated or adhered to *ad absurdum*. In theory, one might argue that any participation by psychiatrists in the judicial or penal systems of a state that permits executions is itself indirect complicity in the process, as a strict abolitionist might (see above), but the reality is that opting out of these systems *en masse* would likely do far more harm than good to mentally ill prisoners. Moreover, it is not at all clear that such drastic action is necessary, as argued below, in order to so extricate medical professions from the process that executions cannot take place.

What is most striking about the approach of various professional organizations to the question of the ethical boundaries of physician participation in execution is how different they are in the conclusions that they have reached. The American Medical Association, for example, prohibits involvement in the execution process, such as forcible medication, but not in determinations of competence for execution. In contrast, a panel of the British Medical Association has advised that neither testimony regarding competence nor medicating for execution is permissible.<sup>208</sup> Other groups have argued that any post-conviction involvement by psychiatrists violates the canons of professional ethics.<sup>209</sup> The reality is that all of these distinctions prove as arbitrary as they are convenient. Assuming that non-maleficence is the principal ethical concern, a better standard would be a proximate cause or “but for” test that asks, “Does the participation of a psychiatrist in this case increase the likelihood of execution?”<sup>210</sup> If the answer is yes, and the reasons noted above regarding non-maleficence are accepted by the profession as to why psychiatric participation in executions is unethical, then the logical result is that psychiatrists must opt out of all matters relating to a specific capital defendant. Such an approach may substantially reduce the workload, and possibly the reimbursement, of forensic psychiatrists, and may substantially impede the capital punishment regimes of the states, but none of these are valid concerns to override strong ethical duties.

### C. Toward a Zero-Tolerance Rule?

If the underlying reason that physician participation in executions is unethical is that it ultimately does not serve the interests of the patient, then it follows logically that *any* act by psychiatrists in the course of their professional duties that increases the likelihood that a patient they have examined will be executed is unethical. The objection might be raised that refusing to participate does not reduce the likelihood of execution, because the state will simply find another psychiatrist to serve its purposes. In reality, the member of the psychiatric profession willing to participate might be more sympathetic to the state—not an unreasonable surmise—and thus the act of refusing to participate by the original psychiatrist might actually have the

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<sup>207</sup> Kevin B. O'Reilly, *Doctor Quits Prison Job Over Execution*, AM. MED. NEWS (Feb. 9, 2009), <http://www.ama-assn.org/amednews/2009/02/09/prsc0209.htm>.

<sup>208</sup> See generally BRITISH MEDICAL ASS'N., *MEDICINE BETRAYED: THE PARTICIPATION OF DOCTORS IN HUMAN RIGHTS ABUSES*, 1992.

<sup>209</sup> Scott, *supra* note 206, at 791-804.

<sup>210</sup> See *Palsgraf v. Long Island R.R. Co.*, 162 N.E. 99, 101 (N.Y. 1928) (providing a definitive discussion of proximate cause).

paradoxical result of increasing the likelihood of execution.<sup>211</sup> However, this reasoning only applies if psychiatrists act individually. While the personal choices of physicians in this area might not have a mitigating effect on executions, if *all* psychiatrists were prohibited from doing so by licensing authorities, then the refusal of individual physicians to participate would effectively shut down the process as it now exists, at least in most states. If capital punishment were to continue at all, it would have to do so under a new set of rules that did not require the participation of psychiatrists. (A rough comparison might be drawn to the Adolph Eichmann trial in Jerusalem, where special provision had to be made for the war crimes defendant to acquire a German attorney, as no member of the Israeli bar was willing to handle the accused war criminal's case.) The key to such collective action would be a blanket and uniform prohibition that prevented psychiatrists from facilitating capital punishment in any direct or indirect manner—from declaring prisoners fit to stand trial in capital cases through rendering them fit for execution. The ultimate result might be a “bottleneck” in which the rules of the psychiatric profession prevent any capital punishment regime from complying with the Constitutional demands required for execution. To state the matter directly, if the Supreme Court's reasoning in cases such as *Ford* and *Sell* stands, it may be impossible, as a practical matter, to maintain any working death penalty system without at least the limited or indirect participation of some psychiatrists. As a result, psychiatry may succeed where teams of defense lawyers and advocacy groups have failed, in imposing a de facto moratorium on executions.

#### VII. CONCLUSION: A POST-PSYCHIATRY CAPITAL PUNISHMENT REGIME?

The question that remains unanswered is whether the Constitutional requirement of due process can be achieved without the participation of psychiatrists.<sup>212</sup> Let us take the hypothetical example of a future situation, not entirely implausible, in which American Psychiatric Association guidelines and state medical board policies will dictate that *all* involvement in capital cases by medical professionals is unethical. Such a broad principle would not only prevent determination of competence for execution—but also determination of competence for trial in situations where the death penalty was a possible outcome. The obvious consequence would be that no defendant would then be able to provide expert evidence strong enough to invoke the threshold required by *Harper* for a hearing on sanity to take place. How might courts respond? One possibility is that they would allow lay evidence, such as testimony from friends and family, to be evaluated by trial courts without the benefit of psychiatric input. The judiciary itself would then assume the responsibility of assessing the competence of defendants. Of course, the challenges of equipping the court system to make such determinations, which now rely upon the expertise of trained professionals, are readily apparent. Whether they are insurmountable—either practically or constitutionally—is a different question. However, if evolving

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<sup>211</sup> See, e.g. James C. Beck, *Psychiatry and the Death Penalty*, HARV. REV. OF PSYCHIATRY 225, 225-29 (1996) (stating that psychiatrists willing to testify in capital cases are more likely to present evidence favoring the prosecution).

<sup>212</sup> Starting with *Solesbee v. Blackom*, 339 US 9 (1950), the court has assumed a role for physicians (and usually psychiatrists) in the process, and has not confronted any state statute that allows determinations of competence without the participation of a psychiatrist, so this question remains entirely unresolved.

medical standards continue to diverge from current legal practice, such a psychiatrist-free capital punishment regime may be the final refuge of defenders of the death penalty.