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THE PSYCHIATRIST AND EXECUTION
COMPETENCY: *FORDING* MURKY
ETHICAL WATERS

*Douglas Mossman, M.D.**

I. INTRODUCTION

Frequently over the last two decades the U. S. Supreme Court has seemed troubled by inconsistent and unfair application of the death penalty. Reflecting this concern, the Court now requires that lower courts consider relevant mitigating evidence, including psychiatric opinions and reports, when rendering capital punishment decisions.¹ As a result, mental health professionals have a variety

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1. See, e.g., *Penry v. Lynaugh*, 492 U.S. 302, 320-30 (1989) (holding that unless the jury is instructed to consider mitigating evidence of mental retardation and childhood abuse, jurors are deprived of a way to express a reasoned moral choice not to impose the death penalty); *Eddings v. Oklahoma*, 455 U.S. 104, 114 (1982) (holding that the sentencing authority must consider any relevant mitigating evidence), *cert. denied*, 470 U.S. 1051

of awkward yet crucial roles in capital punishment decisions.

Supreme Court rulings have firmly established the role of mental health testimony in the sentencing of capital defendants.² In 1972, disturbed by the "arbitrary and capricious" manner in which the death sentence was being imposed, the Court declared all existing death penalty statutes unconstitutional.³ State legislatures re-

(1985); *Lockett v. Ohio*, 438 U.S. 586, 604 (1978) (stating that the sentencer must not be prevented from considering, in mitigating a death sentence, "any aspect of a defendant's character or record and any of the circumstances of the offense that defendant proffers"). See also MICHAEL L. PERLIN, 3 MENTAL DISABILITY LAW: CIVIL AND CRIMINAL § 17.08 (1989) [hereinafter MENTAL DISABILITY LAW] (noting states' reactions to five Supreme Court decisions which held that the death penalty is constitutional only if the sentencer possesses individualized information and is directed by clear standards). See generally Paul S. Appelbaum, *Psychiatrists' Role in the Death Penalty*, 32 HOSP. COMMUNITY PSYCHIATRY 761, 761 (1981) (stating that it is unclear whether psychiatric testimony makes the capital sentencing process fairer and more consistent); James S. Liebman & Michael J. Shepard, *Guiding Capital Sentencing Discretion Beyond the "Boiler Plate": Mental Disorder as a Mitigating Factor*, 66 GEO. L.J. 757, 791-94 (1978) (summarizing the role of mental disability as a mitigating factor in Anglo-American law prior to the twentieth century).

Professor Perlin believes that the Supreme Court's view of the role of the psychiatric opinion is confused and that its decisions reflect widely-shared, ambivalent, and ambiguous feelings about the mentally ill and the death penalty. See, Michael L. Perlin, *The Supreme Court, the Mentally Disabled Criminal Defendant, Psychiatric Testimony in Death Penalty Cases, and the Power of Symbolism: Dulling the Ake in Barefoot's Achilles Heel*, 3 N.Y.L. SCH. HUM. RTS. ANN. 91 (1985) [hereinafter Barefoot's Ake]; Michael L. Perlin, *The Supreme Court, the Mentally Disabled Criminal Defendant, and Symbolic Values: Random Decisions, Hidden Rationales, or "Doctrinal Abyss?"*, 29 ARIZ. L. REV. 1 (1987) [hereinafter *Doctrinal Abyss*]. The "relative paucity of executions and the elaborate procedural requirements applicable in capital cases suggest a profound societal ambivalence on the subject. That ambivalence affects both the judges who must enforce laws which produce intense moral dilemmas and a public which seems to want some executions, but not too many." Jonathan L. Entin, *Psychiatry, Insanity, and the Death Penalty: A Note on Implementing Supreme Court Decisions*, 79 J. CRIM. L. & CRIMINOLOGY 218, 238 (1988) (citation omitted).

2. See *infra* notes 5-16.

3. *Furman v. Georgia*, 408 U.S. 238, 239-40 (1972). *Furman* represented three consolidated cases in which black defendants were sentenced to death. *Id.* at 252-53. While the short *per curiam* opinion in *Furman* gave no reasons for the Court's decision, fears of racial prejudice were present in the concurring opinions of several justices. Justice Douglas, for example, cited a study of U.S. capital cases which concluded that "some suspicion of racial discrimination can hardly be avoided." *Id.* at 250 n.15. Later, the Court rejected a similar study which purported to show a disparity in the imposition of the death penalty based on the race of both the murder victim and the defendant. *McClesky v. Kemp*, 481 U.S. 279, 286-87 (1987), *cert. granted*, 496 U.S. 904 (1990), *aff'd*, 111 S. Ct. 1454 (1991) (denying second habeas corpus petition). Assuming the validity of the study, the court rejected it as evidence that the death penalty was capriciously or arbitrarily applied because the study was insufficient to support the inference that the death penalty was imposed with a discriminatory purpose. *Id.* at 292-97.

sponded by enacting mandatory death penalty statutes that allowed little or no discretion in applying the law, but the Supreme Court ultimately deemed this approach unacceptable as well.⁴ In *Lockett v. Ohio*⁵ the Court held that when imposing the death penalty, sentencers could not be prevented from considering mitigating factors such as information about personality and character supplied by mental health experts.⁶ Judges are now required to instruct jurors in death penalty cases about the nature and relevance of mitigating circumstances.⁷ As a result, psychiatric opinion concerning the impact of a defendant's background and the likelihood of future dangerousness⁸ may play an important part in jurors' decisions about whether to impose the death penalty.⁹ That such opin-

4. *Lockett v. Ohio*, 438 U.S. 586, 600 (1978) (discussing state responses to *Furman*). The Ohio statutes overturned in *Lockett* were OHIO REV. CODE ANN. §§ 2929.03 - 2929.04 (1975). See *Lockett*, 438 U.S. at 589. For examples of other states with mandatory death sentences which were subsequently overturned, see, e.g., *Woodson v. North Carolina*, 428 U.S. 280 (1976) (overturning N.C. GEN. STAT. § 14-17 (Cum. Stat. 1975)). In *Woodson*, the defendants were convicted of murder committed during the course of an armed robbery of a convenience store. *Id.* at 282-83. Under the North Carolina statute, in such circumstances the defendants were to "be punished with death." *Id.* at 286 (quoting N.C. GEN. STAT. § 14-17 (Cum. Supp. 1975)). The Supreme Court held that the imposition of capital punishment without allowing a level of discretion for the decisionmaker is unconstitutional because such laws "depart[] markedly from contemporary standards respecting the imposition of the penalty of death . . ." *Id.* at 301. See also *Rockwell v. Superior Court*, 556 P.2d 1101 (Cal. 1976) (overturning Penal Code §§ 190 - 190.3, which allowed imposition of the death penalty when the defendant committed murder under "special circumstances." 556 P.2d at 1104.) The *Rockwell* defendant, who was convicted of murder in conjunction with attempted rape, qualified for the death penalty. *Id.* The California Supreme Court found the statutes unconstitutional because they called for the mandatory imposition of the death penalty without providing for consideration of mitigating evidence or personal characteristics of the defendant. *Id.* at 1116.

5. 438 U.S. 586 (1978).

6. *Id.* at 604.

7. See *Spivey v. Zant*, 661 F.2d 464, 471-72 (5th Cir. 1981) (holding that the judge must instruct the jury about mitigating circumstances or guide the jury toward considering such circumstances), *cert. denied*, 458 U.S. 1111 (1982).

8. See *Jurek v. Texas*, 428 U.S. 262, 276 (1976) (upholding the constitutionality of TEX. CRIM. PROC. CODE ANN. § 37.071(2) (West Supp. 1976)). The statute in *Jurek* required juries to determine, beyond a reasonable doubt, that a defendant would threaten society through future acts of criminal violence. "What is essential is that the jury have before it all possible relevant information about the individual defendant whose fate it must determine." *Id.*

9. See Richard J. Bonnie, *Psychiatry and the Death Penalty: Emerging Problems in Virginia*, 66 VA. L. REV. 167, 174 (1980) (by requiring individualization of death penalty decisions, the Supreme Court "has virtually assured routine participation by mental health professionals, especially psychiatrists, in the sentencing phase of capital murder trials"); C. Robert Showalter & Richard J. Bonnie, *Psychiatrists and Capital Sentencing: Risks and Responsibilities in a Unique Legal Setting*, 12 BULL. AM. ACAD. PSYCHIATRY & L. 159,

ion has been roundly criticized in both medical and legal literature¹⁰ has not dissuaded the Court from allowing its admission as evidence.¹¹ The increasing importance of mental health testimony in capital trials was recognized in *Ake v. Oklahoma*,¹² a decision in which the Supreme Court explicitly condoned an extensive role for mental health professionals in assisting counsel for capital defendants.¹³ In *Ake*, the defendant's attorney informed the court that he would raise an insanity defense and requested the state pay for a psychiatric evaluation, claiming such an evaluation was guaranteed by the U.S. Constitution.¹⁴ The request was denied even though the defendant's behavior immediately following arrest was so "bizarre" that the court *sua sponte* had him evaluated and subsequently committed to a psychiatric hospital.¹⁵ "The examining psychiatrist reported: 'At times [Ake] appear[ed] to be frankly delusional He claim[ed] to be the 'sword of vengeance of the Lord and that he [would] sit at the left hand of God in heaven.'"¹⁶ Without the psychiatrist's diagnosis that Ake was a paranoid schizophrenic, he would have been executed.

160 (1984) (language of recent death penalty statutes renders psychiatric testimony indispensable).

10. See, e.g., Brief *Amicus Curiae* for the American Psychiatric Association, at 14, *Barefoot v. Estelle*, 463 U.S. 880 (1983) (No. 82-6080) [hereinafter *Barefoot's* Brief] (stating long-term predictions of dangerousness should be based on "predictive statistical or actuarial information that is fundamentally non-medical in nature"); Bruce J. Ennis & Thomas R. Litwack, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom*, 62 CAL. L. REV. 693, 734-735 (1976) ("Psychiatrists have absolutely no expertise in predicting dangerous behavior — indeed, they may be *less* accurate predictors than laymen — and . . . they usually err in overpredicting violence."). See generally MENTAL DISABILITY LAW, *supra* note 1, §§ 2.14, 2.15, 17.13 (discussing empirical studies assessing the accuracy of psychiatric predictions of dangerousness and the accuracy of psychiatric diagnoses, the debate over the role of mental health professionals, and the Supreme Court's response); George E. Dix, *Clinical Evaluation of the "Dangerousness" of "Normal" Criminal Defendants*, 66 VA. L. REV. 523 (1980) (discussing problems posed by clinical prediction of dangerousness of persons not afflicted with traditional mental illness).

11. See *Barefoot*, 463 U.S. at 898-903 (finding psychiatric testimony admissible to prove future dangerousness, despite the argument, supported by the American Psychiatric Association ["APA"], as *amicus*, that such predictions are unreliable).

12. 470 U.S. 68 (1985).

13. *Id.* at 83 (holding that when a defendant shows that his "sanity at the time of the offense is to be a significant factor at trial, the State must, at a minimum, assure the defendant access to a competent psychiatrist who will conduct an appropriate examination and assist in the evaluation, preparation, and presentation of the defense").

14. *Id.* at 72.

15. *Id.* at 71.

16. *Id.*

These rulings have both increased the importance of participation by mental health professionals in capital punishment cases and focused attention on the ethical problems¹⁷ they face. Two other recent Supreme Court cases have raised troublesome issues for psychiatrists who may be called upon to evaluate or treat inmates for whom execution is imminent. In 1986, a sharply-splintered Court ruled that executing Alvin Ford, a Florida inmate who had become psychotic¹⁸ while awaiting execution, would violate the Eighth Amendment's prohibition against cruel and unusual punishment.¹⁹ The Court also ruled that Florida's process²⁰ for deter-

17. For discussions on ethical problems raised by *Ake* for mental health professionals who provide forensic services, see Paul S. Appelbaum, *In the Wake of Ake: The Ethics of Expert Testimony in an Advocate's World*, 15 BULL. AM. ACAD. PSYCHIATRY & L. 15 (1987) (discussing whether after *Ake*, psychiatrists must act as advocates for the defense and, if not, whether their impartiality is still affected); Stephen Rachlin, *From Impartial Expert to Adversary in the Wake of Ake*, 16 BULL. AM. ACAD. PSYCHIATRY & L. 25 (1988) (arguing that psychiatrists should not lose their objectivity and be influenced by the possible outcome of the case). *But see* Paul S. Appelbaum, *The Parable of the Forensic Psychiatrist: Ethics and the Problem of Doing Harm*, 13 INT'L J. L. & PSYCHIATRY 249 (1990) [hereinafter *Appelbaum's Parable*] (stating that forensic psychiatrists are governed by different ethical principles than psychiatrists).

18. "Psychotic" is defined as

[g]ross impairment in reality testing and the creation of a new reality When a person is psychotic, he or she incorrectly evaluates the accuracy of his or her perceptions and thoughts and makes incorrect inferences about external reality, even in the face of contrary evidence

Direct evidence of psychotic behavior is the presence of either delusions or hallucinations (without insight into their pathological nature). The term *psychotic* is sometimes appropriate when a person's behavior is so grossly disorganized that a reasonable inference can be made that reality testing is markedly disturbed. Examples include markedly incoherent speech without apparent awareness by the person that the speech is not understandable

AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 404 (3d ed. rev. 1987).

19. *Ford v. Wainwright*, 477 U.S. 399, 405-410 (1986), *reh'g denied*, *Ford v. State*, 522 So. 2d 345 (Fla. 1988) (denying post-conviction relief), *cert. denied sub nom*, *Ford v. Dugger*, 489 U.S. 1071 (1989).

A subsequent decision, *Penry v. Lynaugh*, 492 U.S. 302, 320-30 (1989), touched on a related issue — the constitutionality of executing the mentally retarded. Despite stating that it may be cruel and unusual punishment to execute individuals who are severely retarded, a majority felt that the protection provided by the insanity defense made it unlikely that such persons would be subject to punishment. *Id.* at 333. In her concurring opinion, Justice O'Connor could not conclude that the Eighth Amendment prohibits executing *all* mentally retarded persons based solely on their mental retardation; instead, the court would need to make an individualized determination of personal responsibility in each case. *Id.* at 340. *Penry* holds that mental retardation does not automatically preclude execution, but *Penry* fails to distinguish between incompetence stemming from mental retardation and incompetence brought on by mental illness. The symptoms of mental illness are often ameliorated by psychotropic medication. Unlike mental illness, mental retardation

mining whether Ford was competent to be executed was inadequate.²¹ However, no majority could agree on what an adequate process might be.²²

In 1990, the Supreme Court was presented with an issue anticipated²³ but not addressed in *Ford*: whether a state can force an incompetent inmate to take medication that would render him competent to be executed. After agreeing in March, 1990 to hear *Perry v. Louisiana*,²⁴ the Court — using reasoning one commentator

is not remediated by medication. See also MENTAL DISABILITY LAW, *supra* note 1, §17.06A (Supp. 1990) (discussing *Penry*); cf. AMERICAN BAR ASS'N, ABA CRIMINAL JUSTICE MENTAL HEALTH STANDARDS, Standard 7-5.6(b) at 290, 293 (1989) [hereinafter ABA STANDARDS] (rejecting the use of the term insanity and employing the term incompetent), discussed *infra*, note 28.

20. See FLA. STAT. § 922.07 (1985 & Supp. 1992); see *infra* text accompanying notes 69-70 (summarizing the process).

21. *Ford*, 477 U.S. at 413-16. The Court noted three defects in Florida's procedures: "1) failing to include the prisoner in the truth-seeking process, 2) denying the prisoner any opportunity to challenge or impeach the state-appointed psychiatrists' opinions, and 3) placing the final decision wholly within the Executive Branch." *Id.*

22. For a summary and discussion of the Justices' differing opinions on appropriate procedures in *Ford*, see Mental Disability Law, *supra* note 1, §§ 17.05-17.06.

23. Numerous authors writing before and after the *Ford* decision analyzed both the legal and ethical problems connected with restoring the competence of inmates whose mental illness, if left untreated, rendered them safe from execution. See, e.g., Douglas Mossman, *Assessing and Restoring Competency to be Executed: Should Psychiatrists Participate?*, 5 BEHAV. SCI. & L. 397 (1987) (raising objections to psychiatric participation but arguing that evaluation and treatment by psychiatrists of condemned inmates does not conflict with ethical standards); Michael L. Radelet & George W. Barnard, *Ethics and the Psychiatric Determination of Competency to be Executed*, 14 BULL. AM. ACAD. PSYCHIATRY & L. 37, 49 (1986); Barbara A. Ward, *Competency for Execution: Problems in Law and Psychiatry*, 14 FLA. ST. UNIV. L. REV. 35, 76-100 (1986) (anticipating the issues of who should determine whether a condemnee is competent, and who should treat that condemnee, as problems associated with the decision to restore a prisoner to competence).

24. 498 U.S. 38 (1990) (vacating the judgment to execute and remanding "for further consideration in light of *Washington v. Harper*, [494 U.S. 210 (1990)]"), *reh'g denied*, 111 S.Ct. 804 (1991), *aff'd in part and vacated in part*, No. 91-KP-1324, 1992 WL 296230 (La. Oct. 19, 1992) (holding that *Perry* could not be forcibly medicated to restore competency for the purposes of execution).

Perry was not the first post-*Ford* case, or even the first Louisiana case, in which the Court was asked to deal with issues addressed in *Ford*. In April, 1988, Leslie Lowenfield, a Louisiana condemnee, petitioned the Court for a stay of execution based on his incompetence; his application was denied. *Lowenfield v. Butler*, 485 U.S. 995 (1988).

In a dissenting opinion, Justice Brennan noted that Lowenfield supported his application with the sworn affidavit of a clinical psychologist who had examined him for five hours. The state trial and supreme courts denied Lowenfield's application without offering any refuting evidence or reason. *Id.* at 995-96 (Brennan, J., dissenting). The district court subsequently denied Lowenfield's application for habeas relief based on an "extended conversation" with the psychologist and ruled that Lowenfield was competent to be executed. *Id.* at 996 (citation omitted). The court of appeals affirmed the decision; its opinion

found "particularly puzzling"²⁵ — ordered the 19th Judicial District Court of Louisiana to reconsider Perry's case in light of *Washington v. Harper*,²⁶ a decision issued by the Supreme Court in February, 1990 which held that a prison inmate with a serious mental illness may be forcibly treated with antipsychotic drugs.²⁷

reached the U.S. Supreme Court "a mere fifteen minutes before the scheduled execution." *Id.* On April 13, 1988, "[a]t 1:05 a.m., with petitioner already strapped in the electric chair, th[e] Court denied his application for a stay of execution At 1:25 a.m. petitioner was pronounced dead . . . before . . . [the Court] voted on the certiorari petition that accompanied petitioner's stay application." *Id.* at 999 (citation omitted).

Commenting on these events, Justice Brennan stated, "every court that has considered petitioner's insanity claim has made a mockery of this Court's precedent and of the most fundamental principles of ordered justice." *Id.* at 996. He added:

The haste that attended disposition of this case is reprehensible. It is hardly surprising that a case scudding through the state courts in 24 hours should yield orders devoid of law or logic — the ones in this case simply read, "DENIED" And simple arithmetic suggests grave injustice when the Court of last resort takes 15 minutes to read and analyze 17 pages of opinions from the court below and cast a vote on life or death

Regrettably, this case is not atypical. It is the natural product of a penal system conducive to inaccurate factfinding and shoddy analysis Even were I not convinced that the death penalty is in all circumstances cruel and unusual punishment . . . , I would have no part of a penal system that permits a State's interest in meting out death on schedule to convert our constitutional duty to dispense justice into a license to dispense with it.

Id. at 999-1000 (citations omitted).

25. Linda Greenhouse, *New Hearing on Forced Medication of Inmate*, N.Y. TIMES, Nov. 14, 1990, at A30.

26. 494 U.S. 210 (1990).

27. *Id.* at 226-27. Although *Harper* was not a death penalty case, it did address the issue of whether prison officials can medicate prison inmates against their will for purposes of prison administration and security. The majority in *Harper* found that the 14th Amendment's due process clause gives inmates a "significant liberty interest" in avoiding unwanted medication, but that, nevertheless, a state may "treat a prison inmate who has a serious mental illness with anti-psychotic drugs against his will, if the inmate is dangerous to himself or others and the treatment is in the inmate's medical interest." *Id.*

Greenhouse finds the Court's reasoning in *Perry* puzzling in view of the fact that the *Harper* decision was issued *before* the Court agreed to hear *Perry*: "In fact, the Court had deferred acting on the Louisiana case for months last term, while the *Washington* case was under consideration." Greenhouse, *supra* note 25, at A30. She speculates that the Court was deadlocked 4 to 4 in the case, because Justice David H. Souter, who joined the Court after *Perry* was argued, could not participate. "A tie would have automatically upheld the state court permitting the inmate . . . to be medicated and executed. By contrast, [the Court's] action vacates the lower court's decision and bars the execution until constitutional question is resolved in a new round of appeals." *Id.*

Dr. Paul Appelbaum speculates that the Supreme Court might be asking the lower court to expand the factual elements in *Perry* that are relevant in light of *Harper*: "[t]he record is devoid of information about Perry's dangerousness, whether he meets Louisiana's commitment criteria, or whether it would be in his best medical interest to be treated," which are the *Harper* criteria for a the involuntary treatment of an inmate. Rojean Wag-

Ford and *Perry* raise a host of practical and procedural problems for mental health professionals who may be called upon to evaluate or treat potentially incompetent prisoners. These problems, which the Court has left unaddressed so far, include the legal standard for execution incompetence,²⁸ the method for selecting competency evaluators, the method and detail with which evaluators should examine prisoners, the nature of adequate representation for prisoners undergoing competency evaluations, the proper forum for hearing evaluators' findings, the proper scope of mental health expert testimony, and the procedure for initiating treatment of prisoners found incompetent.²⁹ Although these problems are important and nettlesome, they are logically secondary to an *ethical* question

ner, *Supreme Court Sends Involuntary Medication Case Back to Louisiana*, 8 PSYCHIATRIC TIMES, January, 1991, at 55 (quoting Dr. Appelbaum).

28. The American Bar Association ["ABA"] recommends that a convict be deemed "incompetent to be executed if, as a result of mental illness or mental retardation, the convict cannot understand the nature of the pending proceedings, what he or she was tried for, the reason for the punishment, or the the nature of the punishment[,] or cannot "recognize or understand any fact . . . which would make the punishment unjust or unlawful, or lacks the ability to convey such information to counsel or to the court." ABA STANDARDS, *supra* note 19, Standard 7-5.6. This language was adapted from Justice Frankfurter's dissenting opinion in *Solesbee v. Balkcom*, 339 U.S. 9, 20 n.3 (1950) (holding that it is not a denial of due process to leave the question of a convicted individual's sanity to the governor, who has the aid of experts). The ABA also suggests standards for selecting evaluators and procedures for hearing their testimony. See ABA STANDARDS, *supra* note 19, Standard 7-5.7.

29. For discussion of the special problems raised by *Ford* regarding informed consent for evaluations, conflicts of interest and the proper scope of psychiatric testimony, see Ward, *supra* note 23, at 76-81. For discussion on current Florida procedures for evaluating and treating an incompetent condemned prisoner, see Michael L. Radelet & George W. Barnard, *Treating Those Found Incompetent for Execution: Ethical Chaos with Only One Solution*, 16 BULL. AM. ACAD. PSYCHIATRY & L. 297, 298, 301-03 (1988) [hereinafter *Ethical Chaos*]. For guidelines concerning clinicians' decisionmaking about whether to participate in the assessment of incompetence and methods for undertaking evaluations and providing testimony, see Kirk S. Heilbrun & Harry A. McClaren, *Assessment of Competency for Execution? A Guide for Mental Health Professionals*, 16 BULL. AM. ACAD. PSYCHIATRY & L. 205 (1988). For some provisional guidelines that clinicians might use when gathering information about execution incompetence, see William D. Kenner, *Competency on Death Row*, 8 INT'L J. L. & PSYCHIATRY 253, 254 (1986). For discussions of issues related to appropriate legal procedures, see Paul F. Enzinna & Jana L. Gill, *Capital Punishment and the Incompetent: Procedures for Determining Competency to Be Executed After Ford v. Wainwright*, 41 FLA. L. REV. 115 (1989); Rachelle Deckert Dick, Note, *Ford v. Wainwright: Warning — Sanity on Death Row May Be Hazardous to Your Health*, 47 LA. L. REV. 1351 (1987); Stephen L. Ihm, Note, *Ford v. Wainwright: The Eighth Amendment, Due Process and Insanity on Death Row*, 7 N. ILL. U. L. REV. 89, 103-112 (1987) [hereinafter *Due Process and Insanity*]; Gordon L. Moore III, Comment, *Ford v. Wainwright: A Coda in the Executioner's Song*, 72 IOWA L. REV. 1461, 1470-82 (1987) [hereinafter *Iowa Comment*].

which psychiatrists must answer³⁰ before practical and procedural issues become relevant: may psychiatrists "ethically . . . participate *at all*"³¹ in the evaluation or treatment of the condemned?

A substantial number of professionals believe that "this arena is no place for a psychiatrist to function, that it downgrades the profession, and that all psychiatrists should refuse to participate" in such proceedings.³² Overall, the profession is divided as to whether participation in the evaluation and treatment of condemnees is ethical. During a debate conducted at the American Psychiatric Association's 1987 Annual Meeting, an audience poll showed listeners to be evenly split on the matter.³³ A subsequent survey of psychiatrists found that a slight majority felt that participation was

30. For much of the rest of this discussion, this article refers to ethical problems faced by *psychiatrists*, even though they comprise only a sub-group of the mental health professionals who might be involved in the evaluation and treatment of condemned prisoners. As physicians, psychiatrists are the sole mental health professionals who could *order* medication for an incompetent condemnee against his will (nurses might share responsibility for *administering* such medication); medication is likely to be the core of treatment for prisoners whose mental disorders are severe enough to make them incompetent for execution. See, e.g., *infra* notes 92-97 and accompanying text (discussing the role of medication in maintaining a prisoner's competency). Psychiatrists must also recognize moral obligations they share with other physicians and hold themselves bound by ethical codes uniquely applicable to physicians. See *infra* text at notes 129, 151, and 180-188 (discussing the Hippocratic Oath and the American Psychiatric Association Code of Ethics). Despite some inter-professional points of difference, however, the ethical issues confronted by psychiatrists and other mental health professionals overlap extensively. This article's focus on ethical problems for psychiatrists is intended primarily to simplify exposition. Many of the ethical difficulties faced by psychiatrists who deal with the condemned are very similar to those faced by other mental health professionals. See *infra* text accompanying notes 334-43.

Indeed, *attorneys* representing the condemned face problems similar to those confronted by psychiatrists treating the condemned, particularly where the issues of inferring prisoners' desires or best interests are concerned. For a discussion of these issues, see Richard J. Bonnie, *Dilemmas in Administering the Death Penalty: Conscientious Abstinence, Professional Ethics, and the Needs of the Legal System*, 14 LAW & HUM. BEHAV. 67, 68-75 (1990).

31. Ward, *supra* note 23, at 76 (emphasis added).

32. Radelet & Barnard, *supra* note 23, at 45 (citation omitted). See also Louis Jolyn West, *Psychiatric Reflections on the Death Penalty*, 45 AM. J. ORTHOPSYCHIATRY 689 (1975) (arguing that capital punishment is outdated, immoral, and unjust and that medical professionals should declare participation unethical); *Questioning Psychiatry's Role in Death Penalty Cases* (interview with Douglas A. Sargeant), PSYCHIATRY '86 at 3 (December, 1986) [hereinafter *Questioning Psychiatry's Role*] (asserting that "a fair reading of the ethics of our profession should ban participation in executions").

33. K. Hansman, *Forensic Experts Debate Ethics of Restoring Prisoners' Competency to Allow Their Execution*, PSYCHIATRIC NEWS (June 5, 1987) 15, 21 (discussing the debate between four leading forensic psychiatrists over the ethics of treating incompetent, condemned inmates).

ethically permissible.³⁴ The American Psychiatric Association's Council on Law and Psychiatry reacted ambivalently to *Ford*. "After much discussion, the council was unable to agree, on the basis of principle, whether psychiatric participation in the evaluation and treatment of persons sentenced to execution is consistent with ethical standards."³⁵ The changing views of the Council's chairman, Dr. Paul Appelbaum, further demonstrate just how perplexing psychiatrists have found this problem. Initially, he believed that both evaluation and treatment were unethical;³⁶ now he views evaluation, but not treatment, of the condemned to be consistent with physicians' moral and social obligations.³⁷ This latter position is consistent with that taken by the American Psychiatric Association ["APA"] and the American Medical Association ["AMA"] in an *amicus curiae* brief filed in *Perry*.³⁸

The focus of this article is whether it is ethical for physicians to participate in the evaluation or treatment of condemned prisoners who are incompetent. According to Ward, this may be the "ultimate question"³⁹ faced by psychiatrists who are asked to deal with execution competency. This article is not intended to offer an answer to this question.⁴⁰ Rather, it seeks to (1) elucidate issues

34. A clear majority of the psychiatrists polled saw no ethical problem in evaluating competency to be executed, and a slight majority felt that treatment to restore competency posed no problem. A substantial minority, however, thought that treatment was ethically problematic or contrary to personal moral standards. Robert Weinstock, *Controversial Ethical Issues in Forensic Psychiatry: A Survey*, 33 J. FORENSIC SCI. 176 (1988).

35. Loren H. Roth, *The Council on Psychiatry and Law*, 144 AM. J. PSYCHIATRY 411, 412 (1987).

36. Dr. Appelbaum previously believed that a psychiatrist who participated in evaluation or treatment of the incompetent condemned "abandon[ed] his role as healer" and acted as the 'final certifying stamp' for the prisoner's execution." Hansman, *supra* note 33, at 15 (quoting Paul S. Appelbaum, Remarks at the Debate at the APA Annual Meeting (1987)). See also Panel Discussion, *The Death Penalty: Dilemmas for Physicians and Society — a Panel Discussion*, 50 THE PHAROS OF ALPHA OMEGA ALPHA HONOR MEDICAL SOCIETY, Summer 1987, at 23-27.

37. *Appelbaum's Parable*, *supra* note 17, at 256-57.

38. Brief for the American Psychiatric Association and the American Medical Association as *Amici Curiae* in support of Petitioner at 25, *Perry v. Louisiana*, 498 U.S. 38 (1990) (No. 89-5120) [hereinafter APA/AMA Brief] (stating that the state cannot medicate a condemned inmate only for the purposes of capital punishment).

39. Ward, *supra* note 23, at 76.

40. In an earlier article I argued that if one "presume[s] that capital punishment can be, under some conditions, justified," both evaluation and participation are ethical. Mossman, *supra* note 23, at 407. I suggested "that those who decry such proceedings are also voicing an aversion to executions." *Id.* However, I wish I had made clearer that I oppose capital punishment on moral grounds and, therefore, oppose psychiatrists' participation in

connected to the "ultimate question's" resolution, (2) articulate a set of premises within which psychiatrists should evaluate their relationship to institutions whose purposes include punishing criminals, and (3) suggest that, if the death penalty itself is just, then there are no coherent ethical objections to psychiatric participation.⁴¹ Part II of this article offers a brief review of the sociopolitical issues that provide the context for *Ford and Perry*, as well as brief summaries of those cases. Part III summarizes four types of arguments that advance the view that psychiatric participation is unethical and shows how these arguments are internally

execution competency proceedings. Professor Richard Bonnie believes that opposition to psychiatric participation in execution competency proceedings, along with opposition to other aspects of capital punishment (e.g., opposition to executing those who commit capital crimes as minors or who are retarded but legally sane), is really opposition to the death penalty. Conversation with Professor Richard Bonnie (May 14, 1990.) Although I suspect many would endorse this view, most mental health professionals who have argued against participation by psychiatrists have *not* explicitly opposed capital punishment. Instead, their arguments are silent on the morality of the death penalty itself. See, e.g., Kirk Heilbrun et al., *The Debate on Treating Individuals Incompetent for Execution*, 149 AM. J. PSYCHIATRY 596, 597 (1992) (voicing opposition to the manner in which the death penalty "is currently practiced," but avoiding taking an explicit, principled opinion on the morality of capital punishment). See *infra* text accompanying notes 107-135.

Psychiatrists, I believe, have a special obligation to be honest with others and themselves. Many psychiatrists are ambivalent about implicitly endorsing punishment as an institution, insofar as punishment involves inflicting an evil or harm on others. See, e.g., *Appelbaum's Parable*, *supra* note 17, at 250 (asking "if psychiatrists are committed to doing good and avoiding harm, how can they participate in legal proceedings from which harm may result?"). As this article explains, by viewing punishment as 'doing harm,' we misconstrue the decision to hold someone accountable. See *infra* notes 120, 293-294 and accompanying text.

Confusion about the justification of punishment and the ethics of holding patients accountable for their actions may create some of the ambivalence psychiatrists have about viewing their patients as responsible for assaults. For discussions of this problem, see John O. Beahrs, *Legal Duties of Psychiatric Patients*, 18 BULL. AM. ACAD. PSYCHIATRY & L. 189, 198-99 (1990) (stating that patients should retain their duties created by an implied contract between the patient and the psychiatrist but that, in practice, involuntary patients are likely to be held to a lower standard of responsibility); Seymour L. Halleck, *The Concept of Responsibility in Psychotherapy*, 36 AM. J. PSYCHOTHERAPY 292 (1982) (arguing that the issue of responsibility is dealt with inconsistently and suggesting a model to think about free will in a practical, rather than an absolute, way); Seymour L. Halleck, *Responsibility and Excuse in Medicine and Law: A Utilitarian Perspective*, 49 LAW & CONTEMP. PROBS., Summer 1986, at 127 (challenging determinate sentencing and proposing the use of a medical model of criminal justice that stresses utilitarian principles).

41. This is not to suggest that psychiatrists, therefore, would be morally obligated to participate. They might refuse to do so for a variety of reasons, such as finding participation repugnant or emotionally intolerable. See, e.g., *Ethical Chaos*, *supra* note 29, at 303-04 (discussing how mental health professionals treating Gary Alvord, a condemned, incompetent inmate, were emotionally torn).

inconsistent and are contradicted by our intuitions about the "right" course of action in other situations. Part IV discusses the ethical justification of retributive punishment in a reasonably fair⁴² criminal justice system. Particular attention is given to those issues that might trouble psychiatrists contemplating evaluation or treatment of the potentially incompetent condemned. Part V suggests in a reasonably fair criminal justice system, psychiatrists can assume that a condemned criminal has given his hypothetical rational consent to evaluation and treatment, and that this consent provides a moral authorization for psychiatric participation in execution competency proceedings.

II. BACKGROUND

A. Sociology and Statistics

Opinion polls consistently show that at the most general level, the American public overwhelmingly supports the use of the death penalty.⁴³ When pollsters probe more specific issues, however, this picture changes somewhat. A majority of the public supports mandatory execution for particular crimes; however, only a fraction of this group is willing to specify the crimes to which the penalty should be mandatorily applied.⁴⁴ In addition, even fewer persons,

42. For a discussion of what is implied by a "reasonably fair" system, see *infra* note 230.

43. Laura A. Kiernan, *After Decades Without It, Is Death Penalty Necessary?*, BOSTON GLOBE, April 26, 1992, New Hampshire Weekly, at 2 (stating that in a 1991 Gallup poll, "76% of adult Americans said they favored the death penalty for murder, . . . [a] number [that] has remained constant for eight years."); Stuart Taylor, Jr., *Death Penalty Laws Return Amid Rising Debate in U.S.*, N.Y. TIMES, June 14, 1981, at 1 (offering Gallup poll evidence that 66% of Americans favor the death penalty); FRANK G. CARRINGTON, NEITHER CRUEL NOR UNUSUAL 58-60 (1979) (citing Gallup and Harris polls for the years 1976 and 1977, which found that at least 65% of Americans supported capital punishment); *Recent Survey Research Data on the Death Penalty*, in THE DEATH PENALTY IN AMERICA 85, 85-88 (Hugo A. Bedau ed., 3d ed. 1982) [hereinafter *Recent Survey*] (attitudes toward capital punishment for persons convicted of murder were examined by various demographic characteristics, such as age, gender, race, religion, education and income; in all categories except race, support for the death penalty was greater than 2:1, while for race, opposition was either greater or equal to support). *But see* Anthony N. Doob & Julian V. Roberts, *Social Psychology, Social Attitudes, and Attitudes Toward Sentencing*, 16 CAN. J. BEHAV. SCI. 269, 277 (1984) (The public's concerns about leniency in sentencing reflect impressions left by the mass media, not courts' actual behavior; thus, policy makers should not accept these attitudes at face value, but should recognize that concerns about judicial leniency are "founded upon incomplete and frequently inaccurate news accounts.").

44. Phoebe C. Ellsworth & Lee Ross, *Public Opinion and Capital Punishment: A*

as jurors, would sentence convicts to death.⁴⁵ The public also is quite ignorant about, and has little interest in, many of the details of capital punishment.⁴⁶ These findings suggest to Entin that "the death penalty remains in force mostly as a symbol of opposition to crime and disorder."⁴⁷ He believes that public acceptance of the ancient prohibition against executing the incompetent shows that "the rule . . . serves an important social function [It] oper-

Close Examination of the Views of Abolitionists and Retentionists, 29 CRIME & DELINQ. 116, 126-137 (1983) (64% percent of the respondents indicated that they would definitely or probably vote for the death penalty; however, support for mandatory execution for a specific crime ranged from a high of 57.4% in the case of a mass murder, to a low of 32.0% for murder committed during a robbery); Neil Vidmar & Phoebe C. Ellsworth, *Research on Attitudes Toward Capital Punishment, in THE DEATH PENALTY IN AMERICA* 68 (Hugo A. Bedau ed., 3d ed. 1982) (indicating that higher support for capital punishment on a general level relative to lower support for capital punishment on a more specific level may reflect the hypothesis that people favor the idea of capital punishment but not the implications).

45. Vidmar & Ellsworth, *supra* note 44, at 83-84 (45% of subjects questioned generally about capital punishment indicated their support for the death penalty; when asked to assume the position of a juror in a trial where the defendant had been found guilty of a very serious crime, only eight percent indicated that they would vote for the death penalty); *Recent Survey*, *supra* note 43, at 85, 90 (39% of individuals questioned reported that, as jurors, they would vote guilty "even though the defendant would automatically receive the death penalty; nationally, general support for the death penalty was 60%).

46. *Furman v. Georgia*, 408 U.S. 238, 362 (1972) (Marshall, J., concurring) (Americans "know almost nothing about capital punishment."); see *Gregg v. Georgia*, 428 U.S. 153, 232 (1976) (Marshall, J., dissenting) (If the public "were better informed they would consider [the death penalty] shocking, unjust, and unacceptable."); Neil Vidmar & Tony Dittenhofer, *Informed Public Opinion & Death Penalty Attitudes*, 23 CAN. J. CRIMINOLOGY 43, 52 (1981) ("[O]n the whole[,] if the public were informed, opinion polls would show more people oppos[ing] . . . capital punishment than favor[ing] it."). See also Robert M. Bohm et al., *Knowledge and Death Penalty Opinion: A Test of the Marshall Hypotheses*, 28 J. RES. CRIME & DELINQ. 360, 369-370 (1991) (finding that during the pretest phase of experimentation, the 272 subjects were able to answer only 52% of knowledge questions correctly; no knowledge question was answered correctly by more than 67.3% of the subjects and only half of the 14 questions were answered correctly by more than 50% of the subjects); Ellsworth & Ross, *supra* note 38, at 139-145, 161 (concluding that "respondents [to the survey] had little knowledge of the factual issues [surrounding the death penalty], . . . and their willingness to admit this ignorance may indicate that they did not feel that factual knowledge is very important); Austin Sarat & Neil Vidmar, *Public Opinion, the Death Penalty, and the Eighth Amendment: Testing the Marshall Hypothesis*, 1976 WIS. L. REV. 171, 184-187 (72% of experimental subjects knew that there were people awaiting execution. However, knowledge of the application and deterrent value of capital punishment and its effects on those sentenced to die, issues which Marshall deemed relevant to the formation of an informed opinion, was considerably lower. Only 36% of subjects were familiar with deterrence arguments. Such findings indicate that people are moderately well-informed about "how capital punishment is applied, but are less well-informed about its effects.").

47. Entin, *supra* note 1, at 239.

ates to reduce the class of persons subject to execution," and thus "diminishes our larger ambivalence" about the use of the death penalty.⁴⁸

The Supreme Court appears to share this ambivalence. Although, since *Furman*, no majority of justices has been willing to declare capital punishment unconstitutional,⁴⁹ the Court generally has affirmed elaborate post-conviction procedural requirements that have slowed the pace of executions. Several justices who object to abolishing capital punishment *judicially* appear to support eliminating it *legislatively*.⁵⁰ The Court's recent frustration with the task of reviewing death sentences⁵¹ should not be construed as support for more executions.⁵²

In the late 1980s, the United States' "death row" population surpassed 2000.⁵³ The combination of undiminishing legislative

48. *Id.* at 238-39.

49. *But see* *Coker v. Georgia*, 433 U.S. 584 (1977) (Execution for the rape of an adult woman is grossly disproportionate and excessive as compared to the crime, and therefore violates the Eighth Amendment prohibition against cruel and unusual punishment.).

50. *See* *Furman v. Georgia*, 408 U.S. at 375 (stating that "[i]f . . . [this Court] were possessed of legislative power, I would either join with Mr. Justice Brennan and Mr. Justice Marshall [to eliminate capital punishment] or, at the very least, restrict the use of capital punishment to a very small category of the most heinous crimes") (Burger, C.J., joined by Blackmun, Powell, and Rehnquist, JJ., dissenting); *see also id.* at 405-06 (Blackmun, J., dissenting) ("Were I a legislator, I would vote against the death penalty.").

51. This impatience is reflected in the Court's recent decision to allow states to limit habeas corpus petitions. *See* *Coleman v. Thompson*, 111 S. Ct. 2546, 2553-55 (1991) (holding that a federal court may not review a state court's decision to deny a prisoner's federal constitutional claim if the decision of the state court is based upon a procedural default established by the state court which is independent of the prisoner's federal question).

52. *See* FRANKLIN E. ZIMRING & GORDON HAWKINS, *CAPITAL PUNISHMENT AND THE AMERICAN AGENDA* 46 (1986) (noting that in the early 1980s there was a "wave of decisions voiding death sentences and sections of state death penalty laws" after which wide latitude was given to states in a series of cases); *cf.* Robert Weisberg, *Deregulating Death*, 1983 SUP. CT. REV. 305, 387-388 (asserting that the federal courts have struck a balance between the competing demands of the death penalty debate by handing down a very large number of death sentences relative to the small number of actual executions).

53. *See* David Bruck, *On Death Row in Pretoria Central*, *THE NEW REPUBLIC*, July 13 & 20, 1987, at 18-19 (number of death row inmates nearing 2000). Articles published after 1988 consistently state that "over 2,000" convicts are residing on death row. *See, e.g.*, Bonnie, *supra* note 30, at 67 (stating that there were over 2000 condemned prisoners awaiting execution); Radelet & Barnard, *supra* note 23, at 297 (stating that in early 1988, America's death row population exceeded 2000 inmates).

According to a Justice Department study, there were, as of December 31, 1990, "2,356 prisoners awaiting death penalties . . . , up 5% from the previous year." Associated Press, *40% on Death Row are Black, Report Says*, *CINCINNATI ENQUIRER*, Sept. 30,

and public support for the rendering of death sentences coupled with a comparatively slow rate of executions suggests that the numbers of persons awaiting execution will continue to rise. Both courts and commentators have noted repeatedly that confinement on death row entails extreme emotional distress.⁵⁴ Many condemned inmates arrive on death row with significant histories of neurological and psychiatric problems.⁵⁵ The inmate who awaits execution faces a unique and terrible form of emotional stress: "the anticipation of death at a specific moment in time and in a known manner."⁵⁶ The available evidence suggests that a substantial fraction of death row inmates — who, by virtue of their psychological and medical histories, are especially vulnerable to stress-induced decompensation — display significant levels of severe psychiatric symptoms, including psychosis.⁵⁷ As the nation's death row population increases, psychiatrists who work within or provide consultation to state prison systems can expect to perform a proportionately greater number of services for those who appear incompetent to be executed.⁵⁸

1991, at A5.

54. See, e.g., *Solesbee v. Balkcom*, 339 U.S. 9, 14 (1950) (Frankfurter, J., dissenting) ("[T]he onset of insanity while awaiting execution of a death sentence is not a rare phenomenon."); *Rector v. Bryant*, 111 S. Ct. 2872, 2875 (1991) (Marshall, J., dissenting) ("The stark realities are that many death row inmates were afflicted with serious mental impairments before they committed their crimes and that many more develop such impairments during the excruciating interval between sentencing and execution."); see also *infra* notes 55-57 and accompanying text.

55. See, e.g., Dorothy O. Lewis et al., *Psychiatric, Neurological, and Psychoeducational Characteristics of 15 Death Row Inmates in the United States*, 143 AM. J. PSYCHIATRY 838, 840, 844 (1986) [hereinafter *Characteristics*] (Lewis detailed the psychiatric and neurological evaluations of 15 condemnees which revealed serious psychiatric impairment. Six were determined to be chronically psychotic, suffering from delusions, hallucinations and bizarre and sadistic behavior; nine suffered from psychiatric symptoms during childhood; three attempted suicide during childhood and one attempted it during adolescence; all had histories of head injuries.).

56. Johnnie L. Gallemore Jr. & James H. Panton, *Inmate Responses to Lengthy Death Row Confinement*, 129 AM. J. PSYCHIATRY 167, 167 (1972); see also Harvey Bluestone & Carl L. McGahee, *Reaction to Extreme Stress: Impending Death by Execution*, 119 AM. J. PSYCHIATRY 393 (1962) ("Presumably, the greatest of stresses would be imposed on the man who knows he is going to be put to death — and knows just when that will be.").

57. See Gallemore & Patton, *supra* note 56, at 168, 169; Bluestone & McGahee, *supra* note 56, at 393. At the time that Ford's case was advancing through the appellate courts, it was estimated informally that half of Florida's condemnees become psychotic at some point during their confinement. Robert Sherill, *Electrocution Binge: In Florida, Insanity is No Defense*, 239 THE NATION 537, 555-556 (1984) (quoting the director of Florida Clearing House for Justice).

58. "The pace and complexity of the present death penalty process guarantees a long

B. *Ford v. Wainwright*⁵⁹

Before the Supreme Court heard *Ford v. Wainwright*, the legal and ethical issues involved in executing an incompetent person had received a modicum of scholarly consideration.⁶⁰ The Court's decision to hear *Ford* greatly increased both academic and practical interest in the potential problems raised for mental health professionals who might become involved in execution competency proceedings.

Neither Alvin Ford's mental competence nor his legal sanity were ever at issue at the time that he was tried and convicted of murder in 1974.⁶¹ Ford began to evince significant mental deterioration after spending eight years on Florida's death row.⁶² His psychosis was initially manifested in a pervasive delusion that he

wait between sentence and execution. Clearly, post-sentencing incompetence will become more common. Therefore, doctors can anticipate that the state will require their services more frequently to provide evaluations and treatment pursuant to competency to be executed statutes." Rochelle G. Salguero, Note, *Medical Ethics and Competency to be Executed*, 96 YALE L. J. 167, 172-73 (1986). See also Heiltrum et al., *supra* note 40, at 996 ("increasing numbers of mental health professionals will be asked to become involved"). During an October, 1988 presentation of an earlier version of this paper to a national audience of forensic psychiatrists, approximately one-fifth of about 60 listeners indicated they had been involved in some way in execution competency proceedings.

59. 477 U.S. 399 (1986), *reh'g denied*, Ford v. State, 522 So. 2d 345 (Fla. 1988) (denying post-conviction relief), *cert. denied sub nom.* Ford v. Dugger, 489 U.S. 1071 (1989).

60. A sample of frequently-cited pre-*Ford* writings on execution competency includes Geoffrey C. Hazard, Jr. & David W. Louisell, *Death, the State, and the Insane: Stay of Execution*, 9 UCLA L. REV. 381, 401 (1962) (reviewing the procedure for determining whether a prisoner is indeed insane, and recommending procedural protections "both commensurate with . . . society's aversion to execution of the insane and consistent with the need to avoid interminable delay"); Paul J. Larkin, Note, *The Eighth Amendment and the Execution of the Presently Incompetent*, 32 STAN. L. REV. 765, 804 (1980) (arguing that the Eighth Amendment forbids execution of the presently incompetent, thus providing an alternative basis for resolving problems raised by the "condemned prisoner who refuses to pursue legal claims that might prevent his execution"); Note, *Insanity of the Condemned*, 88 YALE L. J. 533, 533 (1979) (arguing that court-sanctioned state procedures to assess the sanity of condemnees are inadequate when analyzed under "subsequently prescribed, more stringent constitutional guidelines" and proposing "a framework of procedural safeguards designed to protect the rights of condemned prisoners to raise the issue of insanity and to have that claim properly evaluated").

Prior to *Ford*, the incompetency issue seems to have been raised infrequently by condemned prisoners. For example, only four of 180 condemned California prisoners raised the issue of incompetency between 1942 and 1956. Note, *Post-Conviction Remedies in California Death Penalty Cases*, 11 STAN. L. REV. 94, 131 (1958).

61. *Ford*, 477 U.S. at 401-402.

62. *Id.* at 402.

was the target of a conspiracy in which the Ku Klux Klan and others plotted to induce him to suicide. He believed that prison guards were a part of this conspiracy, and that they were killing people and putting bodies in prison beds. Later, Ford began to believe that his female relatives were being tortured in the prison, and that members of his family had been taken hostage. The hostage delusion then expanded: Ford began to speak of a "hostage crisis" by "day 287" in which Senator Kennedy and others were among the hostages. By 1983, Ford appeared to have assumed authority for the "crisis." He also began referring to himself as "Pope John Paul III," claimed to have fired several prison officials, and claimed to have appointed nine new Florida Supreme Court justices.⁶³

Over the course of his illness, Ford's counsel arranged for two psychiatrists to examine him.⁶⁴ Amidst "long streams of seemingly unrelated thoughts,"⁶⁵ Ford told the second psychiatrist, in November, 1983: "I can't be executed because of the landmark case. I won. Ford v. State will prevent executions all over."⁶⁶ The psychiatrist was convinced Ford was not malingering and concluded that Ford neither understood why he was condemned to death, nor that he would be executed.⁶⁷ One month later, Ford regressed to almost complete incomprehensibility. He spoke in a sort of code that involved the "intermittent use of the word 'one,' making statements such as 'Hands one, face one. Mafia one. God one, father one, Pope one. Pope one. Leader one.'"⁶⁸

Ford's attorney then invoked Florida's procedures for determining a condemned prisoner's competency to be executed.⁶⁹ In

63. *Id.*

64. *Id.* at 402-03.

65. *Id.* at 403.

66. *Id.*

67. *Id.* See also *infra* note 115 (discussing psychiatric detection of malingering).

68. *Ford*, 477 U.S. at 403.

69. *Id.* at 403-04. FLA. STAT. ch. 922.07 (1985) details procedures to be followed when a person sentenced to death appears to be insane. Under the statute, the governor must stay the execution and appoint three psychiatrists to jointly examine the prisoner to determine whether the prisoner "understands the nature and effect of the death penalty and why it is to be imposed upon him." *Id.* at § 922.07(1). After the psychiatrists make a determination, they submit a report to the governor. If, based on the report, the governor decides the prisoner is competent to understand the situation, the governor will order the warden to proceed with the execution. However, if the governor believes that the prisoner is incompetent, the prisoner must be committed to a Department of Corrections mental health facility until he is restored to sanity. At that time, the governor must again appoint

accordance with the statute, the Governor stayed the execution and appointed three psychiatrists to evaluate whether Ford had "the mental capacity to understand the nature of the death penalty and the reasons why it was imposed upon him."⁷⁰ The psychiatrists jointly interviewed Ford for 30 minutes and submitted separate written reports to the Governor. Each psychiatrist offered a different diagnosis, but all thought Ford was competent to be executed. Pursuant to the statute, after receiving the psychiatrists' reports, the Governor signed Ford's death warrant on April 30, 1984, without explanation or comment.⁷¹ After a series of appeals, the Supreme Court granted *certiorari* to consider both the constitutionality of executing the insane and the adequacy of Florida's procedures for hearing Ford's claim.⁷²

Even before Ford's appeal, all states with death penalty statutes prohibited execution of the incompetent.⁷³ Indeed, for centuries, Anglo-American law has protected a person from being executed if he has "lost his sanity."⁷⁴ The *Ford* Court noted that historians and jurists have offered several rationales for this prohibition but "the reasons for the rule are less sure and less uniform than the rule itself."⁷⁵ Justice Marshall agreed with Sir Edward Coke's view that the execution of a "mad man" serves as no example to others, has no deterrent value, and is extremely cruel.⁷⁶ Marshall also noted that Sir John Hawles found execution offensive to religion because it dispatches someone into the next "world,

a panel of three psychiatrists to ascertain the prisoner's competency to be executed.

70. 477 U.S. at 412 (quoting FLA. STAT. ch. 522.07(2)). "The Governor's order specifically directed that the attorneys [who were present at the examination] should not participate in the examination in any adversarial manner. This order was consistent with the present Governor's 'publicly announced policy of excluding all advocacy on the part of the condemned from the process of determining whether a person under a sentence of death is insane.'" 477 U.S. at 412-13 (quoting *Goode v. Wainwright*, 448 So. 2d 999, 1001 (Fla. 1984), *aff'd*, 731 F.2d 1482 (11th Cir. 1984) (holding that FLA. STAT. ch. 522.07 met minimum standards required by procedural due process), *cert. denied and stay denied*, 466 U.S. 932 (1984)).

71. *Ford*, 477 U.S. at 404.

72. 474 U.S. 1019 (1985), *aff'd*, 477 U.S. 399 (1986), *reh'g denied*, *Ford v. State*, 522 So. 2d 345 (Fla. 1988) (denying post-conviction relief), *cert. denied sub nom. Ford v. Dugger*, 489 U.S. 1071 (1989).

73. *Ford*, 477 U.S. at 408 n.2 (noting that 41 states had a death penalty or statutes regulating execution procedures and 26 had statutes requiring that incompetent prisoners' executions be suspended).

74. *Id.* at 406.

75. *Id.* at 407.

76. *Id.* (citing 3 EDWARD COKE, FIRST INSTITUTE OF THE LAWS OF ENGLAND *6).

when he is not of a capacity to fit himself for it."⁷⁷ Blackstone explained that the insane should be spared execution lest they die before having the chance to "[allege] something in stay of judgment or execution."⁷⁸ Justice Powell agreed with Justice Marshall that executing the incompetent is cruel.⁷⁹ Both justices also concurred that the retributive purpose of punishment is ill-served by "executing a person who has no comprehension of why he has been singled out and stripped of his fundamental right to life."⁸⁰

C. *Perry v. Louisiana*⁸¹

Although *Ford* holds that the execution of the incompetent is constitutionally forbidden, the decision is silent as to how a condemned prisoner, once ruled incompetent to be executed, should be treated. In February, 1990, in *Washington v. Harper*,⁸² the Supreme Court recognized that prisoners had a limited right to refuse psychiatric medications, and described minimal procedural safeguards for instituting involuntary treatment of prisoners.⁸³ Harper, a ward of the Washington State Penal System since his 1976 robbery conviction, was treated against his will for a manic-depressive disorder. His treatment included forced administration of antipsy-

77. *Id.* (quoting Sir John Hawles, Solicitor General in the Reign of King William the Third, Remarks on the Trial of Mr. Charles Bateman (1685), in 11 HOW. ST. TRIAL 474, 477 (1816)).

78. *Id.* (citing 4 WILLIAM BLACKSTONE, COMMENTARIES *24-*25).

79. *Id.* at 421 (Powell, J., concurring).

80. *Id.* at 409. For an excellent discussion of the relationship between the criterion for execution incompetence and the rationale for the ancient prohibition against executing the "insane," see Ward, *supra* note 23, at 59-68. Ford died of natural causes on Feb. 28, 1991; at the time of his death he was still under a death sentence and had never been judged incompetent. Heilbrum et al., *supra* note 40, at 598.

81. 498 U.S. 38 (1990) (vacating the judgment to execute and remanding "for further consideration in light of *Washington v. Harper*, [494 U.S. 210 (1990), *reh'g denied*, 111 S.Ct. 804 (1991), *aff'd in part and vacated in part*, No. 91-KP-1324, 1992 WL 296230 (La. Oct. 19, 1992) (holding that Perry could not be forcibly medicated to restored competency for the purposes of execution)]").

82. 494 U.S. 210 (1990).

83. *Id.* at 219-27. The Court found that the due process clause permits involuntary treatment of a prisoner with antipsychotic medication "if the inmate is dangerous to himself or others and the treatment is in the inmate's medical interest." *Id.* at 227. Procedural requirements for instituting involuntary treatment are met as long as the prisoner is given a full and fair hearing and the decisionmaker is independent of those who would treat the inmate. *Id.* at 231. The Court determined that due process does not require a judicial decisionmaker, stating that "an inmate's interests are adequately protected, and perhaps better served, by allowing the decision to medicate to be made by medical professionals rather than a judge." *Id.*

chotic drugs.⁸⁴ However, Harper was not a prisoner whose involuntary treatment might restore his competence and thereby make him fit for execution. This was precisely the situation that the Court appeared ready to address when it granted *certiorari* in *Perry v. Louisiana*.⁸⁵

Unlike Alvin Ford, Michael Perry's mental state figured prominently in the trial proceedings leading to his conviction in 1985. He was arrested in the summer of 1983 and charged with murdering his parents and three other relatives. At the time of his arrest, he told police that his family had harrassed him and had stolen his property and that was why he had murdered them.⁸⁶

Perry was sent to a state psychiatric facility for evaluation and treatment upon the recommendation of two psychiatrists who examined Perry several months after his arrest.⁸⁷ On admission, he stated that he did not have enough blood; that he was hearing voices; that robots, the President, and the CIA were telling him what to do; that robots had told him to kill his family; that he was being fed body parts; and that if shot, he would not be killed.⁸⁸

Perry was found competent to stand trial in 1985 after he had been hospitalized for six months and subsequently imprisoned for one year.⁸⁹ Over the objections of counsel, he withdrew his insanity plea and entered only a plea of "not guilty."⁹⁰ He was convicted and sentenced to death.⁹¹ During the two years following

84. *Id.* at 214.

85. 494 U.S. 1015 (1990).

86. Perry explained his murderous actions by stating "I just couldn't take it anymore." *State v. Perry*, 502 So. 2d 543, 547, 549 (La. 1986) (affirming Perry's conviction and sentencing and holding that the defendant had the burden of establishing incapacity to stand trial), *cert. denied*, *Perry v. Louisiana*, 484 U.S. 872 (1987), *judgment vacated and remanded*, 498 U.S. 38 (1990) (vacating the judgment to execute and remanding "for further consideration in light of *Washington v. Harper*, [494 U.S. 210 (1990)]"), *reh'g denied*, 111 S.Ct. 804 (1991), *aff'd in part and vacated in part*, No. 91-KP-1324, 1992 WL 296230 (La. Oct. 19, 1992) (holding that Perry could not be forcibly medicated to restored competency for the purposes of execution). When asked why he killed his two-year-old nephew, Perry replied, "[t]he kid was evil, some sort of devil, witch of some sort . . . He was a very smart kid . . . too smart for his age. I had to make sure he was dead." *Id.*

87. *Id.* at 547-48.

88. Petitioner's Brief on the Merits at 3-4, *Perry v. Louisiana*, 498 U.S. 38 (1990) (No. 89-5120) [hereinafter *Petitioner's Brief*].

89. *Perry*, 502 So. 2d at 547-48. A competency hearing in September, 1983 resulted in hospitalization. Perry was then returned to prison in March, 1984. A second competency hearing in March, 1985 resulted in a finding of competence to stand trial.

90. *Id.* at 547, 550.

91. *Id.* at 545. A twelve member jury unanimously found the defendant guilty as

his conviction, he was treated almost continuously with haloperidol,⁹² but continued to have periods of psychosis.⁹³

The Louisiana Supreme Court affirmed Perry's conviction but recommended that an assessment of his competency to be executed "might be in order prior to execution."⁹⁴ Over the next nine months, the trial court held four hearings at which medical records and both oral and videotaped testimony were reviewed.⁹⁵ In October, 1988, the court concluded that Perry was competent to be executed.⁹⁶ The court then ordered that his competency was to be maintained⁹⁷ with medication prescribed by the penitentiary's med-

charged. During the sentencing phase, the jury recommended the death penalty, finding the existence of aggravating circumstances. The jury found that the defendant knowingly created the risk of death and that the crime was committed in a particularly heinous manner. *Id.*

92. "Haloperidol is the first of the butyrophenone series of major tranquilizers . . . [and] is indicated for use in the management of manifestations of psychotic disorders." PHYSICIANS' DESK REFERENCE 1236 (1989).

The prevailing theory regarding the mechanism of action of antipsychotic drugs is based on the observation that all of the currently available antipsychotic drugs have a similar action on the dopamine system: the blocking of the binding of dopamine to the postsynaptic dopamine receptor in the brain The theory that psychosis is a result of an excess of dopamine or the result of abnormal activity of certain dopamine receptors has been confirmed by the observation of increased dopamine concentrations and an increased number of dopamine-2 receptors in the brains of some patients with schizophrenia

Jonathan M. Silver et al., *Biological Therapies for Mental Disorders*, in CLINICAL PSYCHIATRY FOR MEDICAL STUDENTS 459, 462 (Alan Stoudemire ed., 1990). The effectiveness of antipsychotic medication in preventing schizophrenic relapse has been amply documented. If treatment is not continued after initial remission of acute psychotic symptoms, schizophrenic patients have a relapse rate of 8-15% per month; with continued medication, patients have a relapse rate of 1.5-3% per month. *Id.*

93. Petitioner's Brief, *supra* note 88, at 6-13. On December 20, 1985, after being sentenced to death, Perry arrived at the penitentiary. From the time of his arrival, his documented behavior included confused thinking, acting out, disorientation as to person and place, wild, uncontrollable rages, yelling, screaming, delusions, hallucinations, a belief that he could not be killed by electrocution, memory impairment and paranoia. *Id.* For a discussion of the psychiatric disorders that might engender execution incompetence, see Heilbrum et al., *supra* note 40, at 598.

94. *Perry*, 502 So. 2d at 564.

95. See Petitioner's Brief, *supra* note 88, at 16-23.

96. *Id.* at 23. The trial court adopted the definition of execution incompetency offered by Justice Powell in his concurring opinion in *Ford*, who held that the Eighth Amendment precludes the execution of inmates who are "unaware of the punishment they are about to suffer and why they are to suffer it." APA/AMA Brief, *supra* note 38, at 4 (quoting *Ford v. Wainright*, 477 U.S. 399 (1986) (Powell, J. concurring in part and concurring in the result)).

97. John M. Davis & Suzanne Andrinkaitis, *The Natural Course of Schizophrenia and Effective Maintenance Drug Treatment*, 6 J. CLIN. PSYCHOPHARMACOLOGY 25, 68-88

ical staff, even if the medication had to be forcibly administered over defendant's objection.⁹⁸ After being ordered by the United States Supreme Court to review its decision, the district court affirmed its ruling to forcibly treat Perry to restored competence so that he could be executed; however, the Louisiana Supreme Court, while affirming the lower court's holding that Perry was insane, held that Perry could not be treated with psychotropic medication without his consent.⁹⁹

D. The Medical Profession's Response

Perry's disposition emphasizes for psychiatrists — especially those “who are in state employment and often under pressure to conform their treatment to the needs of the state”¹⁰⁰ — the ambiguity and discomfort they face in confronting the prospect of evaluating and treating incompetent death row inmates.¹⁰¹ This ambiguity and discomfort has both legal and ethical dimensions. In an effort to bring about a legal resolution of *Perry* that might also relieve physicians of their moral dilemmas in treating death row

(1986) (concerning the role of maintenance medication and the treatment of schizophrenia).

98. Petitioner's Brief, *supra* note 88, at 23.

99. See *Perry v. Louisiana*, 498 U.S. 38 (1990) (vacating the judgment to execute and remanding “for further consideration in light of *Washington v. Harper*, [494 U.S. 210 (1990)]”), *reh'g denied*, 111 S.Ct. 804 (1991), *aff'd in part and vacated in part*, No. 91-KP-1324, 1992 WL 296230 (La. Oct. 19, 1992) (holding that Perry could not be forcibly medicated to restored competency for the purposes of execution). See also *supra* notes 23-24.

100. Howard Zonana, *Keeping Death-Row Inmates Sane: Perry v. Louisiana*, AM. ACAD. PSYCHIATRY & L. NEWSL. (Am. Acad. Psychiatry & Law, Baltimore, Md.), April 1991, at 5, 6.

101. See Heilbrun et al., *supra* note 40, at 599 (discussing the risk that disclosures made by patients in treatment might be used to assess competency for execution). See also Jerome J. Shestack, *Psychiatry and the Dilemmas of Dual Loyalties*, 60 ABA J. 1521 (1974) (recognizing the potential conflict of interest inherent in situations in which a psychiatrist must serve not only a patient, but also a family, an institution, a state, or self, and urging psychiatrists and lawyers to cooperate both in carefully identifying situations presenting a conflict of interest and in fashioning appropriate procedural safeguards); Richard J. Bonnie, *Introduction to PSYCHIATRISTS AND THE LEGAL PROCESS: DIAGNOSES AND DEBATE* xiii, xv (1977) (noting that clinicians are increasingly placed in a “double agent” role where they are called upon to serve interests beyond the patient's health.); cf. Seymore L. Halleck, *The Ethical Dilemmas of Forensic Psychiatry: A Utilitarian Approach*, 12 BULL. AM. ACAD. PSYCHIATRY & L. 279, 279 (1984) (concentrating on psychiatrists involved in the civil commitment process as opposed to condemnee incompetency process, Halleck notes that psychiatrists employed by the government relate to the patient for the government's purposes; consequently, the psychiatrists' allegiances are unclear, leading to possible harm to the patient as a result of the interaction during the evaluation process).

inmates,¹⁰² the American Psychiatric Association and American Medical Association joined in filing an *amicus curiae* brief in *Perry*.¹⁰³

The APA/AMA Brief noted that in *Harper*, the Supreme Court had determined that a prisoner retains a liberty interest in refusing unwanted medication under the Fourteenth Amendment's Due Process Clause.¹⁰⁴ However, involuntary treatment of serious mental illness is permissible "if the inmate is dangerous to himself or others and the treatment is in the inmate's medical interest."¹⁰⁵ The APA/AMA Brief argued that the Louisiana trial court authorized involuntary medication for Perry solely to preserve his competence to be executed; Perry had not been shown to be dangerous or gravely disabled.¹⁰⁶ The brief argued further that treatment of Perry was not in his *medical* interest,¹⁰⁷ so that neither the "dan-

102. The APA proposed commuting to life imprisonment the death sentences of prisoners who are found incompetent to be executed. See *infra* text at notes 110-15.

103. APA/AMA Brief, *supra* note 38.

104. *Washington v. Harper*, 494 U.S. 210, 221-27 (1990) (guaranteeing a right to refuse medication under the Fourteenth Amendment and holding that this right can be sufficiently protected by a hearing before prison officials if the state feels it has an interest in ensuring prison safety).

105. AMA/APA Brief, *supra* note 38, at 12 (quoting *Harper*, 494 U.S. at 227).

106. *Id.* at 10-12.

107. The APA/AMA Brief does not specify what a "medical interest" is. "Medical" is defined as "of, relating to, or concerned with physicians or with the practice of medicine . . . [;] requiring or devoted to medical treatment" WEBSTER'S THIRD NEW INTERNATIONAL DICTIONARY 1402 (3d ed. 1971). By this definition, the only strictly medical issue under consideration in *Perry* was the nature of his symptoms and their proper treatment; Perry's only strictly "medical interest" ought to have been the alleviation of his symptoms. This view of Perry's *medical* interest seems consonant with Justice Scalia's questioning, during oral argument, how one could justify withholding from Perry treatment that would have been prescribed for him under any other circumstances. Zonana, *supra* note 100, at 6. Zonana suggests that

[a] broader definition of medical interests requires looking at the overall goals of management. For example, the use of antibiotics to treat an infection is not always warranted if the patient is in a terminal condition from another disease. The question here is whether to liken the death penalty to another disease (e.g. cancer), or to decide that medical interests are not involved since the death penalty represents a legally authorized judicial decision.

Id.

The question of whether part of a physician's overall goals of management should include withholding medication so as to influence the course of justice is discussed *infra* at text accompanying note 141. Leaving that issue aside, the physician who withholds antibiotics for the pneumonia-stricken cancer patient is best thought of as managing *two* medical conditions at once, whereas Perry's physician would know that Perry had other pressing but *non-medical* interests. The death penalty is *not* a disease.

Medical treatment is undertaken not as an end in itself, but with a view to the non-

gerousness" nor the "medical interest" requirements for involuntary psychiatric treatment of prisoners (as set forth in *Harper*) had been met.¹⁰⁸

The brief recognized that, left untreated, Perry might remain psychotic for an interminable period, and recommended that states commute incompetent condemnees' sentences to life imprisonment and allow them to receive treatment.¹⁰⁹ The APA/AMA Brief viewed commutation as a solution to both the constitutional issues raised by *Perry*, and the ethical problems faced by physicians who might be asked to evaluate or treat an incompetent condemned inmate.¹¹⁰ The brief argued that "to allow a prisoner to languish with a treatable psychosis would violate the Eighth Amendment principle established in *Estelle v. Gamble*,"¹¹¹ which recognizes a prisoner's right to treatment for known medical problems.¹¹² Commutation would insure that antipsychotic medication would be

medical interests, such as happiness or well-being, that it promotes. "We feel, usually, that we can cope with almost all . . . states of vulnerability if we have our health. After all, we perceive health as a means toward freedom and other primary values." EDMUND D. PELLEGRINO & DAVID C. THOMASMA, *A PHILOSOPHICAL BASIS OF MEDICAL PRACTICE* 209 (1981). An important task for physicians is to help patients facing difficult decisions to perceive and weigh their interests, interests which are affected by medical decisions but which, physicians must humbly recognize, are not all medical. The recognition that justly convicted individuals have a strong interest in receiving just punishment should greatly assist psychiatrists to examine the issues raised in *Perry's* case. See *infra* text accompanying notes 256-60.

108. APA/AMA Brief, *supra* note 38, at 10-12.

109. *Id.* at 20-25. See MD. ANN. CODE § 75A(d)(3) (1992 Repl. Vol.) (When an inmate is adjudicated incompetent to be executed, his case is remanded to the sentencing court, which automatically strikes the death sentence and enters a sentence of life imprisonment without possibility of parole.). See also 1 NIGEL WALKER, *CRIME AND INSANITY IN ENGLAND: THE HISTORICAL PERSPECTIVE*, 205, 216 (1967) (Before England abolished the death penalty in 1965, death sentences were commuted for life when prisoners were determined to be insane.); J.D. Feltham, *The Common Law and the Execution of Insane Criminals*, 4 MELB. U. L. REV. 434, 475 (1964) (proposing a mandatory duty to commute the death sentences of insane prisoners as "has been the invariable practice in England since 1840 . . ."). In Montana a court is allowed to suspend a death sentence of an incompetent condemnee when "so much time has elapsed since the commitment of the defendant that it would be unjust to proceed . . ." MONT. CODE ANN. § 46-19-202 (1991).

110. I argue below that, under the premises usually assumed by those who oppose treatment of the incompetent condemned, the possibility of commutation (which, the APA/AMA brief asserts, allows for ethical treatment) substitutes one set of ethical dilemmas for another. See *infra* notes 136 and 183.

111. APA/AMA Brief, *supra* note 38, at 20 (citing *Estelle v. Gamble*, 429 U.S. 97 (1976), *cert. denied*, 434 U.S. 974 (1977)).

112. *Estelle v. Gamble*, 429 U.S. at 104 (concluding that "deliberate indifference to serious medical needs of prisoners constitutes the [gratuitous cruelty] proscribed by the Eighth Amendment").

administered involuntarily only if an underlying *parens patriae* justification for medical treatment were established, and would not be used solely for the purpose of making an inmate fit for punishment.¹¹³ The brief argued that governments have "a deep-seated social interest in preserving medical care, in actuality and in public perception, as an unambiguously beneficent healing art [T]he use of medical treatment . . . in order to facilitate a patient's death . . . would threaten States' vital interests in the ethical standards and the treatment function of the medical profession."¹¹⁴ This combination of constitutional obligations and State interests favoring commutation and treatment outweigh any "interest in allowing an incompetent inmate like Perry to suffer for lack of needed medication."¹¹⁵

113. The constitutionality of this practice has been questioned. See *Washington v. Harper*, 494 U.S. 210, 241 (1989) (Stevens, J., with Brennan and Marshall, JJ., concurring in part and dissenting in part) ("Forced administration of antipsychotic medication may not be used as a form of punishment."); *Jones v. United States*, 463 U.S. 354, 385 (1983) (Brennan, J., dissenting) (The Supreme Court has never approved of either using psychotropic medication to control behavior or using it "for reasons that have more to do with the needs of the institution than with individualized therapy."); *Pena v. New York State Div. for Youth*, 419 F. Supp. 203, 211 (S.D.N.Y. 1976) (Neither behavior control nor punishment may be the objective of involuntary medication; rather, such medication should be used only "as part of an ongoing treatment program authorized and supervised by a physician."); *Nelson v. Heyne*, 355 F. Supp. 451, 455 (N.D. Ind. 1972) (behavior control is an improper goal of involuntary medication), *aff'd*, 491 F.2d 352 (7th Cir.), *cert. denied*, 417 U.S. 976 (1974). See also, e.g., *Knecht v. Gillman*, 488 F.2d 1136, 1140 (8th Cir. 1973) (Involuntary administration of apomorphine, a drug that induces vomiting, is cruel and unusual punishment); *Mackey v. Procunier*, 477 F.2d 877, 878 (9th Cir. 1973) (administration of succinylcholine, a drug that induces paralysis, might trigger "serious constitutional questions respecting cruel and unusual punishment.").

In addition, Louisiana has explicitly forbidden this practice for civilly committed mental patients. See LA. REV. STAT. ANN. § 28:171 (West 1989) ("Medication shall not be used for nonmedical reasons such as punishment or convenience of the staff.").

114. APA/AMA Brief, *supra* note 38, at 15-16.

115. *Id.* at 25. The APA/AMA Brief recognized only two state interests that might preclude commutation: the possibility of spontaneous recovery and the possibility that a prisoner might feign psychosis (or another condition constituting execution incompetence) to avoid execution. The Brief argued that a state might wait years for a spontaneous recovery to occur, during which time an inmate would suffer substantial, but possibly treatable, symptoms of psychosis. For many inmates, recovery might not ever occur without treatment.

As for the possibility of feigning, the Brief argued that "psychiatrists now have at their disposal a range of methods shown by empirical studies to be effective in the detection of malingering." *Id.* at 22. The studies cited in the Brief, *see id.*, at 22-23 nn.24-27, include reports evaluating prisoners, although none of these reports deals with prisoners in Michael Perry's situation. See, e.g., David Schretlen & Ital Arkowitz, *A Psychological Test Battery to Detect Prison Inmates who Fake Insanity or Mental Retardation*, 8 BEHAV. SCI. & L. 75 (1990); Richard Rogers et al., *The SIRS as a Measure of Malingering: A*

Psychiatrists asked to administer treatment to the condemned are faced with "an excruciating ethical dilemma"¹¹⁶ wrought by the knowledge that the very symptoms that medication might diminish, symptoms that cause suffering which psychiatrists ordinarily feel duty-bound to alleviate, are what stand between an inmate and execution. To further bolster its case for commutation of death sentences following determination of execution incompetence, the Brief cited several *Ford*-inspired articles from the mental health and legal literature offering a variety of ethical arguments against physician participation in the execution competency process. The following section critiques arguments that challenge the morality of psychiatric assessment and treatment of incompetent condemned inmates.

III. THE PROFESSION'S ETHICAL RESPONSE: AN INITIAL CRITIQUE

A. Arguments in Opposition to Assessment or Treatment

Although psychiatrists, on the whole, are divided about the appropriateness of assessing and treating incompetent condemned prisoners,¹¹⁷ the professional literature is generally critical of psychiatric involvement in execution competency proceedings.¹¹⁸ The criticism is directed both toward assessing inmates' competence and, even more strongly, toward treating inmates judged incompetent.¹¹⁹ A variety of arguments have been offered in support of

Validation Study with a Correctional Sample, 8 BEHAV. SCI. & L. 85 (1990). The Brief does not mention that there is substantial professional disagreement about the ability of psychologists and psychiatrists to detect malingering, and does not cite studies demonstrating professionals' failure to do so. For a review, see David Faust & Jay Ziskin, *The Expert Witness in Psychology and Psychiatry*, 241 SCIENCE 31, 35 (1988) (reviewing studies of accuracy of mental health professionals' evaluations).

116. APA/AMA Brief, *supra* note 38, at 16.

117. See *supra* notes 32-37 and accompanying text.

118. See *infra* notes 172-79 and accompanying text.

119. The National Medical Association's ("NMA") position represents a striking exception to this criticism. The NMA advises psychiatrists to evaluate and treat incompetent condemnees. It considers inmates who are facing execution deserving of the same kinds of psychotherapy that would be rendered to terminally ill patients. "The NMA views the death penalty as a jurisprudential issue and not a medical one." Ward, *supra* note 23, at 86 (arguing on behalf of the NMA, that a psychiatrist's duty to treat includes a duty to treat incompetent inmates whether or not they are condemned). Dr. Robert T. M. Phillips, chairman of the NMA's psychiatry section, believes that justice will not be served if psychiatrists withdraw from such work (particularly evaluating the inmates who are fighting death sentences). "This work is going to be done. It must be done. And if it's not us doing this work, I'm concerned about who it will be You cannot assume that

the thesis that participation is unethical. In some cases, these arguments are concerned with the anticipated psychological or practical consequences of participation,¹²⁰ but not with moral issues.

For example, in one of their *amicus* briefs, the APA and the AMA argue that treating the condemned incompetent would have the practical consequence of undermining the already-precarious status of the doctor-patient relationship in prison settings.¹²¹

Physicians, and especially psychiatrists, require the trust of their patients

. . . Prisoners already have reasons to be suspicious of psychiatrists, because psychiatrists in an evaluative role often testify against prisoners in competency, insanity, and death penalty proceedings. If psychiatrists are now required to do harm to prisoners in their treatment role, the ability of all physicians to maintain an effective patient-physician relationship with prisoners will be significantly impaired

. . . [P]sychiatric care in the Nation's prisons and jails leaves much to be desired Allowing involuntary medication to be employed for the purposes of facilitating capital punishment would exacerbate those problems.¹²²

Other authorities argue that assessing or treating the condemned incompetent exposes mental health professionals to a high degree of psychological distress.¹²³ Heilbrun and McClaren caution those who are considering whether to participate in assessing potentially incompetent condemnees to beware of the emotional cost of know-

[psychologists and social workers] can read the prison record, see an abnormal EEG, and recognize there's something there that may need to be pursued." Bruce Jancin, *Mitigating Psychiatric Disorders 'Common' in Death Row Inmates*, 18 CLINICAL PSYCHIATRY NEWS, October 1990, 1 at 24 (quoting Dr. Robert T. M. Phillips). "Psychiatry did not write the laws, but it has an important role in the treatment and care [of capital defendants], even if it leads to execution." K. Hansman, *Psychiatry's Role in Capital Cases Important to Ensuring Justice*, PSYCHIATRIC NEWS 13 (August 7, 1992) (quoting Dr. Robert T.M. Phillips).

120. Though these arguments are important, they are not the focus of this essay. I draw attention to them here to distinguish them from those that are related strictly to ethical issues.

121. See APA/AMA Brief, *supra* note 38.

122. *Id.* at 18-19 (citations omitted). "The spectre of the physician donning the executioner's hood inspires little confidence among people who receive medical treatment from the same physician." Salguero, *supra* note 58, at 96.

123. See *infra* notes 125-28 and accompanying text.

ing that their opinions could have life-or-death consequences for the evaluatee.¹²⁴ Radelet and Barnard illustrate this concern by examining the case of Gary Alvord,¹²⁵ a Florida convict who was found incompetent for execution by a state-approved panel of psychiatrists.¹²⁶ Alvord was convicted of murdering three women in spite of evidence presented that a Michigan court had found him not guilty by reason of insanity for a previous rape of a ten year old girl.¹²⁷ The mental health staff who worked with Mr. Alvord found the ethical conflicts they faced to be so upsetting that they resolved never to participate again in the restoration of a condemnee's competency.¹²⁸

The ethical objections voiced by critics of psychiatric involvement in either the assessment of condemnees or their treatment to a state of restored competency can be categorized as four different arguments. The first type of argument equates psychiatric involvement with participation in an execution. The second variety categorizes involvement as a violation of normative principles of medical ethics. The third set of arguments treats involvement as a violation of informed consent standards. The final category criticizes psychiatric participation in a condemnee's competency proceedings as a perversion of medical practice. Each of these arguments is described below.

1. Psychiatric Involvement Constitutes Participation in an Execution

If psychiatric involvement in execution competency proceedings

124. For example, Heilbrun and McLaren write:

"The idea that one consequence of a professional activity might be the death of another human being can evoke confusion, guilt, [and] frustration A strong stomach, a thick skin, and a firm commitment to doing a thorough job will prove useful, even necessary, for participating clinicians.

. . . . A review of the arguments on participation, careful personal reflection, and consultation with colleagues who have done these assessments are recommended Having carefully considered the arguments and his or her own feelings at the outset, the clinician can more easily monitor ongoing feelings and reactions and keep them from overly influencing the assessment."

Heilbrun & McLaren, *supra* note 29, at 207-08.

125. See Alvord v. Wainwright, 725 F.2d 1282 (11th Cir. 1984) (denying the district court's grant of habeas corpus), *cert. denied*, 469 U.S. 956 (1984).

126. See Radelet & Barnard, *supra* note 30, at 303-04.

127. Alvord v. Florida, 322 So. 2d 533, 534 (Fla. 1975), *cert. denied*, 428 U.S. 923 (1976).

128. Radelet & Barnard, *supra* note 30, at 303-04 (reviewing responses of psychiatrists and mental health staff at the institution where Alvord was being treated).

is tantamount to assisting in an execution, then such involvement clearly violates the ethical codes of the American Psychiatric Association.¹²⁹ Several writers interpret psychiatric assessment of execution incompetence in just this manner.¹³⁰ Wallace, for example, objects to psychiatrists making competency assessments because such evaluations involve "the application of medical expertise to induce death."¹³¹ Participation in competency hearings, he believes, constitutes membership in a "tribunal" that makes "the legal decision of readiness of the individual for death."¹³² Such membership, Wallace argues, is "the ultimate form of participation" in carrying out the prisoner's sentence to be executed.¹³³ Ewing notes that the opinions of psychiatrists often carry significant weight in judicial hearings.¹³⁴ He argues that, for practical purposes, psychologists and psychiatrists decide "whether a condemned inmate is to live or die."¹³⁵ Sargent concurs: psychiatric evalua-

129. See AMERICAN PSYCHIATRIC ASSOCIATION, THE PRINCIPLES OF MEDICAL ETHICS WITH ANNOTATIONS ESPECIALLY APPLICABLE TO PSYCHIATRY § 1, ¶ 4, (1989) [hereinafter APA PRINCIPLES] (A psychiatrist may not be "a participant in a legally authorized execution.").

130. See *infra* notes 131-38 and accompanying text.

131. Donald H. Wallace, *Incompetency for Execution: The Supreme Court Challenges the Ethical Standards of the Mental Health Professions*, 8 J. LEGAL MED. 265, 272 (1987) (arguing that the decision of *Ford v. Wainwright* offends the healing ethic of the mental health professional and proposing that psychiatrists assigned by the court to participate in the assessment of a condemned ethically ought to demand a second psychiatrist's opinion).

132. *Id.* at 280. Wallace explicitly notes that he bases his choice of the word "tribunal" generally on the plurality opinion of the Court in *Ford v. Wainwright*, and specifically on Justice Powell's concurrence. *Id.* at 266-67, 280. See *Ford v. Wainwright*, 477 U.S. 399, 423 n.4 (1986) (Powell, J., concurring) ("[A]lthough we need not decide the issue in this case, the term 'State court' may well encompass an independent panel of psychiatric experts who might both examine the defendant and determine his legal sanity."), *reh'g denied*, *Ford v. State*, 522 So. 2d 345 (Fla. 1988) (denying post-conviction relief), *cert. denied sub nom. Ford v. Dugger*, 489 U.S. 1071 (1989).

133. Wallace, *supra* note 131, at 280.

134. See Charles P. Ewing, *Diagnosing and Treating "Insanity" on Death Row: Legal and Ethical Perspectives*, 5 BEHAV. SCI. & L. 175, 177 n.14 (1987) (noting that most state statutes require that physicians, psychiatrists and/or psychologists examine inmates and pointing out that although sanity is a legal rather than an ethical issue, the required presence of mental health professionals indicates that their opinions are essential to judicial determinations).

135. *Id.* at 181 (1987). Entin points out that there may be a moral difference between declaring, on one hand, that a death row inmate who initially claims to be insane is actually not, and, on the other hand, "certifying that a previously insane death row inmate has regained sanity." Entin, *supra* note 1, at 224. In the latter situation, the prisoner has been legally determined to be insane, has gone through psychiatric treatment, and now awaits a reevaluation of his competence to be executed. Entin suggests that a reevaluation

tion, in this context, asks the doctor to pronounce a prisoner "fit for execution."¹³⁶ Although the state of New York does not allow capital punishment,¹³⁷ its medical society recently took the step of defining the ethical rules incumbent on physicians should capital punishment ever be reinstated.¹³⁸ The society reiterated the customary prohibition against physician participation in executions. The society understood participation to include among other things "[t]he determination of mental and physical fitness for execution."¹³⁹

If assessment seems problematic, the treatment of the incompetent condemned is, to most commentators, even more troublesome.¹⁴⁰ Barbara Ward argues that a psychiatrist who treats in-

resulting in a finding of insanity by the participating psychiatrist "could be 'tantamount to imposing a new death sentence.'" *Id.* at 225 (quoting Radelet & Barnard, *supra* note 23, at 49).

136. *Questioning Psychiatry's Role*, *supra* note 32, at 3. Elsewhere, Sargent likens the psychiatrist's role in competency evaluations to the acts of Nazi physician Josef Mengele ("The Angel of Death"). Working in the Nazi concentration camp at Auschwitz, Mengele decided which prisoners were healthy enough to work and would therefore be spared death. See Douglas A. Sargent, *Treating the Condemned to Death*, HASTINGS CENTER REPORT, Dec. 1986, at 5, 6. Sargent addresses the AMA's proscription against physician participation in execution by asking, "[b]ut what about making a *diagnosis* of competency to be executed? If such a determination results in an execution that would not have taken place otherwise, is diagnosis not also a proscribed medical act?" *Id.* Note that Ewing's, Wallace's, and Sargent's argument, if correct, would apply with even more force were the commutation-if-incompetent position of the APA/AMA Brief universally adopted. See *supra* notes 131-136. Psychiatrists who found condemnees competent would not simply be losing chances to *delay* executions; through giving testimony that supported a finding of competence, they would help prevent prisoners' lives from being spared.

137. See *State v. Smith*, 468 N.E.2d 879 (1984) (holding unconstitutional N.Y. PENAL LAW § 60.06 because it failed to allow the sentencer to consider relevant individual circumstances, including the defendant's record and character and the circumstances surrounding the offense).

138. Fred Rosner et al., *Physician Involvement in Capital Punishment*, 91 N.Y. STATE J. MED. 15, 18 (1991).

139. *Physicians Participation in Capital Punishment in New York*, 15 NEWSL. AM. ACAD. PSYCHIATRY & L., Dec. 1990, at 102.

140. The position of the Medical Society of the State of New York constitutes an exception. While its policy statement defines assessment of mental fitness as a form of participation in executions, providing treatment to "[r]elieve acute suffering of a convicted prisoner while he is awaiting execution" is expressly permitted by the statement. *Id.*

Note that physicians often use the word "acute" to refer to a relatively sudden change of condition or a condition requiring immediate intervention, in contrast to problems which may cause recurrent, intermittent, or "chronic" suffering which require treatment over time. It is thus not clear whether this statement would permit only relatively brief medical interventions or more extended courses of treatment as well. Recall that psychiatrists felt that Michael Perry required continuous treatment with antipsychotic medication to maintain mental stability. See *supra* text accompanying notes 87-93.

competent condemnees helps "bring about an execution which would not have occurred *but for* the treatment."¹⁴¹ The APA and the AMA distinguish psychiatric assessment from treatment of the death row inmate who is already insane.¹⁴² They argue that, when testifying for the state in a criminal proceeding, the assessment findings of a forensic psychiatrist are subject to adversarial cross-examination and evidentiary refutation. Treatment of the already insane condemnees, on the other hand, demands that psychiatrists use their therapeutic skills "to maintain [their patient's] competence so that [the] patient may be executed."¹⁴³ Treatment of the incompetent condemned, the AMA and the APA conclude, is "only a small step away from participating in the execution itself."¹⁴⁴ Some commentators suggest that the physician could be considered directly responsible for the inmate's death. After all, there is but a negligible chance that the inmate, once sane, will "articulate a heretofore unknown reason for a stay of execution" thus, "[n]o intervening acts . . . will prevent the execution that the physician . . . made possible."¹⁴⁵ Because the psychiatrist knows that execution is made possible by treatment, the distinction between treatment and execution would be "meaningless."¹⁴⁶

141. Ward, *supra* note 23, at 85 (emphasis added). See also *id.* at 99 ("Modern medical technology may now enable us to cure someone with medication and thereby send him to the electric chair when a century ago he would have been incurable and would have spent the remainder of his life in prisons or hospitals.").

142. APA/AMA Brief, *supra* note 38, at 17 n.19.

143. *Id.*

144. *Id.* at 17.

145. Salguero, *supra* note 58, at 178 (citations omitted).

146. *Id.* at 178 n.64. In fact, Salguero argues that treatment is tantamount to murder:

An analogy can be made to the doctrine of causality in the criminal law with regard to homicide. This doctrine is expressed in the MODEL PENAL CODE § 2.03 (1985), which states: "Conduct is the cause of a result when: (a) it is an antecedent but for which the result in question would not have occurred" Murder is defined as "purposely or knowingly" causing the death of another human being, according to the MODEL PENAL CODE §§ 210.1, 210.2 (1985). In turn, this intent requirement is satisfied when death was within the purpose or the contemplation of the actor.

Salguero, *supra* note 58, at 177 (citations omitted). Cf. Phillipa Foot, *Ethics and the Death Penalty: Participation by Forensic Psychiatrists in Capital Trials*, in *ETHICAL PRACTICE IN PSYCHIATRY AND THE LAW* (Richard Rosner & Robert Weinstock eds., 1990) 207, at 209 ("The psychiatrist *knows* that if he gives an honest opinion . . . he may, in effect, be bringing about the death of a person whom he has examined and perhaps even treated." [emphasis added]).

2. Participation Violates Normative Principles of Medical Ethics

Critics' second major argument is that psychiatric participation in execution competency proceedings violates normative principles of medical practice.

For example, the principles of beneficence, autonomy, and avoiding killing are among the normative principles involved in psychiatric association with execution proceedings. The principle of beneficence, that a physician should relieve suffering, would be violated if the psychiatrist facilitates the state's execution process. The principle of autonomy, that a physician's choices cannot override the patient's choices, would be violated if the psychiatrist treated the inmate to restore competency against the inmate's will. Finally, the principle of avoiding killing would be violated because the psychiatrist's role in execution proceedings may cause the offender's death.¹⁴⁷

Historically, competency was required at the time of execution so that, among other things, the prisoner would suffer in anticipation of his death.¹⁴⁸ This goal seems antithetical to medicine's traditional objective of relieving suffering. Sargent argues that restoring the condemned to competency violates the physician's obligation to assist "the patient to do what the patient wants to do within the constraints of the law."¹⁴⁹ He joins Radelet and Barnard in believing that competency-restoring treatment would be non-beneficial, harmful, and cruel.¹⁵⁰

Some critics of psychiatric participation feel that, "fundamental ethical principles of the[] healing professions"¹⁵¹ prohibit assessment and treatment, even if these principles do not *explicitly* prohibit participation. Traditional norms also suggest that physicians are duty-bound to act beneficently and nonmaleficently, to do no harm, to preserve life, to promote health, and to alleviate suffering.¹⁵² A state-employed psychiatrist, in particular, may be caught

147. See Salguero, *supra* note 58 at 168; see generally ROBERT M. VEATCH, A THEORY OF MEDICAL ETHICS 141-290 (1981).

148. See, e.g., Radelet & Barnard, *supra* note 23, at 39-40; Henry Weihofen, *A Question of Justice: Trial or Execution of an Insane Defendant*, 37 A.B.A. J. 651, 652 (1951).

149. *Questioning Psychiatry's Role*, *supra* note 32, at 3.

150. *Compare id.* ("That isn't the proper business of physicians — to go around killing people or assisting people to kill people.") with Radelet & Barnard, *supra*, note 23, at 49 ("[S]uccessful treatment means the patient will die. This is a use of the state's limited treatment resources that some [people] will find especially outrageous.")

151. Ewing, *supra* note 134, at 183.

152. See, e.g., *id.*; Salguero, *supra* note 58, at 168 ("The physician is bound by a fun-

both ethically and legally between a rock and a hard place: where refusing to treat incompetent condemnees could increase their suffering, treating them could lead to their death.¹⁵³ Ewing believes that psychiatrists faced with these alternatives should withhold treatment from an incompetent condemned inmate because the ultimate purpose of such treatment "is not to heal or relieve suffering of that inmate, but to enable the state to take the inmate's life."¹⁵⁴ Salguero takes the argument one step further: physicians best serve society by placing the welfare of individuals ahead of the state's interest in punishment.¹⁵⁵

damental ethical principle to do no harm and preserve life."). See also VEATCH, *supra* note 147 at 22 (1981) ("Those who have stood in . . . [the Hippocratic] tradition are committed to producing good for their patient and to protecting that patient from harm.").

153. For a discussion of the ethical position a psychiatrist faces when administering antipsychotic drugs for nonmedical purposes, see *Washington v. Harper*, 494 U.S. 210, 222-23 n.8 (1990) ("[W]e will not assume that physicians will prescribe these drugs for reasons unrelated to the medical needs of the patients; indeed, the ethics of the medical profession are to the contrary This consideration supports our interpretation of the state's policy as ensuring that antipsychotic medication will be administered only in those cases where appropriate by medical standards."); APA/AMA Brief, *supra* note 38, at 16 ("[W]hen the State's purpose in medicating someone involuntarily has no connection to either a *parens patriae* or dangerous principle, the directive to medicate creates an excruciating ethical dilemma for treating physicians."). See generally *Estelle v. Gamble*, 429 U.S. 97, 107 (1976) ("[D]eliberate indifference to serious medical needs of prisoners constitutes the 'unnecessary and wanton infliction of pain' proscribed by the Eighth Amendment.") (citation omitted), *cert. denied*, 434 U.S. 974 (1977).

154. Ewing, *supra* note 134, at 183.

155. Salguero, *supra* note 58, at 182.

Along similar lines, the American Psychiatric Association previously endorsed the view that "a psychiatrist's primary obligation is to look out for the examinee's best interests even when they conflict with those of society." Ward, *supra* note 23, at 94 (citing AMERICAN PSYCHIATRIC ASSOCIATION, *PSYCHIATRY IN THE SENTENCING PROCESS* 7 (1984)). However, the APA's position may have changed given its *amicus* brief for the Perry case. There, the APA stated that a competency evaluation would not violate the duty to do no harm because there is "no treatment relationship. Instead, the psychiatrist is acting as a consultant in the adversary process, providing a professional evaluation that is frequently subject to cross-examination or to refutation by contrary evidence." APA/AMA Brief, *supra* note 38, at 17 n.19.

Appelbaum offers an eloquent elaboration of this position. He asks, "if psychiatrists are committed to doing good and avoiding harm, how can they participate in legal proceedings from which harm may result?" *Appelbaum's Parable*, *supra* note 17, at 250. He argues that "the evaluative function that forensic psychiatrists perform" is such that the forensic psychiatrist in truth "does not act as a physician," but as someone who applies "psychiatric expertise in legal contexts." *Id.* at 252 (emphasis added). Thus, "the argument that the principle of nonmaleficence will be violated if [psychiatric testimony yields] harm[ful] results to the evaluatee is irrelevant." *Id.* at 257. In *treating* an incompetent condemnee, however, a psychiatrist *would* be acting as a physician, and thus should give primacy to ethical principles of beneficence and non-maleficence. Appelbaum leaves open the question of whether these principles would prohibit treatment, but emphasizes that "the

3. Participation Violates the Right to Informed Consent

A third criticism of psychiatric participation is that it might require psychiatrists to violate traditional standards of informed consent. The APA instructs psychiatrists to begin competency evaluations with a full description of "the nature and purpose and lack of confidentiality of the examination."¹⁵⁶ Moreover, it is arguable that evaluations of execution competency require the same level of voluntariness of consent as evaluations of competency to stand trial.¹⁵⁷ But as Ward points out, "a true incompetent will not un-

basis on which the question of treatment must be decided is clear: does treatment satisfy the demands of beneficence and nonmaleficence?" *Id.* Salguero concurs: "[I]n performing an evaluation, the role of the physician as a *healer* is not necessarily implicated Further, . . . a diagnosis of incompetency presents the life-affirming possibility of a stay of execution." Salguero, *supra* note 58, at 177.

There are several problems with this position, three of which deserve mention here. First, "competency" is *not* a *diagnosis*, but a legal conclusion that courts, not physicians, reach. The diagnoses that psychiatrists properly render, and about which they inform courts, refer to medical *conditions* (such as schizophrenia). See *infra* notes 180-83 and accompanying text.

A second problem derives from the contention that a psychiatrist who conducts a forensic psychiatric evaluation is not acting as a physician. It simply strains credulity to assert that a physician who interviews someone concerning symptoms, who assesses, and who makes a diagnosis is acting as anything other than a physician. Indeed, Salguero's argument itself actually invokes physicianly obligation — "preserving an inmate's life," by justifying certain competency evaluations if there is hope of finding evidence of incompetence, on the grounds that the evaluation would preserve the inmate's life. *Id.* Salguero might respond that there is an important distinction between physicians' acting as *evaluators* and physicians' acting as *healers*. Foot's response is instructive: We should "be wary of arguments of those who seem to believe that a new role can be created by a difference of purpose, as if the legitimacy of setting aside the principle of nonmaleficence were not exactly what is in question. . . . In spite of the other things that they are called on to do, psychiatrists and other doctors must surely be seen *primarily* as healers, with *primum non nocere* as their guiding light." Foot, *supra* note 146, at 210.

The third problem results from a failure to examine the notion of "harm" *in context*. The maxim *primum non nocere* ("first, do no harm") is usually invoked in customary medical contexts, where the harms to be avoided are side effects or other adverse *medical* events. Punishment is *not* a medical outcome and thus its implications for treatment decisionmaking may require a different analysis.

156. APA PRINCIPLES, *supra* note 129, § 4 ¶ 5. See also ABA STANDARDS, *supra* note 19, at § 7-3.6 (recommending that both defense counsel and the evaluating mental health professional advise defendant of the purposes of the examination); DECLARATION OF HAWAII/II (approved by the General Assembly of the World Psychiatric Association July 10, 1983), 1 WPA BULL. 23 (1989) ("If and when a relationship is established for purposes other than therapeutic, such as in forensic psychiatry, its nature must be thoroughly explained to the person concerned.").

157. Cf. *Estelle v. Smith*, 451 U.S. 454, 466-69 (1981) (holding that, under *Miranda v. Arizona*, 384 U.S. 436 (1966), a prisoner must consent to a psychiatric evaluation before the information can be used against him or her in court).

derstand the process, nature, purpose, or consequences of an insanity evaluation."¹⁵⁸

Treatment of the incompetent condemned appears even more problematic. Restoring a defendant's competency to stand trial — even over his objection — helps him pursue legal remedies such as assisting in his defense.¹⁵⁹ In this manner the government exercises its *parens patriae* power through the psychiatrist to assist the defendant-patient.¹⁶⁰ However, arguably the condemned incompetent has *no interest* in having his competency restored. According to this argument, the principle of *parens patriae* should not apply.¹⁶¹ In Salguero's words, "[t]he state is asking the physician to treat an unwilling individual in order to change him to meet the will of society, [sic] which is especially repugnant to medical ethics."¹⁶² Bonnie imaginesthea situation of an incompetent prisoner, who, while competent, stated had that he would prefer to stay insane rather than provide his consent to be treated. Bonnie concludes:

In light of the prisoner's unequivocal preference for life, I

158. Ward, *supra* note 23, at 77.

159. Wallace, *supra* note 131, at 273-74 ("The treating mental health professional may find some consolation that the use of professional skills at trial . . . allows the defendant to pursue available legal remedies." (citations omitted)); see APA/AMA Brief, *supra* note 38, at 10-11 n.12 ("[T]he benefits of medication . . . may be vital to the defendant's ability to assist in his defense . . ."). Cf. ABA STANDARDS, *supra* note 19, § 7-4.10 cmt. at 223 ("[T]reatment is for the benefit of the criminal justice system . . .").

160. See Brief in Opposition to Petition for Writ of Certiorari at 9-10, *Perry v. Louisiana*, 498 U.S. 38 (1990) (No. 89-5120) (arguing that the sovereign has historically had general custody and care for the insane (citing 3 WILLIAM BLACKSTONE, COMMENTARIES *247)).

161. See Wallace, *supra* note 131, at 276 ("This situation is quite unlike the use of medical skills to prolong the life of the terminally ill."). See also APA/AMA Brief, *supra* note 38, at 9-10 ("It strains credulity to invoke the *parens patriae* power in this case. Louisiana's efforts are aimed not at benefiting Perry as a ward of the the State, but rather at facilitating his death to serve separate state interests."). But see Heilbrun et al., *supra* note 40, at 597 (between 1972 and 1990, 1078 prisoners were removed from death row; "[t]he capacity to work with counsel on collateral appeals is thus more important than it might seem") citing data from Death Row, USA (NAACP Legal Defense and Education Fund, Jan. 21, 1991).

162. Salguero, *supra* note 58, at 181. Note that psychiatrists are by no means invariably opposed to treating patients involuntarily "to meet the will of society," *id.*, so long as they agree with society's will. See, e.g., H. Richard Lamb, *Will We Save the Homeless Mentally Ill?*, 147 AM. J. PSYCHIATRY 649, 650 (1990) ("If homeless persons with major mental illness are incompetent to make a decision with regard to accepting treatment . . . then I believe that outreach teams including psychiatrists should bring all of these patients to hospitals, involuntarily if need be.").

see no way to justify treating the patient on the ground that it is beneficial to him. If the prisoner is to be treated, it will be for the sole purpose of serving the state's interest in carrying out the execution

. . . Because the clinician's actions no longer have any link to the prisoner's own interests . . . the clinician would be serving a role that is ethically indistinguishable from the physician who administers the lethal injection of barbiturates.¹⁶³

4. Participation is a Perversion of Psychiatric Practice

A fourth objection to psychiatric participation in execution competency proceedings is that such participation constitutes an immoral or perversion of psychiatric practice. Although this argument is often not regarded as distinct from the previous three arguments, it nonetheless deserves individual consideration.

The *Ford* decision necessarily entangles psychiatrists in a highly visible, symbolically-charged facet of the American criminal justice system.¹⁶⁴ Dr. Appelbaum suggests that the judiciary has evinced "the universal desire for someone else to make the hard decisions"¹⁶⁵ by increasing the use of psychiatric testimony in the capital sentencing process. The psychiatrist's traditional therapeutic role is to help others gain insight and make hard decisions. However, Appelbaum concludes, the demand for psychiatrists to play a key role in sentencing decisions "may be serving as a substitute for some hard thinking about the purpose of punishment, and particu-

163. Bonnie, *supra* note 30, at 85.

164. See *Ford v. Wainwright*, 477 U.S. 399, 417-18 (1986) (requiring neutral professionals to provide testimony as evidence of competency for execution), *reh'g denied*, *Ford v. State*, 522 So. 2d 345 (Fla. 1988) (denying post-conviction relief), *cert. denied sub nom. Ford v. Dugger*, 489 U.S. 1071 (1989). "There can be little doubt that there will be widespread dissemination of information about the actions of psychiatrists and psychologists in cases of incompetency for execution. The avid public interest in death penalty cases, fueled by intense media scrutiny, is a potentially volatile situation." Heilbrun, et al., *supra* note 40, at 600.

For extensive reviews of the symbolic aspect of death penalty litigation, see Barefoot's Ake, *supra* note 1, at 91 nn.1-3, *passim* ("There can be no question as to the symbolic significance of capital punishment as a political, sociological or penological issue, either historically or contemporaneously." *Id.* at n.2); *Doctrinal Abyss*, *supra* note 1, at 88-97 (arguing that the ambiguity of the Court's treatment of insane criminal defendants reflects the public's ambivalence toward the psychological and social symbols invoked by mental incompetence and crime generally).

165. Appelbaum, *supra* note 1, at 762.

larly about the role of the death sentence in the modern world."¹⁶⁶ Normal psychiatric practice is perverted when it allows courts and society-at-large to avoid their responsibilities.

Several commentators urge psychiatrists not to participate in execution competency proceedings because in doing so a psychiatrist is taking on the criminal justice system's burden and thus reinforcing society's ambivalence toward the death penalty. At the American Psychiatric Association's 1987 Annual Meeting, Dr. Appelbaum told listeners that psychiatric participation in execution competency proceedings would give capital punishment an undeserved "scientific veneer," and would tell society, "we'll do your dirty work . . . and this will make you all feel better."¹⁶⁷ Others criticize participation because they fear that a psychiatric presence legitimizes the death penalty,¹⁶⁸ or may aid society's "attempt to improve the image of execution by cloaking it in the aura of medicine."¹⁶⁹ Arguably, psychiatric input is not required to determine execution competency. Consequently, for retribution to be meaningful, society, in the form of a jury,¹⁷⁰ should evaluate the prisoner and make the ultimate determination of execution competency.¹⁷¹

B. Critique of Arguments Against Participation

In sum, critics of psychiatric involvement in execution compe-

166. *Id.* See also Judge David L. Bazelon, Veils, Values, and Social Responsibility, Address before the American Psychological Association, (August 24, 1981), in 37 AM. PSYCHOLOGIST 115, 118 (1982) (Stating "Public decisions are often so close to impossible that those who are charged with making them are more than anxious to pass their burden to unwitting experts" and arguing that the social expectations placed on mental health professionals by the judiciary may lead the testifying professionals to make unfounded conclusory statements).

167. Hansman, *supra* note 33, at 15, 21.

168. See Radelet & Barnard, *supra* note 23, at 46-47 (arguing that the official creation of professional standards for execution competency will legitimize "the whole process as well as the death penalty itself").

169. Barbara Bolsen, *Strange Bedfellows: Death Penalty and Medicine*, 248 JAMA 518, 519 (1982) (restating the opinion of Dr. Armand Stuart, medical director of the Oklahoma Department of Corrections).

170. See Ewing, *supra* note 134, at 184 & n.57 ("Although the law has given mental experts considerable responsibility for helping decide legal questions raised by crazy behavior, experts have less competence to assist in these decisions than is commonly believed. Moreover, much of the factual knowledge necessary for legal decisionmaking is accessible to lay observers as well as experts.") (quoting Stephen J. Morse, *Crazy Behavior, Morals, and Science: An Analysis of Mental Health Law*, 51 S. CAL. L. REV. 527, 602 (1978)); *Questioning Psychiatry's Role*, *supra* note 32, at 3.

171. Ward, *supra* note 23, at 89.

tency assessment and psychiatric treatment restoring competency assert arguments equating involvement with participation in the execution, categorizing participation as contrary to principles of medical ethics, treating participation as a violation of informed consent standards, and criticizing participation as tainting the public perception of the practice of medicine.¹⁷² Although these arguments are plentiful, they are internally inconsistent and they contradict our intuitions about proper conduct in other scenarios.

1. Psychiatric Involvement Does Not Constitute Participation in Executions

By equating assessment or treatment of a condemned inmate with participation in an execution, those opposed to these activities over-state their case. Unlike administering a lethal injection, assessing or treating psychosis does not *directly* cause death. The direct causes of death in executions are those actions that physically cause death, such as injecting the barbiturate or throwing the switch on the electric chair. To argue that assessment or treatment is an *indirect* cause of a convict's death — the “but for” argument¹⁷³ — would impugn a host of other commonly accepted forensic activities. These activities include testifying for the prosecution in a capital case¹⁷⁴ and giving competency-restoring treat-

172. See *supra* notes 129-71 and accompanying text.

173. Cf. *supra* note 141 and accompanying text; see also Ward, *supra* note 23, at 85 (arguing that the psychiatrist has assisted in an execution which would not have occurred but for the treatment); Salguero, *supra* note 58, at 177 (suggesting that the but-for test is an appropriate measure of causation). It seems odd to label customary medical treatment for psychosis as the ‘proximate cause’ of a condemned prisoner’s execution when it takes a subsequent series of well-planned preparations and acts to effect a death penalty. By contrast, to say that “but for his having committed a crime, psychiatric treatment would have enabled the prisoner to resume a normal life” correctly focuses on the criminal’s responsibility for what are, in his case, the implications of treatment.

174. Bonnie makes this very point:

[P]articipation in capital sentencing evaluations does not, in itself, offend any ethical injunction, and the pertinent question . . . is whether there is a principled basis for declining to perform execution competency evaluations while participating in the capital sentencing process.

Both types of evaluation provide information and opinion . . . that could condemn or spare the prisoner. What seems to differentiate the two contexts is the *immediacy* of the link between the evaluator’s opinion and the decision whether the person being evaluated will live or die

The emotional impact of this contextual difference cannot be doubted, but I do not see its ethical significance. Indeed, . . . the case against participation in a capital sentencing evaluation actually would seem to be stronger than the case against participation in a routine execution competency evaluation.

ment to a patient accused of a capital crime.¹⁷⁵ Many psychiatrists regard these actions as ethical, even though death, although not the purpose of the activity, certainly is "within . . . the contemplation of the actor."¹⁷⁶ The indirect-execution argument might also preclude ever treating a condemned inmate, even though his execution is years away, since that treatment could prevent the development of incompetence that would preclude execution.¹⁷⁷

In . . . a sentencing proceeding, . . . the expert's opinion may very well increase the likelihood that the defendant will be sentenced to death. In . . . a competency evaluation . . . the expert can alter the prisoner's situation *only* by extending his life.

Bonnie, *supra* note 30, at 80-81. Appelbaum agrees: "[T]he immediacy and degree of harm to which the prisoner is subject heighten ethical concerns. But this may simply be a case of being closer to the consequences of one's actions." *Appelbaum's Parable*, *supra* note 17, at 257.

175. The *parens patriae* justification for giving an incompetent defendant treatment is that the potential risk of recovering and being convicted is balanced by the potential benefit of medication (e.g., being able to assist in one's defense and perhaps gain acquittal). See APA/JAMA Brief, *supra* note 38, at 10-11 n.12 (discussing the balance of risks and benefits associated with treatment of defendants). "Whether a particular treatment is in a particular patient's medical interests, however, is always a question involving consideration of risks and benefits. There may well be room for debate about that balance . . ." *Id.* at 10. Few physicians, however, would think it proper to refrain from treating a patient with the intent of helping him avoid being tried, particularly if the patient desired treatment.

The "immediacy" argument raised by Bonnie in connection with competency assessments would seem to apply here as well: the psychological meaning of treating someone who might be punished in the next few weeks seems greater than in the case where punishment may be years away, but ethically, the problem is identical.

176. Salguero, *supra* note 58, at 177; *cf. supra* note 124.

177. Appelbaum comments:

Does not any effort at treatment remove a *potential* obstacle to execution? I think this argument fails since the evidence suggests that only a tiny percentage of prisoners will become severely ill enough to meet the generally strict standards for incompetence. Thus, the balance of risks and benefits is very different for a prisoner for whom the question of incompetence has not been raised, but who may be in need of psychiatric care.

Appelbaum's Parable, *supra* note 17, at 257 (emphasis added).

There are three problems with Appelbaum's counter-argument. First, many, though not all, efforts at treatment will remove potential obstacles to execution. Although psychiatrists who treat condemned inmates may not know in advance which of their patients will become incompetent, they do know that for some inmates their treatment will prevent deterioration and thus be "responsible" for their execution. There seems to be no less reason for criticizing psychiatrists who work under these circumstances, and who know that they are making sure inmates do not get crazy enough to avoid execution, than there is for terming psychiatrists who treat those judged incompetent for execution "the agents of that punishment." *Id.* at 258.

Second, Appelbaum does not cite any evidence. While it is true that the question of execution competency has been raised for relatively few convicts, this may reflect the inadequacy of defense counsel usually afforded the mentally ill, rather than the true inci-

Assessment and treatment should be further distinguished from participation because they are neither performed for the purpose of executing the prisoner, nor are they the reason for his death. If a prisoner has been justly tried, and if capital punishment itself is justified, then the reason for execution is that the prisoner was found guilty of a crime and must be punished.¹⁷⁸ Assessment and treatment of the condemned serve the same purposes and offer the same potential benefits as they do for other patients: restoring sanity, relieving the torment of mental illness, and helping patients cope rationally with their situation. These medical benefits to the condemned inmate are not negated by one of the non-medical consequences of sanity — eligibility for execution — though they may be less welcome than they are for more typical patients. Moreover,

dence of serious mental disorders among death row inmates. See Michael L. Perlin, *Are Courts Competent to Decide Competency: Stripping the Facade from United States v. Charters*, 38 KAN. L. REV. 957, 996 (1990) (noting the generally "scandalous" quality of legal assistance provided to the mentally ill), *cert. denied*, 494 U.S. 1016 (1990); cf. Michael L. Perlin, *Competency, Deinstitutionalization, and Homelessness: A Story of Marginalization*, 28 HOUS. L. REV. 63, 126 (1991) ("Traditionally, lawyers assigned to represent state hospital patients have failed miserably in their mission"). See also *supra* notes 54-56 (discussing rates of severe mental illness among condemned prisoners).

Third, even if the majority of death row inmates are not likely to develop mental disorders severe enough to render them incompetent for execution, psychiatrists may be able to recognize a sub-group of inmates whose medical histories or presenting symptoms make the possibility of execution incompetence quite high. Michael Perry would appear to be a case in point: even the trial court recognized his competency was "achieved through the use of . . . antipsychotic drugs." APA/AMA Brief, *supra* note 38, at 4 (quoting Pet. App. 62). For prisoners like Perry, the "risk" of being treated and remaining sane are clear long before the scheduled execution date. As Professor Bonnie explains:

As legal challenges for death row prisoners proceed through the courts, those who are mentally ill become well known to the mental health professionals responsible for providing services. As a prisoner's likely execution draws near, the potential legal significance of his questionable competency — and the enabling effect of continued treatment — will be apparent, even in the absence of any formal adjudication. Thus, ethical objections to treatment can arise in many cases other than those in which the condemned prisoners have been adjudicated incompetent for execution — indeed, the problem is discernible whenever a death row prisoner becomes psychotic. The slope of the "no treatment" argument is very slippery indeed.

Bonnie, *supra* note 30, at 84-85.

178. Cf. Salguero, *supra* note 58, at 178, n.64: "On its face, the purpose of treatment is to cure the patient, and the consequence of the care is to enable to state to execute. However, . . . the distinction [between purpose and consequence] is meaningless." Even if the first sentence were correct, it is not clear why the distinction is meaningless. The law does not authorize the state to execute someone because he is competent, but because he has been convicted of a capital crime and sentenced to death. Execution is a consequence of criminal conviction and of nothing else.

these benefits are not necessarily *outweighed* by the prospect of execution.¹⁷⁹

2. Normative Principles of Medical Ethics Do Not Prohibit Psychiatric Participation

Ethical codes often provide physicians with general behavioral directives (e.g., "preserve life," "alleviate suffering," "do no harm") which are useful in the typical medical contexts in which they were developed, but which may fail physicians who attempt to apply them in novel circumstances.¹⁸⁰ To use a well-worn example, the exhortation to "preserve life," which has guided and inspired modern physicians for two centuries,¹⁸¹ is no longer an adequate guide to late twentieth-century decisionmaking, when medical technology enables physicians to indefinitely prolong the agony-filled lives of terminally-ill patients.¹⁸²

179. See *infra* text accompanying notes 305-26.

180. Veatch argues that, in general, physicians will go astray if they simplistically "appeal to some parochial set of ethical rules or code of ethics to decide what is morally right in any medical ethical dilemma." VEATCH, *supra* note 147, at 74 (emphasis added). What Veatch terms "the dangerous Hippocratic principle," *id.* at 147, which simply prescribes benefiting patients, is consequentialistic, paternalistic, and individualistic. *Id.* More-over this principle lacks validity because it "has never involved pledges or promises made with or accepted by those outside the professional group." *Id.* at 90. Veatch utilizes contract theory to establish a sounder foundation for medical ethics. *Id.* at 108-38. Veatch's theory recognizes that physicians and patients "are members of a common moral community of responsible people endowed with reason, dignity, and equality of moral worth." *Id.* at 327. In thus placing respect for individuals' humanity and autonomy at the center of his conceptualization of ethical issues, Veatch's arguments correspond closely to those of this paper, *infra*, Part IV, concerning the justification of punishment.

181. "The Hippocratic Oath does not require a physician to use his skill to preserve life. It does require the Hippocratic physician to avoid giving 'a deadly drug to anybody if asked for it,' but that is certainly quite different." VEATCH, *supra* note 147, at 166. The notion that physicians have a duty to preserve life seems connected with ideas of progress that gained prominence by the seventeenth century. See Amundsen, *The Physician's Obligation to Prolong Life: A Medical Duty without Classical Roots*, 8 HASTINGS CTR. REP. 23, 28 (August, 1978) (noting that the duty to preserve life was not developed until the seventeenth century); GERALD J. GRUMAN, A HISTORY OF IDEAS ABOUT THE PROLONGATION OF LIFE 83-90 (1966) (discussing the contemporaneous development of the duty to preserve life and the progress of the eighteenth century).

182. See PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT (1983) (suggesting that the changing context of death and dying in the modern age requires a different moral framework). Many commentators would suggest that holding the preservation of life to be an absolute duty was *never* a satisfactory guide to decisionmaking. See, e.g., Talcott Parsons et al., *The "Gift of Life" and Its Reciprocation*, 39 SOC. RES. 367, 395 (1972) (arguing that traditional medical ethics has tended toward "absolutizing . . . the value of preserving life" which has "strongly insulated medical ethics from any ethical system or complex that did not place a commensurate emphasis

In the context of capital punishment generally, the directive to “preserve life” could be read as asking physicians to interfere with the determination or imposition of death sentences whenever they have an opportunity to do so. In the particular context of execution competency, such interference could take the form of testifying falsely that a convict is incompetent, or of manipulating medical treatment so as to delay recovery from psychosis. The knowledge that physicians would behave in these ways would undoubtedly give prosecutors and prison officials ample incentive to limit doctors’ activities in legal arenas. But leaving this consequence aside, for physicians to feel that their professional ethics afford a special justification for interfering with the execution of the law in ways that other citizens may not would be arrogant.¹⁸³

upon the value of preserving life”); VEATCH, *supra* note 147, at 169 (The putative duty always to preserve life lacks a broad moral consensus, and “either reduces to a more general Hippocratic principle of benefiting the patient” or is “a careless expression of a more narrow and sophisticated role-specific duty . . . to avoid knowingly and actively killing human beings.”). For example, *In re Conroy*, 486 A.2d 1209 (N.J. 1985) involved the decision to remove a nasogastric (feeding) tube from an eighty-four year old terminally ill woman who suffered from severe organic brain syndrome, urinary tract infection, gangrene, and arteriosclerotic heart disease. *Id.* at 1217. It was only through technology that the woman’s life was extended at all. However, the physician still faced ethical concerns; obviously the goals of alleviating suffering and preserving life clashed mightily.

183. One might raise the point that the duty to preserve life — like other physician duties — is activated only by the establishment of a doctor-patient relationship, which does not obtain in forensic contexts: “psychiatrists operate outside the medical framework when they enter the forensic realm.” *Appelbaum’s Parable*, *supra* note 17, at 258. “When professionals function as either evaluators or consultants, they establish no therapeutic or rehabilitative relationship with defendants and thus owe them no loyalty.” ABA STANDARDS, *supra* note 19, at Standard 7-7.1 cmt. Even if psychiatrists are in fact outside the medical framework and do not establish therapeutic relationships with evaluatees, psychiatrists are not precluded from seeking out relationships with defendants and prisoners with the intent of saving lives, even if they interfere with legal outcomes by doing so. Thus some clinicians, for example, will conduct capital sentencing evaluations only for the defense, with the intent of finding mitigating evidence. *Cf.* Foot, *supra* note 146, at 216 (suggesting that psychiatrists might “work against capital punishment from the inside”). My purpose is not to criticize these clinicians, but to point out that the urge to use one’s clinical prowess to preserve life frequently enters the minds of clinicians who engage in forensic activities.

Were the APA/AMA Brief’s commutation-if-incompetent position adopted, *see supra* text at notes 110-15, psychiatrists who wished to work in opposition to the death penalty would have an enormous temptation to seek opportunities to testify that condemnees are incompetent; the duty to “preserve life” — if accepted at face value — would appear to place all psychiatrists under enormous pressure to find reasons to suggest that prisoners are incompetent. The potential conflict between the duty to preserve life and the duty to tell the truth in court would be at least as troublesome as the ethical conflicts faced by psychiatrists whose treatment might restore execution competency. Even if one felt that psychiatrists were not obligated to individual prisoners with whom they have evaluative,

Ewing and Wallace conclude from their reading of the codes of conduct that professional organizations should officially declare most involvement in execution competency proceedings to be unethical.¹⁸⁴ But if the psychiatrist refuses to evaluate a prisoner, he forfeits a chance to preserve life.

The ethical codes' outcome-oriented prescriptions appear to conflict with one another.¹⁸⁵ Codes of ethics direct physicians to preserve life, avoid harm, heal the sick, and prevent suffering. They do not answer the question of which is more harmful, treating psychotic condemned inmates with the knowledge that they could then be executed, or leaving them psychotic for months or years. The codes give no guidance as to how they apply when healing the sick and preventing suffering may not preserve life. Psychiatrists who use only the codes' directives to choose a course of action "cannot make an ethical choice."¹⁸⁶

Assessment and treatment of incompetent condemned prisoners are not clear violations of professional codes of ethics. Codified directives often may produce laudable results in "typical" circumstances in which physicians find themselves. These directives are ill-suited to prescribe psychiatrists' behavior in atypical doctor-patient relationships, as when the patient is an incompetent condemnee. In the novel or atypical context, the psychiatrist must

but not treatment, relationships, the APA/AMA Brief's argument about the desirability of regarding psychiatrists as practitioners of a beneficent healing art would provide the basis for psychiatrists' having a moral obligation to prisoners in general. APA/AMA Brief, *supra* note 38, at 13. This general moral obligation would only be satisfied by finding condemnees incompetent. The Brief's position thus seems to entail physicians' working to subvert the capital punishment process.

Clinicians unambiguously have advocated subverting strict civil commitment laws when these would prevent involuntary hospitalization of someone who very much needs this type of care. See, e.g., Louis McGarry & Paul Chodoff, *The Ethics of Involuntary Hospitalization*, in SIDNEY BLOCH & PAUL CHODOFF, *PSYCHIATRIC ETHICS* 203, 211-212 (1981) (suggesting that psychiatrists not "acced[e] too readily to current trends" nor "succumb to prevailing fashion when they are convinced that it is not always in the best interests of those patients"); see also R. Michael Bagby & E. Leslie Atkinson, *The Effects of Legislative Reform on Civil Commitment Admission Rates: A Critical Analysis*, 6 *BEHAV. SCI. & L.* 45, 58 (noting that there is little evidence to suggest that psychiatrists adhere to tightened commitment requirements; some psychiatrists ignore restrictive laws and commit those "whom they believe should be committed").

184. See Ewing, *supra* note 134, at 185 (recommending that the American Psychiatric Association prohibit members from treating or assessing condemned prisoners); Wallace, *supra* note 131 at 278 (arguing that professional organizations should explicitly deem unethical any member's treatment or assessment of persons sentenced to capital punishment).

185. Salguero, *supra* note 58, at 168.

186. *Id.*

make an effort to abstract general principles¹⁸⁷ of conduct to guide decisionmaking and to explain, for example, why physicians are often obligated to alleviate suffering and preserve life, yet sometimes obligated *not* to do so. For example, a cancer patient may prefer to endure pain rather than be unconscious from pain medication so that he may put his affairs in order during the last weeks of his life. An AIDS patient may wish to forego life-prolonging respirations and drugs in order to die a peaceful death. In these situations it is clear that the physician's primary obligation is to do other than relieve suffering or save lives.

Physicians are dedicated to, and have special skills to undertake, healing and life-saving activities. But ethical directives to alleviate pain or save lives are always limited by the prior context of a doctor-patient relationship. Without the relationship, in this and all other medical contexts, individuals have a fundamental right to be left alone.¹⁸⁸

3. Participation Does Not Violate Informed Consent

The physician's contractual duty to the patient is normally created when the patient gives informed consent. Usually these contractual agreements between doctor and patient create a duty on the part of the doctor to perform activities for the patient who seeks their benefit.¹⁸⁹ When dealing with an incompetent condemned prisoner, however, the psychiatrist must infer what the reasonable prisoner would want in order to determine what duties accompany the relationship.¹⁹⁰

187. The process is analogous to Dworkin's description of how an ideal judge would decide hard cases. See RONALD DWORKIN, *TAKING RIGHTS SERIOUSLY*, 81, 105-130 (1977) (suggesting that an ideal judge would decide difficult cases by initially constructing broad legal theories). For a neurologically-based account of how general theories, explanations, and moral principles are developed from a series of particular experiences, see PAUL S. CHURCHLAND, *A NEUROCOMPUTATIONAL PERSPECTIVE: THE NATURE OF MIND AND THE STRUCTURE OF SCIENCE*, 153-230, 297-303 (1989).

188. *Schloendorff v. Society of New York Hospital*, 105 N.E. 92, 94 (N.Y. 1914) (holding that the doctor's duty to the patient supersedes the duty to uphold the Hippocratic Oath); *Canterbury v. Spence*, 464 F.2d 772, 780 (D.C. Cir. 1972) (upholding the patient's right to accept or refuse treatment), *cert. denied*, 409 U.S. 1064 (1972).

189. See Robert M. Veatch, *Models for Ethical Medicine in a Revolutionary Age*, 2 HASTINGS CENTER REPORT 5, 7 (June 1972) (discussing the contract model of doctor-patient relationships). See also VEATCH, *supra* note 147, at 108-30, 327-30 (proposing a draft for a nested "triple contract" to guide the creation and boundaries of physician-patient relationship).

190. Cf. *Canterbury*, 464 F.2d 772 (describing the "reasonable patient" standard of informed consent).

Professor Bonnie emphasizes the importance of sensitivity to the patient's wishes in a scenario exploring the ethics of treating the incompetent condemned.¹⁹¹ This scenario suggests that psychiatric practice might be perverted most by a position that absolutely forbids treatment. Bonnie asks us to "consider the possibility of a 'living will' in which the condemned prisoner — contemporaneously determined to be competent — states that if he becomes incompetent while awaiting execution, he wishes to be treated."¹⁹² To categorically reject a competent prisoner's requests for treatment would deprive him of his autonomy "and thereby erase[] [his] human dignity."¹⁹³ Bonnie offers as plausible motivations for a prisoner's request for treatment the prisoner's preference for death over the ravages of psychosis. Some prisoners prefer execution to life-long imprisonment following commutation.¹⁹⁴ In addition, it is not difficult to imagine a treatment request being made by a prisoner who accepts his guilt and deems execution his just desert.¹⁹⁵

191. Bonnie, *supra* note 30, at 83.

192. *Id.*

193. *Id.* at 84.

194. *Id.* at 83. Bonnie's discussion here assumes the existence of a clause such as that existing in Maryland, which calls for commutation of death sentences when condemnees are found incompetent to be executed. See *supra* note 109. Gary Gilmore was one person who preferred execution to imprisonment. See *Gilmore v. Utah*, 429 U.S. 1012 (1976). Convicted and sentenced to death for the murder of a hotel clerk, *id.*, he found execution preferable to imprisonment. See NORMAN MAILER, *THE EXECUTIONER'S SONG* 484 (1979). He told a Mormon chaplain of his preference for execution, stating "I'll be honest with you. I've been in for eighteen years and I'm not about to do another twenty. Rather than live in this hole, I'd choose to be dead." *Id.* But see *infra* note 195 (quoting Gilmore's statement that his punishment was proper and was the result of a fair trial).

Gilmore instructed his attorneys, who believed they had strong grounds upon which to mount an appeal, to forego any appeal of his death sentence. MAILER, *infra* at 489. He explained, "I've been here for three weeks and I don't know that I want to live here for the rest of my life" *Id.* Gilmore fired his counsel and withdrew his motion for a new trial. *Id.* He continued to resist efforts to postpone or vacate his death sentence, and was ultimately executed by a firing squad on January 17, 1977. *Id.*

195. Socrates provides an important historical example; see *infra* note 247 and accompanying text. Gary Gilmore may represent another such case. In speaking to the Justices of the Utah Supreme Court in November, 1976, he stated:

Your Honor, I don't want to take up a lot of your time with my words. I believe I was given a fair trial and I think the sentence is proper and I am willing to accept it like a man. I don't wish to appeal I desire to be executed on schedule, and I just wish to accept that with the grace and dignity of a man

MAILER, *supra* note 194, at 534. See also *Gilmore v. Utah*, 429 U.S. 1012, 1013 (1976) ("[T]he Court is convinced that Gary Mark Gilmore made a knowing and intelligent waiver of any and all federal rights he might have asserted after the Utah trial court's sentence was imposed"). Of course, only a minority of convicts view their punishment

One possible counterargument is that problems in obtaining proper consent arise in many other forensic situations without resulting in prohibitions against psychiatric participation. It seems appropriate for psychiatrists to respond to calls for execution competency evaluations in the same way they do in these other circumstances. For example, Halleck and colleagues offer sentencing evaluation guidelines that should also provide ample safeguards against a psychiatrist's improper evaluation of a prisoner's execution competency when the prisoner is unable to give consent.¹⁹⁶ They recommend that "the psychiatrist should stop the examination, inform the party who requested the evaluation [of the prisoner's incompetence] . . . , and allow the legal system to arrive at a solution to the problem."¹⁹⁷ Following this suggestion could produce at least two possible outcomes. First, a court may rule that the state's interest in carrying out sentences, or the loss of liberty entailed by conviction, render unnecessary the usual requirements for prisoner consent. Second, a court might rule that it is reasonable to assume that if the prisoner is incompetent to consent to be interviewed he is incompetent to be executed.¹⁹⁸

4. Participation is Not a Perversion of Psychiatric Practice

While treating an incompetent prisoner might carry with it all the emotional burden¹⁹⁹ of treating a condemnee who had expressed no preferences about competency restoration, it is hard to see how such treatment could be criticized as doing "society's dirty work" or as a perversion of medical practice. Nor can a competency evaluation of a consenting prisoner, under these circumstances, be dismissed as an unwise appropriation of the duty of society to

this way. "According to the NAACP Legal Defense fund, of the first 100 executions in the United States after 1976, 11 were consensual." Radelet & Barnard, *supra* note 23, at 307 n.20. These examples are intended primarily to expose certain features of our ethical predilections, rather than prepare us for a particular (and unlikely) exigency.

196. Seymour L. Halleck et al., *Psychiatry in the Sentencing Process*, in AMERICAN PSYCHIATRIC ASSOCIATION, *ISSUES IN FORENSIC PSYCHIATRY* 181, 201 (1984).

197. *Id.*

198. "While competency for execution and competency to give informed consent are not the same, under many execution competency standards they are similar." Ward, *supra* note 23, at 78.

199. See *supra* text accompanying notes 123-28. See also Radelet & Barnard, *supra* note 23, at 303-04 (discussing emotional impact on Chattahoochee Florida State Hospital staff involved in caring for Gary Alvord, who was adjudicated incompetent for execution in 1984).

judge an inmate's fitness for execution.²⁰⁰ One purpose of the evaluation would be to determine whether the inmate needs a type of treatment that he has requested — an eminently medical undertaking. Even where the condemnee consents, many psychiatrists might wish, for emotional reasons, to shun the evaluation and treatment of condemned prisoners. But psychiatrists have little basis to absolutely condemn their colleagues who choose to evaluate and treat condemned prisoners²⁰¹ unless these psychiatrists adopt the position that there is never any justification for the death penalty, so that all psychiatrists must be absolutely enjoined from treating the condemned.²⁰²

This article characterizes the "participation as perversion" objection²⁰³ as having three components: (a) psychiatrists have no special expertise in assessing execution competency; (b) society, represented by a judge or jury, not a psychiatrist, has the responsibility for determining execution competency; and, (c) psychiatrists should not abet society's refusal to accept its responsibility for addressing problems associated with capital punishment or its unwillingness to confront matters about which it is profoundly ambivalent. "Participation as perversion" is an important objection because it deals with psychiatrists' roles in a highly visible and symbolically important arena. The role psychiatrists play in forensic matters, and how they think about that role, says a great deal about how they perceive themselves and their patients generally.²⁰⁴ Psychiatrists can respond to this objection, however, in ways that fall short of complete abstention from involvement with incompetent condemnees.

200. *But see* text accompanying note 145; Ward, *supra* note 23, at 89.

201. Note that I leave open the possibility that psychiatrists who felt the death penalty was always immoral might logically object to fellow physicians' acting in ways that allow the machinery of capital punishment to work. However, none of the published objections that I discuss in this article explicitly call upon psychiatrists to refuse to participate because capital punishment is wrong or unjust.

202. Limited condemnations, e.g., that the evaluating or treating psychiatrists were not impartial, were misdiagnosing, or were using poor therapeutic technique, would, of course, still be reasonable.

203. *See* Mossman, *supra* note 23, at 400-01, 403-04 (discussing "psychiatry's 'social function' in the capital punishment process" and "role conflicts").

204. *See Appelbaum's Parable, supra* note 17, offering an elegant, succinct discussion of this issue. One of the most frequently-cited defenses of psychiatric participation in forensic matters is Richard J. Bonnie & Christopher Slobogin, *The Role of Mental Health Professionals in the Criminal Process: The Case for Informed Speculation*, 66 VA. L. REV. 427 (1980) (justifying participation and offering guidelines for psychiatrists). *See infra* text accompanying notes 293-302.

Attorneys, philosophy professors, and other well-educated persons could probably assess the ethicality of competency evaluations as well as psychiatrists. In fact, only a minority of psychiatrists can be expected to have enough understanding of the complex legal and philosophical issues at stake to perform an adequate evaluation of execution competency. However, psychiatrists do have unique expertise concerning the disorders that cause incompetence. With special training, psychiatrists can explain to fact-finders how those disorders impair thought processes, understanding, and judgment.²⁰⁵ There is, therefore, reason to presume that the lack of psychiatric input in execution competency judgments might entail "a serious loss to the pursuit of justice."²⁰⁶

No matter how valuable their expertise may be, when psychiatrists participate in execution competency proceedings they must avoid usurping or being thrust into the roles of the other "players." It is properly only the judge's or jury's task to decide whether a convict is competent to be executed. Wallace's concern about psychiatrists' participation in a competency tribunal²⁰⁷ seems justified in view of the actions of psychiatrists evaluating Alvin Ford. Those psychiatrists submitted unchallenged written conclusions that Ford was competent to be executed.²⁰⁸ Psychiatrists need proce-

205. Gutheil and Bursztajn describe methods for assessing uncooperative patients and for showing courts how subtle forms of psychosis and mood disturbance affect competency to refuse treatment. Thomas G. Gutheil & Harold Bursztajn, *Clinician's Guidelines for Assessing and Presenting Subtle Forms of Patient Incompetence in Legal Settings*, 143 AM. J. PSYCHIATRY 1020 (1986). Psychiatrists with proper training might offer analogous kinds of services to courts charged with adjudicating execution competency.

206. Compare Appelbaum's Parable, *supra* note 17, at 255 with Ewing, *supra* note 134, at 184 (Psychiatric input, though desired by courts and legislators, is not necessary; competency decisions "could be made just as well — if not better — on the basis of lay evidence provided by those who know the inmate best and have had the greatest opportunity to observe him."). Professor Stephen Morse feels that mental health testimony in general has little courtroom value:

Although the law has given mental experts considerable responsibility for helping decide legal questions raised by crazy behavior, experts have less competence to assist in these decisions than is commonly believed. Moreover, much of the factual knowledge necessary for legal decisionmaking is accessible to lay observers as well as experts.

Stephen Morse, *Crazy Behavior, Morals, and Science: An Analysis of Mental Health Law*, 51 S. CAL. L. REV. 527, 602 (1978).

207. See *supra* text accompanying note 132; see also Wallace, *supra* note 131, at 280.

208. *Ford v. Wainwright*, 477 U.S. 399, 403-04 (1986), *reh'g denied*, *Ford v. State*, 522 So. 2d 345 (Fla. 1988) (denying post-conviction relief), *cert. denied sub nom. Ford v. Dugger*, 489 U.S. 1071 (1989). This circumstance was not unique:

[A] team of three psychiatrists was appointed by the Governor [of Florida] to

dural regulations that clarify the psychiatrist's role and the proper scope of expert testimony. Professional guidelines for conducting evaluations and providing testimony²⁰⁹ might reduce the likelihood that a psychiatrist would decide the ultimate legal conclusions about execution competency.²¹⁰

Society may be trying to ignore the problems associated with capital punishment, but that fact, by itself, does not argue against psychiatrists' participation in the process. Execution competency is only one problem area in which the legal system uses psychiatry in an attempt to resolve awkward situations or avoid "hard thinking." Psychiatrists should remain aware that society often asks them to make uncomfortable decisions in a variety of forensic situations, including the determination of competence for decisionmaking, child custody determinations, the need for involuntary commitment, and the prediction of long-term future dangerousness for sentencing purposes. Psychiatrists therefore must guard against assuming responsibilities that properly belong to judges or juries.

While psychiatrists are not responsible for making decisions about legal status, they do routinely make decisions about whether to provide treatment. The psychiatrist must answer the difficult question of whether providing treatment for an incompetent, psychotic condemnee—treatment that, were he not condemned, he might receive as a matter of course—is necessarily a perversion of

assess [Gary] Alvord's competency, and [on November 26, 1984,] three days before the scheduled execution, the prisoner was evaluated. After the psychiatrists dictated a five-sentence report in the prison parking lot stating their belief that Alvord was indeed incompetent to be executed, the governor stayed the execution We note in passing that the psychiatrists' report simply offered the conclusion that Alvord was incompetent for execution; no details were given as to how the examination was conducted or what medical impairments were found. In short, it was really the psychiatrists, not the governor, who made the decision that Alvord was incompetent. As in every other case in which the issue of competency has been raised in Florida death penalty cases, the physicians in the Alvord case acted as both experts and judges.

Radelet & Barnard, *supra* note 23, at 301.

209. See *supra* note 29 (citing guideline sources).

210. The APA offers similar guidelines for psychiatrists involved in trials where legal sanity is at issue, and recommends that psychiatrists not testify as to the ultimate legal conclusion. See Insanity Defense Work Group, *American Psychiatric Association Statement on the Insanity Defense*, 140 AM. J. PSYCHIATRY 681 (1983). In practice, it is often difficult for courtroom experts to make a clear statement about the results of their evaluations without at least coming very close to commenting on the ultimate legal issue. Cf. Heilbrun & McClaren, *supra* note 29, at 212-13 (discussing strategies for commenting on a patient's mental state without reaching a conclusion as to the ultimate legal issue — competency).

medical practice. This article suggests that if such treatment had been competently and explicitly requested by the inmate *prior* to his becoming psychotic, withholding it might seem more offensive.²¹¹ If such explicitly-requested treatment seems justifiable, it must serve some interest of the inmate. Is it possible that another condemnee who became psychotic without having made an explicit prior request for competency-restoring treatment would have the same interest in being treated? I believe he would, and that this interest derives from a *paramount interest in receiving punishment*. Section IV explains this position, which has substantial implications for physicians who work with patients who have committed crimes.

C. Illustrations of Psychiatrists' Dilemmas

To appreciate physicians' need for an approach to treating prisoners that acknowledges the justification of punishment, consider the following three scenarios in which the ethical issues facing physicians seem analogous to those raised by execution competency proceedings. But in these scenarios the typical or expected actions of physicians do not generate immediate or vigorous denunciation.

(1) Inmates convicted of non-capital crimes can be transferred to mental hospitals if they develop psychiatric disorders,²¹² and returned to prison once they have recovered. Suppose a psychiatrist is asked to evaluate or treat a convict who has been serving a life sentence in a particularly nasty prison prior to being transferred to a hospital for psychiatric care. The psychiatrist knows that the convict understandably prefers living in the mental institution (which in this case is a relatively pleasant place) to being returned to the prison. All of the arguments cited above against evaluating or treating the incompetent condemned apply to the psychiatrist involved with a convict who faces non-capital punishment. A psychiatric evaluation would determine whether the prisoner is "fit" to

211. See *supra* note 202 and accompanying text.

212. Such inmates are entitled to a number of due process protections before they may be subjected to involuntary treatment. *Vitek v. Jones*, 445 U.S. 480, 494-95 (1980). In *Vitek*, the Supreme Court distinguished criminal confinement from involuntary psychiatric hospitalization on grounds that the latter can result in a distinct social stigma and "[c]ompelled treatment," which are not associated with mere imprisonment. *Id.* at 492. A prisoner retains a liberty interest in not being committed to a psychiatric hospital without appropriate due process safeguards because of "the stigmatizing consequences of a transfer to a mental hospital . . . , coupled with the subjection of the prisoner to mandatory behavior modification as a treatment" *Id.* at 494. See MENTAL DISABILITY LAW, *supra* note 1, § 3.66, at 394-403 (discussing transfer rights and procedures).

resume punishment.²¹³ The treatment can be expected to allow punishment, which would otherwise not continue, to proceed. Evaluation and treatment might violate informed consent requirements and the psychiatrist might be viewed as an ally or agent of the state, "an instrument of punishment,"²¹⁴ rather than as an advo-

213. Note that transferring a prisoner to a hospital is *not* equivalent to punishment. Even though time spent in-hospital prior to or following sentencing may be counted as part of a prisoner's total sentence, persons who are not convicted also spend time in hospitals, so hospitalization cannot be equated with punishment. *See, e.g., Franklin v. Berger*, 544 A.2d 650, 653 (Conn. App. 1988) (denial of credit for pretrial confinement denied defendant equal protection), *certification granted in part*, 546 A.2d 282 (Conn. 1988), *rev'd*, 560 A.2d 444 (Conn. 1989); *State v. Tal-Mason*, 515 So. 2d 738, 740 (Fla. 1987) (prisoner entitled to credit for "precommitment coercive detention"), *appeal granted*, 596 So. 2d 796 (Fla. Dist. Ct. App. 1992) (second habeas corpus appeal); *Matter of Knapp*, 687 P.2d 1145, 1152 (Wash. 1984) (equal protection violation to deny defendants credit for time spent in hospital as part of probationary term and for presentence evaluation); and ABA STANDARDS, *supra* note 19, at Standard 7-10.10(a) (prisoner hospitalized in psychiatric facility "is entitled to earn good time credits on same terms as prisoners in adult correctional facilities").

Suppose a prison has an infirmary which, *arguendo*, is relatively pleasant when compared with the rest of the institution and the prisoner has requested treatment and is receiving it voluntarily. Because the infirmary is part of the penal institution, the convict would still be "in prison" while treated in the infirmary. In this situation, a return to a regular cell technically would not entail a resumption of punishment. Yet, the ethical issues faced by a physician who must decide whether the convict is ready to leave the infirmary are similar to those faced by a physician who must decide whether a hospitalized convict is ready to return to prison. Although these morally awkward positions are faced regularly by prison psychiatrists — albeit in less dramatic contexts than when the death penalty is involved — psychiatrists have not been exhorted to abjure treating convicts. *See* American Psychiatric Association, TASK FORCE REPORT 29: PSYCHIATRIC SERVICES IN JAILS AND PRISONS (1989) (discussing the issues facing psychiatrists who treat convicts). For a discussion of the procedural rights available to prisoners who might be compelled in treatment, see MENTAL DISABILITY LAW, *supra* note 1, § 3.66 (discussing *Baugh v. Woodward*, 604 F. Supp. 1529, 1535 (E.D.N.C. 1985) (Prisoners have "a protected constitutional liberty interest in not being transferred to an inpatient prison mental health facility."), *aff'd in part, vacated in part*, 808 F.2d 333 (4th Cir. 1987) (vacating the judgment that a hearing must be provided before a prisoner is physically transferred to a mental health facility and holding that a hearing promptly after physical transfer does not raise constitutional concerns)).

214. APA/JAMA Brief, *supra* note 38, at 18. The Brief continues, "this concern is at its greatest with respect to patients in prison. Prisoners already have reasons to be suspicious of psychiatrists, because psychiatrists in an evaluative role often testify against prisoners in competency, insanity, and death penalty proceedings." *Id.* The Brief argues for preserving psychiatrists' evaluative role in execution competency cases, but states that competency-restoring treatment should not be imposed on inmates contrary to their "medical interests." *Id.* at 12. Psychiatrists, however, regularly treat non-capital patients and restore their ability to return to prison, and may do so over their objection. *Washington v. Harper*, 494 U.S. 210 (1990) (upholding the state's right to treat an inmate against his will). While the emotional impact of psychiatrists' activity may be greater where the death penalty is involved, the ethical issue raised by psychiatrists' dual role as treaters and as state em-

cate for the patient's "medical" interests. Yet psychiatrists often undertake evaluations and treatment under such controversial circumstances, with far less concern that their functions violate ethical norms.²¹⁵ In fact, a psychiatrist might feel some obligation to administer treatment; helping a prisoner avoid treatment might be viewed as collusion with his desire to avoid punishment.

(2) A physician who is asked to evaluate and/or treat an unconscious inmate whose execution is imminent but who has developed a potentially fatal medical disorder (for example, a myocardial infarction, or respiratory suppression caused by the inmate's intentional ingestion of a surreptitiously-obtained barbiturate) faces a difficult ethical problem. Suppose that the physician believes that without treatment the inmate stands a good chance of dying a peaceful death; but with pharmacologic interventions and other conventional supportive measures, there is a high likelihood that his condition can be stabilized. The physician knows that if he elects to treat the convict, there will come a point where he will be asked to determine whether the convict is ready to be returned to prison, where the convict's execution will be scheduled and carried out.²¹⁶

Clearly, the decision whether to treat is an awful one. What is not clear is whether the physician would either appear or feel worse for treating rather than withholding treatment. The physician who treats an unconscious prisoner wrestles with the same ethical problems that accompany psychiatric assessment or treatment of the incompetent condemned. Most physicians would choose "instinctively" to evaluate and treat the convict. In fact, most physicians would feel tempted to reproach a colleague who refrained from providing medical care, allowing the convict to die. Such evaluation and treatment probably would not raise criticisms that the physician was indirectly participating in an execution, violating ethical codes, vitiating the requirements of informed consent doctrine, or perverting the profession. It is unlikely many physicians

ployees seems no different in the case of persons convicted of non-capital crimes.

215. "To our knowledge, nobody has cited ethical difficulties in treating" to restore competency to stand trial, "even though treatment might again facilitate the administration of punishment. . . ." Heilbrun et al., *supra* note 40, at 601.

216. Note the grim irony involved in the case of the potentially-fatal barbiturate overdose: in a state where convicts are executed with lethal injections, saving the convict's life would make it possible for the state to administer *another* lethal overdose in order to bring about the same result sought by the prisoner.

would criticize such treatment even though the ethical considerations raised by the inmate's physical disorder are identical to those raised by mental incompetence.

(3) One final scenario further illustrates the ethical complexity of psychiatric treatment of the condemned. Suppose a psychiatrist had available a medication that would safely induce a pleasurable psychosis but would render a prisoner *permanently* incompetent to be executed.²¹⁷ Such a medication would have the potential for saving the lives of condemned prisoners, and many prisoners might desire it. If psychiatrists felt that their obligation to save lives were of paramount ethical importance, they would have an obligation to offer this medication to competent death row inmates and could be remiss in withholding it.

Understandably, these hypothetical scenarios produce ambivalent reactions. The purpose of examining them is only to emphasize the importance of thinking about execution competency dilemmas in a much broader framework that reflects different perspectives about the role and justification of punishment itself. My contention is that psychiatrists can resolve such dilemmas only if they acknowledge the moral basis for criminal sanctions described in the next section.

IV. THE PSYCHIATRIST AND THE JUSTIFICATION OF PUNISHMENT: HYPOTHETICAL CONSENT

If the death penalty itself is immoral,²¹⁸ physicians may have a powerful ethical justification for spurning involvement in many aspects of the capital punishment process.²¹⁹ Yet most of the lit-

217. Many legal (as well as illegal) pharmaceuticals induce psychosis, particularly in overdose. "Overdose with psychostimulants [e.g., amphetamines] results in marked sympathetic overactivity . . . often accompanied by toxic psychosis or delirium." STEVEN E. HYMAN & GEORGE W. ARANA, *HANDBOOK OF PSYCHIATRIC DRUG THERAPY* 141 (1987). Usually, stimulant-induced psychoses are not pleasant; fortunately, they are usually self-limited.

218. A full discussion of the morality and constitutionality of capital punishment lies beyond the scope of this article. For a concise introduction to the case against capital punishment, see, e.g., Jack Greenberg, *Against the American System of Capital Punishment*, 99 HARV. L. REV. 1670 (1986) (arguing that the capital punishment system assumed by death penalty proponents does not exist; capital punishment is rarely inflicted, often spares the most vicious killers and exists primarily in former slave-holding states against killers of whites). For a succinct defense of the death penalty, see, e.g., Ernest van den Haag, *The Ultimate Punishment: A Defense*, 99 HARV. L. REV. 1662 (1986) (arguing that maldistribution of capital punishment cannot be an argument against its morality, since guilt is individual and that the tendency to apply death sentence to killers of whites suggests an injustice to black victims who receive lesser vindication).

219. There is no reason to assume that physicians markedly vary from the rest of the

erature discussing the propriety of psychiatric participation in execution competency proceedings is silent on the morality of the death penalty itself, preferring to separate the legal issue of punishment from the medical issue of treatment.²²⁰ The psychiatric literature on execution competency is also largely silent on the issue of the morality of punishment in general. Punishment is often recognized as an evil or a form of "harm,"²²¹ but the justification for punishment is a subject which this literature ignores.²²² Many of the ethical issues generated by the psychiatric problems of condemnees are also present in the evaluation or treatment of pris-

American public in their views about the death penalty. If, however, physicians were unanimous in the view that capital punishment is immoral, or if their professional organizations declared involvement in the evaluation and care of capital defendants and condemnees to be unethical, physicians' reluctance to assess or treat these classes of prisoners might constitute a powerful and effective method of attaining legislation against the execution of those who become insane while awaiting the death penalty. *See, e.g., Ewing, supra* note 134, at 185 (arguing that, if medical professionals refused to treat incompetent condemned inmates, the United States legislature may be led to exempt insane condemnees from execution).

A number of writers have commented that a psychiatrist's reluctance to participate in execution competency proceedings is an implicit rejection of the death penalty. *See, e.g., Ward, supra* note 23, at 99 ("If we shudder at the thought of an inmate who would have been spared the gas chamber but for an injection of Prolixin [an anti-psychotic medication], our uneasiness reflects a more basic abhorrence of the death penalty itself.").

Weinstock and colleagues note, "If one opposes capital punishment one might consider it unethical to evaluate the sanity of a death row prisoner if such evaluation were to be used to certify that he it fit to be executed." Robert Weinstock, et al., *The Role of Traditional Medical Ethics in Forensic Psychiatry*, in *ETHICAL PRACTICE IN PSYCHIATRY AND THE LAW* 31, 38 (Richard Rosner & Robert Weinstock eds., 1990) (citing personal communication from Bernard Diamond (April 25, 1988)). While I am not sure that the view that the death penalty is immoral entails an obligation to abstain from evaluation or treatment of condemned inmates, such a view seems implicit in the argument that physicians should abstain lest they absolve jurors' guilty consciences or inadvertently give capital punishment a "vener" of respectability. *See, e.g., Appelbaum's Parable, supra* note 17.

220. This is not surprising. It would be very difficult for the leadership of the American Psychiatric Association to take an official position against a punishment the use of which a substantial portion of its membership may favor. However, the APA is not totally opposed to taking stands on controversial political or moral issues. *See, e.g., Commission on AIDS, American Psychiatric Association, Position Statement Opposing Mandatory Name Reporting of HIV-Seropositive Individuals*, 147 *AM. J. PSYCHIATRY* 541 (1990).

221. Appelbaum, for example, discusses the potential conflict between physicians' customary obligation to "do no harm" and the potential results of psychiatrists' participation "in criminal proceedings, especially on behalf of the prosecution, when their testimony may result in a defendant[s] . . . punish[ment]." *Appelbaum's Parable, supra* note 17, at 254. Arguably, this conflict arises out of a failure to analyze the peculiar moral status of punishment. *See supra* note 155.

222. *See Mossman, supra* note 23, at 404-07, for a brief discussion of this issue.

oners accused or convicted of non-capital crimes.²²³ The prospect of assessing or treating a possibly-incompetent condemned inmate thus forces the psychiatrist to come to grips with his own views about the morality of both capital punishment and the justification of criminal sanctions in general.²²⁴

This section sketches out a theory of punishment which addresses concerns central to general principles of ethical medical practice. More precisely, it presents a perspective on punishment that accords with the respect for autonomy and dignity that are at the core of medical ethics.²²⁵ Although this theory could help psychiatrists sort out their duties and obligations toward most individuals who have been accused or convicted of either capital or non-capital crimes, this article focuses on the obligations befalling psychiatrists who might be asked to evaluate or treat incompetent condemnees. This discussion assumes the truth of a number of propositions which, although entirely consistent with published viewpoints objecting to psychiatric participation,²²⁶ are all, to some degree, controversial.²²⁷ This article argues that disagree-

223. See *supra* notes 212-17 and accompanying text.

224. For perhaps the best-known discussion by a psychiatrist of the morality of punishment, see KARL MENNINGER, *THE CRIME OF PUNISHMENT* (1968) (arguing that the desire to punish arises from sadistic and vindictive feelings). See also *infra* notes 263 and 375 and accompanying text for a discussion of Menninger's views.

225. See VEATCH, *supra* note 147, at 22. See also *supra* note 166. Presenting an argument for a general theory of punishment is well beyond this article's intended scope. Yet some discussion of this issue seems unavoidable given the connection between the morality of psychiatric participation in execution competency proceedings and in non-capital proceedings.

226. Bonnie is in favor of abolishing the death penalty. See Richard J. Bonnie, *The Dignity of the Condemned*, 74 VA. L. REV. 1363, 1364, 1390-91 (1988) (arguing that the law should override an incompetent condemnee's wish to die because doing otherwise would subordinate the societal interest in the integrity of the legal process to the individual interests of the prisoner). However, his ideology does not enter into his considerations about how psychiatrists should deal with requests to evaluate or treat the incompetent condemned; his recommended grounds for abstention have other bases. See, e.g., *supra* text accompanying note 163. I suspect other writers share my opposition to the death penalty, but, like Bonnie, they argue for abstention on other grounds.

227. This is an understatement. But, to review, even briefly, the scholarly argumentation justifying punishment in general, capital punishment, or the fairness of the criminal justice system would take me far beyond this article's scope. This article's modest goal in discussing these points is only to flesh out a moral context and framework for considering the ethical status of psychiatric participation in execution competency proceedings. The purpose of listing these propositions is to emphasize that psychiatrists must recognize these issues before they can adopt a coherent conclusion about the morality of participation. This article suggests that opponents to participation really disagree with one or more of these propositions.

ment on these propositions underlies the moral controversy about psychiatrists' interactions with incompetent condemnees.

Proposition 1: Punishment is an appropriate and morally-justifiable response by society to criminal wrongdoing.²²⁸

Proposition 2: The criminal justice system metes out criminal sanctions in a reasonably fair manner.²²⁹

228. Psychiatrists confronted with the dilemma of treating or evaluating the incompetent condemned cannot resolve the ethical controversy without understanding and accepting the moral justification of punishment. Efforts to understand the moral justification must be kept distinct from those that attempt to elucidate historical or emotional roots for our notions about punishment. For a summary of the literature on the historical, emotional, cultural, and theological roots of American society's approach to punishment, see Michael L. Perlin, *Mental Illness, Crime, and the Culture of Punishment* (manuscript in preparation at 51-79, on file with the author).

229. Stipulating that the criminal justice system be only "reasonably fair" allows for such human imperfections as occasional wrongful acquittals and wrongful convictions, failures to detect and detain the perpetrators of a substantial number of crimes and the inevitable level of inequality that results from the fact that not all criminals can be apprehended, tried, and sentenced by the same court at the same time. Despite a fairness requirement that punishment must be proportional to the offense, it is very difficult to assign punishments with perfect proportionality. Reasonably fair criminal justice systems, while humanly imperfect, must not tolerate persistent or systematic injustices. In addition reasonably fair systems must, at a minimum, satisfy constraints of Hobbesian political theory. See GREGORY S. KAVKA, *HOBESIAN MORAL AND POLITICAL THEORY* 245-54 (1986) (reviewing the effect of power on crime and punishment in the Hobbesian state). For a discussion of Hobbesian constraints on social justice, see *infra*, note 280 and accompanying text.

In his defense of the death penalty, Professor van den Haag comments "that irrational discrimination, or capriciousness, would be inconsistent with constitutional requirements [for just administration of capital punishment]. But I am satisfied that the Supreme Court has in fact provided for adherence to the constitutional requirement of equality as much as is possible." van den Haag, *supra* note 218, at 1663-64. There is ample reason to believe that a host of unconscious, cognitive errors influence a variety of aspects of the legal process, from the formulation of laws to the adjudication of constitutional issues. For example, after John Hinckley was acquitted of the attempted assassination of President Reagan in 1981, some state legislatures changed their statutes regarding the insanity defense to add a guilty but mentally ill option. Salvador C. Uy, *From the Ashes of Penry v. Lynaugh, The Diminished Intent Approach to the Trial & Sentencing of the Mentally Retarded Offender*, 21 COL. HUM. RTS. L. REV. 565, 580 (1990). The Model Penal Code had two requirements for culpability, volition and cognition, but the public was not supportive of the idea that mentally ill defendants were not acting of their own volition. *Id.*

When prospective jurors who admit they could not vote to impose the death penalty are excluded the result is a death-qualified jury more likely to convict. For a sample of the research showing that death-qualified juries are more prone to convict and impose death sentences, see George L. Jurrow, *New Data on the Effect of a "Death Qualified" Jury on the Guilt Determination Process*, 84 HARV. L. REV. 567 (1971) (presenting findings of a survey showing that jurors' beliefs about capital punishment affect verdicts through a process involving belief in authoritarian or conservative legal positions); Robert Fitzgerald & Phoebe C. Ellsworth, *Due Process vs. Crime Control: Death Qualification*

Proposition 3: Capital punishment is administered in a reasonably fair manner and is a just and moral punishment for some crimes.²³⁰

Proposition 4: The death penalty is morally the same as other punishments; all punishment, when ethical, involves a justified infliction of harm sanctioned by a moral

and Jury Attitudes, 8 LAW & HUM. BEHAV. 31 (1984) (presenting findings of a demographic survey showing, among other things, that greater proportions of blacks and women are excluded by death qualification process); Claudia L. Cowan, William C. Thompson, & Phoebe C. Ellsworth, *The Effects of Death Qualification on Jurors' Predisposition to Convict and on the Quality of Deliberation*, 8 LAW & HUM. BEHAV. 53 (1984) (presenting findings of a simulated trial showing that diversity of death — qualified and non-qualified jurors leads to jury deliberations which are more vigorous, thorough and accurate); Craig Haney, *On the Selection of Capital Juries: The Biasing Effects of the Death - Qualification Process*, 8 LAW & HUM. BEHAV. 121 (1984) (arguing that certain psychological features of the death qualification process may account for the bias that death — qualified jurors have toward conviction). For a discussion of the role of cognitive errors in legal decisionmaking, see Michael J. Saks & Robert F. Kidd, *Human Information Processing and Adjudication: Trial by Heuristics*, 15 LAW & SOC'Y REV. 123 (1980-81) (addressing the effect of quantitative evidence on the truth-finding process in adjudication and concluding that mathematical evidence may be necessary to prevent jurors from thinking intuitively as opposed to rationally). For a discussion of the Supreme Court's inconsistent application of medical and social science data, see Paul S. Appelbaum, *The Empirical Jurisprudence of the United States Supreme Court*, 13 AM. J. L. & MED. 335, 346 (1987) (concluding that a majority of the Court may be vulnerable to misreadings of statistical analysis). For a discussion of how one segment of the American criminal justice system really operates, see DAVID HEILBRONNER, *ROUGH JUSTICE: DAYS AND NIGHTS OF A YOUNG D. A.* (1990).

230. A "reasonably fair manner" of application would include, among many other things, assurances that such decisions do not reflect beliefs based on inflammatory or unreliable testimony. It also assumes that capital punishment can be fair and just *in principle*.

The Supreme Court appears to accept capital punishment decisions that fall outside these bounds. For example, in *Barefoot v. Estelle*, 463 U.S. 880 (1983), the Supreme Court affirmed the denial of a habeas corpus petition filed in a death sentence case on the basis of the testimony of experts who had not examined the defendant. The Court deemed such testimony to be acceptable despite unanimous psychiatric opinion that such testimony is of little or no probative value. See *Barefoot's* Brief at 11-18, (82-6080), *supra* note 10. In his dissenting opinion, Justice Blackmun noted that psychiatrists are able to predict violence with no greater ability than laymen, and that it was "crystal clear" that the witnesses "had no expertise whatever" in making predictions of violence. *Barefoot*, 463 U.S. at 920-22 (Blackmun, J., dissenting). He concluded, "when the Court knows full well that psychiatrists' predictions of dangerousness are specious, there can be no excuse for imposing on the defendant, on the pain of his life, the heavy burden of convincing a jury of laymen of the fraud." *Id.* at 935-36. The subsequent commentary on *Barefoot* is summarized in MENTAL DISABILITY LAW, *supra* note 1, § 17.14. Cf. D. Michael Risinger et al., *Exorcism of Ignorance as a Proxy for Rational Knowledge: The Lessons of Handwriting Identification "Expertise,"* 137 U. PA. L. REV. 731, 780 n.215 (1989) ("[W]e have yet to find a single word of praise for, or in defense of, *Barefoot* in the literature of either science or law.").

legal system. The kinds of arguments legitimizing punishment in general (*i.e.*, those that would justify Proposition 1) are the same types of arguments that legitimize capital punishment.²³¹

Proposition 5: As physicians, psychiatrists owe their evaluative and treatment obligations to the individuals they evaluate and treat, and should not color their evaluations or

231. Both abolitionists and supporters of the death penalty have endorsed the assertion that "the penalty of death is qualitatively different' from other forms of criminal punishment." Bonnie, *supra* note 226, at 1363 (quoting Woodson v. North Carolina, 428 U.S. 280, 305 (1976) (Stewart, Powell, and Stevens, JJ., plurality)). Proposition 4 merely asserts that the death penalty is morally justified in the same way that other punishments are. In general, punishment has been justified as a means to restrain and/or deter the wrongdoer from committing further offenses, to deter other individuals from wrongdoing, to rehabilitate the offender, and/or to indicate society's general, vindicative condemnation of the wrongdoer. Punishment has also been explained as the community's symbolic means of judging and regulating behavior through "proportional deprivation" of personal liberty. Perlin, *supra* note 228, at 52-53. Of course, that the death penalty is as morally justified as other punishments leaves open the possibility that its administration might require special legal procedures, despite its moral similarity to other punishments. Such procedures could be justified without reference to a moral difference from other punishments, but in reliance on notions of "severity and irrevocability." Spaziano v. Florida, 468 U.S. 447, 468 (1984) (Stevens, J., concurring in part and dissenting in part).

However, the harshness of capital punishment may provide an unsatisfactory justification for special legal proceedings. For example, it is far from clear that, for a 20-year-old man, the prospect of execution is a fate more horrible than the prospect of spending the rest of his life in prison. Although Kant wrote that retribution requires the execution of murderers because "[t]here is no sameness of kind between death and remaining alive even under the most miserable conditions," IMMANUEL KANT, THE METAPHYSICAL ELEMENTS OF JUSTICE 102 (John Ladd trans., 1965) [hereinafter KANT'S METAPHYSICAL ELEMENTS], other writers have viewed life imprisonment as a worse fate than death. See, e.g., van den Haag, *supra* note 218, at 1669 ("Does not life imprisonment violate human dignity more than execution, by keeping alive a prisoner deprived of all autonomy?"); CESARE BECCARIA, ON CRIMES AND PUNISHMENTS, 62-70 (1764); Jacques Barzun, *In Favor of Capital Punishment*, in THE DEATH PENALTY IN AMERICA 154, 161-63 (Hugo A. Bedau ed., 1964) (arguing that, given prison conditions and the pace of change in the outside world, life sentences produce more suffering than execution).

The finality of the death penalty provides the clearest reason why "courts in virtually every state have abandoned the traditional rules on direct appeal of death sentences," and have ruled "direct review of death sentences to be obligatory," even over the defendant's objections. Bonnie, *supra* note 239, at 1368. Capital punishment places a special kind of pressure on courts to vindicate society's interest in the integrity of its institutions of criminal punishment. This moral interest is, however, also expressed in requirements of non-capital cases (*e.g.*, that the actions of a defendant who pleads guilty to an offense must satisfy the factual predicates for sentencing). *Id.* at 1369-71. For a recent analysis of the nature and importance of retaliation in punishing murderers, see Jeremy Waldren, *Lex Talionis*, 34 ARIZ. L. REV. 25, 41-42 (1992) (arguing that what is unique about murder is not necessarily the victim's death, but the crime's radical disruption of an autonomous life).

use the treatment of their patients to achieve either particular social outcomes (e.g., abolition of the death penalty) or particular legal outcomes (e.g., acquittal²³² or clemency).

If these propositions are true, then it is ethically permissible for physicians to participate in the evaluation and treatment of an incompetent death row prisoner, with the full awareness that such participation might make possible the prisoner's execution.²³³

Caring citizens should regard even a "reasonably fair" system of criminal punishment with ambivalence; such a feeling is consonant with a sober acknowledgement of the inevitability of and necessity for such a system. Criminal conviction in a just legal system marks a failure by a fellow citizen. Caring citizens should share a sense of sadness about (as well as disapproval of) this failure, and perhaps some empathy for the criminal who, however guilty, must suffer for his wrong-doing.²³⁴ Physicians (among

232. Cf. *supra* note 183 and accompanying text. For a discussion that favors psychiatrists' restricting their forensic services to uses that serve only defendants, see Bernard L. Diamond & David W. Louisell, *The Psychiatrist as an Expert Witness: Some Ruminations and Speculations*, 63 MICH. L. REV. 1335 (1965). Positions like this may form the basis for what is often perceived as psychiatrists' "peculiarly tolerant attitude toward criminal behavior." Manfred S. Guttmacher, *The Psychiatric Approach to Crime and Correction*, 23 L. & CONTEMP. PROBS. 633, 633 (1958). See also Benjamin Karpman, *Criminality, Insanity and the Law*, 39 J. CRIM. LAW & CRIMINOLOGY 584, 584 (1949) (Karpman is a psychiatrist who believes that "criminality is without exception symptomatic of abnormal mental states and is an expression of them."). A decision to serve only defense interests has been criticized as an attempt by mental health professionals to impose their views on society in GARY B. MELTON et al., *PSYCHOLOGICAL EVALUATIONS FOR THE COURTS: A HANDBOOK FOR MENTAL HEALTH PROFESSIONALS AND LAWYERS* § 3.05(b) (1986) (asserting that a function of mental health professionals is to balance the needs of the individual and society and that this function would be subverted if mental health professionals were only allowed to represent the individual). The notion that psychiatrists consistently are biased toward acquittal of criminal defendants may be mistaken. See JONATHAN ROBITSCHER, *THE POWERS OF PSYCHIATRY* 24, 389-404 (1980) (arguing that most psychiatrists are prosecution-minded and project the values of their traditional upwardly-mobile class backgrounds into their practice and into their testimony at criminal trials).

233. This article also contends — both as a logical consequence and as an important heuristic device — that the contrapositive contention is true: If participation seems unethical, then one or more of the above propositions is false. See *infra* notes 375-76 and accompanying text.

234. Punishment also presents all citizens with a moral dilemma insofar as it imposes suffering on our fellow human beings. See, e.g., HERBERT L. PACKER, *THE LIMITS OF THE CRIMINAL SANCTION* 63 (1968). Hegel recognized this as a powerful indication that consequentialist views of punishment are morally flawed:

If crime and its cancellation . . . punishment are regarded only as evils in general, one may consider it unreasonable to will an evil merely because another evil is already present. This superficial character of an evil is the primary

them, psychiatrists) may have special reason to view punishment with some measure of "gut-level" antipathy. Physicians frequently begin their careers with oaths in which they profess their dedication to the alleviation of suffering; ideally physicians' training engendered emotional as well as ethical aversions to the notion of intentionally-imposed suffering.

Physicians' training also acquaints them with the grounds and justification for intentionally-imposed suffering. Most of the procedures physicians undertake involve varying degrees of intrusion and discomfort; even the questions they ask often make their patients uncomfortable. Physicians believe that the medical benefits justify the intrusions and discomfort. For example, the intense distress caused by chemotherapy for cancer is outweighed by the chance this treatment offers for prolonged life. Physicians encourage patients to choose the violent intrusion and risks of coronary bypass surgery in the belief that they will survive with a higher quality of life. While this type of 'cost-benefit' judgment may influence both a physician's decision to recommend a course of treatment and a patient's acceptance of treatment, the justification for the treatment derives from the patient's consenting to it.²³⁵ Without such consent, treatment, however beneficial it may be, is morally impermissible.²³⁶

assumption in the various theories of punishment as prevention, as a deterrent, a threat, a corrective, etc [T]he objective consideration of justice . . . is the primary and substantial point of view in relation to crime The various considerations which are relevant to . . . [punishment's] relation to the particular consciousness, and which has its effect on representational thought (as a deterrent, corrective, etc.) . . . take it for granted that punishment is and for itself is just.

G. W. F. HEGEL, *ELEMENTS OF THE PHILOSOPHY OF RIGHT* (Allen W. Wood ed. & H.B. Wisbet trans., Cambridge University Press 1991) (1821) (citation and original emphasis omitted). For a discussion of the value of our emotional reaction to crime in guiding our appropriate moral and punitive response, see Michael S. Moore, *The Moral Worth of Retribution*, in *RESPONSIBILITY, CHARACTER AND THE EMOTIONS: NEW ESSAYS IN MORAL PSYCHOLOGY* 179, 198-217 (Ferdinand Schoeman ed., 1987) (discussing the epistemic relevance and virtuous nature of some emotions in guiding our moral judgments).

235. "If the normative principles of ethics are articulated by reasonable people . . . then no reasonable person would be foolish enough . . . to contract with medical professionals authorizing them to do simply whatever they think will benefit patients." VEATCH, *supra* note 147, at 11.

236. For a discussion of the ethical primacy of consent over anticipated benefits of treatment, see *id.* at 192-213. Veatch's views appear to derive from Kantian considerations, particularly Kant's "affirmation that 'every rational being exists as an end in himself not merely as a means for arbitrary use by this or that will.'" *Id.* at 193 (quoting IMMANUEL KANT, *THE GROUNDWORK OF THE METAPHYSIC OF MORALS* 95 (H. J. Paton

There is an important and extensive homology²³⁷ between the justification of medical treatment and the justification of punishment. Medical care often requires the imposition of pain and sacrifice, which would be unconscionable for physicians to inflict without the prior consent of the patients who suffer them. These patients must base their decision to accept care on the view, shared with their physicians, that the pain and sacrifice are justified by the benefits obtained through treatment. Punishment involves coercion and deprivation, which would be *prima facie* wrongs for society to inflict²³⁸ were it not for the consent²³⁹ of the criminals who suffer them. Prior to committing crimes, criminals shared with their fellow citizens important moral and practical reasons for wanting all citizens who committed crimes to be justly punished.

The homology between the justifications of medical treatment and punishment extends further. By requiring that the justification of medical treatment include the physician's and patient's consent, we place medical care amidst a broad array of human interactions that protect and affirm persons' mutual respect, dignity, and autonomy. Accordingly we view the practice of medicine from the standpoint of a broader ethical theory that governs inter-individual obligation in the largest sense.²⁴⁰ Similarly, a justification of criminal sanctions based on the consent of those who are punished

trans., 1964 2d ed. 1785) [hereinafter KANT'S GROUNDWORK]. Veatch writes:

From the standpoint of one committed to the principle of autonomy, consent is required independent of the calculations of consequences if a person is to be touched (as in assault and battery), if privacy is to be invaded, or if the person is to be used in research. Whether the context be research, therapy, or preventive medicine, if a person is to be treated as an end and not as a means only, then permission is needed when that person is brought into the professional medical nexus.

VEATCH, *supra* note 147, at 201.

237. That is, a close correspondence in structure and origin. See WEBSTER'S THIRD NEW INTERNATIONAL DICTIONARY, *supra* note 107, at 1085.

238. Cf. Waldron, *supra* note 231, at 27 ("A justification of punishment is required in all cases because punishments usually have features that, in general, make actions impermissible.")

239. This article argues for a contractarian justification of punishment. See *infra* at text accompanying notes 241-59. Bonnie, *supra* note 30, at 85 n.50, argues that a comparison between the justifications of treatment and punishment is flawed because the consent given by medical patients is paradigmatically explicit, while the consent given by criminals — if one accepts contract theory to begin with — is implicit and/or hypothetical. For a discussion of the implications of this 'hypotheticality,' see notes 328-37 and accompanying text.

240. For a discussion of the relationship between basic, general principles of inter-individual obligation and the obligations incumbent upon the medical profession and individual physicians engaged in treating patients, see VEATCH, *supra* note 147, at 324-27.

sets punishment in the broader context of a general theory of political obligation, the centerpiece of which is the implicit consent of all citizens who, to secure their basic rights, establish governments among themselves.²⁴¹

The notion that legitimate government derives its authority from a hypothetical contract binding all citizens to obedience to law appears repeatedly in the political theories of the last four centuries.²⁴² In all these theories, just social arrangements are those to which free and equal rational people would agree, were they to find themselves in a situation where no laws or sociopolitical organizations had control over individuals. Hobbes,²⁴³ among others, termed such a situation a "state of nature," where individuals, lacking civil governments, relied solely on themselves for protection. He imagined this state to be a dismal anarchy, a war of all against all, which he describes in this famous passage from

241. "We hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain unalienable Rights; that among these are Life, Liberty, and the pursuit of Happiness. That to secure these rights, Governments are instituted among Men, deriving their just powers from the consent of the governed" THE DECLARATION OF INDEPENDENCE para. 3 (U.S. 1776).

242. Because contractarian political theory forms the basis for my justification for psychiatrists' participation in the capital sentencing process, I note a few of the historically-important works on the philosophy: John Locke, *The Second Treatise of Government, OF CIVIL GOVERNMENT AND LETTER ON TOLERATION* 3 (J.W. Gough ed., 2d ed. Basil Blackwell 1956) (1698); HENRY S. MAINE, *ANCIENT LAW* (1861) (Fredrick Pollock, ed., 1957) (10th ed. 1884); and J. W. GOUGH, *THE SOCIAL CONTRACT: A CRITICAL STUDY OF ITS DEVELOPMENT* (2d ed. 1957). Contractarian theory justifies punishment by arguing that citizens have agreed to accept state coercion in exchange for the benefits and protections of a society ruled by law. Lynn A. Stout, *Strict Scrutiny and Social Choice: An Economic Inquiry Into Fundamental Rights and Suspect Classifications*, 80 GEO. L.J. 1787, 1790 (1992) (noting that individuals consent to state-imposed restrictions on liberty). Although its roots may be traced to antiquity, contractarian theory "first came to prominence in the seventeenth century", *id.* at 1791 n.24, through such influential writings as THOMAS HOBBS, *LEVIATHAN* (Richard Tuck ed., Cambridge University Press 1991) (1651); and 3 (J.W. Gough ed., 2d ed. Basil Blackwell 1956) (1698) and JEAN JACQUES ROUSSEAU, *THE SOCIAL CONTRACT AND DISCOURSES* (G.D.H. Cole trans., 1950) (1762). Contractarian theory remains a powerful influence which forms the basis of important modern works. *E.g.*, JOHN RAWLS, *A THEORY OF JUSTICE* (1971); JAMES M. BUCHANAN & GORDON TULLOCK, *THE CALCULUS OF CONSENT: LOGICAL FOUNDATIONS OF CONSTITUTIONAL DEMOCRACY* (1965).

243. The Hobbesian version of contractarianism allows for a partial defense against what have been termed "Marxist" critiques of other versions (*e.g.*, Kant's theories). Marxist critiques argue that crime is caused primarily by economic conditions; and that since society is responsible for these conditions, to claim that the individual has either chosen to commit a crime or to accept the conditions and contract imposed by society is inaccurate. Robert Blecker, *Haven or Hell? Inside Lorton Prison: Experiences of Punishment Justified* 42 STAN. L. REV. 1149 (1990). See *infra* text accompanying notes 276-97.

Leviathan:

Whatsoever therefore is consequent to a time of Warre, where every man is Enemy to every man; the same is consequent to the time, wherein men live without other security, than what their own strength, and their own invention shall furnish them withall. In such condition, there is no place for Industry; because the fruit thereof is uncertain: and consequently no Culture of the Earth, no Navigation, nor use of the commodities that may be imported by Sea; no commodious Building; no Instruments of moving, and removing such things as require much force; no Knowledge of the face of the Earth; no account of Time; no Arts; no Letters; no Society; and which is worst of all, continuall feare, and danger of violent death; And the life of man, solitary, poore, nasty, brutish, and short.²⁴⁴

Hobbes believed that rational individuals would want to extricate themselves from this dismal state.²⁴⁵ To achieve this end, they would surrender their individual power and right of absolute self-government to a sovereign,²⁴⁶ who would then have the power to defend them from the injuries of each other. This sovereign would retain the right to punish subjects "as he should think fit, for the preservation of them all."²⁴⁷

244. HOBBS, *supra* note 242, at 89.

245. Residents of inner cities provide an obvious example. Nicholas Lemann described the conditions that existed in the mid-1970s in the Robert Taylor Homes, a public housing project in Chicago:

After . . . [Larry Haynes, son of Ruby Haynes] left, there were no adult men permanently in residence on Ruby's floor in 5135. The unemployment rate in their section of the project rose during the seventies from 18.6 per cent to 31.4 per cent. Several times in the late 1960s and early 1970s police were fired upon by snipers in the windows of high-rise public-housing projects; in 1975, a policeman was killed by a sniper in [another project] . . . Visitors to the project from the outside world — firemen, emergency medical technicians, poll takers, bill collectors, delivery men, salesmen, social workers, maintenance workers, truant officers, sociologists — were often robbed or roughed up, and as a result most of these people found excuses not to go there any more.

When gang members and other vandals incapacitated the elevators, they weren't speedily repaired . . . Problems with the heat, water, electricity, and fire alarms were also slow to be fixed. The project was becoming a world unto itself, completely cut off from the institutions and mores of the wider society.

NICHOLAS LEMANN, *THE PROMISED LAND: THE GREAT BLACK MIGRATION AND HOW IT CHANGED AMERICA* 266 (1991).

246. HOBBS, *supra* note 242, at 117-21.

247. *Id.* at 214.

Hobbes's account is one of many versions of the thesis that justifies punishment on the basis of benefits (such as self-preservation or the opportunities available in well-developed civil society) that accrue even to those who are punished. Socrates was perhaps the earliest proponent of the notion that citizens make a bargain with the polity, receiving its benefits in exchange for a commitment to, among other things, accepting punishment as a cost of breaking the law.²⁴⁸

Notwithstanding differences in intellectual temperament (as well as differences in historical setting), the 18th century philosopher Rousseau arrived at justifications for punishment quite similar to those offered earlier by Socrates and Hobbes.²⁴⁹ Punishment is the price we pay for self-preservation: "[I]t is in order that we may not fall victims to an assassin that we consent to die ourselves if we ourselves turn assassins."²⁵⁰ Each of us willingly consents to punish murderers and thieves, since not doing so would establish the freedom of others to kill or rob us.²⁵¹

Kant, a great admirer of Rousseau,²⁵² adapted Rousseau's conception of the proper subordination of individuals to a "general will"²⁵³ to his own moral philosophy. Rousseau's notion of the

248. See, e.g., Plato, *Crito*, in SOCRATES, THE MAN AND HIS TEACHINGS 54 (F.J. Church trans., R.J. Mason et al., eds., 1955) (discussing the death of Socrates). Socrates' followers encouraged him to flee Athens to avoid the death sentence, his punishment for corrupting the city's youth. Socrates argued that gratitude and a sense of fairness required that he accept punishment, for he had benefited for seventy years from the protection of the laws of Athens. If he had fled the city to escape execution, he would have broken his bargain with the Laws, a bargain that he had made willingly and with knowledge of its implications, a bargain that he could have revoked at any time he wished by leaving the city.

249. See *supra* note 248 and accompanying text.

250. ROUSSEAU, *supra* note 242, at 32.

251. ROGER D. MASTERS, THE POLITICAL PHILOSOPHY OF ROUSSEAU 331 (1968).

252. For example:

[Kant] maintained throughout his life a severe regimen. It was arranged with such regularity that people set their clocks according to his daily walk along the street named for him, "The Philosopher's Walk." Until old age prevented him, he is said to have missed this regular appearance only on the occasion when Rousseau's *Émile* so engrossed him that for several days he stayed at home.

10 ENCYCLOPAEDIA BRITANNICA 390, 393 (1979).

253. Rousseau stated:

If . . . we discard from the social compact what is not of its essence, we shall find . . . the following terms: "Each of us puts his person and all his power in common under the supreme direction of the general will, and, in our corporate capacity, we receive each member as an indivisible part of the whole."

universalization of the "maxims"²⁵⁴ governing action plays a central role in determining whether conduct is permissible. Kant's approach to the exploration of the justification of criminal sanctions²⁵⁵ has received its most prominent modern expression in the writings of John Rawls.²⁵⁶ Both Kant and Rawls believe that a system of just laws and criminal sanctions rationally would be chosen by criminals themselves if they were freed from their idiosyncratic preferences,²⁵⁷ and were asked to develop social regula-

ROUSSEAU, *supra* note 242, at 15.

[W]hat makes the will general is less the number of voters than the common interest uniting them; for, under this system, each necessarily submits to the conditions he imposes on others [T]he social compact sets up among the citizens an equality of such a kind[] that they . . . bind themselves to observe the same conditions and should therefore . . . enjoy the same rights [E]very authentic act of the general will[], binds or favors all the citizens equally

Id. at 30.

254. "[T]he conformity of actions to universal law . . . must serve the will as its principle. That is to say, I ought never to act except in such a way that *I can also will that my maxim should become a universal law.*" KANT'S GROUNDWORK, *supra* note 236, at 70.

255. For a general discussion of Kant's political theories, see Jeffrie G. Murphy, KANT: THE PHILOSOPHY OF RIGHT (1970) [hereinafter THE PHILOSOPHY OF RIGHT].

256. See, e.g., John Rawls' *magnum opus*, A THEORY OF JUSTICE (1971) (Although not primarily concerned with punishment, the book outlines Rawls' views on punishment's justification as a stabilizer of just social relationships.). For a discussion of the relationships between Kant's and Rawls's theories of punishment, see JEFFRIE G. MURPHY, RETRIBUTION, JUSTICE, AND THERAPY: ESSAYS IN THE PHILOSOPHY OF LAW 77-92 (1979) [hereinafter RETRIBUTION].

257. Being freed from "idiosyncratic preferences" is implicit in Kant's universalization test. It is also an explicit feature of Rawls's philosophy, embodied in his notions of the "original position" and the "veil of ignorance." Rawls argues that the conditions needed for making objective decisions are contained in an imaginary situation where hypothetical individuals convene to choose principles to govern themselves. The parties are aware of the nature of the world, but are ignorant of their own particular status in it. See RAWLS, *supra* note 242, at 17-22, 136-42.

An oft-repeated critique of Rawlsian contract theory is that it ignores one of the major benefits of civil society: the moral upbringing from which comes our sense of what morally acceptable political agreements would be.

In a world where people raise children, live in communities, and value friendships, a moral theory that demands rational cognition to the degree that Rawls's does is little help and may well be a burden. It teaches people to distrust what will help them most — their personal attachments to those they know — and value what will help them least — abstract principles that, for all their philosophical brilliance, are a poor guide to the moral dilemmas of everyday life Having sacrificed their affective and known bonds for abstract principles, and having yielded their capacity to empathize and interpret in favor of a capacity to reflect, how would such principled individuals govern their moral obligations in a thoroughly secularized society?

tions to govern their community. Punishment is justified as a logically-required institution, the necessary outcome of rational, moral relations among rational, moral beings. It would be chosen as a form of sacrifice by all citizens as part of their "hypothetical rational consent" to the requirements of justice.²⁵⁸ Criminal sanctions are justified by the criminal's implicit, rational promise to submit himself "along with everyone else to those laws which, if there are any criminals among the people, will naturally include penal laws."²⁵⁹

Hypothetical consent theory prescribes schemes of punishment that are, in the literal sense of the word, retributive: the wrongdoer, through punishment, fulfills his obligation to "pay back" society as the cost of his disobedience.²⁶⁰ By committing a crime,

ALAN WOLFE, *WHOSE KEEPER?: SOCIAL SCIENCE AND MORAL OBLIGATION* 125 (1989). See also DWORKIN, *supra* note 187, at 173-77 (arguing that Rawls' position is too abstract and removed from the real world). However, Rawls's theory is neither intended as a comprehensive or exclusionary psychological technique, nor as social psychology; it is a philosophical account of what considerations people should have when they contemplate the requirements of a just polity:

The conception of the original position is not intended to explain human conduct except insofar as it tries to account for our moral judgments and helps to explain our having a sense of justice So while the conception of the original position is part of the theory of conduct, it does not follow at all that there are actual situations that resemble it. What is necessary is that the principles that would be accepted play the requisite part in our moral reasoning and conduct.

RAWLS, *supra* note 242, at 120-21. Note, finally, that the "veil of ignorance" is not a feature in Hobbesian contract theory; on Hobbes' account, those in a "state of nature" need not see themselves as perfect equals to appreciate the benefits that accrue from civil government. This aspect of Hobbesian theory is discussed further. See *infra* note 282.

258. See Jeffrie G. Murphy, *Does Kant Have a Theory of Punishment?*, 87 COLUM. L. REV. 509, 516-17 (1987) [hereinafter *Does Kant Have a Theory?*] (summarizing and questioning the consistency of Kant's view of punishment as necessary for individuals to enjoy a maximum amount of liberty compatible with similar liberty for others).

259. KANT'S METAPHYSICAL ELEMENTS, *supra* note 231, at 105.

260. Hypothetical consent theory does not *require* that society punish each and every criminal; rather, it tells us why punishment in general is justified, why there are good reasons ordinarily to punish criminals and why, in a just legal system, the commission of a criminal offense is a sufficient reason to subject a guilty person to a punishment that is (one would hope, at least roughly) proportional to the magnitude of his crimes. Retribution, in this literal sense, refers to the basis of a criminal debt to society. In judging an individual's guilt, however, there is room to draw distinctions among criminals, to consider individual situations, to consider aggravating or mitigating circumstances in assigning particular punishments and even to consider "forgiving" some "debts." The criminal law allows those who commit crimes to adduce a variety of mitigating circumstances and recognizes that each case brings with it a host of unique factors that may be relevant to sentencing. It also allows wrongdoers to obtain immunity *via* agreements to testify against others, and to be excused from punishment when procedural or constitutional rights are

the criminal has selected an alternative means, undergoing punishment, rather than the usual method, obedience, of repaying his fellow citizens for the benefits he receives by virtue of their sacrifices in upholding the law.²⁶¹ To those citizens who choose to obey the law, the expectation that those who disobey will be punished provides assurance that their sacrifice will be acknowledged by a society that expects reciprocation even from those who choose not to obey.

Legal texts²⁶² commonly list, among the justifications of punishment, the three future-oriented²⁶³ goals of 1) incapacitating those whose acts threaten society (special deterrence), 2) providing disincentives for potential offenders (general deterrence), and 3) offering offenders the potential for rehabilitation. In addition, these texts discuss a fourth goal, the past-oriented goal of retribution. Retribution is a troublesome justification because of its historical association with the view that punishment offers society emotional satisfaction, and provides a socially-acceptable means for citizens

violated. See generally YALE KAMISAR ET AL., MODERN CRIMINAL PROCEDURE (7th ed. 1989).

Consequently, what Morawetz terms "the weak form of retributivism which merely asserts that only the guilty should be eligible for punishment" seems most in accord with our collective sense of what justice requires. Thomas H. Morawetz, *Retributivism and Justice*, 16 CONN. L. REV. 803, 814 (1984). For a general discussion of this point, see *id.* at 812-15. This "weak form" is consistent with Kant's notion of a social obligation to punish criminals, although Kant is typically associated with a "strong form" of retributivism that *always* requires punishment of all guilty persons. Kant himself may have been somewhat inconsistent in his writings about what conditions except society from this obligation. See *Does Kant Have a Theory?*, *supra* note 258, at 509, 512-13. See also *infra* notes 285-88 and accompanying text (discussing the obligation to punish).

261. See THE PHILOSOPHY OF RIGHT, *supra* note 255, at 142-143 (discussing Kant's theory of punishment as an obligation to be analyzed in terms of reciprocity).

262. See, e.g., WAYNE R. LAFAVE & AUSTIN W. SCOTT, JR., CRIMINAL LAW § 1.5(a) (2d ed. 1986), and PACKER, *supra* note 234, at 35-61.

263. "Future-oriented" parallels Morawetz's term "forward-looking" to describe what are also called "utilitarian" goals of punishment. See Morawetz, *supra* note 260, at 818. He feels that "utilitarianism" is a "tainted" term because of its association "with the notion that happiness or satisfaction is only contingently or accidentally related to the moral features of a social context. A context in which the greatest happiness is gained by the greatest number may or may not be a just society; its justice remains to be demonstrated." *Id.* Morawetz cites Hart's recognition that utilitarianism ignores of what we usually take to be "uncontroversial" values. *Id.* (referring to HERBERT L. A. HART, THE CONCEPT OF LAW 195 (1968)). The utilitarian's response to this critique should be that moral features are *definitionally* related to happiness. If there is a conflict between our utilitarian calculus and conventional values, either the calculus was wrong (and the "arithmetic" should be "checked") or the values need revision. The term "future-oriented" focuses attention on utilitarian defenses of a practice, *i.e.*, the practice's consequences.

both to express their disgust and to experience a sense of revenge.²⁶⁴ Retribution can be distinguished logically from revenge on grounds that, whatever our individual feelings about an offender may be, the goals of retribution are the collective goals of justice. Justice requires us to direct our attention to a rational and dispassionate determination of what kind of punishment a criminal deserves.²⁶⁵

Retribution remains problematic, however, even when distinguished from revenge. Retribution authorizes punishment for committing a crime simply because the criminal deserves punishment, regardless of whether any other clear benefit will occur as a result of the punishment. Retributive thinking is pointless to those who fashion and justify punishment practices with a view to how they will make the future better.²⁶⁶ But as Michael Moore points out,

264. This idea has been seen as both a defense of punishment and a reason for criticizing it.

We punish and blame people to express our resentment and disapproval of their deeds and our detestation of the ugliness of character that their crimes bespeak. Both in praising and in blaming we intend the deserved treatment to hit home and to sink in deep, to mark our judgments of the person in virtue of the deed.

Stanley C. Brubaker, *In Praise of Punishment*, 97 THE PUBLIC INTEREST 44, 49 (1989). See also JAMES F. STEPHEN, LIBERTY, EQUALITY, FRATERNITY 161 (1873) (punishment is undertaken "for the sake of gratifying the feeling of hatred — call it revenge, resentment, or what you will — which the contemplation of such conduct excites in healthily constituted minds"); David Dolinko, *Three Mistakes of Retributivism*, 39 UCLA L. REV. 1623, 1647-57 (1992) (retributive theories of punishment are associated with the legitimization and even glorification of anger and hatred); MENNINGER, *supra* note 224, at 190:

[B]ehind what we do to the offender is the desire for revenge on someone We call it a wish to see justice done, i.e., to have him "punished." But in the last analysis this turns out to be a thin cloak for vengeful feelings directed against a legitimized object.

Personal revenge we have renounced, but official legalized revenge we can still enjoy.

265. "Criminals should get what they deserve, but their deserts are determined by fair enforcement of the principles of right, and not by a counting up of the public outrage." Alexander E. Rawls, *Of Rawls, Responsibility, and Retribution*, 99 THE PUBLIC INTEREST 130 (1990). In a similar vein, Morawetz notes Strawson's comparison of resentment and justified disapproval.

Unlike resentment, justified disapproval carries with it a claim to be able to justify or demonstrate that the disapproved conduct violates *shared* norms of mutual respect and dignity. Resentment is a personal responsive attitude toward actions affecting oneself, while disapproval is a responsive attitude *backed by reasons* and concerned with actions affecting oneself or others.

Morawetz, *supra* note 260, at 816 (emphasis added); see also P. F. STRAWSON, FREEDOM AND RESENTMENT AND OTHER ESSAYS 1-25 (1974) (arguing that different views of determinism are actually expressions of different moral attitudes).

266. Morawetz, *supra* note 260, at 804. As Murphy points out, this is not a valid

retributivism underlies the societal sense of right and wrong and who should be punished.²⁶⁷ We do not condone punishing a person whom we know is innocent,²⁶⁸ even if doing so would keep him from committing future criminal acts, would deter genuine criminals or would provide him the opportunity for moral improvement. We *do* condone punishing a justly-convicted person (e.g., a Nazi found guilty of crimes committed nearly five decades ago) simply because he deserves it, even when it produces no clear social benefit.

Hypothetical consent justification of criminal sanctions reinforces our moral intuitions about whether punishment of an individual is defensible. Consent theory reconceptualizes retributive punishment as serving the common good. As Hobbes and other contract theorists point out, our hypothetical consent to subject ourselves to rules of law stabilizes and secures for us the opportunities of civil society. This stability and security allow us to make plans and act with the expectation that our lawful treatment of others will be reciprocated to everyone's mutual advantage. A system of punishment that reflects shared notions about acceptable conduct provides a public mechanism for both expressing those notions and affirming the law's relationship to shared moral values, even if it does not deter or reform criminals.

The "good" that is served by imposing retributive punishment is not a utilitarian good. Retributive punishment does not yield any particular, specific, tangible, or expected social benefits. The mutual advantage supported by a criminal justice system that stabilizes fair, reciprocal arrangements among persons merely allows them to

criticism of retributivist theory. "If 'pointless' is to be analyzed as 'disutilitarian', then the whole question is being begged. You cannot refute a retributive theory merely by noting that it is a retributive theory and not a utilitarian theory. The circle here is not large enough even to be interesting." THE PHILOSOPHY OF RIGHT, *supra* note 255, at 141.

267. See MICHAEL S. MOORE, LAW AND PSYCHIATRY: RETHINKING THE RELATIONSHIP 233-243 (1984) (positing that retribution, utilitarianism and a combination of the two theories are the only *prima facie* justifications of punishment. Retribution is an integral element in both utilitarianism and the combination theory).

268. Laws governing the involuntary commitment of the mentally ill may constitute a partial exception. These authorize detaining persons who are not charged with or convicted of violent acts, but who are believed to represent a substantial risk of harm to others. Although such individuals are incarcerated in hospitals rather than in prisons, they may not necessarily receive any treatment — indeed, they have a right to refuse treatment. Hospitalization for such persons is little different from being jailed from the standpoint of individual liberty interests. See Paul S. Appelbaum, *The New Preventive Detention: Psychiatry's Problematic Responsibility for the Control of Violence*, 145 AM. J. PSYCHIATRY 779 (1988).

act as rational beings, to organize their lives around rational plans, and to have reasonable expectations about the fulfillment of those plans.²⁶⁹ Retributive punishment in this way ultimately preserves the opportunity for rational action. This opportunity is essential to any conception of the good that includes individual dignity, self-respect, and autonomy.

Punishment thus affirms and respects an individual's humanity in the same way that ethical medicine does. Medical treatment generally²⁷⁰ is permissible not because it will benefit others or society, or even because the doctor knows treatment would benefit the patient himself, but because the patient has consented to it. Punishment is permissible neither because it will deter others or the criminal himself, nor because it will rehabilitate and thus confer a concrete expected benefit to him, but because the criminal has implicitly consented to it.²⁷¹ Medical treatment may further practical goals (just as may punishment), but it is constrained by respect for individuals' humanity and autonomy, and is justified only by virtue of the non-consequentialist reason that the patient and doctor have consented to its undertaking. Medical treatment and criminal punishment share the central ethical imperative that persons must not be regarded as means to the fulfillment of societal goals, but as ends in themselves — "self-originating sources of claims who also have moral power to develop and change their own conceptions of the good."²⁷²

269. Rawls explains why this "mutual advantage" should be recognized by everyone in his "thin" (or minimal) theory of the good. This theory stipulates that persons, as rational individuals, seek to organize their activities around rational plans, and thus require those minimal things necessary to the fulfillment of any rational plan. These minimal requirements include self-respect and a modicum of possessions. See RAWLS, *supra* note 242, at 62, 92, 396-99, 433-39, 447.

The law clearly addresses itself to persons who organize their lives rationally and thus should be interested in the minimal requirements for doing so. See MOORE, *supra* note 267, at 44-112 (discussing "the legal view of persons") and *infra* notes 306-27 and accompanying text.

270. There are exceptions, but these should be recognized as "proving the rule." Persons with tuberculosis, for example, can be confined and treated so long as they are contagious. But a legal theory that places the highest value on individual freedom will recognize that individuals must co-exist; thus, such quarantining is allowable in a society that, to use Rawls' words, guarantees "an equal right to the most extensive basic liberty compatible with a similar liberty for others." RAWLS, *supra* note 242, at 60.

271. See *supra* note 243 and accompanying text.

272. Samuel J.M. Donnelly, *The Goals of Criminal Punishment: A Rawlsian Theory (Ultimately Grounded in Multiple Views Concerned with Human Dignity)*, 41 SYRACUSE L. REV. 741, 747 (1990) (discussing John Rawls, *Kantian Constructivism in Moral Theory*,

The crucial thrust of Kant's claim that society is morally obligated to punish criminals is that criminals are ends in themselves. A person's humanity generates the obligation to treat him as an end in himself, and prohibits a just system of criminal punishment from invoking societal goals when determining who is to be punished.²⁷³ If respect for the humanity of others prescribes that punishment be rendered if and only if someone is guilty,²⁷⁴ it also prohibits ignoring the humanity of those who are guilty; refraining from punishing a criminal does not respect his humanity.²⁷⁵ Humanity entitles us to experience the logical consequences of our acts. We implicitly, communally promise to obey the law and to punish the disobedient. Failure to punish a criminal is failure to give him what his humanity entitles him to.²⁷⁶

Kantian contractarianism²⁷⁷ has some problematic features,

77 J. PHIL. 515, 520-522 (1980)).

273. Kant's theory thus would prohibit imposing harsh punishment on a criminal for the purpose of 'sending other criminals a message.' Of course, if a criminal's (deservedly) harsh punishment incidentally were to deter other would-be criminals from wrongdoing, this would be acceptable on Kant's theory. "Judicial punishment can never be used merely as a means to promote some other good for the criminal himself or for civil society, but instead it must in all cases be imposed on him only on the ground that he has committed a crime; for a human being can never be manipulated merely as a means to the purposes of someone else." KANT'S METAPHYSICAL ELEMENTS, *supra* note 231, at 100.

274. *See supra* notes 267-68 and accompanying text (summarizing necessary and sufficient conditions for punishment).

275. Note that this argument only establishes a *prima facie* obligation to punish. It does not preclude adducing mitigating circumstances, which might allow a person to escape punishment but still allow his humanity to be respected.

276. Hegel provides a succinct version of this argument: punishment vindicates the individual's will and freedom, and affirms "the formal rationality of the *individual's volition*." HEGEL, *supra* note 234, at 71. Respect for the criminal entails a *right* to be punished, for by being punished "the criminal is *honoured* as a rational being He is denied this honour . . . if he is regarded simply as a harmful animal which must be rendered harmless, or punished with a view to deterring or reforming him." *Id.*

277. Although the above discussion has relied heavily on Kant's moral and judicial philosophy, I should point out that I view differences between Kant's theories and those of other contract theorists as more or less reconcilable.

Kant theorizes that the motivation for punishment arises as the logical consequence of an appreciation of the individual's autonomy and rationality. Hobbes and Rawls believe punishment stabilizes a system of relationships — a "social fabric" — that makes it possible to pursue otherwise-unavailable opportunities to achieve happiness. Hobbes' and Rawls' theories speak to *opportunities*, rather than specific consequences of punishment (e.g., deterring someone). These later theories focus on and elaborate the *purpose* of punishment. Kant's theory, on the other hand, focuses on punishment's logical and moral *justification*.

As Donnelly points out, one can incur an obligation to repair the fabric of society only

however. Hypothetical consent theory presumes that there can be no objection *in principle* to social arrangements that would be established by free, rational, uncoerced parties to an original social contract. But how does hypothetical consent theory affect our thinking about arrangements in the world as we actually find it? Among those convicted of crimes, willingness to undergo punishment is unusual. Unlike Socrates,²⁷⁸ criminals typically retain lawyers to help them avoid conviction, and once convicted, they rarely ask to be punished.²⁷⁹ Why should anyone, especially crim-

because one is a free, equal, and moral person engaged in social cooperation with others. In that context one respects others as persons by repairing the fabric of society. Those imposing punishment respect both the criminal, by punishing him in a manner consistent with his obligation as a free, equal, and moral member of society, and other persons in society, by repairing the fabric of society.

Donnelly, *supra* note 272, at 765. Donnelly and Rawls see punishment as limited by desert, but also require that punishment repair the fabric of society. Donnelly, *id.*, and RAWLS, *supra* note 242, at 313-15. If the "damage" done by an individual criminal to the "fabric of society" were an empirically-verifiable entity (a "rip" or a "tear" or some "fraying around the fabric's edges"), I could accept this "damage" as an important consequence of crime, and thus see an important difference between, for example, Rawls or Donnelly and Kant.

Of course, it may be the case that widespread criminal activity would have socially deleterious consequences. But the "damage" done by an individual criminal to the "social fabric" of a generally law-abiding society seems to be appreciable only by those who maintain a sense of fairness and a concern that justice be done. The "damage" creates a *logical* duty to repair the "fabric" of social cooperation. This duty is *logically* grounded in implicit promises or a hypothetical contract. The only way to measure such damage is to determine the transgressor's level of criminal guilt. I do not see how, as Donnelly claims, "[t]he repair of social relations" achieved through punishment has any *concrete* effect on social circumstances "and thereby reaches out to Utilitarian thought and crime control goals of criminal punishment." Donnelly, *supra* note 272, at 792. My analysis, therefore, suggests that the practical difference between Rawls/Donnelly and Kant is minimal.

Another approach to reconciling apparent differences between Kant and Rawls is contained in Murphy's writings. For example, he sees both as analyzing political obligation in terms of reciprocity and the fair distribution of benefits:

In order to enjoy the benefits that a legal system makes possible, each man must be prepared to make an important sacrifice — namely, the sacrifice of obeying the law even when he does not desire to do so Now if the system is to remain just, it is important to guarantee that those who disobey will not thereby gain an unfair advantage over those who obey voluntarily. Criminal punishment thus attempts to maintain the proper balance between benefit and obedience by insuring that there is no profit in criminal wrongdoing.

RETRIBUTION, *supra* note 256, at 77.

278. See *supra* note 248 and accompanying text (discussing Socrates' acceptance of his death sentence).

279. There are exceptions:

inal wrongdoers,²⁸⁰ be concerned, motivated, or obligated by what they would consent to under counterfactual circumstances?²⁸¹

From his death-row cell, [Martin] Rojas [convicted of rape and murder in 1988] filed a motion with the [Ohio Supreme C]ourt Thursday [November 15, 1991], asking it to . . . "direct the state of Ohio to carry out the sentence of . . . death by electrocution."

Rojas said after his trial and death sentence in 1988 . . . that he wanted to be executed. "If the death sentence is not imposed, then justice will not be completed," he told the judges.

Dave Beasley, *Murderer Requests Own Electrocution*, THE CINCINNATI ENQUIRER, November 16, 1991, at C1. See also *supra* notes 194-95 and accompanying text (discussing Gary Gilmore).

While criminals try to evade punishment, they do so through plea bargains, grants of immunity in exchange for testimony, protestations of innocence, claims of extenuating or mitigating circumstances, or pleas for mercy. Rarely do criminals claim that the law's prescribed consequences for disobedience simply ought not apply to them. Even if this is simply because the law assumes its own validity and constrains the claims they may make, it reflects criminals' awareness of the general expectation that punishment follow crime.

280. Kant's legal theory, on its face, seems to have little to do with reality. In what he has characterized as a "Marxist" objection to Kantian retributivism, Murphy writes:

The retributive theory really presupposes what might be called a "gentlemen's club" picture of the relation between man and society — i.e., men are viewed as being part of a community of shared values and rules. The rules benefit all concerned and, as a kind of debt for the benefits derived, each man owes obedience to the rules. In the absence of . . . obedience, [each man] deserves punishment For, as a rational man, he can see that the rules benefit everyone (himself included) and that he would have selected them in the original position of choice.

Now this may not be too far off for certain kinds of criminals — e.g., business executives guilty of tax fraud But to think that it applies to the typical criminal, from the poorer classes, is to live in a world of social and political fantasy [These criminals] certainly would be hard-pressed to name the benefits for which they are supposed to owe obedience.

RETRIBUTION, *supra* note 256, at 107. Decency, Murphy writes, demands that we object to punishing "those who, in a socially uneven community, always get the short end of the stick." *Id.* at 80. See *supra* text accompanying note 245 (discussing this problem further).

281. Rawls's answer to this question is that the duty of justice is a fundamental natural duty.

Now in contrast with obligations, it is characteristic of natural duties that they apply to us without regard to our voluntary acts

. . . Thus if the basic structure of society is just, or as just as it is reasonable to expect in the circumstances, everyone has a natural duty to do his part in the existing scheme. Each is bound to these institutions independent of his voluntary acts, performative or otherwise. Thus even though the principles of natural duty are derived from a contractarian point of view, they do not presuppose an act of consent, express or tacit, or indeed any voluntary act, in order to apply. The principles that hold for individuals, just as the principles for institutions are those that would be acknowledged in the original position.

RAWLS, *supra* note 241, at 114-15. While this argument is both intellectually and emo-

There are a variety of reasons to assume that most individuals²⁸² ought to be motivated to accept conditions of a social contract that obligates them to undergo punishment should they become criminals. Some people can really be motivated by hypothetical consent theory's appeal to our sense of justice and fairness,²⁸³ which suggests that we abjure illegitimate social advantages such as those achieved through criminal acts. A purely egoistic view would lead others to consent to fair social arrangements because these are in everyone's long-term self-interest.²⁸⁴ Hobbes's arguments about the dangers and misery of anarchy, and the benefits to all persons of stable governments and social arrangements,²⁸⁵ "appeal to enlightened long-run *prudence* as a mo-

tionally satisfactory, its opponents would argue:

[Hypothetical consent] theory says that someone ought morally to do something if and only if an ideal unbiased observer would approve of his doing it; but the theory does not say how the reactions of such a hypothetical unbiased ideal observer give a typically biased actual person a reason to do anything, because the theory does not say why anyone should care about the reactions of this imaginary person.

GILBERT HARMAN, *THE NATURE OF MORALITY* 91 (1977). Rawls would direct the skeptic's attention to a sense of fairness. See, e.g., RAWLS, *supra* note 242, at 18, 21, 587 (stating that principles of justice should not favor any specific individual). Zimmerman argues that the force of hypothetical consent theories derives from its appeal to "second-order" desires for impartiality, rationality, and consistency; these second-order desires put constraints on, among other things, what kind of political arrangements we can support. See generally David Zimmerman, *The Force of Hypothetical Commitment*, 93 *ETHICS* 467 (1983).

282. In Rawls's theory, the social contractors are unaware (by virtue of the "veil of ignorance") of their own endowments, but in reality, we know who we are. As Kavka points out, however, Hobbesian political theory — which assumes contractors are aware of who they really are and are motivated essentially by egoistic considerations — explains why our real individual differences do not undermine the validity of a hypothetical social contract. Individuals of very different endowments all can expect to benefit from the mutual constraints characteristic of civil society, for these restrictions are far preferable to life in a "state of Warre;" in this sense, they would "operate essentially as equals, and the social arrangements they [would] select may properly be regarded as reasonable and morally justified." Kavka, *supra* note 229, at 404. See also HOBBS, *supra* note 242, at 86-90 (discussing the essential equality of men in the state of nature). As the following discussion elaborates, "predominant egoism" elaborates motives for cooperating with just social arrangements. See KAVKA, *supra* note 229, at 405-07, for a fuller exposition of "predominant egoism."

283. See Rawls, *supra* note 242, at 453-512 (discussing our "sense of justice.")

284. Egoism is consistent with appeals to justice and fair play. See generally KAVKA, *supra* note 229, at 357-84 (explaining that egoism gives preference to the well-being of the actor and, like utilitarianism would ensure that all persons would be treated as fairly as possible).

285. Reich suggests that these kinds of considerations historically have appealed to Americans. He cites de Tocqueville:

tive of obedience" to the dictates of a reasonably fair legal system.²⁸⁶ Prudence also suggests, to those unmoved by any of the previous reasons for acquiescence to the law, that anyone who refuses to make sacrifices along with the vast majority will be regarded by their fellow citizens as an enemy of the state. The vast majority would be inclined to treat recalcitrants in a very hostile manner.²⁸⁷

Criminals (along with everyone else) *accept* political obligations in exchange for the benefits they receive as citizens. "In particular, it may be argued that a citizen in a stable law-governed society receives from his fellow citizens numerous important benefits following from their general compliance with the civil law and therefore owes them similar compliance on his own part as a matter of fairness."²⁸⁸ In other words, those who benefit when their fellow citizens accept social burdens and constraints on personal liberty must be expected to accept similar burdens and constraints themselves.²⁸⁹ Particular criminals may not always realize they benefit from social cooperation and general obedience to law, but

'The Americans,' Tocqueville noted, 'are fond of explaining almost all the actions of their lives by the principle of self-interest rightly understood; they show with complacency how an enlightened regard for themselves constantly prompts them to assist one another and inclines them willingly to sacrifice a portion of their time and property to the welfare of the state.'

It is an important insight. Americans have willingly sacrificed for the nation's well-being because — Americans have repeatedly claimed — such sacrifices are ultimately in their own best interests.

ROBERT B. REICH, *THE WORK OF NATIONS* 23-24 (1991) (quoting ALEXIS DE TOCQUEVILLE, 2 *DEMOCRACY IN AMERICA* 122 (Henry Reeve trans., Francis Bowden et al., eds., Alfred E. Knopf 1945) (1840)).

286. KAVKA, *supra* note 229, at 406.

287. *Id.* at 416. See also HOBBS, *supra* note 242, at 121-29. Kavka discusses the problem of how a satisfactory legal system may treat those recalcitrant independents who refuse to acknowledge an obligation to obey the laws

On grounds of peace and self-defense (if nothing else), the State and its citizens may justifiably enforce . . . the fundamental rules of conduct necessary for civil peace. Thus, independents can rightly be prevented and deterred from killing, assaulting, stealing, . . . and so forth, so long as they are provided with similar protection from others (should they wish it). Further, on grounds of fair play they may be required to pay their full share of the costs of these fundamental protections [B]ecause there are moral grounds of political obedience besides hypothetical consent, independents in the satisfactory State are not morally free to do as they please.

KAVKA, *supra* note 229, at 416-17 (citation omitted).

288. *Id.* at 409.

289. See *THE PHILOSOPHY OF RIGHT*, *supra* note 255, at 142 (arguing that Kant's theory of punishment is based on reciprocity).

they do, and their ignorance or ignorement of this fact does not excuse them from the requirements of fairness and justice.²⁹⁰ Most criminals, if asked prior to their own arrests, would want and expect protection from being murdered, assaulted, or robbed, and would want and expect those who committed crimes against them to be prosecuted and punished. Of course, some criminals do not have this expectation, and others might legitimately doubt whether a particular criminal justice system would do this reliably and fairly; but these expectations and doubts are not sufficient to undermine the *principle* of requiring punishment for those who fail to adhere to just laws.

A final argument for the force of hypothetical consent derives from the common experience that "the homely challenge 'How would you like it if someone did that to you?' is frequently an effective way to get someone to see that he is in fact committed to an impartial point of view."²⁹¹ It is a central feature of normal moral development²⁹² that one becomes capable of recognizing that one's own individual interests are set within a social context where multiple, competing interests have equal claim to satisfaction. As Zimmerman explains,

It is a mistake to think that the desire to act impartially is easily escapable just because it is a feature of one's empirical self and thus contingent I do not *decide* to take seriously the interests of persons qua persons. It is a deep feature of my psychological makeup which I encounter in myself as motivational rock bottom.²⁹³

290. This source of obligation is discussed more fully in KAVKA, *supra* note 229, at 409-13. Kavka concludes that "a carefully developed fair-play account of political obligation might actually apply to a large number of people, including some citizens of nonsatisfactory States." *Id.* at 413.

291. Zimmerman, *supra* note 281, at 481.

292. Jean Piaget, the pioneering developmental psychologist, writes:

The ethics of mutual respect, which is that of good (as opposed to duty), and of autonomy, leads, in the domain of justice, to the development of equality, which is the idea at the bottom of distributive justice and of reciprocity As the child grows up . . . unilateral respect [for adults and the authority they represent] tends of itself to grow into mutual respect and to the state of cooperation which constitutes the normal equilibrium.

JEAN PIAGET, *THE MORAL JUDGMENT OF THE CHILD* 324 (Marjorie Gabain trans., Free Press 1966) (1932).

293. Zimmerman, *supra* note 281, at 482 (emphasis added). Zimmerman concludes that anyone who merely tries "to monitor his beliefs and desires in accordance with principles of epistemic rationality" is committed to acknowledging the force of hypothetical com-

V. WHY IS PARTICIPATION PERMISSIBLE?

Contractarian theory supports the *prima facie* assumption that individuals are bound by a reasonably fair criminal justice system's rules concerning obedience to the law and infliction of punishment.²⁹⁴ If citizens would give their rational consent to these rules from an antecedent position of choice, a citizen who breaks the law is presumptively obligated to undergo appropriate punishment.²⁹⁵ This obligation provides guidance to psychiatrists for fording the murky, ethically-treacherous waters swirling around execution competency proceedings.

Prisoners who are so ill that they lack execution competence would likely fail to meet competence standards to give informed consent for evaluation or treatment.²⁹⁶ However, present legal and ethical doctrine advises physicians dealing with incompetent patients to defer to what those patients' wishes would be if they were competent, provided those wishes can be determined.²⁹⁷ Assuming that a just conviction implies that the criminal met minimum standards of rationality at the time of the offense, hypothetical consent theory posits that the criminal, in committing the offense, made a valid choice to be punished.²⁹⁸ From a choice to be punished one can reasonably infer a choice to accept the lawful means to bring about punishment. In the case of the incompetent death row inmate, the means would include psychiatric evaluation and treatment.

In addition to providing general rules to govern decisionmak-

mitment; "there is little . . . point is making moral judgments about the obligations of creatures who cannot take up any practical attitudes toward their own desires." *Id.* at 482-83.

294. See *supra* text accompanying note 257 (deriving the justification for punishment from political obligations to which an individual consents).

295. See *supra* text accompanying notes 258-59 (discussing contractarian political theory and the binding obligations this theory imposes on citizens).

296. See *supra* text accompanying note 158 (discussing the incompetent person's inability to comprehend).

297. See, e.g., Rebecca Dresser, *Life, Death, and Incompetent Patients: Conceptual Infirmities and Hidden Values in the Law*, 28 ARIZ. L. REV. 373, 376 (1986) (analyzing the substituted judgment standard to determine what an incompetent patient would choose if competent); Elias Baumgarten, *Patient Autonomy and the Refusal of Psychotropic Medications*, in *DIFFICULT DECISIONS IN MEDICAL ETHICS* 13, 21-26 (1983) (finding consciousness is not a prerequisite to autonomy and, therefore, wishes expressed by a competent person should be respected if that person becomes incompetent).

298. See *supra* text accompanying notes 248 and 259 (presenting the theory that a criminal offense is the willing breach of a citizen's bargain with the polity).

ing, moral reasoning helps resolve apparently contradictory intuitions about the right course of action in specific situations.²⁹⁹ As suggested earlier, a ban on participation would preclude a psychiatrist's involvement with a condemned inmate who had sincerely and competently requested evaluation and treatment should he become incompetent.³⁰⁰ This ban contradicts society's intuitive sense that such involvement would be ethical.³⁰¹ Banning competency-restoring evaluation or treatment of a death row inmate runs counter to sentiments about the psychiatric evaluation or treatment of a non-capital inmate,³⁰² which most would condone³⁰³ even though it would enable the inmate to face punishment he would otherwise avoid.

If the criminal justice system and the death penalty are justified and administered reasonably fairly,³⁰⁴ the contractarian argument that punishment is an appropriate and morally justified response by society³⁰⁵ resolves these contradictions. The condemned prisoner's "living will"³⁰⁶ can be honored without breaching medical ethics, not because the prisoner has given *explicit* prior consent,³⁰⁷ but because the prisoner has incurred an obligation. The fulfillment of this obligation both vindicates his autonomy and confirms his free-

299. See *supra* notes 211-17 and accompanying text (describing scenarios that generate mixed feelings about the proper course of action).

300. See *supra* text accompanying notes 192-95 (asserting that it is not a perversion of medical ethics for a psychiatrist to treat a condemned prisoner who made a "living will" requesting treatment should he become incompetent).

301. See *id.*

302. See *supra* text accompanying notes 196-98.

303. See *Washington v. Harper*, 494 U.S. 210, 227 (1990) (finding that treating an inmate with a psychotropic drug to control his manic depression disorder did not violate his due process rights). It is important to recognize that society condones treatment even if the prisoner enjoyed being mentally ill, and especially if the prisoner's only reason for wanting to remain ill was to avoid returning to prison. It would be wrong for a physician to withhold treatment in collusion with someone's desire to avoid his obligations. See *supra* notes 275-76 and accompanying text (explaining that failure to punish a guilty person denies the person's humanity). If Propositions 3-5 (see *supra* notes 230-32 and accompanying text) are correct, then there is no ground for making a distinction between obligations to undergo capital as opposed to non-capital punishments.

304. See *supra* text accompanying notes 229-32 (Propositions 2-5).

305. See *supra* text accompanying note 228 (Proposition 1).

306. See *supra* text accompanying note 199; see also Bonnie, *supra* note 30, at 83.

307. Psychiatrists working with prisoners may be emotionally reassured when those prisoners have given previous explicit consent for treatment, especially if the prisoners' statements of consent included explicit acknowledgement of the prisoners' duty to undergo punishment. See *supra* notes 236-41 and accompanying text (establishing consent as the basis for treatment and punishment).

dom.³⁰⁸ Wrongdoers who are justly convicted find themselves with a peculiar interest, an interest in undergoing the sacrifice of liberty attendant upon receiving just punishment. A political theory that holds liberty to be the highest value can tolerate such a sacrifice only "for the sake of liberty itself."³⁰⁹ The only acceptable justification of punishment, therefore, must be that the criminal, in an antecedent position of choice, rationally would have consented to it because it presents the greater liberty of receiving the benefits of civil society.³¹⁰ Respect for the criminal's dignity and freedom demands that society honor his liberty-enhancing commitments above all other competing commitments (such as a physician's commitment to preserve life).³¹¹ Honoring those commitments, psychiatrists ethically can evaluate and treat both capital and non-capital prisoners, even when psychiatric intervention might lead to further punishment, not because of some state interest³¹² in making sure punishments are carried out, but because such intervention furthers prisoners' paramount interest in having the law respect their dignity and autonomy.³¹³

308. See *supra* text accompanying notes 242-43 and 275-76 (describing both the process by which an individual implicitly consents to punishment and how the failure to give this punishment deprives the individual of the consideration due him under his contract with society).

309. RAWLS, *supra* note 242, at 241.

310. See *supra* text accompanying note 248 (discussing hypothetical consent theory as a willing exchange of commitments for benefits).

311. See *supra* notes 235 and 275-76 and accompanying text (admonishing physicians to acquaint themselves with justifications for intentionally imposing suffering and to uphold their obligation to preserve the convicted person's dignity).

312. In the exercise of their physicianly skills, doctors ordinarily owe their allegiance to individual patients and direct their efforts toward treatment interventions that are consistent with their individual needs. The American Bar Association suggests that the same obligations apply when physicians engage in decisionmaking about the psychiatric treatment of prisoners:

When providing treatment or habilitation for a person charged with or convicted of a crime, the mental health or mental retardation professional's obligations to the person and to society derive primarily from those arising out of the treatment or habilitative relationship. Consistent with institutional security requirements, correctional and mental health or mental retardation facilities should not interfere with that traditional professional relationship

. . . If therapists or habilitators are to play a helping role, their relationships with defendants should be structured as far as possible as if it were an ordinary therapist-patient or habilitator-client relationship. Thus, professional obligations to patients or clients undergoing treatment or habilitation within the criminal justice system should be, to the greatest extent possible, identical to those governing any treatment or habilitation relationship.

ABA STANDARDS, *supra* note 19, Standard 7-1.1(d) and cmt. (citation omitted).

313. Professor Bonnie views these considerations as central to the prohibition against

Another reason to respect the criminal's interest in undergoing punishment above all other interests comes from a fundamental societal obligation to respect others' humanity.³¹⁴ In a discussion that elucidates the connections between rationality, autonomy, and personal accountability,³¹⁵ Moore explains how society's determination of criminal responsibility establishes the legal and moral personhood³¹⁶ as well as the rationality of the lawbreaker.³¹⁷

Necessary condition[s] of personhood . . . [are] rationality and autonomy, defined as the ability to perform actions in response to valid practical inferences It is only persons like us — practical reasoners — who are obligated by moral norms and thus have the capacity to be responsible (culpable) when we breach them.³¹⁸

The statement that a criminal "deserves to be punished" is ordinarily a critical one. It is associated with overtones of emotional harshness and an unwillingness to tolerate human fallibility, to understand difficult circumstances, and to empathize with someone's misfortune.³¹⁹ Saying that someone deserves punishment seems,

executing the incompetent:

[A] contemporary justification for [this] prohibition . . . must be found in the dignity of the condemned.

The prisoner has a right, even under imminent sentence of death, to be treated as a person, worthy of respect, not as an object of the state's effort to carry out its promises He should have the opportunity to decide . . . whether he will repent or go defiantly to his grave. A prisoner who does not understand the nature and purpose of the execution is not able to exercise the choices that remain to him. To execute him in this condition is an affront to his dignity as a person.

Bonnie, *supra* note 30, at 88.

314. See *supra* text accompanying notes 288-89 (finding citizens owe each other compliance with the law and the corresponding benefits which result from that compliance).

315. MOORE, *supra* note 267, at 44-112.

316. Moore argues that the legal and moral guilt of individuals are contingently connected. "We *could have* laws that assign rights and liabilities in ways that have little resemblance to moral theory, and they would still be laws. As it happens, however, our laws do reflect underlying moral theories." *Id.* at 49.

317. Only entities that are, in Moore's terminology, "practical reasoners" can be eligible for criminal conviction. *Id.* at 61. A practical reasoner, among other things, is an entity for whom actions are interpretable as the outcome of valid practical syllogisms, i.e., for whom explanations are the appropriate means for discussing *why* they did something. *Id.* at 13-14. Moore argues that logically, in order for legal standards to be binding, the standards must address "practical reasoners capable of forming belief/desire sets around such laws, and then acting accordingly. If persons were not like this, . . . laws . . . would have no point." *Id.* at 61.

318. *Id.* at 62.

319. See Dolinko, *supra* note 264, at 1647-57 (lamenting "harshly punitive attitudes" of

in a word, uncaring; but there is no logical contradiction between caring about someone and passing judgment on him.³²⁰ Kant,³²¹ Hegel,³²² and Moore³²³ remind us that moral and legal denunciation implicitly affirm our belief in, and paramount concern for, someone's worthiness as a rational being and his interest in being respected as a moral agent.

If capital punishment is moral and just, one cannot invoke an incompetent condemned prisoner's "medical interest"³²⁴ to oppose his execution; one cannot adduce any medical concern more important than a prisoner's humanity.³²⁵ Even if execution is mistaken-

those who would not excuse criminals who have suffered social and economic privations).

320. See *supra* note 234 and accompanying text (recognizing caring citizens should share a sense of sadness and empathy when they realize that a system that induces suffering is necessary).

321. See *supra* notes 273-76 and accompanying text (discussing Kant's belief that punishment is not designed to serve society's ends but the individual's ends, namely recognition of and respect for the individual's humanity).

322. See *supra* note 276 and accompanying text (continuing the discussion of punishment as a reaffirmation of an individual's power of choice).

323. See *supra* notes 315-17 and accompanying text.

324. The phrase "medical interest" is taken from the APA/JAMA Brief. See *supra* notes 103-08 and accompanying text (requiring "medical interest" to justify giving involuntary psychiatric treatment to prisoners).

325. What about life itself? Courts have consistently recognized that "[n]o right is held more sacred . . . than the right of every individual to the possession and control of his own person." *Union Pac. Ry. Co. v. Botsford*, 141 U.S. 250, 251 (1891) (holding a court cannot order a plaintiff to submit to a surgical examination when the injuries form the basis of a negligence claim against defendant). The interest an individual or a state may have in the preservation and sanctity of life is outweighed by an individual's "much stronger personal interest in directing the course of his life." *In re Conroy*, 486 A.2d 1209, 1224 (N.J. 1985) (discussing how the right to self-determination ordinarily outweighs any competing state interest in decisions concerning refusal of medical treatment). The Supreme Court recently affirmed this interest (often termed the "right to die") in *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261 (1990) (recognizing the liberty interest of a competent person to refuse lifesaving hydration and nutrition, but requiring clear and convincing evidence of the vegetative patient's desire to withdraw treatment). Physicians would commit a legal as well as a moral error if their dedication and their traditional commitment to preserving life were to prevent them from recognizing that the ultimate justification for the use of their skills is in the service of higher values. *Id.* at 267 (stating the corollary of the informed consent doctrine, informed refusal, that can subject a physician to tort liability for treating a patient against his will). "Living will" legislation is evidence of the public's need for assurance that physicians will respect the fundamental and constitutional right to be left alone. See generally, MENTAL DISABILITY LAW, *supra* note 1, § 18.12 & Supp. 1991 (discussing the emergence of legislation that allows a competent patient to direct doctors to withhold life-saving treatment without judicial intervention).

Although most "right to die" cases and ethical discussions deal with the right to refuse treatment, the rationale for honoring someone's refusal of treatment (even if death

ly³²⁶ viewed as a *consequence* of competency-restoring treatment, respect for the prisoner's humanity dictates that restoration to rationality is his paramount need.³²⁷

If contractarian theories of punishment do provide a basis for asserting an incompetent condemnee's *hypothetical* consent to psychiatric evaluation and treatment,³²⁸ how may a psychiatrist respond to an incompetent prisoner whose *actual*, pre-incompetence sentiments, behavior, or pronouncements indicate³²⁹ that he does

might follow) should be the same as the rationale for honoring someone's acceptance of treatment (even if death might follow). *See, e.g., id., supra* note 1, §§ 18.07-18.12 (surveying cases, commentary and legislation on right to refuse treatment); Cruzan, 497 U.S. at 273 (recognizing the individual's liberty interest as the underlying rationale for decisions regarding medical treatment).

Bonnie makes a similar argument where a competent condemned prisoner requests that appeals cease and that his execution be carried out. Bonnie, *supra* note 239, at 1376-80. Bonnie believes that society's interest in preserving the integrity of the law precludes a prisoner from refusing mandatory appeals that determine whether the prosecution proved "a legally sufficient predicate for a death sentence." *Id.* at 1377. The prisoner should consent, however, before the procedures leading to his death sentence are reviewed. *Id.* at 1378. Bonnie notes:

A convicted prisoner does not become a pawn of the state. Even a prisoner sentenced to death retains a constitutionally protected sphere of autonomy — of belief, expression, and, to a limited extent, action

As long as the prisoner is competent to make an informed and rational choice, the argument for respecting this choice would appear to be a powerful one.

Id. at 1376 (citation omitted).

326. Punishment is a consequence of violating the law. To ignore this invites moral confusion. *See supra* note 276 (quoting Hegel in support of the proposition that punishment results from an individual's own volition), and notes 178-83 and accompanying text (finding that punishment is a result of a decision to commit the crime and not a direct or indirect result of competency-restoring treatment).

327. A variation of the argument that psychiatrists' ethical issues are similar in cases involving the treatment of capital and non-capital offenders emphasizes this point: psychiatrists have not argued that treatment should be withheld from incompetent, psychiatrically-hospitalized, non-capital convicts in order to prevent them from being able to return to prison. *See supra* notes 196-98; *Washington v. Harper* 494 U.S. 210, 224 (1990) (treating with antipsychotic drugs did not violate the due process rights of a non-capital offender). Arguably, psychiatrists who withhold treatment from non-capital criminals interfere with the workings of the law and tacitly encourage criminals to avoid their legal responsibilities. This action would violate Proposition 5: a psychiatrist's obligation to treat should not be used to achieve particular social or political outcomes. *See supra* note 250 and accompanying text. Propositions 3 and 4 leave no room to argue for different attitudes toward the obligations of capital and non-capital inmates. *See supra* notes 230-31 and accompanying text. Objectors to participation in evaluation and treatment of incompetent condemnees are *really* objecting to either Proposition 3 or 4, unless they also approve psychiatric assistance in non-capital prisoners' efforts to escape imprisonment by refusing psychiatric treatment.

328. *See supra* notes 241-60 and accompanying text.

329. The condemned prisoner, for example, might have expressed an intense desire ei-

not want treatment? Ordinarily, past explicit acts or utterances provide proof of the sorts of treatment an incompetent patient would have consented to were he still competent.³³⁰ Hypothetical consent's effect on the actual refusal of treatment has two parts.

First, to be meaningful in general, hypothetical consent to undergo punishment must outweigh the actual desire to escape it.³³¹ If a person, justly convicted of a capital crime, says, "I know that I gave my hypothetical consent to being executed under these circumstances, but I've changed my mind,"³³² we would likely respond, "We're sorry, but you already promised."³³³ Suppose the prisoner says, "I know I gave my hypothetical consent, but in spite of that, I don't — in actuality — wish to be punished." We would explain how hypothetical consent theory, especially in this circumstance, establishes a general obligation to undergo punishment. The obligation stems from a rational pre-conviction wish that logically overrides the post-conviction wish to avoid punishment. More precisely, hypothetical consent theory delimits what wishes can be honored or have weight in determining how we treat others and how others treat us.³³⁴

ther for having his life spared if at all possible or for having his execution delayed as long as possible (sentiments consistent with a preference to remain psychotic); or he might have been intensely involved in filing of legal motions to prevent execution; or he may have stated, "If I go crazy, don't let me get treated — I want to live as long as possible."

330. See *Cruzan*, 497 U.S. 261 (upholding the state's requirement of clear and convincing evidence to establish that an accident victim would not wish to live in a vegetative state before terminating her hydration and nutrition).

331. Murphy comments,

The test for an illegitimate interference with freedom cannot . . . be that the interference thwarts the particular empirical wishes or desires that a citizen might have at the moment. (If this were so, we could never punish at all, for what criminal *wants* to be punished? . . .) The test, rather, must be this: a law's interference with freedom is justified (or, if you prefer, is not a *genuine* interference with freedom), even if it thwarts desires, so long as it does not thwart the *rational* will of any citizen Consent is required for justice, but it is hypothetical rational consent — a consent to be modeled in social contract terms.

Does Kant Have a Theory?, *supra* note 258, at 528.

332. I am indebted to James C. Ballenger, M.D., for this succinct formulation of this problem.

333. See *supra* notes 241-59 and accompanying text.

334. *Does Kant Have a Theory?*, *supra* note 258, at 528. Kant characterizes justice as "the aggregate of those conditions under which the will of one person can be united with the will of another in accordance with a universal law of freedom." Kant, *supra* note 245, at 34. The purpose of the law, in other words, is to insure that one's choices (expressed in actions) can be reconciled with the choices of others.

Second, in certain situations medical treatment without explicit consent is justified.³³⁵ In ordinary medical practice, obtaining explicit consent is more the exception than the rule. When we go to a doctor's office with a complaint, the doctor ordinarily neither asks for our consent to be evaluated or examined, nor is he likely to obtain our formal, explicit consent for the treatment he prescribes. We tacitly accept evaluation and treatment by going to the doctor and filling the prescription.³³⁶ In emergency circumstances, physicians also ethically evaluate and treat both unconscious patients, who cannot consent, and delirious patients who reject evaluation and treatment, yelling "no, no," on the grounds that most *reasonable people would want* such care if they were conscious and found themselves in such circumstances.³³⁷ Competent patients also may *waive* their right to be informed and consulted about treatment by informing their physician, "I've sought your help believing that you're the doctor and know what's best for me; give me whatever treatment will benefit me."³³⁸

Again assuming that the criminal justice system and capital punishment are morally justified and fair,³³⁹ hypothetical rational consent provides the grounds for evaluation and treatment of the incompetent prisoner. The prisoner's consent is implied because he accepts the benefits of civil society and because he rationally would have consented in an antecedent position of choice. The condemnee has waived the right to avoid suffering in exchange for the benefits of civil society.³⁴⁰

Evaluations of execution competency should be conceptualized as attempts to determine whether a prisoner needs treatment.³⁴¹ Ordinarily, people consult a physician because they believe they

335. HARRY J. GRAYSON, *PHYSICIAN AND PATIENT LEGAL RELATIONSHIPS*, §§ 5-1 to 5-49 (1971) (While explicit consent is desired, most treatment is based on implied consent — actions and behaviors that demonstrate consent for treatment. Most commonly, bases for implied consent are emergency care and the treatment a patient receives when he submits to a physician for diagnoses and care.). See also THOMAS GUTHEIL & PAUL S. APPELBAUM, *HANDBOOK OF CLINICAL PSYCHIATRY AND THE LAW* 159-162 (2d ed. 1982).

336. See MARC FRANKLIN, *TORT LAW AND ALTERNATIVES* 608-9 (2d ed. 1979) (discussing implied consent theory).

337. See GRAYSON, *supra* note 335, at §§ 5-1 to 5-49.

338. *Id.* at 165.

339. See *supra* notes 225-26 and accompanying text (Propositions 1-5).

340. See *supra* notes 241-58 and accompanying text.

341. See *supra* notes 296-97 and accompanying text (inferring that treatment is needed when a prisoner is incompetent for execution).

have a problem the physician can somehow remedy. Patients have little reason to seek a doctor's diagnosis absent a belief in the possibility of gaining relief or some other form of help with their problems.³⁴² Justifying evaluation of the incompetent condemned on the condition that treatment is needed places evaluation in its typical context within medical practice. Regarding evaluation as subsidiary to treatment not only reinforces customary roles and attitudes in medical practice,³⁴³ it also addresses the moral problems associated with the position that evaluation of the condemned is ethically permissible while treatment to restore competency is not.³⁴⁴

First, those who draw an ethical distinction between evaluation and treatment point out that evaluation is potentially life-saving.³⁴⁵ But attention to this outcome alone dictates that psychiatrists adjust their testimony to maximize the possibility that a court would rule that the prisoner is incompetent.³⁴⁶ However, such a

342. "Remedies" for medical problems include providing emotional support for patients suffering incurable diseases, reassuring patients that nothing serious is wrong, and informing patients that the illness will get better on its own. Information, even if it does not change treatment (e.g., being told that one has an untreatable, incurable disease), allows for rational planning of one's life, and thus is a remedy for the very important problem of medical uncertainty. See David A. Asch et al., *Knowing for the Sake of Knowing: The Value of Prognostic Information*, 10 *MEDICAL DECISION MAKING* 47, 48 (1990) (discussing the role of prognostic tests and how these tests allow patients to view themselves differently, even if the tests do not directly alter the course of medical treatment).

For a succinct discussion of the essence of the doctor-patient encounter, see George L. Engel, *The Clinical Application of the Biopsychosocial Model*, 137 *AM. J. PSYCHIATRY* 535, 535-36 (1980) (recognizing doctor-patient relationships as human encounters characterized by assigned roles and expectations).

343. See *supra* note 153 and accompanying text (asserting the distinction between treatment and evaluation of condemned prisoners is that an evaluating "professional" does not act as a physician and therefore, is not bound by a physician's ethical standards).

344. See, e.g., *supra* note 183 and accompanying text (noting the conflict that exists between a physician's duty to "preserve life" and the duty to tell the truth in court).

345. See, e.g., Salguero, *supra* note 58, at 177 (asserting evaluation can only preserve an inmate's life because the evaluation affirms the sentence, changing nothing, or delays the sentence, thereby saving the inmate's life). Competency evaluations would have this life-saving potential, especially if a subsequent court determination of incompetence were to lead to commutation of a death sentence. See *supra* notes 109-15 and accompanying text (discussing state statutes that either automatically commute a death sentence to life imprisonment, or suspend the sentence, based on a finding that the inmate is incompetent, as well as recommendations contained in the APA/JAMA Brief, *supra* note 38, at 20).

346. See *supra* note 183 and accompanying text. The physician is more likely to offer false testimony that the prisoner is incompetent if he or she believes a determination of competence to be "tantamount to imposing a . . . death sentence." Radelet & Barnard, *supra* note 23, at 49 (discussing the implications of an initial assessment of incompetence and a subsequent assessment of competence). See also *supra* notes 129-38 and accompa-

strategy, even if not deemed perjury, removes any pretense of scientific accuracy that the psychiatrist might claim. The psychiatrist's testimony would be relatively valueless to the fact-finder.³⁴⁷

Second, placing evaluation in its usual relationship to treatment obviates the need for the counter-intuitive argument that a psychiatrist who is evaluating a potentially-incompetent prisoner is not acting as a physician but as a "forensicist;" in this alternate role the duty to do no harm is suspended.³⁴⁸ Evaluation and treatment offer potential benefits to prisoners, even if punishment follows efficacious treatment. This position is counter-intuitive³⁴⁹ only until one recognizes that all benefits are context-specific. Those accused or convicted of crimes find themselves in a peculiar context with what would otherwise be peculiar desires.³⁵⁰ Those desires are governed by what we would want if we viewed possible life situations from an antecedent position of choice. From an antecedent position of choice, all of us rationally would decide to accept punishment should we become criminals ourselves.³⁵¹ We would know that if we were mentally impaired and accused or convicted of a crime, the availability of psychiatric competency evaluations and treatment to restore competency would fulfill our decision to be punished. Psychiatric participation thus would be a desirable feature of a fair legal system.³⁵² The integrity of the legal system, and our hypothetical, rational desires, would be compromised unless psychiatrists were constrained to conduct objective evaluations, to testify truthfully, and to help us fulfill our rationally-determined obligations and promises. We would see the opportunity for having courts know our mental status to be a benefit that furthered our wish in attaining just results; and we rationally would request a

nying text (declaring competency determinations are tantamount to participation in execution because these determinations render an inmate fit for punishment).

347. See *supra* note 153 (asserting professionals who evaluate in the adversary system act as consultants whose function it is to apply expertise in the legal context).

348. Physicians can "forego[] primary adherence to the principles of beneficence and nonmaleficence when they act as other than physicians." *Appelbaum's Parable*, *supra* note 17, at 252. See also *supra* note 153 and accompanying text (asserting a lower ethical standard for evaluating physicians who act as consultants).

349. See *supra* notes 312-13 and accompanying text.

350. See *supra* note 333 and accompanying text (proposing that a person's view of punishment depends on whether he is facing it).

351. See *supra* note 257 and accompanying text.

352. See *supra* notes 347-48.

psychiatrist's help in presenting evidence about our mental status. We would utilize appropriate psychiatric treatment in furtherance of our paramount desire to have our humanity respected.

These are *general* justifications of competency evaluation and restoration. They also justify psychiatric participation in non-capital contexts and in situations where punishment is not imminent. Applying the justifications in all contexts rebuts the argument that participation in execution competency proceedings violates the physician's duty to avoid harm.³⁵³ As Professor Bonnie explains:

It is sometimes argued that the principle of nonmaleficence . . . is fundamentally contradicted by any professional interaction with a client that might elicit information or opinion that could be used to support a death sentence. However, this same premise could be deployed against professional participation *in any criminal case*, when information elicited during the evaluation . . . could be used to support a criminal conviction and imprisonment [I]t would seem that clinical participation in capital cases is, in principle, no more (or less) problematic than forensic participation in any criminal case.³⁵⁴

The problem is solved if we recognize that, for an accused or convicted individual, exposing the truth is a hypothetically, rationally desired benefit. In the context of being tried, sentenced, or punished, this benefit outweighs many others, including the "benefit" of avoiding the "harm" of being punished. Truthful psychiatric input into the determination of the various competencies associated with trials, sentencing, and administration of punishment³⁵⁵ helps assure that the rationality and humanity of the accused or convicted individual is respected.³⁵⁶ Insofar as an individual's humanity is

353. See *supra* notes 180-87 and accompanying text.

354. Bonnie, *supra* note 30, at 75-76 (emphasis added) (citations omitted). "It would seem difficult to sustain the argument . . . that forensic testimony that might lead to execution offends the tenet of nonmaleficence even though the presentation of testimony that might lead to profoundly debilitating imprisonment does not." *Id.* at 76. Cf. Appelbaum's position, *supra* notes 155, 174 (asserting that the immediacy and degree of harm facing the prisoner heighten the ethical concerns associated with execution competency evaluations).

355. Such competencies include competency to stand trial, to waive counsel and to proceed without assistance of counsel, to plead guilty, to waive appeals, etc. These issues implicitly concern the personhood of an accused or convicted individual at a variety of points in criminal proceedings. See ABA STANDARDS, *supra* note 19, Standards 7-5.1 to 7-5.4 and cmt.

356. See *supra* notes 238-59, 273-76 and accompanying text (asserting that contracts

of paramount interest to him, a psychiatrist is bound to respect that interest above all others.³⁵⁷ A psychiatrist thus fulfills his physicianly duty to avoid harm by conducting honest and objective forensic evaluations, even when the information obtained supports criminal conviction or punishment.

This section concludes with a reconsideration of the four scenarios discussed in Section III.³⁵⁸ The four hypothetical situations will be examined from the perspective that punishment is justified by hypothetical rational consent and by society's paramount interest in vindicating its citizens' autonomy and humanity — the thesis of this article.

In the first scenario an incompetent condemned prisoner, prior to becoming incompetent, expressed a wish to be evaluated and treated to restore his competency so as to allow him to be executed.³⁵⁹ His expressed consent provides a substantial source of *emotional* support for those involved in his care.³⁶⁰ Given his status as a convicted prisoner, the treatment's potential for helping him regain his legal personhood and his moral status as a responsibility-fulfilling human being provide the *ethical* justification for psychiatric care.³⁶¹

The second scenario describes an inmate who, while serving a life sentence in a nasty prison, had deteriorated mentally.³⁶² The inmate was transferred to a relatively nice psychiatric hospital for care; he then recovered, and faced being returned to prison.³⁶³ The evaluation and treatment of this prisoner raise many of the

result from individuals' rational free choices; therefore, punishment based on these choices affirms the rationality of the individual). See also ABA STANDARDS, *supra* note 19, at 266 (declaring that competency tests must focus on rational choices among alternatives when the tests are performed on a person who has pled guilty).

357. Professor Bonnie points out that "the paramount ethical obligation in the forensic setting is objectivity. This is not to say, however, that the principle of nonmaleficence is irrelevant, only that it is subsidiary to the search for truth." Bonnie, *supra* note 30, at 76, n.25 (citation omitted). This is the case only because *not* having the truth available would be a *greater* harm to the humanity of an accused or convicted individual than would his receiving just punishment.

358. See *supra* notes 191-94, 211-17 and accompanying text.

359. See *supra* notes 191-94 and accompanying text (discussing Professor Bonnie's concept of a "living will" to permit psychiatric treatment).

360. See Radelet & Barnard, *supra* note 23, at 301-05 (noting the conflict faced by professionals requested to treat mentally incompetent death row prisoners).

361. See *supra* notes 269-76 and accompanying text.

362. See *supra* part III.C.

363. See *id.*

same ethical problems raised by assessment and treatment of prisoners for execution competency.³⁶⁴ Yet psychiatrists perform such services for non-capital inmates without generating extensive ethical debate.³⁶⁵ This article's contractarian argument suggests that the issues for capital and non-capital inmates are similar: in both cases, assessment or treatment allows the prisoner to receive punishment and vindicates the prisoner's humanity.³⁶⁶

A similar argument justifies evaluation and treatment by physicians confronting the third scenario.³⁶⁷ In this situation, the physician must decide whether to administer life-saving medical treatment to a condemned inmate whose execution is imminent.³⁶⁸ Here, the obligation to "preserve life" seems futile, given that a potentially more painful and grisly death looms in the near future. Most physicians would "instinctively" treat the prisoner anyway.³⁶⁹ Their instinct would serve the ailing prisoner well, for it would offer him the opportunity to fulfill an obligation of paramount importance — the obligation to accept punishment.³⁷⁰

The last scenario involved the ethics of administering a drug that would induce a pleasant, permanent, and competency-destroying psychosis.³⁷¹ This drug would save a condemned prisoner's life but would destroy his rationality.³⁷² Even if he desired such treatment, respect for the prisoner's personhood and humanity would preclude its administration.³⁷³ The psychiatrist

364. See *supra* notes 213-14 (including determination of the inmate's fitness for punishment, allowing the punishment to proceed, and operation as "an instrument of punishment").

365. See *supra* notes 214-15 and accompanying text.

366. See *supra* notes 213-14 (listing various reasons why psychiatrists should face the same ethical dilemmas regardless of whether the prisoner is facing the death penalty or a non-capital sentence).

367. See *supra* part III.C.

368. See *supra* note 215 and accompanying text.

369. See *supra* note 225 and accompanying text (declaring that the physician who refused to treat in this situation would be reproached).

370. See *supra* notes 242-59 (asserting citizens bargain with society to receive benefits and accept the corresponding responsibilities of punishment as the cost of those benefits).

371. See *supra* part III.C.

372. This imaginary drug scenario is ethically distinct from the use of real medications to induce death in competent individuals who are suffering excruciating, terminal illnesses. While this article does not deal with the ethics or merits of euthanasia, it is important to consider the argument that euthanasia can, in situations where the natural course of death is degrading or gruesome, convey the utmost respect for someone's humanity. See generally JOHN LADD, *ETHICAL ISSUES RELATING TO LIFE AND DEATH* (1979) (discussing the ethics of euthanasia and individual autonomy).

373. This argument also shows why treatment with such a drug should not be consid-

must honor those ethically-prior wishes that are consistent with the prisoner's hypothetical, rational consent to just punishment.³⁷⁴

VI. CONCLUSION: THEORY AND REALITY

If capital punishment is just and is administered fairly,³⁷⁵ psychiatrists ethically may both evaluate condemned prisoners' competency to be executed and treat incompetent condemnees in an effort to restore their rationality. This conclusion avoids the inconsistencies in published arguments which oppose psychiatric participation while remaining silent on the morality of capital punishment as administered in the United States. Anyone who rejects this article's conclusions must either reject its assumptions about capital punishment or object to some aspect of its argument concerning the morality of punishment. As I have noted above, the assumptions are entirely consistent with published arguments opposing psychiatric participation in execution competency proceedings. For example, no one has suggested that organized psychiatry should oppose participation because the legal system is unfair or because capital punishment is immoral. However, there may be valid grounds for disagreeing with at least some of these assumptions.³⁷⁶

In the course of defending a contractarian theory of punishment, this article tried to anticipate some of the answerable objec-

ered as an acceptable substitute for capital punishment (assuming capital punishment is just) or life imprisonment. Such treatment is, we have stipulated, not cruel and is even pleasant. It might even render individuals forever docile and harmless. But this "chemical lobotomy" would undoubtedly vitiate the prisoner's humanity, which is something that just punishment must never do. *See supra* notes 274-77 and accompanying text (insisting that respect for humanity is a condition for imposing punishment).

374. *See supra* notes 241-67 and accompanying text.

375. This phrase is intended as a brief encapsulation of Propositions 1-5. *See supra* notes 228-32 and accompanying text.

376. Although some might disagree with Proposition 1, I would argue that such views either lack coherence or misunderstand punishment. Menninger seems to be guilty of the latter type of error, which arises in part from a conflation of attitudes and justifications. "Punishment is in part an attitude, a philosophy. It is the deliberate infliction of pain in addition to or in lieu of penalty." MENNINGER, *supra* note 224, at 203. Of course, some have praised this conflation. *See supra* note 264. Expressed views or feelings about criminals that may be morally unsavory and may taint legal proceedings do not imply that punishment is unjustified. In fact, Menninger endorses Platonic and Kantian justifications for retaliatory or retributive punishments. MENNINGER, *supra* note 224, at 205-06. However, he prefers to call these punishments "penalties" in order to avoid the vindictive connotations. "Penalties should be greater and surer and quicker in coming. I favor stricter penalties for many offenses, and more swift and certain assessment of them." *Id.* at 202.

tions to the theory. I believe that contractarian arguments support the view that most Americans should be presumed accountable for their crimes because they are obligated by the dictates of the imperfect but reasonably fair legal system under which they live. Citizens can be punished because they benefit from others' obedience, from others' expectations that obedience will be reciprocated, and from the social arrangements made possible by these expectations. The hypothetical, rational choice between citizens' current situations and those that they would experience in a "state of nature" is an obvious choice. Most citizens, therefore, can be presumed to be obligated by that choice.

But there is a substantial fraction of citizens — e.g., many residents of inner cities — whose lives are not much different from a Hobbesian "state of Warre," and who benefit little from current social arrangements; these groups account for a disproportionate number of those convicted of serious crimes.³⁷⁷ A substantial number of citizens may legitimately claim that their "bargain with the Laws" to undergo punishment for committing a crime is nullified when their fellow citizens fail to provide the reciprocal benefits of a civil society. They may also point to the racial and class biases that characterize criminal sentencing, especially in the application of the death penalty,³⁷⁸ as reasons to feel less-than-obliged by court decisions.

An equally important problem in the practical application of contractarian theories of punishment is that a considerable fraction of incarcerated individuals suffer from genetic and environmental influences which limit their ability to plan and act responsibly.³⁷⁹ In this regard, death row inmates are especially stigmatized. Many of them, when examined, are found to suffer from brain damage

377. "The [Justice] [D]epartment's Bureau of Justice Statistics said that as of Dec. 31, 1990, 40% of the prisoners awaiting death penalties were black. The 1990 Census found that the U.S. population is 12.1% black." ASSOCIATED PRESS, *supra* note 53, at A5. The Supreme Court ruled that statistical evidence demonstrating racial discrimination in Georgia prosecutors' decisions to seek the death penalty and juries' decisions to impose it does not render an individual's execution unconstitutional unless that individual shows "that the decisionmaker in his case acted with discriminatory purpose." *McClesky v. Kemp*, 481 U.S. 279, 292, 313 (1987), *aff'd*, 111 S. Ct. 1454 (1991) (denying the second habeas corpus petition).

378. See, e.g., ASSOCIATED PRESS, *supra* note 53.

379. See *supra* note 55 and accompanying text. See generally JAMES Q. WILSON & RICHARD J. HERRNSTEIN, *CRIME AND HUMAN NATURE*, 69-285 (1985) (providing an in-depth discussion of both environmental influences such as schools and families and genetic factors such as gender, age, intelligence, personality and psychopathology).

and severe neuropsychiatric disorders; most of them had appallingly traumatic childhoods.³⁸⁰

These two objections — unequal class and racial distribution of punishment, and punishment of persons unable to act responsibly — actually *strengthen* the case for a contractarian approach to justify punishment. Kant's theory particularly reinforces the contractarian model.³⁸¹ His vision of roughly equal, intelligent, reflective, and responsible individuals who create a system of laws for their mutual benefit³⁸² establishes a frame of reference from which to judge the fairness of our society. The Kantian "Kingdom of Ends" appears so different from the actual character of society that it seems inapplicable to many real-life criminals, especially those who find their way to death row. Kant's theory tells us the source of our urge to protest the punishment of those who suffer from disabilities or grossly unjust disadvantages in an imperfect society. Kant argues that just punishment rests on reciprocal agreements among equals, but often the conditions of reciprocity are not met in our society, particularly when the criminal justice system tolerates erratic arrest patterns or sentencing practices that favor certain racial or socioeconomic groups.

To the extent that a condemned inmate has suffered unfair social disadvantages or has been treated unfairly in the capital sentencing process, it *should* be hard to regard the inmate as having made a rational choice to be executed. Even those psychiatrists who find the death penalty morally acceptable should struggle with the idea that the inmate's humanity and rationality are honored by holding him responsible. Participation in execution competency proceedings may thus be deemed unethical because the death penalty is wrong or because the legal system is unfair to those whom it wishes to execute. But this is not an argument that psychiatric participation is immoral *per se*, but an argument that psychiatrists should refuse to participate because the criminal justice system's use of capital punishment itself is offensive.

If my thesis is correct organized psychiatry is left with two coherent alternatives. First, it could officially oppose participation in execution competency proceedings based on an opposition to the

380. See, e.g., *Characteristics*, *supra* note 55, at 840 (discussing the histories of 15 death row inmates).

381. See RETRIBUTION, *supra* note 256, at 79-80.

382. *Id.*

death penalty.³⁸³ Second, organized psychiatry could support efforts by mental health professionals to develop appropriate evaluation procedures and standards of thoroughness for competency evaluations. It could also suggest limits and restrictions on forensic testimony.³⁸⁴ Clear and authoritative legal opinions³⁸⁵ would greatly assist psychiatrists by defining execution competence more precisely, specifying proper procedures when the issue of incompetence is raised, insuring that judicial procedures will maintain and distinguish the psychiatrist's role vis-a-vis those of judicial and executive authorities,³⁸⁶ and clarifying how the treatment of the

383. An official ban on evaluation and treatment has been proposed by Ewing, *supra* note 134, at 185. He does not suggest that capital punishment is wrong, but rather that evaluation and treatment have "the practical effect of authorizing . . . [an] execution[.]" *id.* at 182, or "result[ing] in the death of an otherwise healthy human being." *Id.* at 184. Further, Ewing feels that traditional clinical ethics preclude mental health professionals' participation in capital sentencing proceedings. As a result, he proposes an official ban on these activities. See Charles P. Ewing, *Psychologists and Psychiatrists in Capital Sentencing Proceedings: Experts or Executioners*, 8 SOC. ACTION & L. 67, 70 (1982). Donald H. Wallace also proposes an official ban "based on the healing ethic of the mental health professions," Wallace, *supra* note 131, at 278, but suggests an alternative posture, in which "the ethical mental health professional could . . . refuse to provide . . . [a competency] assessment if the prisoner is not provided the adversary assistance of a mental health professional." *Id.* at 279. Foot argues that, if capital punishment is immoral, "then something will follow for anyone who has anything to do with it A special duty will also belong to those actually asked to participate in the business Psychiatrists are asked to make significant contributions to legal proceedings involving the death penalty, and this is the reason that they, as psychiatrists, have a special obligation to consider the ethics of capital punishment." Foot, *supra* note 146, at 214.

384. For examples of proposed procedures and standards for evaluation of execution competency, see Heilbrun & McClaren, *supra* note 29; *Iowa Comment, supra* note 29, at 1480; Radelet and Barnard, *supra* note 23, at 46-48. For a discussion of the clinical, ethical, and legal pitfalls associated with efforts to assess execution incompetence, see Ward, *supra* note 23, at 79-87.

385. Data from a national survey showed that, prior to the *Ford* decision, few states had even formally addressed the issue of competency for execution; and that there is significant ignorance at the attorney general level of what actually happens when inmates raise the issue of incompetence

The major reason for the lack of procedural specificity appears to be lack of experience with the problem [O]nly four states have had (at the time of my survey [1987]) any cases

Robert D. Miller, *Evaluation of and Treatment to Competency to Be Executed: A National Survey and an Analysis*, 16 J. PSYCHIATRY & L. 67, 71 (1988). The problem persists. See Heilbrun et al., *supra* note 40, at 599 (discussing ambiguity and inconsistency in statutory definitions of execution incompetence).

386. See *Due Process and Insanity, supra* note 29, at 108-09 (citations omitted).

A judicial inquiry is the best alternative for the initial hearing [concerning a prisoner's execution competence] [P]sychiatrists can analyze, if not agree upon, factual medical aspects of the prisoner's competency, [but] they should

incompetent condemned can be legally authorized.³⁸⁷

Although it is an issue that will personally and directly concern very few individuals, the question of whether psychiatrists should evaluate or restore the competency of the condemned touches all of us. Answering the question leads us to examine the foundations of political obligation, the justification of punishment, the ends of medical practice and the implications of respect for our fellow human beings' autonomy, rationality, and responsibility. Answering the question also forces us to examine both the appearance and the moral status of psychiatrists' social role as it is increasingly affected by judicial decisions.³⁸⁸

If the death penalty is just, psychiatrists will not be ethically

not be expected to apply the law and arrive at formal legal conclusions regarding the prisoner's rights [R]esponsibility for the final decision with respect to the legal question [sh]ould be placed in the hands of a judge.

Id.

387. If capital punishment is just, then psychiatrists may morally assume that the criminal has implicitly requested the psychiatric care necessary to effect his choice to be punished for his crime. Criminals hypothetically request such care because the evaluation is the means for determining whether the criminal needs care that would allow him to achieve his wishes. However, psychiatrists should not actually evaluate or treat incompetent persons without first obtaining proper judicial authorization. The point is, in thinking about how to deal with the criminal's incompetence, both the legal system and psychiatrists may, with some justification, assume that the incompetent criminal's paramount desire is to have his humanity vindicated. This entails engaging in those activities that will enable him to be punished.

Various authors have disagreed as to what findings the American legal system, which does not recognize a "right to be punished," actually would require to permit involuntary treatment of someone adjudicated incompetent for execution. Compare G. Linn Evans, *Perry v. Louisiana: Can a State Treat an Incompetent Prisoner to Ready Him for Execution?*, 19 BULL. AM. ACAD. PSYCHIATRY & L. 249, 258 (1991) (arguing that the Louisiana court order forcing Perry's treatment violated the Supreme Court's ruling in *Washington v. Harper*. "From *Harper*, the state must establish both a police power and *parens patriae* interest in forcibly administering psychotropic drugs to an incompetent inmate," but there can be "no *parens patriae* justification for facilitating an incompetent prisoner's death.") with Bonnie, *supra* note 30, at 85 ("[D]oes the incompetent prisoner have a right to refuse treatment? I doubt it. If presented with this question, the courts would probably hold that the state has a compelling interest in carrying out its lawful sentences that overrides the prisoner's interests in bodily privacy and self-determination."). For a summary of pre-*Ford* case law that might bear on these issues, see Ward, *supra* note 23, at 95-97.

For additional discussion of "suggested procedures," see Miller, *supra* note 385, at 80-82 (discussing different ways to deal with execution competency such as choosing "death qualified" evaluating clinicians, establishing a "conscientious objector" status for clinicians and automatically changing a death sentence to life imprisonment upon a finding of competency to be executed).

388. Cf. Heilbrun et al., *supra* note 40, at 596 ("Even for clinicians who will never be involved with inmates under death sentence, the competency issue is useful as a heuristic device with which to explore issues such as trust and beneficence.").

compromised when they perform competency evaluations of, or give competency-restoring treatment to, death row inmates. Some psychiatrists will not be swayed by this argument, especially those who profoundly dislike being associated with the execution competency process. However, their sentiment really expresses moral reservations about capital punishment's place in the modern criminal justice system, not a reasoned assessment of psychiatric participation itself.

