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Is Prosecution "Medically Appropriate"?

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ABSTRACT

Each year, U.S. courts send thousands of incompetent defendants to hospitals for treatment, where psychiatrists frequently administer psychotropic medication that can alleviate symptoms and allow the defendants to proceed with criminal adjudication. Although defendants and their attorneys usually do not object to such treatment, treatment refusals in two recent, nationally prominent cases—those of Russell Eugene Weston, Jr., the accused Capitol shooter, and Charles T. Sell, a dentist charged with filing false insurance claims—have focused legal and media attention on whether and under what conditions competence restoration can be forced on an unwilling defendant.

In its June 2003 decision in *Sell v. United States*, the Supreme Court issued guidelines for forcible administration of medication to restore competence to stand trial. Among those guidelines is a requirement that the proposed treatment be "*medically appropriate.*" This requirement forces both testifying and treating physicians to consider some under-appreciated ethical issues: How can it be proper, or "medically appropriate," for a physician to treat a patient when "success" makes the patient eligible for prosecution, a guilty verdict, and punishment? Can any meaningful consideration of what is "medically appropriate" treatment for a patient ignore the consequences of treatment which, in the case of many incompetent criminal defendants, includes the likelihood that they will regain competence, be prosecuted, and be punished? Where defendants are charged with capital crimes, can it ever be "medically appropriate" for doctors to administer antipsychotic therapy, knowing that if convicted, their patient would face life in prison at the very least, and could possibly be sentenced to death?

This Article explains why medicating incompetent defendants is ethical,

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despite the practical consequences of such treatment. After summarizing the psychiatric backgrounds of Weston and Sell, the Article describes major legal developments in their cases. Next, the Article describes how the *Sell* ruling frames the question of medical appropriateness for courts and testifying physicians, and examines what occurrences of the phrase "medically appropriate" in case law and medical literature tell us about what doctors consider when they evaluate a proposed treatment.

The Article then returns to the *Sell* and *Weston* cases to review the arguments made by their attorneys in opposition to administering antipsychotic medication. The Article then lays out what the author believes is the strongest argument—grounded in *medical ethics,* as opposed to legal concerns—that one might advance for opposing the treatment of many incompetent defendants. Finally, the Article uses a Kantian conceptualization of punishment's justification to show that the same principles that permit fair, justly administered punishment also provide physicians with an ethical imperative to give defendants competence-restoring medical therapy.

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I. INTRODUCTION

During the past quarter-century, American psychiatrists have maintained an awkward relationship with the U.S. criminal justice system, and the awkwardness intensifies in cases where the death penalty is a possibility. Mental health experts' opinions on matters related to adjudicatory competence, criminal responsibility, and amenability to treatment are often crucial to fair trial procedure, accurate determinations of guilt, and appropriate sentencing by courts.[1] Those very same opinions, however, can also be central events in processes that lead to defendants' being put on trial, found guilty and punished – even, in capital cases, being put to death.[2]

Several forensic psychiatrists[3] have recognized a conflict between the doctor's traditional Hippocratic obligation to help patients and the legal system's need for psychiatric evidence that may support conviction and punishment. The late Bernard Diamond dealt with this issue by being a

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1. GARY B. MELTON ET AL., PSYCHOLOGICAL EVALUATIONS FOR THE COURTS: A HANDBOOK FOR MENTAL HEALTH PROFESSIONALS AND LAWYERS, Chs. 6-9 (2d ed. 1997).

2. Richard J. Bonnie, *Dilemmas in Administering the Death Penalty: Conscientious Abstention, Professional Ethics, and the Needs of the Legal System*, 14 LAW & HUM. BEHAV. 67 (1990).

3. That is, physicians who specialize in providing mental health expertise to lawyers and courts. As the website for the American Academy of Psychiatry and the Law states: "Forensic psychiatry is a medical subspecialty that includes research and clinical practice in the many areas in which psychiatry is applied to legal issues." *Available at* http://www.emory.edu/AAPL/org.htm (last visited Nov. 23, 2004).

"defense psychiatrist" and testifying only when his input might result in a defendant's exoneration.[4] An early career experience as a prosecution witness led Alan Stone to conclude that the courtroom's expectations made it unethical for him to use his medical skills as an expert witness.[5]

Most forensic psychiatrists, however, have adopted the view promulgated in a frequently cited 1990 article by Paul Appelbaum. He suggests that doctors can resolve the moral dilemma posed by testimony that aids the prosecution by recognizing "a qualitatively different basis for forensic ethics"[6] in which "beneficence and nonmaleficence are not the obligatory primary duties."[7] Appelbaum believes that doing good and avoiding harm are paramount duties for psychiatrists only insofar as they act as physicians, that is, only when they have assumed the characteristic responsibilities of a clinician who administers treatment.

> [T]he forensic psychiatrist in truth does not act as a physician . . . . If the essence of the physician's role is to promote healing and/or to relieve suffering, it is apparent that the forensic psychiatrist operates outside the scope of that role . . . . [W]ere we to call such a person a "forensicist" some other similar appellation, it might more easily be apparent that a different nonmedical role with its own ethical values is involved.[8]

Although his position has received some criticism,[9] Dr. Appelbaum's

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4. Bernard L. Diamond, *From Durham to Brawner: A Futile Journey*, WASH. U. L.Q. 109, 116 (1973).

5. Alan A. Stone, *Presidential Address: Conceptual Ambiguity and Morality in Modern Psychiatry*, 137 AM. J. PSYCHIATRY 887, 887-89 (1980); *see also* Alan A. Stone, *The Ethics of Forensic Psychiatry: A View from the Ivory Tower*, *in* LAW, PSYCHIATRY, AND MORALITY: ESSAYS AND ANALYSIS 57 (1984) (arguing that psychiatrists lack appropriate ethical guidelines for courtroom conduct).

6. Paul S. Appelbaum, *The Parable of the Forensic Psychiatrist: Ethics and the Problem of Doing Harm*, 13 INT'L J.L. & PSYCHIATRY 249, 254 (1990).

7. *Id.* at 252.

8. *Id.*

9. To my knowledge, the most vehement criticism of Dr. Appelbaum's views is Alfred M. Freedman & Abraham L. Halpern, *The Psychiatrist's Dilemma: a Conflict of Roles in Legal Executions*, 33 AUSTL. & N.Z. J. PSYCHIATRY 629, 629 (Oct. 1999) (stating: "This justification has similarities to the rationale offered by physicians involved in human experiments and other criminal acts in Nazi Germany, as well as psychiatrists in the former Soviet Union.").

For other criticisms, see S. N. Verdun-Jones, Forensic Psychiatry, Ethics and Protective Sentencing: What Are the Limits of Psychiatric Participation in the Criminal Justice Process?, 399 ACTA PSYCHIATRY SCAND. SUPPL. 77, 77 (2000) (rejecting "the view that a forensic psychiatrist, who undertakes an evaluation for the state, is to be considered as an advocate of justice who is not bound by conventional ethical duties to the individual" undergoing evaluation), and Douglas Mossman, Is Forensic Testimony Fundamentally

distinction between customary medical ethics and the obligations of an expert witness has gained wide acceptance. In its ethical guidelines, the American Academy of Psychiatry and the Law ("AAPL") makes this distinction an essential feature of a properly conducted forensic interview: "before beginning a forensic evaluation, psychiatrists should inform the evaluee that although they are psychiatrists, they are not the evaluee's 'doctor.'"[10] The same distinction underlies reasoning in a 1995 report by the American Medical Association ("AMA") concerning evaluations of, and providing testimony about, a condemned inmate's competence to be executed: "The important principle in this situation is that the physician is acting as an advocate of justice, not as a source of punishment. The physician is acting as an expert advisor providing important information that assists in the pursuit of a just result."[11]

Over the last few years, however, two nationally prominent criminal cases have posed—more precisely, have forced psychiatrists to address—an ethical dilemma that the therapist-expert distinction cannot resolve. The first case involves Russell Eugene Weston, Jr., accused of fatally shooting two Capitol police officers in July 1998. According to press reports and legal opinions, Weston has a long history of mental illness and became increasingly delusional after his arrest. In April 1999, the federal district judge assigned to preside over the criminal trial ruled that Weston was "incompetent to stand trial," meaning that he could not consult rationally with his lawyers or comprehend the proceedings against him. The second case is that of Charles T. Sell, a St. Louis area dentist arrested in 1997 for filing false insurance claims. Public record documents report that, like Weston, Sell has suffered from a serious mental disorder for several years, symptoms which led to his being found incompetent to stand trial the same month as Weston.

Each year, U.S. courts send thousands of incompetent defendants to hospitals for treatment.[12] Typically, that treatment includes psychotropic

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Immoral?, 17 INT'L J.L. & PSYCHIATRY 347 (1994).

10. American Academy of Psychiatry & the Law Ethical Guidelines for the Practice of Forensic Psychiatry, Section II, *at* http://www.emory.edu/AAPL/ethics.htm (last visited Nov. 23, 2004).

11. Freedman & Halpern, *supra* note 9, at 631 (quoting Council on Ethical and Judicial Affairs, Report 6-A-95, *Physician Participation in Capital Punishment: Evaluations of Prisoner Competence to be Executed: Treatment to Restore Competence to be Executed, in* Proceedings of the House of Delegates of the American Psychiatric Association: 144th Annual Meeting 223 (1995)).

12. Precise numbers on these matters are hard to come by. A frequently cited estimate is that in the United States, "approximately 60,000 defendants, or between 2% and 8% of all felony defendants are referred for fitness to stand trial assessments each year." Jodi L. Viljoen & Patricia A. Zapf, *Fitness to Stand Trial Evaluations: A Comparison of Referred*

medications that often alleviate symptoms to a point where the defendant can proceed with criminal adjudication.[13] In most cases, patients and their attorneys do not object to such treatment. But in Sell's and Weston's cases, attorneys kept their clients from receiving psychotropic drugs for years, arguing that such medication would interfere with their clients' rights to a fair trial. Weston's lawyers went further, and argued that by medicating the client, doctors would be violating their professional obligation to help their patients. This was because "successful" treatment would set in motion a chain of events that could lead to Weston's being tried, convicted, imprisoned, and possibly executed for murder.

While Weston's case was before the federal trial court and the D.C. Court of Appeals, psychiatrists were not permitted to give him antipsychotic drug therapy. In December 2001, however, the U.S. Supreme Court refused to hear appeals challenging lower courts' decisions that authorized treating Weston,[14] and he began to receive medication. Just

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and Non-Referred Defendants, 1 INT'L J. FORENSIC MENTAL HEALTH 127, 127 (2002) (citations omitted). A Virginia study suggests that roughly one-sixth of these individuals are found incompetent to stand trial. Janet I. Warren et al., *Beyond Competence and Sanity: The Influence of Pretrial Evaluation on Case Disposition*, 22 BULL. AMER. ACAD. PSYCHIATRY LAW 379, 381 (1994). "The best available data—though somewhat dated—suggest that approximately 3400 incompetent defendants are hospitalized for treatment at any point in time." THOMAS G. GUTHEIL & PAUL S. APPELBAUM, CLINICAL HANDBOOK OF PSYCHIATRY AND THE LAW 266 (3d ed. 2000).

A back-of-the-envelope calculation suggests that this last estimate is still reasonable. Information obtained on the Internet shows that on November 30, 2002, 173 patients were undergoing competence restoration in Ohio public sector hospitals (which are the only sites where competence restoration occurs in the state). *Available at* www.jamesraia.com (last visited Nov. 23, 2004). U.S. census estimates from 2003 put Ohio's population at 11,435,708 and the U.S. population at 290,809,777, or about 25.4 times that of Ohio. *Available at* http://quickfacts.census.gov/qfd/states/39000.html (last visited Nov. 23, 2004). Extrapolating from Ohio's figures (*i.e.*, multiplying 173 times 25.4) suggests that approximately 4400 persons are hospitalized nationally—in rough agreement with the figure cited by Gutheil and Appelbaum.

13. One study, for example, reports an 89.5% success rate for competence restoration. Robert A. Nicholson et al., *Predicting Treatment Outcome for Incompetent Defendants*, 22 BULL. AM. ACAD. PSYCHIATRY L. 367 (1994). Concerning the matter on which this Article focuses—involuntary medication for restoration—a New York state study found that eighty-seven percent of incompetent felony defendants involuntarily treated with medication were ultimately restored to competence. Brian Ladds et al., *Involuntary Medication of Patients Who Are Incompetent to Stand Trial: A Descriptive Study of the New York Experience with Judicial Review*, 21 BULL. AM. ACAD. PSYCHIATRY L. 529 (1993). For a review of studies concerning involuntary medication to restore competence, *see* Brian Ladds & Antonio Convit, *Involuntary Medication of Patients Who Are Incompetent to Stand Trial: A Review of Empirical Studies*, 22 J. AM. ACAD. PSYCHIATRY L. 519 (1994).

14. Weston v. U.S., 534 U.S. 1067 (2001).

eleven months later, however, the Supreme Court granted *certiorari*[15] after Sell's efforts to avoid medication failed at the district and appellate court levels. In its June 2003 decision in *Sell v. United States*,[16] the Supreme Court issued guidelines under which U.S. trial courts could order administration of medication solely for the purpose of restoring a defendant's competence to stand trial. Among those guidelines is a requirement that the proposed treatment be "*medically appropriate.*"

This Article contends that this requirement forces both testifying and treating physicians to confront a neglected, under-appreciated ethical issue: How can it be proper conduct—how can it be "medically appropriate"—for a physician to treat a patient when "success" makes the patient eligible for prosecution, a guilty verdict, and punishment? Even if a trial court issues an order making it *legally* permissible for doctors to medicate a defendant-patient over his objection, is it *ethically* appropriate for doctors to do so? Can any meaningful consideration of what is "medically appropriate" treatment for a patient ignore the consequences of treatment, which, in the case of many incompetent criminal defendants, includes the likelihood that they will regain competence, be prosecuted, and be punished? How, in Russell Weston's case, can it be "medically appropriate" for doctors to administer antipsychotic therapy, knowing that, if convicted, their patient would face life in prison at the very least, and could possibly be sentenced to death?

In responding to the questions in the preceding paragraph, this Article explains why medicating incompetent defendants is ethical, despite the practical consequences of such treatment. Part II summarizes Weston's psychiatric background, major legal developments following the Capitol shootings, and his attorneys' efforts to keep him from getting antipsychotic medication. Part III reviews similar events in Sell's case, and describes how the Supreme Court's *Sell* decision frames the question of medical appropriateness for courts and testifying physicians. Part IV examines occurrences of the phrase "medically appropriate" in case law and medical literature to develop a sense of what things doctors consider when asked (on or off the witness stand) about a particular treatment.

Part V returns to legal and ethical arguments offered by attorneys for Sell and Weston. Part VI lays out what the author believes is the strongest argument—grounded in *medical ethics,* as opposed to legal concerns —that one might advance for opposing the treatment of Weston and many other

15. Sell v. United States, 537 U.S. 999, 999-1000 (2002) (granting *certiorari* on the issue of "[w]hether the Court of Appeals erred in rejecting petitioner's argument that allowing the government to administer antipsychotic medication against his will solely to render him competent to stand trial for non-violent offenses would violate his rights under the First, Fifth, and Sixth Amendments.").

16. 539 U.S. 166 (2003).

incompetent defendants. Part VII describes a conceptualization of punishment's justification, and Part VIII concludes that the principals that permit fair, justly administered punishment provide physicians with an ethical imperative to give defendants competence-restoring medical therapy. Part IX examines these issues in the context of defendants whose competence restoration will allow them to face charges that carry the death penalty.

II. RUSSELL EUGENE WESTON, JR.

A. Background[17]

Weston was born to married parents in December 1956 and grew up in Illinois. After graduating in the lower third of his high school class in 1974, he moved to Montana. There, he rented a cabin and earned the nickname "Crusty Rusty" because he changed his clothes infrequently. He held a series of jobs over the next nine years; his trouble sustaining employment seemed related to difficulties getting along with others. In the mid-1980s he underwent medical evaluations for various physical complaints. Psychiatric and psychological evaluators detected paranoid and grandiose thinking, but did not diagnose a major mood or thought disorder. He began receiving SSI payments for asymptomatic polyneuropathy[18] of the lower extremities, cervical strain, and a mixed personality disorder; in April 1989, when those payments had been stopped, he requested reconsideration, saying, "I am accusing SSI of deceptive acts and fraud, refusal to give me copies of doctor reports, refusal to reset doctor appointment with non-abusive doctor."[19] In December 1989, a psychiatric examiner wrote, "This man has not been believed to be schizophrenic, but does display a lot of paranoia, hostility, and difficulty assessing reality."[20]

Around 1990, Weston's parents noted that he became "obsessed" about a kidnapping. Eventually, Weston thought the victim was Chelsea Clinton,

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17. This Part's information on Weston's background comes primarily from a report prepared by David G. Daniel, M.D., who evaluated Weston for the federal district court. One can find Dr. Daniel's report *at* http://www.dcd.uscourts.gov/district-court-2000.html (last visited Nov. 23, 2004). News articles elucidate some details that Dr. Daniel's report does not make clear.

18. "Polyneuropathy is the simultaneous malfunction of many peripheral nerves throughout the body." THE MERCK MANUAL OF MEDICAL INFORMATION—SECOND HOME EDITION Ch. 95, § 6 (2004), *available at* http://www.merck.com/mrkshared/mmanual_home 2/sec06/ch095/ch095h.jsp (last visited Nov. 23, 2004).

19. Evaluation of Defendant by Dr. David G. Daniel, U.S. v. Russell Eugene Weston, Jr., Case No. 98CR-357, at 7, *available at* http://www.dcd. uscourts.gov /district-court-2000.html (last visited Nov. 23, 2004) [hereinafter *Daniel's Report*].

20. *Id.* at 8.

and he developed an elaborate set of illogical beliefs related to this. By the mid-1990s, he thought that he had secret information about being the target of a government plot and that President Clinton wanted him dead. In May 1996, Weston underwent psychiatric hospitalization in Helena, Montana, where he told care-givers that President Clinton and government officials were harassing him, that an airplane was poisoning him, and that a radioactive chip implanted in his jaw let him communicate with the Russian ambassador. Two months later, Weston traveled to Washington, D.C. to apply for a CIA job. During the interview (which was videotaped),[21] Weston said he was "a clone," talked about pre-birth bombardment with microwaves, and discussed a movie made by President Kennedy in which Weston and President Clinton were actors.[22]

After Weston sent a letter to the White House that accused President Clinton of sending CIA agents to kill him, state health officials in Montana committed him to a public mental hospital in October 1996.[23] By the end of a fifty-five day hospital stay, staff members had concluded that Weston suffered from schizoaffective disorder, bipolar type,[24] and had benefited from treatment with loxapine and divalproex sodium.[25] At a follow-up appointment several days after discharge, however, he was not taking medication and seemed "very bizarre and paranoid."[26]

During the next twenty months, Weston often lived with his parents in Illinois. In mid-July 1998, Weston's grandmother paid him to shoot several of the stray cats that lived on the family's property. This upset Weston's father, who was fond of the cats, and the father told his son to find another

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21. Anne Hull, *A Living Hell or a Life Saved? Capitol Shooter's Untreated Madness Fuels Legal and Ethical Debate*, WASH. POST, Jan. 23, 2001, at A1.

22. A transcript of the interview appeared in the June 2001 issue of *Harper's Magazine*, and may be viewed at http://articles.findarticles.com/p/articles/mi_m1111/is_1813_302/ai_75122016 (last visited Nov. 23, 2004).

23. Jon Jeter, *Suspect's Family Recalls His Ailing Mind, Aimless Life*, WASH. POST, July 27, 1998, at A1.

24. Schizoaffective disorder is a chronic, severe mental illness during which, at some point, an episode of mania or depression coincides with the psychotic symptoms (*e.g.*, hallucinations, delusions, or disorganized speech) that characterize schizophrenia. AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, FOURTH EDITION, TEXT REVISION 319 (2000) [hereinafter DSM-IV-TR]. The descriptor "bipolar type" refers to manic symptoms that are part of the illness's presentation. *Id.* at 321.

25. Loxapine is the generic name for Loxitane®, an antipsychotic medication "indicated for the treatment of schizophrenia." PHYSICIANS' DESK REFERENCE 3300 (57th ed. 2003). Divalproex sodium is the generic name for Depakote®, a multi-use medication "indicated for the treatment of the manic episodes associated with bipolar disorder." *Id.* at 432.

26. *Daniel's Report*, *supra* note 19, at 14.

place to live. On July 23, 1998 (the day before the Capitol shootings), Weston left his parents' home with his father's revolver, and drove 755 miles to Washington, D.C.

The next day, according to the government's indictment, Weston shot and killed two Capitol officers. Weston believed that "cannibals" had used a "ruby Satellite system" to spread a dread disease ("Black Heva") that threatened the entire U.S. population. Weston believed that the system's override console was located in the Capitol building, and was trying to gain access to the console when he shot the two officers.[27] The second officer returned fire and wounded Weston, who was then taken to D.C. General Hospital for treatment of multiple gun shot wounds and bone fractures. Weston remained there until October 1998, when he was transferred to a correctional treatment facility.

B. Post-Arrest Evaluations and Testimony

The federal trial court asked Sally C. Johnson, M.D. to evaluate Weston. She concluded that Weston had a "mental disease rendering him mentally incompetent to understand the nature and consequence of the proceedings against him and assist in his defense."[28] On February 3, 1999, Weston was sent for additional competence evaluations to the U.S. Medical Center for Federal Prisoners in Springfield, Missouri ("USMC–Springfield"). However, he would not share personal information or discuss his legal situation with the clinicians who tried to evaluate him, replying stereotypically, "'Upon the advice of my attorneys I have no comment,'" or similar phrases.[29]

On April 29, 1999, Judge Emmet G. Sullivan of the D.C. federal district court ruled that Weston was incompetent to stand trial, and sent him to a treatment facility at the Federal Correctional Institution in Butner, North Carolina ("FCI–Butner"), where Dr. Johnson works. For the next three years, Weston remained at FCI-Butner except for times when he traveled to Washington DC for hearings; he spent much of his time in seclusion. Clinicians at FCI–Butner thought Weston should be given antipsychotic therapy, but Judge Sullivan's order specified that Weston could not receive involuntary psychotropic medication without the court's prior approval. On September 9, 1999, following two administrative hearings held at FCI-Butner and two district court hearings on the issue of involuntary treatment, Judge Sullivan concluded that psychotropic medication was "medically

27. Bill Miller, *Weston's Mind-set Detailed: Capitol Suspect Feared Disease, Cannibal Threat*, WASH. POST, Apr. 23, 1999, at A1.

28. Bill Miller, *Capitol Suspect Not Fit for Trial, Doctor Reports*, WASH. POST, Dec. 5, 1998, at B1.

29. *Daniel's Report*, *supra* note 19, at 20.

appropriate and that, considering less intrusive alternatives, it [wa]s essential for the defendant's own safety or the safety of others[,]"[30] and authorized FCI-Butner clinicians to medicate Weston involuntarily.

The district court also stayed its order to permit defense lawyers to file an appeal. They did, and on March 24, 2000, a panel of the D.C. Circuit Court of Appeals reversed the medication order and remanded the case to the district court for further fact-finding. The appeals court panel found that the record indicated "that in his current circumstances Weston poses no significant danger to himself or to others."[31] The panel directed the district court to consider whether medication was necessary to render Weston competent to stand trial, an issue the lower court had expressly avoided in its September 1999 decision. The district court also was to "consider the potential impact of compelled medication on Weston's Sixth Amendment fair trial right."[32]

Finally, in a footnote, the Court of Appeals' panel directed the district court to "also consider whether there is any merit to Weston's contention that medical ethics preclude ordering a patient medicated in a potential capital case."[33] This matter had been raised by defense counsel in the district court hearings, but was expressly ignored in Judge Sullivan's September 1999 decision. Because the government had not yet announced that it would seek the death penalty, the case, wrote Judge Sullivan, had "not at this time—and it may never—present the issue of medicating a person to restore his mental competency to execute him."[34]

During the July 2000 district court hearings, several testifying clinicians said that Weston's mental condition had deteriorated at FCI-Butner in the absence of antipsychotic therapy, and that he was dangerous to himself and others. He was deteriorating mentally and physically because he could or would not cooperate with needed physical therapy. He was at an ongoing,

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30. U.S. v. Weston, 69 F. Supp. 2d 99, 118 (D.D.C. 1999).

31. U.S. v. Weston, 206 F.3d 9, 13 (D.C. Cir. 2000).

32. *Id.* at 14. In a concurring opinion, Judge Tatel stated that forced medication might implicate four defendant's rights: (1) the right not to be tried unless he is competent to consult with counsel and assist in preparing a defense; (2) the right to testify and present his version of events – perhaps in a psychotic state; (3) the right to be present in court throughout his trial; and (4) the right to present an insanity defense. Judge Tatel noted that drug side effects might "flatten or deaden" Weston's emotional responses and influence jurors' opinions about his remorsefulness, which in turn could affect their judgments about imposing the death penalty. If medications ameliorated his symptoms, jurors might not find his own testimony about a *former* psychosis nearly as convincing as testimony delivered by a man who still harbored the delusions that made him travel to the Capitol. *Id.* at 19-20 (Tatel, J., concurring).

33. U.S. v. Weston, 206 F.3d at 14 n.3.

34. U.S. v. Weston, 69 F. Supp. 2d at 119.

high risk of suicide, and he posed a risk to staff members who entered his room to care for him. The psychiatrists believed there was a substantial likelihood that antipsychotic medication would lower these risks and restore Weston's competence to stand trial. The benefits of antipsychotic medication outweighed potential side effects, they said, and side effects could be managed if they occurred. Finally, the psychiatrists said that current professional ethical canons contained no proscription against involuntarily administering medication to restore a defendant's competence, even if the medication would make the defendant subject to legal proceedings that could result in a guilty verdict and a death sentence.[35]

On August 23, 2000, the district court appointed its own expert, Dr. David G. Daniel, "for the purpose of providing the Court with an expert opinion as to whether it is in the defendant's medical interests to administer anti-psychotic medication without his consent."[36] In a report filed several weeks later, and at a hearing held November 15, 2000, Dr. Daniel said that such treatment was in Weston's interest. Dr. Daniel wrote:

> The determination of whether a treatment is in the medical interest of a patient involves fundamental questions:
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> 1. Does the patient have a diagnosable illness causing the patient to experience significant distress or disability?
>
> 2. Does a treatment exist that is available and appropriate for treatment of that condition?
>
> 3. Is the treatment reasonably safe and is the treatment likely to be reasonably well tolerated?
>
> 4. Is there a less invasive treatment that may provide adequate benefit?
>
> 5. Does an individual clinical risk-benefit analysis for the patient indicate that the treatment is in the patient's medical interest?[37]

Dr. Daniel thought involuntary treatment offered several potential benefits to Weston, including "[a]melioration of symptoms that distress[ed]

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35. This paragraph summarizes opinions of the government's expert witnesses, which includes Dr. Johnson, Dr. Debra DePrato, and Dr. Howard Zonana. *See* U.S. v. Weston, 255 F.3d 873, 877 (D.C. Cir. 2001), *and* Brief for Appellant, U.S. v. Weston, *available at* http://www.dcfpd.org/motions/appeals/drug%20expert/weston2.htm (last visited Nov. 23, 2004) [hereinafter *Brief for Appellant*]. Dr. Zonana acknowledged that pre-trial treatment could initiate a chain of events in which execution could result. *Id.*

36. *Daniel's Report, supra* note 19, at 29.

37. *Id.*

the patient" and impaired Weston's functioning, reducing his risk of harming himself or others, preventing "an extended, very prolonged period of untreated behavioral regression," and "gaining insight into the nature of his illness and its treatments."[38] No recent peer-reviewed publication would support leaving a schizophrenic patient unmedicated for a prolonged period, said Dr. Daniel. Without medication, Weston would remain in seclusion indefinitely, which could "interact with and worsen core 'negative' symptoms of schizophrenia . . . Involuntary medication appears to be a more medically appropriate intervention and more in the patient's medical interest than living for years in seclusion."[39] These considerations led Dr. Daniel to conclude "that it is currently medically appropriate and in the defendant's medical interest to treat him with antipsychotic medication without his consent."[40]

Judge Sullivan issued his next decision on March 6, 2001. He held that Weston's potential desire to be and look psychotic when presenting an insanity defense had to be balanced against the government's need to bring him to trial. Noting that "antipsychotic medication is the only therapeutic intervention that may address Weston's symptoms, lessen his delusions, and make him competent to stand trial,"[41] Judge Sullivan ruled that involuntary treatment was the "medically appropriate" means of treating Weston's illness,[42] and authorized FCI–Butner to administer competence-restoring drugs.

Judge Sullivan stayed the medication order while Weston's lawyers appealed his decision.[43] On July 27, 2001, the D.C. appeals court affirmed Judge Sullivan's ruling, and explicitly rejected the idea that ethical principles were relevant to a determination that Weston should be forcibly medicated: "Even if a particular doctor had ethical objections to administering antipsychotic drugs to a non-consenting patient, this would not undercut the consensus in the medical profession that anti-psychotic medication is the medically appropriate response to Weston's condition."[44] On December 10, 2001, the U.S. Supreme Court declined Weston's request to review the appellate court's affirmation of the medication order.[45] Federal law makes an appeals court decision effective when the Supreme Court declines to review it, meaning that the legal barriers to Weston's

38. *Id.* at 39.
39. *Id.* at 38, 42.
40. *Id.* at 43.
41. U.S. v. Weston, 134 F. Supp. 2d 115, 121 (2001).
42. *Id.* at 138.
43. *Id.*
44. U.S. v. Weston, 255 F.3d at 878.
45. Weston v. U.S., 534 U.S. 1067 (2001).

treatment had been removed.[46] Weston began receiving antipsychotic medication in January 2002[47] but never became competent to stand trial. Following a hearing in mid-November 2004, Judge Sullivan ruled that Weston was unlikely to soon become competent and recommended that he be committed to a federal mental hospital, while leaving open the possibility that Weston could undergo trial for murder should he ever become competent.[48]

III. CHARLES THOMAS SELL, D.D.S.

A. Background

Sell graduated from college in 1972, and married his first wife, Deborah, in 1977, a year after he completed dental school.[49] He operated a private practice in Des Peres, Missouri (a St. Louis suburb), and between 1982 and 1990, he served in the Army Dental Reserve, eventually achieving the rank of Major.[50]

During the 1980s and 1990s, Sell experienced emotional problems and was arrested for assault, resisting arrest, and false imprisonment; he received a two-year suspended sentence on the false imprisonment charge for keeping a woman in his office. He had many contacts with the local police department and filed several harassment accusations against its officers. He had claimed that the Governor and the local police chief were trying to kill him. When the Missouri Dental Board investigated allegations against him, Sell went to the investigator's home and threatened him, and threatened the investigator's wife over the telephone. He kept guns at his office and told an employee he would shoot insurance examiners if they came to look at his records.[51]

Sell underwent hospitalization in September 1982, having claimed at one point that communists had contaminated the gold he use for fillings.[52]

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46. Neely Tucker, *High Court Passes on Capitol Suspect: Decision Clears Way For Medicating Weston*, WASH. POST, Dec. 11, 2001, at B1.

47. U.S. v. Weston, 260 F. Supp. 2d 147, 149 (D. D.C. 2003) (Memorandum Opinion & Order issued May 1, 2003 by Judge Emmet G. Sullivan).

48. Carol D. Leonnig, *Capitol Suspect Still Unfit for Trial: Hospitalization Advised for Man Accused of Killing Officers*, WASHINGTON POST, Nov. 25, 2004, at B7; U.S. v. Weston, Crim. No. 98-357 (EGS), 2004 U.S. Dist. LEXIS 23579, at *2-6 (D. D.C. Nov. 22, 2004).

49. Brief of Appellant at 3, Sell v. United States, 282 F.3d 560 (8th Cir. 2002) (No. 01-1862) [hereinafter *Appellant Brief*].

50. *Id.* at 3-4.

51. Brief of Appellee at 4-5, Sell v. United States, 282 F.3d 560 (8th Cir. 2002) (No. 01-1862) [hereinafter *Appellee Brief*].

52. Sell v. U.S., 539 U.S. 166, 169 (2003).

Sell's first wife left him in 1983, which caused him great emotional difficulty.[53] In 1984, Sell again underwent hospitalization after police responded to a 9-1-1 call in which Sell reported a leopard outside his office. When police arrived at the office, Sell told them, "Go ahead and shoot me, the leopard is getting on the bus! Shoot me! Shoot me!"[54] During the multi-year course of his illness, Sell received antidepressant medications; for a short time, he also took the antipsychotic medication haloperidol, which caused him severe side effects and which he likened to having a "lobotomy."[55]

In April 1997, the FBI searched Sell's office and home. Just after this, Sell asked one of his employees whether she was willing to die for him, and said he wished to "kill the bastards." The employee contacted the FBI and agreed to wear a transmitter wire at the office. By means of the transmitter, FBI agents heard talking about bombing the home of an FBI supervisor and saying that G–d had told him "a soul will be saved" for every FBI agent that Sell killed.[56]

B. Sell's Arrest and Adjudicatory Incompetence

On May 16, 1997, the authorities arrested Sell on charges of submitting false insurance claims. Because of his history of mental problems, the Government asked that Sell undergo examination of his competence to stand trial. The examining psychologist concluded that Sell had a "paranoid personality disorder" but was neither psychotic nor incompetent to stand trial. The psychologist cautioned, however, that Sell might become psychotic in the future. Later, a grand jury produced a superseding indictment charging Sell and his second wife with numerous counts of health insurance fraud, Medicaid fraud, and money laundering.[57]

In August 1997, Sell was released on bond, but was re-arrested in January 1998 after the Government claimed that he had tried to intimidate a witness.[58] At an initial bail revocation hearing, Sell screamed, uttered personal insults and racial slurs, and spat in the presiding magistrate's face. A psychiatrist reported that Sell's condition had worsened: he was not sleeping and was more paranoid. Sell's bail was revoked, and in April 1998, he received the additional criminal charges of attempting to murder a former employee who planned to testify against him in the fraud case and

53. *Appellant Brief, supra* note 49, at 4.
54. *Appellee Brief, supra* note 51, at 4 n.1.
55. *Appellant Brief, supra* note 49, at 5.
56. *Appellee Brief, supra* note 51, at 5-6.
57. *Sell*, 539 U.S. at 170; *Appellant Brief, supra* note 49, at 3-4.
58. *Appellant Brief, supra* note 49, at 8.

the FBI agent who had arrested him.[59]

In April 1999, Sell underwent evaluation at USMC–Springfield after he had asked the Court to reconsider his competence to stand trial. Sell was found incompetent to stand trial and returned to USMC–Springfield for a four-month assessment to see whether treatment might restore his capacity to proceed with adjudication. After two months, psychiatrist James Wolfson and psychologist Richart DeMier (both USMC-Springfield clinicians) recommended that Sell take antipsychotic medication. When he refused to do so, USMC-Springfield initiated proceedings for getting approval to medicate Sell over his objection.[60]

The first two steps involved reviews within USMC-Springfield of the treating clinicians' recommendations. In June 1999, Dr. Charles Glazzard, a non-treating psychiatrist, considered Sell's mental health history, delusions of persecution, an outside psychiatrist's views, Sell's opinion, and opinions of laypersons who knew Sell and believed he had no mental illness. Dr. Glazzard thought involuntary administration of medication was proper because Sell was mentally ill, dangerous, and in need of medication to treat his mental illness and to become mentally fit for trial. Dr. Glazzard noted that the determination of dangerousness reflected what Sell might do if released in the community, rather than risks that he posed while confined to USMC-Springfield.[61]

Next, USMC-Springfield administratively reviewed what Dr. Glazzard had recommended, concluded that antipsychotic medication was the treatment most likely to benefit Sell and address his delusions, and upheld Dr. Glazzard's conclusions about treatment. The reviewing official also noted that other forms of treatment were unlikely to be effective, and that Sell's pervasive persecutory delusions and his attempted murder charges signaled a risk of violence were he to return to the community.[62]

In July 1999, Sell filed a court motion to contest USMC-Springfield's right to force antipsychotic drugs on him. On September 29, 1999, a federal magistrate held a hearing at which the evidence mostly replicated matters considered at the USMC-Springfield administrative hearing. However, Drs. Wolfson and DeMier discussed the question of the medication's effectiveness more thoroughly, and they also testified about Sell's behavior following the administrative proceedings. This included a July 1999 incident in which Sell approached a USMC-Springfield nurse and suggested that he was in love with her. When told that his behavior was inappropriate and that he should stop it, Sell indicated that this kind of

59. *Sell*, 539 U.S. at 170.

60. *Id.* at 170-71; *Appellant Brief*, *supra* note 49, at 12.

61. *Sell*, 539 U.S. at 171-72; *Appellant Brief*, *supra* note 49, at 12-13.

62. *Sell*, 539 U.S. at 172.

conduct would continue. Drs. Wolfson and DeMier said that given Sell's history and unwillingness to desist, such amorous incidents were not harmless and showed he was a safety risk, even while confined within USMC-Springfield.[63]

On April 9, 2000, the magistrate ruled that government had shown that (1) Sell was dangerousness to himself and others at USMC-Springfield, (2) antipsychotic medication was "the only way to render him less dangerous," (3) the availability of newer antipsychotic drugs would reduce the risk of severe side effects, (4) the benefits of medication outweighed the risks, (4) there was "a substantial probability" that antipsychotic medication would render Sell competent to stand trial, and (5) receiving such medications was the only way for Sell to achieve competence. The magistrate authorized involuntary administration of antipsychotic drugs, but stayed his order while Sell appealed to the federal district court.[64]

The district court issued its opinion a year later, in April 2001, and determined that, because Sell was currently housed in an open ward within USMC-Springfield, he was not dangerous to himself or others in his current living situation. The district court nonetheless affirmed the magistrate's order to medicate Sell because such treatment was "medically appropriate," constituted "the only viable hope of rendering defendant competent to stand trial," and served "the government's compelling interest in obtaining an adjudication of defendant's guilt or innocence."[65]

Both the Government and Sell appealed, and on March 7, 2002, a panel of the Eighth Circuit Court of Appeals affirmed 2-to-1 the district court's judgment.[66] The panel's majority agreed with the district court that Sell's behavior toward the nurse did not constitute evidence of dangerousness while he was at USMC-Springfield.[67] The majority also agreed that Sell's fraud charges were serious enough that the Government had a "paramount" interest in restoring his mental fitness for trial, and that competence could not be achieved by a means "less intrusive" than antipsychotic medication.[68] The dissenting judge believed that charges of fraud and money laundering were "not serious enough" to justify forcing Sell to take antipsychotic medication.[69]

In November 2002, the U.S. Supreme granted *certiorari* to determine whether the Eighth Circuit's decision to let the Government involuntarily

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63. *Id.* at 172-73.
64. *Id.* at 173.
65. *Id.* at 173-74.
66. Sell v. United States, 282 F.3d 560 (8th Cir. 2002).
67. *Id.* at 565.
68. *Id.* at 568.
69. *Id.* at 574 (Bye, J., dissenting).

medicate Sell would violate his Constitutional rights guaranteed by the First, Fifth, and Sixth Amendments.[70]

C. The Supreme Court's *Sell* Decision

In a 6-to-3 decision,[71] the Supreme Court ruled that a pre-trial detainee in Sell's position might indeed be forced to take antipsychotic medication to restore competence to stand trial. In reaching this conclusion, the Court looked to rulings and *dicta* from its two previous decisions on involuntary medication, *Washington* v. *Harper*[72] and *Riggins* v. *Nevada*.[73]

Neither earlier decision had addressed the question of medicating a pre-trial detainee solely for the purpose of rendering him competent. *Harper*, a 1990 decision, concerned a mentally ill prison inmate for whom doctors had recommended antipsychotic drugs to treat his illness and to reduce his dangerousness to himself and others; the Court had concluded that Washington State's procedures for administering such medication was a constitutionally acceptable "accommodation between an inmate's liberty interest in avoiding the forced administration of antipsychotic drugs and the State's interests in providing appropriate medical treatment to reduce the danger" posed by the inmate.[74] *Riggins*, issued in 1992, concerned a pre-trial detainee who had not been found incompetent to stand trial, but who was nonetheless forced to take antipsychotic medication and later convicted of murder. A Supreme Court majority overturned Riggins's conviction and remanded the case on grounds that the medication had possibly prejudiced his fair trial rights.[75] Six members of the *Riggins* court had noted, however, that forced medication might be permissible in cases where such treatment was necessary to assure a pre-trial detainee's safety or the safety of others, or where no means less intrusive than medication would allow the Government to achieve an adjudication of guilt or innocence.[76]

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70. Sell v. United States, 537 U.S. 999 (2002).

71. Three justices did not join with the majority on grounds that neither the Eighth Circuit Court of Appeals nor the Supreme Court had jurisdiction to hear the case. *Sell v. U.S.*, 539 U.S. 166, 216 (Scalia, J., dissenting) (holding that the district court's Apr. 4, 2001 order was neither a "final decision" under 28 U.S.C. § 1291 nor one of the types of specified interlocutory orders discussed in 28 U.S.C. § 1292). The majority concluded that the district court's decision was an appealable collateral order, and that the appeals court had jurisdiction. *Sell*, 539 U.S. at 175-77.

72. 494 U.S. 210 (1990).

73. 504 U.S. 127 (1992).

74. *Harper*, 494 U.S. at 236.

75. *Riggins*, 504 U.S. at 137-8.

76. *Id.* at 135. Justice Kennedy concurred in the judgment, but took a much more critical view of antipsychotic medication. After reviewing the potential side effects of the antipsychotic drugs available in 1992, and the possibility that these side effects might

Guided by *Harper* and *Riggins*, the *Sell* majority opinion, *per* Justice Breyer, concluded that

> the Constitution permits the Government to involuntarily administer antipsychotic drugs to a mentally ill defendant facing serious criminal charges in order to render that defendant competent to stand trial, but only if the treatment is medically appropriate, is substantially unlikely to have side effects that may undermine the fairness of the trial, and, taking account of less intrusive alternatives, is significantly necessary to further important governmental trial-related interests.[77]

To implement this conclusion, said the *Sell* majority, trial courts must investigate four matters. First, trial courts should evaluate the importance of prosecution by considering (a) the seriousness of the allegations against the defendant, (b) how long the defendant has already been confined (*i.e.*, time that could count against any sentence he might receive), and (c) whether the defendant might, if not treated, be confined to a psychiatric hospital for a lengthy period, which "would diminish the risks that ordinarily attach to freeing without punishment one who has committed a serious crime."[78] Second, a trial court must conclude that the proposed medication would "be substantially likely" to render the defendant fit to stand trial without causing side effects that would interfere with his ability

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adversely influence jurors' opinions about a defendant, Justice Kennedy stated:

> If the State cannot render the defendant competent without involuntary medication, then it must resort to civil commitment, if appropriate, unless the defendant becomes competent through other means. If the defendant cannot be tried without his behavior and demeanor being affected in this substantial way by involuntary treatment, in my view the Constitution requires that society bear this cost in order to preserve the integrity of the trial process. The state of our knowledge of antipsychotic drugs and their side effects is evolving and may one day produce effective drugs that have only minimal side effects. Until that day comes, we can permit their use only when the State can show that involuntary treatment does not cause alterations raising the concerns enumerated in this separate opinion.

Riggins, 504 U.S. at 145 (Kennedy, J., concurring in the judgment).

Given the frequency with which legal briefs and case law have quoted Justice Kennedy's just-described views, it is interesting to note the brevity of *Sell*'s entire comments about currently available antipsychotic medications: "Different kinds of antipsychotic drugs may produce different side effects and enjoy different levels of success." *Sell*, 539 U.S. at 181. For a discussion of this matter as it existed in 2002, *see* Douglas Mossman, *Unbuckling the "Chemical Straitjacket": The Legal Significance of Recent Advances in the Pharmacological Treatment of Psychosis*, 39 SAN DIEGO L. REV. 1033, 1139-49 (2002).

77. *Sell*, 539 U.S. at 179.

78. *Id.* at 180.

to assist defense counsel.[79] Third, a trial court must find that no less intrusive treatment would restore the defendant's competence.[80] Finally, *Sell* allows involuntary medication only if the trial court determines that such treatment would be "*medically appropriate*," *i.e.*, in the patient's best medical interest in light of his medical condition."[81]

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79. *Id.* at 181.

80. *Id.* This requirement deserves two parenthetical comments. *Sell* states that before ordering involuntary medication, trial courts must find "that *any* alternative, less intrusive treatments are unlikely to achieve substantially the same results" as would medication. *Id.* (emphasis added). *Sell* then contrasts the claim made by the American Psychological Association (in its *amicus* brief) that "nondrug therapies may be effective in restoring psychotic defendants to competence," with psychiatrists' assertion (in the *amicus* brief filed by the American Psychiatric Association and American Academy of Psychiatry and the Law) that "alternative treatments for psychosis [are] commonly not as effective as medication." *Id.*

Sell thus implies that virtually any nonpharmacological therapy is "less intrusive" than taking drugs. But is this really so? Assume that a defendant charged with assaulting a police officer suffers from fixed delusional beliefs about the legal system: he thinks that local law enforcement agencies, the local judiciary, the prosecutor's office, and all defense attorneys are conspiring against him in a plot to have him imprisoned so that they can proceed uninhibited to turn his wife and daughters into prostitutes. The defendant-patient has two treatment options: (1) having a "therapist" meet with him an hour several times a week (perhaps for months) with the express purpose of getting the defendant to see that his beliefs are preposterous, or (2) having a psychiatrist or nurse administer a medication for a few moments once a day, watching carefully for any side effects, but allowing the defendant-patient to revise his opinions as he wishes. Why would medication be necessarily "more intrusive" than months of government-induced therapeutic indoctrination?

Sell also states that trial courts "must consider less intrusive means for administering the drugs, *e.g.*, a court order to the defendant backed by the contempt power, before considering more intrusive methods," where "more intrusive methods" presumably refers to injections or medication. *Id.* This is curious. What conceivable persuasive effect could a contempt citation have on a defendant, given that the defendant would already be charged with a serious crime and involuntarily hospitalized? Former APA president Paul S. Appelbaum suggests this idea may reflect the Supreme Court's poor grasp of

> the realities of severe mental illness . . . .
>
> . . . For a justice of the U.S. Supreme Court to suggest that a psychotic, treatment-refusing defendant, found incompetent to stand trial and already confined in a prison medical facility would agree to take medication because a judge threatened to hold him in contempt bespeaks a remarkably optimistic view of judicial power – and a serious lack of appreciation of the nature of psychosis.

Paul S. Appelbaum, *Treating Incompetent Defendants: The Supreme Court's Decision Is a Tough Sell*, 54 PSYCHIATRY SERV. 1335, 1336 (2003).

81. *Id.* Justice Breyer then recommends that, before considering forced medication for adjudicatory competence, trial courts should first determine whether forcing medication is needed to address the individual's dangerousness and whether the individual is competent to make decisions about medication. He sees determinations of dangerousness as "more

IV. DEFINING "MEDICALLY APPROPRIATE"

What, then, should testifying experts—and the trial court judges who hear their testimony—consider when offering opinions about whether a treatment is "medically appropriate"? By itself, the Supreme Court's just-quoted phrase suggests that a trial judge need only find out whether clinicians think administering medication is the right way to treat the condition[82] that they have diagnosed. Doctors[83] who might testify about

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'objective and manageable'" and easier for medical experts "than the inquiry into whether medication is permissible to render a defendant competent." *Sell*, 539 U.S. at 181-82, quoting *Riggins*, 504 U.S. at 140 (Kennedy, J., concurring in judgment). Moreover, courts are accustomed to instituting guardianship for persons who lack capacity to make medical decisions. "If a court authorizes medication on these alternative grounds," concludes Justice Breyer, "the need to consider authorization on trial competence grounds will likely disappear." *Sell*, 539 U.S. at 182-83.

Concerning this portion of the *Sell* opinion, Appelbaum comments, "Even granting the Court's unfamiliarity with several generations of research that demonstrate the frustration of trying to predict who will be violent, the record of this case itself should have suggested that such prognostication is no simple matter." After describing the divergent opinions about Sell's dangerousness offered by treating clinicians, lower courts, and Justice Breyer himself, Appelbaum states, "Given this record, it should have been obvious to the Court that determining dangerousness is typically neither 'objective' nor particularly 'manageable.'" Appelbaum, *supra* note 80, at 1336.

82. This Article uses the word "condition" to designate the broad array of medical problems (psychiatric and nonpsychiatric) for which persons may seek treatment. *See* WEBSTER'S NEW TWENTIETH CENTURY DICTIONARY OF THE ENGLISH LANGUAGE UNABRIDGED 358 (1951) (first definition of "condition" is "state of being; situation in relation to . . .' physical or mental soundness"). Although many sources list the words "disease" and "disorder" as synonyms (*see, e.g., id.* at 498), "disease" has a connotation of physical alteration ("any morbid state of the body generally, or of any particular organ or part of the body," *id.* at 497), whereas "disorder" connotes disruption of function ("[w]ant of order or regular disposition" . . . "[i]rregularity, disturbance or interruption of the functions of the animal economy," *id.* at 501-02), including mental functioning ("[d]iscomposure of the mind; turbulence of passions," *id.* at 502). Although legal sources (*e.g.*, many states' insanity statutes) refer to mental "diseases" and "defects," U.S. psychiatric manuals have, for the last half-century, referred to mental ailments as "disorders," DSM-IV-TR, *supra* note 24, at xxv-xxvi, and the current diagnostic manual defines "mental disorder" as disruption in various forms of functioning, *id.* at xxxi. DSM-IV-TR uses the term "general medical condition" to refer to those ailments listed outside the "Mental and Behavioural Disorders" section of the *International Statistical Classification of Diseases and Related Health Problems*. *Id.* at xxxv.

83. As of this writing, only two states—Louisiana and New Mexico—permit psychologists to prescribe psychotropic medications. Elsewhere, this is a privilege reserved primarily for physicians, and thus psychiatrists usually would be the only professionals likely to be viewed as having appropriate expertise on this topic. The appellate record in *Sell* shows, however, that the federal magistrate and district court judge considered the opinion of Dr. DeMier, a psychologist, in their decisions to authorize involuntary medication. *See*

such matters would only need to consider this narrow issue, applying what I shall call a "right-treatment-for-the-condition" approach, when formulating their conceptualization opinions. This approach is reflected in the above-quoted conclusion of Dr. Daniel,[84] and is typical of discussions that appear in medical textbooks: a disease's signs and symptoms are described, techniques for diagnosing the disease are explained, and the disease's treatments are discussed.

The appellate ruling in *Weston* exemplifies this right-treatment-for-the-condition interpretation of what counts toward deciding that competence-restoring treatment is "medically appropriate." In discussing treating Russell Weston with antipsychotic medication, the D.C. Court of Appeals wrote,

> Whether a proposed course of action is "medically appropriate" obviously depends on the judgment of medical professionals . . . . The district court relied on several experts in concluding that "antipsychotic medication is the medically acceptable and indicated treatment for Weston's illness." . . .
>
> The district court measured the medical appropriateness of antipsychotic medication by examining the capacity of antipsychotic drugs to alleviate Weston's schizophrenia (the medical benefits) against their capacity to produce harm (the medical costs, or side effects) . . . . Numerous experts testified that antipsychotic medication is the medically appropriate treatment for Weston's illness . . . . While there are potential side effects, . . . the professional judgment of the medical experts was that "each of these potential side effects is generally manageable." . . . The short of the matter is that the record leaves no basis for doubting the district court's conclusion that antipsychotic medication is the medically appropriate treatment for Weston's condition.[85]

Yet examination of *Sell* suggests that deciding whether a treatment is "medically appropriate" may require a broader view. When considering whether to force medications on a criminal defendant, *Sell* instructs trial courts to first ask whether involuntary treatment is needed because the defendant's "refusal to take drugs puts his health gravely at risk," or is involuntary treatment "medically appropriate and necessary to control a patient's potentially dangerous behavior (or to avoid serious harm to the

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Appellant Brief, *supra* note 49, at 14.

84. *See supra* text at notes 36-40.

85. United States v. Weston, 255 F.3d 873, 876-77 (D.C. Cir. 2001) (citations omitted).

patient himself)."[86] Even when the answers to these questions are negative,

> the findings underlying such a decision will help to inform expert opinion and judicial decisionmaking in respect to a request to administer drugs for trial competence purposes. At the least, they will facilitate direct medical and legal focus upon such questions as: Why is it medically appropriate forcibly to administer antipsychotic drugs to an individual who (1) is *not* dangerous *and* (2) *is* competent to make up his own mind about treatment? Can bringing such an individual to trial *alone* justify in whole (or at least in significant part) administration of a drug that may have adverse side effects, including side effects that may to some extent impair a defense at trial?[87]

This paragraph from *Sell* clearly suggests that, to determine the medical appropriateness of a particular drug regimen, a trial court should consider more than whether the drug will alleviate symptoms and whether the benefit of relieving symptoms outweighs the potential side effects that the drug might directly, physically induce.[88] Before deciding that forced treatment of a defendant is "medically appropriate," a trial court must also consider, at the very least, the defendant's health, his safety, and whether the Government's interest in prosecution justifies subjecting the defendant to the effects of medication. At most hearings on forced medication, the principal source of information and opinion on these topics will be the testimony of physicians.[89]

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86. Sell v. U.S, 539 U.S. 166, 182 (2003).

87. *Id.* at 183.

88. By the phrase "side effects that the medication might directly, physically cause," I refer to movement abnormalities, sedation, clouding of thinking, and other side effects that any individual might experience when undergoing treatment. I wish to emphasis a distinction between such "directly, physically" caused side effects and the "side effect" of eligibility for prosecution, which is not a physical result of medication, but a consequence of what medication makes legally permissible.

89. That psychiatrists will need to address these matters is anticipated by *Sell*'s comment that

> the inquiry into whether medication is permissible, say, to render an individual nondangerous is usually more "objective and manageable" than the inquiry into whether medication is permissible to render a defendant competent . . . . The medical experts may find it easier to provide an informed opinion about whether, given the risk of side effects, particular drugs are medically appropriate and necessary to control a patient's potentially dangerous behavior (or to avoid serious harm to the patient himself) than to try to balance harms and benefits related to the more quintessentially legal questions of trial fairness and competence.

Id. at 182, citing *Riggins*, 504 U.S. at 140 (Kennedy, J., concurring in judgment).

A. "Medically Appropriate": Legal Interpretations

In seeking clarification about what counts when considering whether a proposed treatment is "medically appropriate," courts and experts might turn, among other places, to other cases that use the phrase. There is no shortage of these. A June 24, 2004 search of the Lexis "Federal & State Cases, Combined" database using the strategy "MEDICA! PRE/1 APPROPRIAT!" yielded 755 cases.[90] It is beyond the scope of this Article to review all these occurrences, so I have chosen a few instances that represent the variety of uses to which case law puts this phrase.

1. Supreme Court Cases

The phrase "medically appropriate" appears in four U.S. Supreme Court cases besides *Sell*, three of which involve individuals with mental disabilities.[91] In *Riggins*, the majority decided to "presume" that giving the defendant the antipsychotic drug Mellaril had been "medically appropriate" because, "[a]lthough defense counsel stressed that Riggins received a very high dose of the drug, at no point did he suggest to the Nevada courts that administration of Mellaril was medically improper treatment for his client."[92] Here, then, "medically appropriate" seems to refer only to whether the drug was the right type of medication for the patient's condition.

The phrase occurs twice in *Harper*. In the first occurrence, the majority uses the "right-treatment-for-the-condition" interpretation to address the dissent's contention that prison procedures would permit involuntarily administering medication

> without reference to whether the treatment is medically appropriate . . . . For various reasons, we disagree. That an inmate is mentally ill and dangerous is a necessary condition to medication, but not a sufficient condition; before the hearing committee determines whether these requirements are met, the inmate's treating physician must first make

90. The phrase "medically appropriate" appears in 517 cases. Other hits included phrases such as "medical appropriateness," which appears twice in *Riggins*, 504 U.S. at 135.

91. The nonpsychiatric case is Webster v. Reproductive Health Services, 492 U.S. 490 (1989) (holding constitutional provisions of a Missouri law prohibiting public employees and facilities from performing abortions unless they were necessary to save the mother's life, and barring public funds, employees, and facilities from being used to counsel a woman to have an abortion not needed to save her life). Dissenting, Justice Blackmun construed a portion of the law in question merely to "instruct[] the physician to make a finding of viability using tests to determine gestational age, weight, and lung maturity when such tests are feasible and medically appropriate." *Id.* at 545 (Blackmun, J., dissenting).

92. *Riggins*, 504 U.S. at 133.

the decision that medication is appropriate.[93]

The phrase's second occurrence in *Harper*, however, incorporates a result of medication that goes beyond controlling a patient's psychotic symptoms, *viz.*, "the legitimate governmental interest in treating him where medically appropriate for the purpose of reducing the danger he poses."[94]

The U.S. Supreme Court's third use of the phrase "medically appropriate" appears in Justice Kennedy's concurrence in *Olmstead v. L.C.*,[95] a 1999 ruling that addresses the rights of two institutionalized patients, under the Americans with Disabilities Act ("ADA"),[96] to placement in community treating settings.[97] Concerning the patients, Justice Kennedy writes that "it is undisputed that the State's own treating professionals determined that community-based care was medically appropriate for respondents."[98] After emphasizing that persons with severe mental problems often need inpatient care and deteriorate in the community because they do not take medication, Justice Kennedy opines that "[t]he opinion of a responsible treating physician in determining the appropriate conditions for treatment ought to be given the greatest of deference."[99] Here, then, the phrase "medically appropriate" addresses matters that go beyond the psychotropic drugs that psychiatrists prescribe, and encompasses a doctor's judgments about *where* a patient should live and receive psychopharmacological treatment.

2. Disputes about Reimbursement

A large fraction of the "medically appropriate" cases involve disputes between parties who desire treatments or services provided by physicians and the parties who have to pay for such services. In these cases, "medically appropriate" typically designates a treatment or service that doctors – applying the "right-treatment-for-the-condition" model – recommend, but that the payor wishes not to reimburse.[100] Since the

93. *Harper*, 494 U.S. at 223 n.8.

94. *Id.* at 226.

95. 527 U.S. 581 (1999).

96. 42 U.S.C. §§ 12101 *et seq.*

97. The main thrust of the decision is that, under Title II of the ADA, states must place persons with mental disabilities in community settings rather than in institutions when the state's treating professionals believe that community placement is appropriate, the patient accepts outpatient placement, and "the placement can be reasonably accommodated, taking into account the resources available to the state and the needs of others with mental disabilities." *Olmstead*, 527 U.S. at 587.

98. *Olmstead*, 527 U.S. at 609 (Kennedy, J., concurring).

99. *Id.* at 610.

100. When I performed this search, the most recent such example was *Erringer v.*

landmark *Wickline* decision,[101] physicians have been gravely concerned about the influence of third-party payors on what were once sovereign medical decisions. A portion of the California Professional and Business Code (which explicitly responds to *Wickline*) attempts to restrict decision-making to physicians by declaring that "medically appropriate" hospital care "shall be defined by the hospital medical staff and approved by the governing body, consistent with that degree of learning and skill ordinarily possessed by reputable physicians practicing according to the applicable legal standard of care."[102] The Code encourages doctors "to advocate for medically appropriate health care" by appealing "a payor's decision to deny payment for a service pursuant to the [established] reasonable grievance or appeal procedure."[103]

Sometimes the uses of "medically appropriate" get stretched in these cases, even if the argument is about payment. An example is found in *Barnett v. Kaiser Foundation Health Plan*,[104] a suit brought by a man who had hepatitis and sought treatment at Kaiser-Sacramento Medical Center. Barnett's doctor investigated the option of a liver transplant and consulted informally with the medical group's liver specialists, but decided the transplant "was not medically appropriate."[105] Barnett paid for the transplant himself, then sued to recover his medical expenses. The Court of Appeals found in Kaiser's favor, holding that medical criteria are an appropriate way to make allocation decisions about such resources. In this instance, the use of "medically appropriate" plainly goes beyond right-treatment-for-the-condition – liver transplants are the treatment for terminal liver failure – to include the essentially ethical issue of when payment for very expensive treatments may be denied.

3. Other Varieties of Cases

"Medically appropriate" appears, and takes on varying meanings, in other types of cases. In *R.A.J. v. Miller*,[106] a case dealing with the right of a civilly committed psychiatric inpatient to withhold consent to the

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Thompson, No. 03-16408, 2004 U.S. App. LEXIS 11432, at *7 (9th Cir. June 10, 2004) (discussing regulations for Medicare coverage of a contractor's services).

101. Wickline v. State of California, 192 Cal. App. 3d 1630 (1986) (holding that the decision to discharge a patient, and responsibility for the consequences thereof, were the treating physician's, notwithstanding Medi-Cal's agreeing to pay for a four-day extension of hospitalization, rather than the eight days that doctors had requested).

102. CAL. PROF. & BUS. CODE § 2056(e).

103. CAL. PROF. & BUS. CODE § 2056(b). These portions of the Code are cited in *Khajavi v. Feather River Anesthesia Medical Group*, 84 Cal. App. 4th 32, 43 (2000).

104. 32 F.3d 413 (9th Cir. 1994).

105. *Id.* at 415.

106. 590 F. Supp. 1319 (N.D. Tex. 1984).

administration of psychotropic medication, plaintiffs argued that competent, committed patients had the right to refuse treatment, proposed a rule for administration over a patient's refusal, and convinced the court to accept this rule. The rule included a requirement that treatment be "medically appropriate," meaning

> that without such medication the patient's condition cannot realistically be expected to improve within a reasonable period of time; or that without such medication deterioration of the patient's condition cannot be prevented; or that without such medication there is a significant possibility that the patient's mental condition will not be stabilized in time to prevent injury to himself or other persons . . .
>
> The administration of psychotropic medication may be continued if the Clinical Director or his physician designee determines that the administration of such medication is medically appropriate treatment. In making this determination, the clinical director or his physician designee will consider the following factors:
>
> (A) the accuracy of the diagnosis;
>
> (B) indications for the medication;
>
> (C) probable benefits and risks of the medication; and
>
> (D) the existence and value of alternative forms of treatment, if any.[107]

The second portion of this rule defines "medically appropriate" along right-treatment-for-the-condition lines. The first portion, however, takes into account what a patient might do to others if not treated.

Cases outside psychiatric contexts sometimes use "medically appropriate" to point to issues concerning the safety of third parties. *Vega v. Sielaff*[108] concerned the opening of a jail that (along with other persons) would need to house, and eventually release, potentially contagious individuals with HIV or AIDS. Individuals quoted in the case discuss "the need to find medically appropriate housing for contagious patients immediately" and "the release of contagious patients, . . . [which] might well be medically appropriate if the patients were being sent home where their families had already been exposed to them."[109]

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107. *Id.* at 1323-24.

108. No. 82 Civ. 6475(MEL), 1990 U.S. Dist. LEXIS 19427 (S.D. N.Y. May 22, 1990).

109. *Id.* at *8, 10.

Bruno v. State[110] concerns a provision in Florida law that permits a criminal court to "sentence" individuals convicted of sexual battery to "treatment" with medroxyprogesterone acetate[111] following a medical examination. Florida law requires the State's Department of Corrections to provide the services necessary to administer the drug, but does not "require the continued administration of medroxyprogesterone acetate (MPA) treatment when it is not medically appropriate."[112]

Perhaps the most curious case-law occurrence of the phrase "medically appropriate"—used in a context that has nothing to do with any particular medical condition—appears in *Campbell v. Wood*,[113] a Ninth Circuit decision upholding the constitutionality of hanging as a method of execution. In a dissenting opinion, Judge Reinhardt contrasts hanging with

> a more medically appropriate method of execution – lethal injection . . . [T]he administration of an injection to a person who has been sedated and placed on a bed by a medically trained person in a medical environment is obviously far less barbaric and uncivilized, far less inhumane and degrading, than the forced march of a prisoner up the gallows steps where the untrained hangman waits in hope that the drop will be spoiled only by the defecation and voiding that result from the state's crude and violent effort to forcefully terminate a human life at the end of a rope.[114]

4. Psychiatric Patients and Criminal Cases

Returning our attention to criminal cases involving psychiatric patients, one finds many instances in which the phrase reflects a court's judgment only about the direct physical effects of psychotropic medication,

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110. 837 So. 2d 521 (Fla. App. 2003).

111. Injectable medroxyprogesterone acetate (MPA) is officially indicated for use as a long-acting contraceptive; an oral form of MPA is indicated in the treatment of menopausal symptoms. PHYSICIANS' DESK REFERENCE 2762, 3451 (57th edition, 2003). However, "[o]nce a product has been approved for marketing [for any disorder], a physician may choose to prescribe it for uses or in treatment regimens or patient populations that are not included in approved labeling . . . . [A]ccepted medical practice includes drug use that is not reflected in approved drug labeling." *Id.*, foreward. Several states now have laws that mandate, under various circumstances, that sex offenders receive treatment with MPA. This process, which reduces testosterone levels, is frequently referred to as "chemical castration." *See, e.g.*, "Is chemical castration an acceptable punishment for male sex offenders?" *available at* http://www.csun.edu/~psy453/crimes_y.htm (last visited Nov. 23, 2004). For a recent discussion of androgen-lowering agents and other treatments for pedophilia, *see* Peter J. Fagan et al., *Pedophilia*, 288 JAMA 2458 (2002).

112. *Bruno*, 837 So. 2d at 523, n. 1, quoting FLA. STAT. 794.0235.

113. 18 F.3d 662 (9th Cir. 1994).

114. *Id.* at 702-03 (Reinhardt, J., dissenting).

irrespective of outside issues. *United States v. Williams*[115] provides a recent example. Before adjudication, the district court had ordered Williams to take medication for competence-to-stand-trial purposes, noting that the defendant

> "has experienced some lethargy, blurred vision, and dry mouth. He fears tremors, facial paralysis, and other side effects may follow, and he is concerned all of the side effects may be long term." Based on Williams' treating psychiatrist's testimony, the court concluded that the medication would cause Williams "only minimal, temporary side effects. The Court finds the medication, therefore, is 'medically appropriate.'"[116]

As the district court uses the phrase, medication is "medically appropriate" because side effects – direct, physical results of the medication—would be "minimal" and "temporary."

To the appeals court, however, "medical" considerations encompass more than drugs' physical effects. After Williams regained competence (while taking medication), he pled guilty to having sent a threatening e-mail message to a teacher at the college where he had been a student. His proposed sentence included a three-year period of supervised release, during which the district court required him to continue taking antipsychotic medication. Williams objected to this requirement on grounds that it had no adequate basis, and the appeals court vacated the requirement and remanded it for further proceedings. The appeals court faulted the district court for failing to "make on-the-record, medically-grounded findings that court-ordered medication,"[117] which it deemed "an especially grave infringement of liberty,"[118] would "'*involve[] no greater deprivation of liberty than [wa]s reasonably necessary*'" for "deterring and protecting the public from further crimes by Williams."[119] Here, then, as in *Harper*, broader social concerns enter the sphere of matters that require medical expert opinion.

Other cases reflect similar variations in meaning. *State v. Kotis*,[120] which deals with medicating defendants who pose threats to themselves or others, requires that the proposed treatment be "medically appropriate, that is, in the defendant's medical interest;" this right-treatment-for-the condition issue is enumerated separately from whether, "considering less intrusive alternatives, the treatment is essential to forestall the danger posed by the

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115. 356 F.3d 1045 (9th Cir. 2004).

116. *Id.* at 1049.

117. *Id.* at 1057.

118. *Id.* at 1055.

119. *Id.* at 1052-53, quoting 18 U.S.C. § 3583(d) (emphasis as in *Williams*).

120. 91 Haw. 319 (1999).

defendant."[121]

United States v. Gomes,[122] the Second Circuit's leading pre-*Sell* case on forced competence restoration, takes the right-treatment-for-the-condition approach endorsed by the D.C. Circuit in *Weston*:

> As part of its inquiry into the medical appropriateness of administering antipsychotic medication in Gomes's case, the district court appropriately considered the expert's diagnosis of the defendant's mental illness . . . . The government offered the testimony of Gomes's treating psychiatrist at USMC-Springfield, Dr. Wolfson, who testified extensively about the likely effects and side effects of both the older and newer types of antipsychotic medication. Weighing the benefits of this type of medication against the possible harms, Dr. Wolfson concluded that medication was appropriate for Gomes.[123]

The Eighth Circuit decision that was vacated by the Supreme Court's *Sell* ruling states that antipsychotic "[m]edication is medically appropriate if: (1) it is likely to render the patient competent; (2) the likelihood and gravity of side effects do not overwhelm its benefits; and, (3) it is in the best medical interests of the patient."[124] Although the Eighth Circuit's formulation looks, on first glance, to be a right-treatment-for-the-condition approach (à la *Gomes*), one of the "conditions" to be considered is not a psychiatric disorder, but instead the patient's incompetence to stand trial.

The Eighth Circuit's *Sell* decision, like many of the cases we have been examining, refers to a patient's "medical interest" without further defining that term. As the term is used by the Eighth Circuit, for a court to conclude that receiving a drug would be in a patient's "medical interest" appears only to require a finding that the drug is the right treatment for the patient's mental disorder. In other words, the court would consider the direct physical effects of the proposed drug, weighing its anticipated impact on the symptoms of the disorder and against the drug's possible adverse effects; if the prospects for symptoms alleviation were clearly greater than the expected adverse effects, the court would find such treatment in the patient's medical interest. That a patient's "medical interest" is distinguishable from the personal, social, or legal consequences of treatment is made clear by the Eighth Circuit having listed, as a separate consideration, the potential capacity of medication to make patient-defendants eligible for prosecution.

In sharp contrast is the Louisiana Supreme Court's use of the phrases

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121. *Id.* at 334.

122. 289 F.3d 71 (2nd Cir. 2002).

123. *Id.* at 86 (citations to *Weston* and *Harper* omitted).

124. United States v. Sell, 282 F.3d 560, 567 (8th Cir. 2002).

"medical interest" and "medically appropriate" in *State v. Perry*,[125] which considered whether a psychotic death row inmate could be involuntarily medicated to render him competent to be executed.[126] In concluding that such treatment was impermissible, *Perry* held that "[d]rugging [f]or [e]xecution" would be "[p]unishment, [n]ot [m]edical [t]reatment,"[127] despite (actually, because of) the fact that the medication would alleviate the disabling impact[128] of a severe mental disorder. After quoting portions

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125. 610 So.2d 746 (La. 1992).

126. Common law has long recognized that individuals must be competent to be executed. *Perry*, 610 So.2d at 749. In *Ford v. Wainwright*, 477 U.S. 399, 409-10 (1986), the U.S. Supreme Court declared, as a matter of constitutional law, that "the Eighth Amendment prohibits a State from carrying out a sentence of death upon a prisoner who is insane." *Ford* did not address whether death row inmates may be involuntarily medicated to restore their competence for execution. *Perry* and *Singleton v. State*, 437 S.E.2d 53 (S.C. 1993), are the two state supreme court cases that say they may not; *Singleton v. Norris*, 319 F.3d 1018 (8th Cir. 2003), held that they may.

127. *Perry*, 610 So.2d at 752.

128. The plurality opinion in *Ford v. Wainwright* did not establish a constitutional standard for determining whether a prisoner is incompetent to be executed, but Justice Powell's concurrence addressed this issue: "I would hold that the Eighth Amendment forbids the execution only of those who are unaware of the punishment they are about to suffer and why they are to suffer it." *Ford*, 477 U.S. at 422 (Powell, J., concurring). Justice Powell thought that Alvin Ford met this standard. *Id.* That Justice Powell's criterion implies a severe degree of disability is demonstrated by the description, in the plurality opinion, of Ford's clinical course several years after his conviction:

> In early 1982, . . . Ford began to manifest gradual changes in behavior. They began as an occasional peculiar idea or confused perception, but became more serious over time. After reading in the newspaper that the Ku Klux Klan had held a rally in nearby Jacksonville, Florida, Ford developed an obsession focused upon the Klan. His letters to various people reveal endless brooding about his "Klan work," and an increasingly pervasive delusion that he had become the target of a complex conspiracy, involving the Klan and assorted others, designed to force him to commit suicide. He believed that the prison guards, part of the conspiracy, had been killing people and putting the bodies in the concrete enclosures used for beds. Later, he began to believe that his women relatives were being tortured and sexually abused somewhere in the prison. This notion developed into a delusion that the people who were tormenting him at the prison had taken members of Ford's family hostage. The hostage delusion took firm hold and expanded, until Ford was reporting that 135 of his friends and family were being held hostage in the prison, and that only he could help them. By "day 287" of the "hostage crisis," the list of hostages had expanded to include "senators, Senator Kennedy, and many other leaders." . . . In a letter to the Attorney General of Florida, written in 1983, Ford appeared to assume authority for ending the "crisis," claiming to have fired a number of prison officials. He began to refer to himself as "Pope John Paul, III," and reported having appointed nine new justices to the Florida Supreme Court . . . .

of the Hippocratic Oath in which a physician pledges to prescribe "for the good of my patients," to "never do harm," to not "prescribe a deadly drug," and to act "only for the good of my patients,"[129] *Perry* states:

> Medical treatment does not consist merely of dispensing drugs; other ingredients are essential to the healing arts. The Hippocratic Oath, dating from the fifth century B.C., is the seminal source of the principles of medical ethics and the goals of medical treatment. Under the oath, the physician pledges to do no harm and to act only in the best medical interests of his patients. Consequently, medical treatment cannot occur when the state orders a physician to administer antipsychotic drugs to an insane prisoner in an attempt to render him competent for execution.
>
> Because the physician is required by his oath both to alleviate suffering and to do no harm, the state's order forces him to act unethically and contrary to the goals of medical treatment. If any physician administers the drugs forcibly and thereby enables the state to have the inmate declared competent for execution, the doctor knowingly handles the prisoner harmfully and contrary to his ultimate medical interest.[130]

Perry then notes that to not give the inmate treatment would perpetuate a type of suffering that physicians ordinarily feel obligated to diminish.[131] Yet under a "forcible medicate-to-execute structure," a physician must "serve two masters," the state and the patient, and this generates "a substantial concern that the patient's well-being may be subordinated to the duty the doctor owes the state."[132] In contrast to *Harper*, where the state's

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> Ford told [a psychiatrist] that "I know there is some sort of death penalty, but I'm free to go whenever I want because it would be illegal and the executioner would be executed." . . . When asked if he would be executed, Ford replied: "I can't be executed because of the landmark case. I won. Ford v. State will prevent executions all over." . . . These statements appeared amidst long streams of seemingly unrelated thoughts in rapid succession. . . . The following month, in an interview with his attorneys, Ford regressed further into nearly complete incomprehensibility, speaking only in a code characterized by 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."

Ford, 477 U.S. at 402-03. For another description of the severity of illness in an execution-incompetent inmate, *see Singleton*, 319 F.3d at 1030-33 (Loken, J., concurring in part and dissenting in part).

129. *Perry*, 610 So.2d at 752, quoting STEDMAN'S MEDICAL DICTIONARY 647 (4th Unabridged Lawyer's ed. 1976).

130. *Perry*, 610 So.2d at 752.

131. *Id.*

132. *Id.*

interests coincided with the patient's medical needs as determined by doctors, medicating Perry could not be justified legally as being in Perry's medical interest "because forcible administration of drugs to implement execution is not medically appropriate."[133]

Perry thus stands clearly for the notions that (1) the potential for a treatment to make possible a legal outcome is a factor in calculating whether that treatment is in a patient's "ultimate medical interest," and (2) considerations of what a physician may ethically do may affect what treatment a court may legally order.

5. Conflict Between Statutes and Medical Appropriateness

In the Matter of Baby "K"[134] raised the issue of whether doctors and hospitals could be required by statute to provide care that they deemed medically inappropriate. The case evolved from a disagreement between doctors at a Virginia hospital and the mother of an infant born with anencephaly, a congenital condition in which large portions of the brain and skull are missing. Because she lacked cerebral hemispheres, Baby K would never see, hear, interact with her environment, or attain consciousness. However, her brainstem supported autonomic functions and reflexes. Because of difficulty breathing on her own at birth, Baby K's physicians placed her on a mechanical ventilator. They then discussed the infant's grim prognosis with her mother and recommended that aggressive treatment measures – including continued ventilatory support – be discontinued, though supportive measures such as providing nutrition and warmth would continue.[135] Baby K's mother disagreed, however, and insisted that her daughter receive mechanical ventilation whenever she had trouble breathing on her own. Baby K was eventually weaned from a respirator and transferred to a nursing home, but was brought back to the hospital's emergency department three times when her breathing problems recurred. Each time, the hospital admitted Baby K and placed her back on a ventilator. After the second admission, however, the hospital went to federal court seeking a declaration that it was not required to provide such aggressive treatment.[136]

In making this request, the hospital was, in effect, seeking a way around obligations created by the federal Emergency Medical Treatment and

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133. *Id.* at 754.

134. 16 F.3d 590 (4th Cir. 1994). For a more detailed discussion of this case, and the national attention that it received, *see* Heather Tierney, *Conjoined Twins: The Conflict Between Parents and the Courts Over the Medical Treatment of Children*, 30 DENV. J. INT'L L. & POL'Y 458, 467-71 (2002).

135. *Baby "K,"* 16 F.3d at 592.

136. *Id.* at 593.

Active Labor Act.[137] EMTALA requires, among other things, that a patient coming to an emergency department receive screening for any life-threatening, "emergency medical condition;"[138] if such a condition is present, the hospital must at least provide enough treatment to assure that the patient will not deteriorate while being transferred to another facility.[139] Each time Baby K had come to the hospital, her breathing problems had been life-threatening, and because no other facility that could treat Baby K would accept her as a patient, the hospital appeared to have no choice, under EMTALA, other than to continue to ventilate her until she could breath independently.[140] The hospital argued, however, that this interpretation of EMTALA failed to accommodate a provision in Virginia's Health Care Decisions Act stating that nothing in the act could "require a physician to prescribe or render medical treatment to a patient that the physician determines to be medically or ethically inappropriate."[141]

Both the district court[142] and the Fourth Circuit Court of Appeals agreed with the mother, however. To the extent that the Virginia statute conflicted with EMTALA, the federal law's requirements preempted provisions of the state law.[143] On "a straightforward application" of EMTALA, Baby K's respiratory distress was indeed an emergency condition, and when she arrived at the hospital for care, the hospital was legally obligated to provide treatment adequate to stabilize her condition.[144] "We recognize the dilemma facing physicians who are requested to provide treatment they consider morally and ethically inappropriate," wrote the appeals court, "but we cannot ignore the plain language of the statute . . . The appropriate branch to redress the policy concerns of the Hospital is Congress."[145]

B. "Medically Appropriate": Medical Uses

A June 22, 2004 search of the "MEDLINE" database[146] revealed 72 occurrences of the phrase "medically appropriate." In most instances, context implies that the phrase points to a behavior, decision, or form of

137. 42 U.S.C.A. § 1395dd.

138. 42 U.S.C.A. § 1395dd(a).

139. 42 U.S.C.A. § 1395dd(e)(3)(A).

140. *Baby "K,"* 16 F.3d at 594.

141. VA. CODE ANN. § 54.1-2990.

142. *In the Matter of Baby "K,"* 832 F. Supp. 1022 (E.D. Va. 1993).

143. *Baby "K,"* 16 F.3d at 597.

144. *Id.* at 594-95.

145. *Id.* at 596.

146. MEDLINE ® is a bibliographic database of medical journals that contains titles, authors, and abstracts (but not the full text) of articles dating back to 1966. *See* http://www.nlm.nih.gov/pubs/factsheets/medline.html (last visited Nov. 23, 2004).

therapy that is "right" or optimal according to some criterion that takes into account just the patient's medical condition. For example, the earliest instance is a 1980 article examining whether a physician-prepared triage algorithm would allow nonphysicians to assign military patients to various categories of need, including a category of ailments addressable through "medically appropriate self-care protocols."[147] A similar use occurs in an article that deems prenatal alpha-fetoprotein screening to be "medically appropriate for diabetic women" because of the test's effectiveness in detecting fetal neural tube defects during early pregnancy.[148]

In several abstracts, "medically appropriate" is used to contrast an idealized state of affairs—in which the only issue governing medical decisions is whether a proposed treatment is the right one for the patient's condition—with the 'real world,' where doctors and hospitals respond to financial incentives and drugs, and medical procedures have to be paid for. For example, a 1985 article notes that because of then-recent changes in Medicare reimbursement patterns,

> the clinical laboratory needs to find ways to maintain the quality of its service while operating more profitably. Many laboratories have decided to focus on reducing the volume of testing. How effective and medically appropriate is this approach, and what are the alternatives?[149]

A 1990 article notes that three common, invasive gastrointestinal and vascular procedures often "were performed for reasons that were less than medically appropriate," and that getting care from a surgeon who did many carotid endarterectomies "decreased the likelihood of an appropriate endarterectomy by one third."[150] In a 1995 article, a pediatrician admonishes his colleagues:

> The ethical practice of medicine in a managed care environment involves providing care at a level that avoids high cost with poor outcomes. . . . Purchasers of health care today are clear about what they want—low cost, convenient access for their employees, medically appropriate, documented treatment, and patient satisfaction—and they

147. P. B. Vaughn et al., *Effective Algorithm-based Triage and Self-care Protocols: Quality Medicine at Lower Costs*, 9 ANNALS OF EMERGENCY MED. 31 (1980).

148. A. Milunsky and E. Alpert, *Results and Benefits of a Maternal Serum Alpha-fetoprotein Screening Program*, 252 JAMA 1438 (1984). In diabetic women, the rate of neural tube defects was 7.6 times higher than the rate for nondiabetic women, for whom the authors thought screening should be a "voluntary option." *Id.*

149. J. W. Winkelman and L. H. Bernstein, *The Unordered Test: Cost of the Benefit vs. Benefit of the Cost*, 39 PATHOLOGIST 12 (July 1985).

150. R. H. Brook et al., *Predicting the Appropriate Use of Carotid Endarterectomy, Upper Gastrointestinal Endoscopy, and Coronary Angiography*, 323 NEW ENGL. J. MED. 1173 (1990).

> are clear about how they intend to get what they want.[151]

A physician and medical consultant for Blue Cross/Blue Shield[152] provides what may be the best short summary of how the term "medically appropriate" functions in policy decisions about medical coverage:

> Over the years the concept of medical necessity has evolved to encompass a multitude of medical management strategies. Essentially, in terms of the contract language, medical necessity has become a workhorse concept to determine coverage eligibility. In the process, the interpretation of the term has taken on various guises, [including] . . .
>
> [d]etermining whether the proposed therapy is medically appropriate for the patient's condition[.]
>
> Most definitions of medical necessity in health plan contracts include some sort of statement regarding medical appropriateness. While this term merely seems to substitute the vague term "necessary" for the equally obscure term "appropriate," in practice the concept of medical appropriateness often includes determining whether the service in question is appropriate for the individual, given the patient's unique set of circumstances.[153]

Often implicit in discussions about reimbursement are moral questions about whether doctors can remain devoted to their patients' welfare – doing what is "medically appropriate"—and, at the same time, respond to demands of third-party payors. Ethical considerations become the focus in another, not infrequent use of the phrase, when "medically appropriate" points to actions or decisions that incorporate considerations beyond what disease(s) a patient has and what treatment(s) might address the disease(s). In one of several articles she has written on the subject, bioethicist Ruth Macklin concludes that using growth hormone to increase the height of very short children is "medically appropriate" not because such children have a disease (often, determining whether they do is difficult), but because of their potential suffering.[154] Cardiopulmonary resuscitation is the correct

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151. Henry E. Golembesky, *How to Integrate Your Practice into the New Health Care System*, 96 PEDIATRICS 866 (1995).

152. See Dr. Brown's listing at http://www.cancernetwork.com/library/MCCboard.htm (last visited Nov. 23, 2004).

153. Elizabeth Brown, *Medically Necessary?*, 25 PHYSICIAN EXEC. 74 (Mar/Apr 1999).

154. R. Macklin, *Growth Hormone in Short Children: Medically Appropriate Treatment*, 90 ACTA PAEDIATR. 5 (2001). Dr. Macklin notes, however, that "there are several problems with using" alleviation of suffering as the "approach to determine appropriateness of administering GH [growth hormone] to children, including knowing whether shortness really will cause the child (as opposed to his parents) to suffer, and balancing the possible suffering shortness would cause with the real suffering that years of

treatment for cardiac arrest, but Dr. Gordon Snider concludes that "[i]f CPR does not offer even a modicum of lasting benefit, it is not medically appropriate to administer the treatment."[155] In discussing a physician training program for end-of-life care, family practitioner Richard Ackermann notes, "Withholding or withdrawing life-sustaining therapies is ethical and medically appropriate in some circumstances."[156] All these instances of "medically appropriate" evince the viewpoint urged by Joseph Fletcher in his seminal text, *Morals and Medicine,* that ethical medical care is about more than treating disorders:

> As Dr. Francis Peabody of the Boston City Hospital once told the Harvard medical students, "One of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is in caring for the patient . . . . The treatment of a disease may be entirely impersonal; the care of a patient must be completely personal." The moralist's interest in the ethics of medicine has to do with *the care of a patient*, not with the treatment of the disease. We are concerned with medical care rather than with medical treatment . . . . [A] patient's moral and ethical rights and interests must weigh as heavily in the medical scales as his physical needs and condition[.][157]

C. "Medically Appropriate": Conclusion

This sampling of legal and medical literature suggests that most often, using the phrase "medically appropriate" signifies that a procedure or drug is the right way to diagnose, monitor, or treat a particular medical condition, without regard to the wishes or social circumstances of the person who has that condition. This may well be because usually, identifying and treating a medical condition are activities consonant with the patient's expressed or reasonably inferred desires, the patient's legitimate long-term goals (whatever those may be), society's views of appropriate conduct, and the patient's or a third party's willingness to pay. Under such circumstances, identifying and treating medical ailments are activities that raise no moral questions.

Yet when treating a patient's condition has the potential to conflict with

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injections will cause. *Id.* at 6; *see also* R. Macklin, *Is Short Stature a Disease and Does That Matter?*, 8 GROWTH GENET. HORM. 39 (1992).

155. Gordon L. Snider, *The Do-Not-Resuscitate Order: Ethical and Legal Imperative or Medical Decision?*, 143 AM. REV. RESPIR. DIS. 665 (1991).

156. Richard J. Ackermann, *Withholding and Withdrawing Life-sustaining Treatment*, 62 AM. FAM. PHYSICIAN 1555 (2000) (summarizing the AMA's Education for Physicians on End-of-life Care curriculum module on withholding or withdrawing therapy).

157. JOSEPH FLETCHER, MORALS AND MEDICINE 8 (1954), quoting FRANCIS PEABODY, THE CARE OF THE PATIENT 12, 48 (1928) (Fletcher's italics).

patients' wishes, social norms, economic pressures, legal requirements, or moral dictates, "medically appropriate" may or may not refer merely to diagnosing and curing ailments. Frequently, "medically appropriate" has a moral force that directs attention beyond what is convenient or economically expedient and toward the broad interpersonal or social obligations that govern physicians' conduct. When asked, in court, whether a proposed medication is "medically appropriate" for an incompetent defendant, a psychiatrist could construct an answer that focused merely on whether the drug would alleviate the patient's symptoms. In doing so, however, the psychiatrist should recognize that by ignoring the extra-medical consequences of treatment—the criminal proceedings that treatment makes legally allowable—such testimony would betray doctors' traditional and fundamental concerns for the welfare of patients whom they treat. The next Part examines how these extra-medical consequences influenced defense arguments in *Sell* and *Weston*, and the potential role that physician's professional scruples might play in future arguments against competence restoration.

V. THE *SELL* AND *WESTON* CASES:

A. Comparing Defense Arguments Against Medication

The objections raised by Sell's attorneys against involuntary medication were primarily legal ones. They argued, in their merits brief,[158] that forcing their client to take medication would violate his "fundamental right to 'bodily integrity' and to make 'choices central to personal dignity and autonomy.'"[159] Medication also would implicate Sell's First Amendment right to freedom of thought and expression because the government's "very purpose" in treating him was "to change Dr. Sell's thought and speech so that he does not evidence persecutory delusions."[160] The government's interest in prosecuting Sell was not strong enough to override these rights, said Sell's attorneys, because their client was not dangerous,[161] and because civil remedies were available to recoup any losses from their client's allegedly fraudulent insurance billings.[162]

Sell's attorneys also contested the need for and potential efficacy of antipsychotic medications for their client. No nonpharmacological—and

158. Reply Brief of Petitioner, Sell v. U.S., 537 U.S. 1186 (2003) (No. 02-5664) (hereinafter "Sell Merits Brief").

159. *Id.* at 1, quoting Planned Parenthood v. Casey, 505 U.S. 833, 851, 857 (1992).

160. *Id.* at 4.

161. *Id.* at 9.

162. *Id.* at 7.

putatively "less restrictive"[163]—attempts had been made to restore Sell's trial competence.[164] Attorneys also cited psychiatric publications that described potential side effects of medication and the scientific disagreements about how well antipsychotic drugs worked in treating delusional disorder.[165] Finally, said Sell's attorneys, medication might interfere with their client's capacity to present a diminished capacity defense, and would violate his right to present a jury with his own version of events, free of government efforts that could prejudicially "manipulate his appearance."[166]

Many of the arguments raised by Sell's attorneys echoed concerns that attorneys had raised to block forced medication for Russell Weston. In an April 2001 brief filed with the D.C. Circuit Court of Appeals,[167] Weston's lawyers argued that their client, then held in a secure prison hospital, did not pose an immediate danger to himself or the public, and any danger that remained was controlled by Weston's being in seclusion. Neuroleptic medication posed several known risks, and novel antipsychotic agents might have yet-unknown risks. Antipsychotic drugs could cloud Weston's thinking or affect his memory of past events.[168]

Weston's defense lawyers also argued, as did Sell's attorneys, that medication might adversely affect their client's ability to mount a successful mental state defense. Weston's lawyers believed that, as part of an insanity defense strategy, Weston might need to be delusional during his criminal trial. That way, jurors could observe him talking, thinking, and behaving as he did when the shootings occurred; they could see for themselves that he was genuinely crazy, rather than rely on what expert witnesses said or videotapes showed. Even if treatment were successful and free of adverse effects, competence-restoring medication might permanently change Weston's demeanor and outlook, and he might not experience a psychotic relapse even if treatment were then withdrawn before trial. If Weston could not appear in an unmedicated or relapsed state at trial, it could adversely affect his ability to mount a successful insanity defense, and this would violate his Sixth Amendment right to undergo trial in an unmedicated state.[169]

But Weston's attorneys raised an additional issue that did not arise in

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163. Related to this assertion, *see supra* note 80, (discussing relative intrusiveness of medication and other forms of psychiatric therapy).

164. Sell Merits Brief, *supra* note 158, at 10.

165. *Id.* at 11, 16-17.

166. *Id.* at 18.

167. *Brief for Appellant*, *supra* note 35.

168. *Id.*

169. *Id.*

Sell's legal proceedings: whether principles of medical ethics prohibited Weston's involuntary treatment. Thinking about the appropriateness of involuntary drug treatment was not simply a matter of whether medication might ameliorate Weston's symptoms, said Weston's lawyers. Instead, doctors also had to consider "[t]he context in which the forced medication issue arises and the state['s] purpose" for the treatment, along with "alternatives that the government could pursue, such as foregoing prosecution and seeking civil commitment."[170] It would be unethical for a psychiatrist to administer involuntary medication to Weston if, by doing so, the doctor were acting "solely as an agent of the government."[171]

An additional ethical proscription arose from potential extra-medical consequences, that is, the possibility that forced medication would "initiate a chain of circumstances" that could end in Weston's execution. "[A] psychiatrist treating a pretrial detainee [in a criminal case] is required to assume that the most negative consequence, from the patient's perspective, will occur in light of the uncertain outcomes (including uncertain legal outcomes) that [could] arise" after receiving medication,[172] said Weston's lawyers. As a result of treatment, Weston might experience a sustained remission in which he would be competent not only to stand trial, but remain well enough to undergo execution if he were convicted and sentenced to death.

> [I]f a physician's participation in the forced medication of a pretrial detainee initiates a chain of circumstances or 'ongoing nexus' resulting in the person's continued competence to the point of execution, then such participation in the pretrial context is ethically prohibited . . . .
>
> [A] treating physician in any case potentially involving the death penalty must assume that the ongoing nexus will exist to the point of execution, however unlikely the probabilities may be.[173]

VI. THE ETHICAL QUANDARY

All physicians would agree that saying a particular behavior is legal does not necessarily make that behavior ethical. For example, if a state passed a law permitting doctors to administer deadly doses of drugs to effect a death sentence, such behavior would still be expressly banned by the American Medical Association's Principles of Medical Ethics.[174]

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170. *Id.*

171. *Id.*

172. *Brief for Appellant*, *supra* note 35.

173. *Id.*

174. *See* AMA CODE OF ETHICS, §E-2.06, which states, in part:

But many physicians who have commented publicly on the conditions of Russell Weston or Charles Sell see no ethical barrier to involuntarily administered treatment for competence restoration, despite the potential legal consequences. In Weston's case, part of the reason may be that his psychosis appears to be so pervasive and severe. As Arthur Caplan, who directs the Center for Bioethics at the University of Pennsylvania, put it, "Keeping him in a florid psychotic condition in seclusion, leaving him as a stark raving madman is not good . . . . It's keeping him alive, but the cost is absurd."[175] At the October 2001 Annual Meeting of the American Academy of Psychiatry and the Law, Seymour Halleck—one of many psychiatrists who had examined Weston at his attorneys' request—expressed hope that Weston would receive treatment because "he's suffering."[176] In a commentary on the *Sell* decision, former American Psychiatric Association president Alan Stone articulates an illness-focused approach:

> In my view, the most important medical considerations in involuntary treatment are the patient's diagnosis, severity of illness, nature of symptoms, and the efficacy and potential side effects of the proposed medications . . . .
>
> . . . The legal grounds for [involuntary] treatment [should be] that the

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> A physician . . . should not be a participant in a legally authorized execution. Physician participation in execution is defined generally as actions which would fall into one or more of the following categories: (1) an action which would directly cause the death of the condemned; (2) an action which would assist, supervise, or contribute to the ability of another individual to directly cause the death of the condemned; . . .
>
> Physician participation in an execution includes, but is not limited to, the following actions: prescribing or administering tranquilizers and other psychotropic agents and medications that are part of the execution procedure; . . .
>
> . . . where the method of execution is lethal injection, the following actions by the physician would also constitute physician participation in execution: selecting injection sites; starting intravenous lines as a port for a lethal injection device; prescribing, preparing, administering, or supervising injection drugs or their doses or types; . . .

Available at http://www.ama-assn.org/ama/pub/category/8419.html (last visited Nov. 23, 2004)

175. Hull, *supra* note 23, at A1.

176. Comments following paper presentation: Douglas Mossman, "Should Psychiatrists Medicate Russell Weston?" AAPL Annual Meeting (Oct. 26, 2001).

As was noted earlier, most of the psychiatrists who testified at Weston's district court hearing felt that involuntarily medication was in the defendant's interest, though the medication could make him subject to prosecution. *See supra*, text at note 35.

> patient has a serious mental illness, is suffering, there is an efficacious treatment, the patient is incompetent to make medical decisions, and a judge or guardian makes a proxy decision for the patient.[177]

Appelbaum's commentary on *Sell* implicitly takes an illness-focused approach, too. He believes that:

> Medical appropriateness, the absence of nonmedical therapies, and the likely ineffectiveness of threats to hold psychotic prisoners in contempt should be straightforward in almost all cases. But the strong suggestion in the opinion that hearings be held first on the issue of dangerousness . . . will lead to additional and often needless litigation . . . .
>
> As for Dr. Sell, . . . [s]ix years after his arrest and more than four years after he was first found incompetent to stand trial, he remains imprisoned, psychotic, and untreated.[178]

By contrast, some nonphysician commentators have felt that the extra-medical legal consequences must play a role in deciding whether to medicate a defendant-patient. Discussing Russell Weston's situation before he began receiving psychotropic medication, Professor David Siegel of the New England School of Law told National Public Radio:

> There's not any other circumstance where we allow people to be medicated [involuntarily] unless it's for their own good . . . And it is very difficult to say with a straight face that medicating Mr. Weston under these circumstances, where the possible outcome could be his being sentenced to death, is gonna help him."[179]

Leonard Rubenstein, a lawyer and executive director of the Washington-based advocacy organization Physicians for Human Rights (PHR), told the Washington Post that medicating Weston to achieve "the government's interest in pressing a case . . . raises serious ethical issues for the doctor charged with giving the medication."[180] In an *amicus* brief urging the Supreme Court to hear Weston's case, PHR argued that Weston's

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177. Alan A. Stone, *The Right to Refuse Treatment: Sell v United States*, PSYCHIATRIC TIMES, Sept. 2003, at 1, 9.

178. Appelbaum, *supra* note 80, at 1341. A year later, this remained the case; *see* Carolyn Tuft, *Sell Is Sent to Different Prison Hospital,* ST. LOUIS POST-DISPATCH, Nov. 30, 2004, at B1 (trial judge orders Sell sent to FCI–Butner for competence restoration after Sell's attorneys report he "was so obsessed with mistreatment at Springfield that he could not assist in preparing for trial").

179. Transcript, "Legal and Ethical Questions in the Case of Russell Weston Jr.," Morning Edition, May 16, 2001.

180. Tucker, *supra* note 46, at B1.

dangerousness had been addressed by his confinement in a hospital.[181]

George Annas, Chair of the Department of Health Law, Bioethics, and Human Rights at Boston University, makes a similar point in an essay about the *Sell* decision published in the *New England Journal of Medicine*. Annas suggests that Sell's criminal charges were not serious enough to justify forcing drugs upon him so that he could undergo trial,[182] and thus would not satisfy the *Sell* majority's requirement that medication have the potential to "further important governmental trial-related interests."[183] By contrast, says Annas, Weston's case might be one in which the state's interest in prosecution was important enough to justify forced medication. However,

> the important state interest at stake still must be articulated. Because Weston is mentally ill and dangerous, for example, he is likely to be civilly committed for a long time—at least until he is no longer a danger to others. Thus, a criminal trial is not necessary to promote public safety.[184]

Annas then suggests that the needs and interests of individual patients may conflict with the needs and interests of the criminal justice system. He questions whether the state-employed psychiatrists who treat pre-trial detainees might fail to appreciate this conflict, might inappropriately identify with state interests, and might therefore make medication decisions that satisfy the state's wishes for retribution at the expense of their individual patients' welfare. By extending the circumstances in which mentally ill persons can be forcibly medicated, concludes Annas, the *Sell* decision has highlighted the dual loyalties of the forensic psychiatrist whose patients are criminal defendants.

> [P]sychiatrists can respond by taking the Supreme Court at its word that competent adults should not be involuntarily medicated solely for the convenience of the state . . . Drugs should be prescribed by a physician only if the physician makes an independent judgment that treatment is in the patient's best medical interests.[185]

Indeed, the doctors who advocated medicating Weston to alleviate his symptoms, reduce his dangerousness, or decrease his suffering did not

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181. Brief of Physicians for Human Rights as Amicus Curiae in Support of Petitioner, Weston v. U.S. (Nov. 8, 2001), *available at* http://www.phrusa.org/research/methics/phys_brief.html) (last visited Nov. 23, 2004).

182. George J. Annas, *Forcible Medication for Courtroom Competence – The Case of Charles Sell,* 350 N. ENGL. J. MED. 2297, 2300 (2004).

183. *Sell,* 539 U.S. at 179.

184. Annas, *supra* note 182, at 2300.

185. *Id.* at 2301.

address a straightforward, important ethical argument.[186] This argument is most easily appreciated by imagining the following response of a treating psychiatrist who was asked whether medicating Weston for competence restoration was really in his "best medical interests":

> "As Weston's treating physician, I must consider not only whether medication would safely and effectively address his psychotic symptoms, but the consequences of my treatment. Even if I give Weston antipsychotic therapy, he might not become competent.[187] Then he would stay confined in a secure hospital, just as he is now.
>
> "But if medication rendered Weston competent, he would stand trial for murder. Acquittal is not possible; there is no doubt that Weston planned and carried out the Capitol shootings. His trial could have only three possible outcomes: an insanity acquittal, a guilty verdict with a life sentence, or a guilty verdict and a death sentence.
>
> "If found insane, Weston's prospects would be not much different from those he now faces without medication: prolonged confinement in a secure hospital setting. As John Hinckley's experience has shown,

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186. Here is how law professor and physician M. Gregg Bloche briefly described the matter:

> At hearings held in 1999 and 2000 to consider whether Weston should be medicated, his prison physician acknowledged the tension between the state's purposes and her therapeutic role . . . .Testifying for the prosecution was Weston's psychiatrist, Sally Johnson. She conceded that her main purpose was to make Weston competent to stand trial—and that therapeutic success could lead to a death sentence. Yet she and the prosecution denied any conflict between her duties to Weston and the justice system.
>
> By framing her clinical role in narrow, biological terms, unconnected to Weston's personal fate, Johnson sought to steer clear of the obvious conflict between Weston's and the government's interests: "I see him as suffering from a mental illness that requires treatment for alleviation of his symptom picture," she said, "and I feel no conflict in providing that treatment to him."

M. Gregg Bloche, *What Would Hippocrates Do?; When the State Calls, It's a Tough Question*, WASH. POST, Jan. 27, 2002, at B2.

187. Appelbaum observes, "Although medications are usually effective for the control of psychotic symptoms, it [is] not always . . . easy to establish in advance that a treatment regimen is 'substantially likely' to restore competence." Appelbaum, *supra* note 80, at 1336. *See*, however, studies cited *supra* note 13, reporting high rates of successful competence restoration.

obtaining release from the hospital might take decades,[188] and given what Weston did and the publicity his case has received, his release might never occur.

"But there is no guarantee that a jury would find Weston would find insane if he were tried. The government seems very unlikely to accede to an insanity verdict without trial, which is the usual way criminal defendants obtain insanity verdicts. National statistics show that few defendants achieve insanity verdicts in jury trials,[189] and given what Weston did and the government's desire for a conviction, going to trial would entail an especially high likelihood of a guilty verdict. If this occurred, the best Weston could hope for is life in prison—that is, confinement for the rest of his life, the same prospect he faces now without medication. A guilty verdict could also result in a death sentence, a worse prospect than Weston faces now.

"Even if I think Weston should take antipsychotic medication," the treating psychiatrist continues, "he would not view that medication as beneficial. He took antipsychotic medication during his Fall 1996 hospitalization, and stopped it shortly after leaving the hospital. For all the supposed effectiveness of drugs, Weston saw no value in taking them.

"Also, Weston functioned in society for years—often, it appears, contentedly—without medication. In his present environment, he poses little risk of harming others; his risk to himself is similar to the risk of the many thousands of persons in our country who have untreated schizophrenia.

"Because I am a treating psychiatrist," the argument concludes, "I am bound by Hippocratic obligations to help my patients and do nothing that would harm them. Medication would at best yield benefits that

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188. John W. Hinckley, Jr., attempted to kill President Reagan in March 1981. He remains a patient at St. Elizabeth's Hospital in Washington, DC. Only in December 2003 did a federal judge permit Hinckley to have unsupervised visits with his parents off hospital grounds. The Secret Service trails Hinckley when he makes off-grounds trips with hospital personnel. Michael Janofsky, *Man Who Shot Reagan Allowed To Visit Parents Unsupervised,* N.Y. TIMES, Dec. 18, 2003, at A1. A year later, a federal court denied the hospital's request to allow Hinckley to go on more lengthy passes. John Files, *Judge Denies Hinckley's Request For Extended Hospital Leaves,* N.Y. TIMES, Nov. 26, 2004, at A37.

189. The most comprehensive study to date suggests that the insanity defense is used in about one percent of felony cases and is successful about one-quarter of the time. Only seven percent of successful insanity defenses are disposed of by a jury. Lisa A. Callahan et al., *The Volume and Characteristics of Insanity Defense Pleas: An Eight-State Study*, 19 BULL. AM. ACAD. PSYCHIATRY LAW 331 (1991).

> Weston has never valued, and 'successful' treatment could well permit trial, conviction, life imprisonment, or a death sentence. I conclude that despite his illness, treating Weston with antipsychotic medication is not in his interest and would therefore be unethical."

In support of this argument, a treating psychiatrist could cite several ethical codes.[190] The AMA Principles of Medical Ethics ask the physician to "respect the law" but also to "recognize a responsibility to seek changes in those requirements which are contrary to the best interest of the patient."[191] The Declaration of Helsinki states that when the patient is a prisoner, "[t]he doctor's fundamental role is to alleviate the distress of his or her fellow men, and no motive whether personal, collective or political shall prevail against this higher purpose."[192] The World Medical Association's International Code of Ethics lists, among the duties of physicians, the obligation to "act only in the patient's interest when providing medical care which might have the effect of weakening the physical and mental condition of the patient" and to "always bear in mind the obligation of preserving human life."[193] The same association's Declaration of Geneva requires the physician to pledge, "The health of my patient will be my first consideration."[194]

What makes the argument against treating Weston so important is the fact that a similar utilitarian calculus would bar the treatment of many other mentally ill defendants, who might experience greater well-being if they remained psychotic than they would if they had to face the probable consequences of criminal prosecution, and for whom competence-restoring medication would also enable successful prosecution. Charles Sell's case is a well-publicized example of circumstances frequently encountered at public hospitals that treat individuals found incompetent to stand trial: patients receive competence-restoring treatment despite being untroubled by their mental illnesses, and despite facing a high probability of conviction and imprisonment if their treatment is 'successful.'[195] The

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190. For a useful historical summary of medicine's ethical commitment to helping and avoiding harm to individual patients, *see* Donald P. Judges, *The Role of Mental Health Professionals in Capital Punishment: an Exercise in Moral Disengagement*, 41 HOUS. L. REV. 515, 557-64 (2004).

191. AMA PRINCIPLES OF MEDICAL ETHICS, No. 3 (2001), *available at* http://www.ama-assn.org/ama/pub/category/2512.html (last visited Nov. 23, 2004).

192. WORLD MEDICAL ASSOCIATION, DECLARATION OF TOKYO (1975), *available at* http://www1.umn.edu/humanrts/instree/tokyo.html (last visited Nov. 23, 2004).

193. WORLD MEDICATION ASSOCIATION INTERNATIONAL CODE OF MEDICAL ETHICS, *available at* http://www.wma.net/e/policy/c8.htm (last visited Nov. 23, 2004).

194. *Id.*

195. This sentence refers to "treatment," not just "medication." Hospitalized patients who have disorders for which medication is the primary treatment also receive other

Hippocratic obligations to help patients and "do no harm" seem to require that in some circumstances, psychiatrists should withhold ordinary medical treatment from psychotic, incompetent defendants to help their patients avoid prosecution and punishment.

VII. UTILITY-MAXIMIZATION VERSUS A KANTIAN APPROACH[196]

A. The Typical Physician's Pragmatic, Individualized Utilitarianism

Both Hippocratic principles and the moral basis for medical treatment are more complex than physicians often acknowledge. Although physicians ardently espouse the dictum "do no harm," they know that sometimes they have to make their patients suffer. The treatments administered by surgeons and oncologists often are agonizing, but physicians typically justify such treatments to themselves and their patients using a utilitarian approach, saying that the potential benefits outweigh the pain and risks associated with therapy. In like manner, although some mental health procedures—

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therapeutic measures, such as group therapy, individual therapy, education, and a peaceful environment that is conducive to recovery. The ethical problem that I discuss here is not peculiar to pharmacotherapy; any medical treatment that makes patients susceptible to prosecution raises the same issue.

For two recent descriptions of competence restoration programs that emphasize education during hospitalization, see Barry W. Wall et al., *Restoration of Competency to Stand Trial: A Training Program for Persons With Mental Retardation*, 31 J. AM. ACAD. PSYCHIATRY LAW 189 (2003) (training for persons with mental retardation), and Lisa Jo Bertman et al., *Effect of an Individualized Treatment Protocol on Restoration of Competency in Pretrial Forensic Inpatients*, 31 J. AM. ACAD. PSYCHIATRY LAW 27 (2003) (deficit-focused education and legal rights training).

196. Portions of this and the following section are modifications of previous discussions of the justification of punishment in Douglas Mossman, *The Psychiatrist and Execution Competency: Fording Murky Ethical Waters*, 43 CASE WESTERN RES. L. REV. 1, 53-88 (1992), and Douglas Mossman, *Immoral*, *supra* note 9, at 357-68. In this Section, citations to English translations of Kant's works follow this scheme:

"KrV" = CRITIQUE OF PURE REASON (Norman Kemp Smith's translation of KRITIK DER REINEN VERNUNFT (1781/87), New York, St. Martin's Press, 1965).

"Rechtslehre" = The Metaphysical Elements of Justice (John Ladd's translations of Metaphysische Anfangsgründe der Rechtslehre (1797), New York, Macmillan, 1965).

"KpR" = CRITIQUE OF PRACTICAL REASON (Lewis White Beck's translation of KRITIK DER PRAKTISCHEN VERNUNFT (1788), 3rd ed., New York, Macmillan, 1993).

"GMS" = GROUNDWORK OF THE METAPHYSIC OF MORALS (H. J. Paton's translation of GRUNDLEGUNG ZUR METAPHYSIK DER SITTEN (1785), New York, Harper & Row, 1964).

Unbracketed page numbers refer to pagination in the above English translations. Bracketed page numbers utilize the standard method of reference to Kant's writings, (*i.e.*, referring to pagination in the Königlich preußische Akademie der Wissenschaften edition of KANTS GESAMMELTE SCHRIFTEN).

particularly involuntary hospitalization, physical restraint, and forcible administration of medication—can be odious and frightening, psychiatrists often justify these actions by arguing that patients, once restored to rationality, will be better off and even thankful for having treatment thrust upon them.[197] Physicians (psychiatrists among them) hew not to strict policies of alleviating pain and "do no harm," but to an approach that might be termed "individualized, pragmatic utilitarianism," in which they ask themselves instead whether the gains individual patients will receive from treatment are worth the discomfort or pain the treatment causes those individuals.

As the previous section shows, however, the pragmatic utilitarian considerations about individuals' consequences will often fail to justify psychiatric treatment that restores competence to stand trial, and even lead to the troubling conclusion that psychiatrists should sometimes withhold treatment to keep their patients from suffering punishment. Physicians as a group do not typically contemplate matters of political philosophy,[198] but if

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197. "For the past two decades, an important psychiatric rationale for involuntary hospitalization has been that patients who initially object to being hospitalized change their views after receiving hospital treatment . . . . It has been argued that patients may even be grateful that clinicians overrode their initial refusals of hospital treatment. [Professor Alan A.] Stone . . . called this rationale for involuntary-hospitalization the 'thank you' theory." William Gardner et al., *Patients' Revisions of Their Beliefs About the Need for Hospitalization*, 156 AM. J. PSYCHIATRY 1385, 1385 (1999) (citations omitted). Although theoretically persuasive, empirical support for this assertion is lacking. For example, in the just-cited study, the authors evaluated 433 inpatients shortly after admission and again after discharge, and found that "[c]oerced patients did not appear to be grateful for the experience of hospitalization, even if they later concluded that they had needed it." *Id.* In an earlier study, only a minority of involuntary patients later perceived their hospitalization as helpful. James C. Beck and Edward A. Golowka, *A Study of Enforced Treatment in Relation to Stone's "Thank You" Theory*, 6 BEHAV. SCI. LAW 559 (1988).

198. The late psychiatrist Karl Menninger represented a clear exception to this, and offered an extended criticism of the desire to punish, which he saw as arising from sadistic and vindictive feelings:

> [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. . . .
>
> Punishment is in part an attitude, a philosophy. It is the deliberate infliction of pain in addition to or in lieu of penalty.

KARL MENNINGER, THE CRIME OF PUNISHMENT 190, 203 (1968). Menninger's argument conflates the actual practice of punishment with its justification; simply because people express inhumane views or feelings about criminals does not mean that punishment, as a

the question were posed to them, I suspect they typically would justify the need to administer punishment on utilitarian grounds. That is, physicians might say that people do not naturally think about how their actions will affect the general well-being, and therefore need social institutions to engender appropriate feelings and attitudes about various forms of conduct. Physicians might endorse a justification of punishment which (borrowing from University of North Carolina Professor Thomas Hill's characterization of a utilitarian approach to this topic) holds that people need incentives for good conduct, and society needs "to instill internal sanctions through training as well as relying on social pressure, rewards and punishments, to induce people to maximize utility . . . . Social pressure is a necessary and legitimate utilitarian means to get people to make utility maximizing decisions,"[199] and punishment is a necessary institution that benefits society by incapacitating miscreants and deterring other would-be criminals.

Yet physicians would also say that subjecting a person to prosecution and punishment is a moral matter,[200] and that it is not the business of physicians (when they act in their social role as physicians) to express or carry out acts of moral condemnation. Whereas the legitimate utilitarian aims of punishment are proper concerns of the criminal justice system, which serves society, the aims of physicians, insofar as they function as deliverers of medical treatment, must focus on serving and protecting the welfare of individual patients. Psychiatrist Alan Stone's commentary on the *Sell* decision captures this contrast nicely:

> [I]n cases like . . . *Sell* the prosecutors are not primarily concerned with treating the defendant, as we might be when we are dealing with a patient. Their interest and the state's interest is to restore the patient to competency so that they [*sic*] can be tried . . . The needs of the criminal justice system—not the needs of the patient—are the focus of these legal controversies. In my view, the courts are asking and attempting to answer the wrong questions. Involuntary psychiatric treatment, like any other medical treatment, should be given only when the patient is incompetent to make medical decisions and only when the goal of treatment is to restore the person's mental health . . . . [T]he needs of

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social institution, is unjustified. In fact, Menninger endorses Platonic and Kantian justifications for retaliatory or retributive punishments, *id.* at 205-06, but prefers to call criminal sanctions "penalties" to avoid vindictive connotations. "Penalties should be greater and surer and quicker in coming," writes Menninger. "I favor stricter penalties for many offenses, and more swift and certain assessment of them." *Id.* at 202.

199. Thomas E. Hill, Jr., *Kant on Wrongdoing, Desert, and Punishment*, 18 LAW & PHIL. 407, 423 (1999).

200. *See, e.g.*, *id.* at 439 (suggesting "that punishment is an institution that in fact conveys the moral disapproval of the community").

> the criminal justice system and the strategies of lawyers should not be the basis of involuntary psychiatric treatment.[201]

Yet, as important as risks and benefits are to making recommendations about medical treatment, such concerns, which are at the center of the typical physician's individualized utilitarian calculus, are not the ultimate basis of medical treatment's permissibility. What really makes medical treatment—or, more precisely, the actions of physicians who administer it—morally and legally acceptable is the prior consent of patients. Consent is central to the justification of medical treatment, and such considerations underlie Stone's earlier-quoted point that involuntary administration of psychotropic drugs may occur only after a judge or guardian has made "a proxy decision for the patient."[202] By recognizing this, psychiatrists (and other physicians) gain a more sophisticated vantage point from which to evaluate their ethical duties. A consent-based theory of medical ethics allows medical care to be seen as one of many human interactions that affirm and protect individuals' dignity and autonomy, and places medical ethics in a larger moral context that encompasses many features of interpersonal obligation.[203]

Consent-based theories of political obligation figure prominently in Anglo-American intellectual history. For example, in *The Second Treatise of Government*, John Locke writes, "[E]very man, by consenting with others to make one body politic under one government, puts himself under an obligation to every one of that society, to submit to the determination of the majority, and to be concluded by it."[204] Physicians wrestling with the ethical questions surrounding the forced treatment of Sell, Weston, and other individuals who are incompetent to stand trial should consider that consent also is a central feature in prominent liberal defenses of criminal sanctions. In particular, Immanuel Kant's theory of political authority shares many features with consent-based justifications of physician-induced suffering, and provides psychiatrists with an understanding of punishment that makes it unnecessary to resolve apparent ethical conflicts created by utilitarian considerations.[205]

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201. Stone, *supra* note 177, at 9.

202. *Id.*

203. ROBERT M. VEATCH, A THEORY OF MEDICAL ETHICS 108-38 (1981).

204. JOHN LOCKE, THE SECOND TREATISE OF GOVERNMENT, OF CIVIL GOVERNMENT AND LETTER ON TOLERATION §97 (J. W. Gough ed., 2d ed., Basil Blackwell 1956) (1690).

205. My previous discussions of Kant's theories, cited *supra* note 196, relied extensively on the work of Professor Jeffrie G. Murphy, particularly KANT: THE PHILOSOPHY OF RIGHT (1970), *Kant's Theory of Punishment in* RETRIBUTION, JUSTICE, AND THERAPY 82 (1979), and *Does Kant Have a Theory of Punishment*, 87 COLUM. L. REV. 532 (1987). Murphy's writings offer a procedural interpretation of Kant's social contract similar to that developed in JOHN RAWLS, A THEORY OF JUSTICE (1971). Although I find this

B. Kant's Philosophical Method

At the outset, it is important to lay out two general aspects of Kant's philosophical approach. First, a key feature of Kant's moral and political theories is his unfailing emphasis on the dignity of individual persons. For Kant, individual persons have value and intrinsic worth that are "infinitely above all price," and their dignity is grounded in their autonomous capacity to act in accordance with moral principles that they regard as applying to themselves and everyone else.[206] This leads Kant to conclude, in his *Groundwork of the Metaphysic of Morals*, that the basis for morality must be his famous categorical imperative: "Act only according to that maxim through which you can at the same time will that it should become a universal law."[207] Kant also shows that as a practical manner, this categorical imperative is equivalent to stating that one must "[a]ct in such a way that you always treat humanity, whether in your own person or in the person of any other, never simply as a means, but always at the same time as an end."[208] Neither legal nor moral principles may be justified by considerations of general happiness, social benefits, or other utilitarian considerations, but must instead be grounded in considerations of individual rights. In the context of this Article's concerns, the significance of this point is the following: If Kant is to find that a system of criminal sanctions is justified, he must do so in a way that addresses and centralizes the humanity of the criminal himself. Thus, for psychiatrists concerned about conflicts in their obligations to defendant-patients, a Kantian defense of punishment, if successful, will preserve as a paramount value respect for the personhood of an individual facing potential punishment—just as a physician, by withholding treatment until consent is obtained, respects the personhood of an individual undergoing treatment.

A second key aspect of Kant's moral and political theories is Kant's "critical" approach, a "deductive" method that characterizes much of Kant's mature philosophy. Kant *assumes* that certain of our notions, such as the notion that we make choices and act freely, or (to take a legal example) the notion that we may be rightful owners of property, are valid. He sees the role of philosophy as attempting to show, not that freedom or valid property ownership is possible—Kant assumes this is the case—but

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approach appealing (and a convincing way to understand the force of political authority), more recent scholarship suggests a different reading of Kant's theories. The present discussion is indebted to Hill, *supra* note 199, and especially to the lucid explanations in Kevin Thompson, *Kant's Transcendental Deduction of Political Authority*, 92 KANT-STUDIEN 62 (2001).

206. GMS at 102-103 [78-79].

207. GMS at 88 [52].

208. GMS at 96 [66-67].

how and why such notions are possible. The political authority that allows and protects property ownership (and other fundamental rights) is essentially a coercive force.[209] A key task for Kant's political philosophy, then, is to show how political coercion can be justified within a moral context that requires individuals always to be treated as ends in themselves.

One of Kant's methods for achieving resolution of philosophical questions is what he terms a "transcendental deduction" of a regulative idea of reason. Used in this context, the word "idea" ("*Idee*" in German) is Kant's technical term for a necessary concept of reason that arises not from sensing or experiencing something that actually exists, but that is an ideal toward which reason strives as it organizes experience.[210] In general, the role of a transcendental deduction of a regulative idea is to demonstrate that reason can bring a specific area of its functioning into "systematic unity" only by employing this idea.[211] As Kevin Thompson of DePaul University explains, Kant sees reason as "fundamentally a spontaneous activity of human intellect striving to achieve order and systematicity."[212] Those ideas that allow reason to achieve coherence and arrive at "systematic unity" are necessary rules or "maxims" that govern the area of reason under consideration.[213]

C. Rights and the Acceptance of Living in Civil Society

Kant sees justice as concerned not with personal motives or reasons for doing things, nor with the intended goals of actions, but only with the effect that one person's choices and ensuing actions can have on other persons. Laws must apply to everyone equally, and thus, the key consideration for evaluating the legal permissibility of a freely chosen action is whether that action can be consistent with the freely chosen acts of all other persons. Homologous with the categorical imperative, this freedom-maximizing

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209. John Ladd, *Translator's Introduction* to Kant's THE METAPHYSICAL ELEMENTS OF JUSTICE xxvii-xxviii (New York, Macmillan 1965).

210. *Id.* at xviii.

211. In the CRITIQUE OF PURE REASON, Kant explains that "transcendental" knowledge refers to knowledge "by which we know that—and how—certain representations (intuitions or concepts) can be employed or are possible purely *a priori*. The term 'transcendental,' that is to say, signifies such knowledge as concerns the *a priori* possibility of knowledge, or its *a priori* employment." KrV at 96 [A56=B80]. The "transcendental deduction of all ideas of reason" involves showing that these ideas are "rules of the empirical employment of reason [that] lead us to a systematic unity, under the presupposition of such an *object in the idea*; and that they thus contribute to the extension of empirical knowledge, without ever being in a position to run counter to it." From such a deduction, we conclude that reason must "always proceed in accordance with such ideas." KrV at 550 [A671=B699]

212. Thompson, *supra* note 205, at 66.

213. *Id.*

"Universal Principle of Justice" requires that "my action or my condition in general can coexist with the freedom of everyone in accordance with a universal law."[214]

The law is not concerned with my motives for obedience—why I obey the law—but only whether I am obedient. Therefore, I am not required to adhere to the Universal Principle of Justice (and laws consistent with it) out of a sense of moral obligation or any other virtuous personal motive, but simply out of recognition that my "freedom is restricted in this way and may be so restricted by others in practice."[215] My having a right to act freely, within the bounds of this restriction, entails a right to prevent others from unjust hindrances of my freedom. Using coercion to counteract unjust hindrances to freedom "is consistent with freedom according to universal laws," and thus, any right I have to act in a permissible way "is united with the authorization to use coercion against anyone" that interferes with my right.[216]

If I loan someone money, for example, my right to expect repayment should not be regarded as the debtor's moral obligation to repay coupled with my authorization to use coercion to convince him to do so. The debtor may indeed have a moral obligation, but my "right means only that the use of coercion" in any instance in which a debtor might fail to repay a creditor "is entirely compatible with everyone's freedom, including the freedom of the debtor, in accordance with universal laws. Thus 'right' . . . and 'authorization to use coercion' mean the same thing."[217]

We cannot conceive of a world in which persons had freedom to act, but could not rightfully use or possess any real physical things on which to act. Therefore, Kant's "Juridical Postulate of Practical Reason"[218] requires that

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214. RECHTSLEHRE at 35 [230].

215. RECHTSLEHRE at 35 [231].

216. RECHTSLEHRE at 36 [231].

217. RECHTSLEHRE at 37 [232].

218. Kant defines "practical reason" obliquely: "Only a rational being has the power to act . . . in accordance with principles—and only so has he a *will*. Since *reason* is required in order to derive actions from laws, the will is nothing but practical reason." GMS at 80 [36] (italics in original). That is, practical reason is the human faculty, often referred to as the "will," that utilizes conscious motives (that is, motives or reasons of which we can be aware, as opposed to impulses of which we are unconscious) to determine conduct. Lewis White Beck, *Translator's Introduction*, CRITIQUE OF PRACTICAL REASON xi (3d ed., Macmillan 1993). Kant believes that rational beings who exercise practical reason must be regarded as free, because such beings explain their actions by giving their own reasons for what they do, rather than regarding themselves as externally directed. Only under the "Idea of freedom" can "the will of a rational being be a will of his own." GMS at 116 [101]. In Kant's terminology, a "postulate of pure practical reason" is "a theoretical proposition which is not as such demonstrable, but which is an inseparable corollary of an a priori unconditionally valid practical law." CpR at 129 [122].

I regard all objects of my potential choices as things that potentially could be possessed by me or someone else.[219] This, in turn, "confers on us an authorization . . . to impose an obligation on all others . . . to refrain from using certain objects" if we have previously taken lawful possession (*e.g.*, if we have legally acquired ownership) of those objects.[220] Such obligations must come from universalizable rules, however, meaning that any rational claim of legal possession that I might make would have to contain "an acknowledgment of being reciprocally bound to everyone else to a similar and equal restraint with respect to what is theirs."[221]

When I legally acquire a possession, I make a claim that entails coercive force to preserve my ownership that extends beyond my own physical powers to control that possession. At the same time, however, I must respect the potential applicability to me of the same coercive force that may be used to protect all others' legitimate claims of ownership. Moreover, in claiming an entitlement to use coercive force to defend my ownership right, I am also recognizing the legitimacy of all other persons' legitimate claims of ownership against me, and am thus affirming the very concept of legal ownership.[222] But all this is only possible in the context of a society where laws protecting ownership can exist; the only kind of will that can bind everyone in this way is a collective, universal will that operates through public legislation, backed by coercive power, in civil society.[223]

Kant uses the philosophical term "state of nature" to refer not to any actual period before societies formed, but rather, to a hypothetical condition in which laws and legal systems do not exist. As our example shows, absent law and legal systems, there is no possibility of legal ownership enforced by legitimate political authority, only physical control of possessions enforced by interpersonal violence, including preemptive violence against any perceived threat to such control. In this hypothetical state of "lawless freedom, . . . [people] cannot wrong each other by fighting among themselves; for whatever goes for one of them goes reciprocally for the other as though they had made an agreement to that effect."[224] One can never be secure in one's ownership or anything else that requires mutually recognized rights, because without a recognized legal system, "each will have his own right to do what *seems just and good to him*, entirely independently of the opinion of others."[225] Kant therefore postulates "as an

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219. RECHTSLEHRE at 52-53 [246].
220. RECHTSLEHRE at 53 [247].
221. RECHTSLEHRE at 64 [255].
222. Thompson, *supra* note 205, at 74-75.
223. RECHTSLEHRE at 65 [256].
224. RECHTSLEHRE at 71-72 [307].
225. RECHTSLEHRE at 76 [312] (emphasis added).

a priori Idea of reason" that people should participate in a legal system "if they ever could (even involuntarily) come into a relationship with one another that involves mutual rights,"[226] because it is only within such a system that one's ownership can "be established lawfully and secured . . . by an effective power" that is more than one's own mere physical capacity.[227]

The very notion that we can have enforceable rights thus requires us to give up the possibility of living in a lawless "state of nature" and to enter civil society, where we subject ourselves (along with everyone else) to "public lawful external coercion."[228] Because consent is necessary to avoid injustice, legislation (and with it, the establishment of rules for lawful coercion) can only derive from "the united and consenting Will of all—that is, a general united Will of the people by which each decides the same for all and all decide the same for each."[229] What makes such common consent possible is the "original contract," which, on Kant's view, is the idea that lets us conceptualize political legitimacy.[230] Under this idea, we regard ourselves as having agreed to renounce whatever individual freedom we could exercise in the state of nature "in order to take it back again

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226. RECHTSLEHRE at 70 [306].

227. RECHTSLEHRE at 76 [312].

228. RECHTSLEHRE at 76 [312].

229. RECHTSLEHRE at 78 [314].

230. RECHTSLEHRE at 80 [315]. Here, the term "idea" designates a Kantian "idea of reason." The function of the idea of the "original contract" emerges most clearly in his essay, "*On the Common Saying: this May Be True in Theory but it Does Not Apply in Practice.*" Kant states that the original contract, through which a "completely lawful constitution and commonwealth can alone be established," is something that we regard as having arisen from "a coalition of the wills of all private individuals in a nation to form a common, public will for the purposes of rightful legislation." Though such a contract does not physically exist, and is

> . . .in fact merely an *idea* of reason, . . .[it] nonetheless has undoubted practical reality; for it can oblige every legislator to frame his laws in such a way that they could have been produced by the united will of a whole nation, and to regard each subject, in so far as he can claim citizenship, as if he had consented within the general will. This is the test of the rightfulness of every public law. For if the law is such that a whole people could not *possibly* agree to it (for example, if it stated that a certain class of *subjects* must be privileged as a hereditary *class),* it is unjust; but if it is at least *possible* that a people could agree to it, it is our duty to consider the law as just, even if the people is at present in such a position or attitude of mind that it would probably refuse its consent if it were consulted. (TP p. 79).

For further discussion of the need for a distinction between the idea of the social contract and a contract *per se*, *see* Vernon Thomas Sarver, Jr., *Kant's Purported Social Contract and the Death Penalty*, 31 J. VALUE INQUIRY 455, 467-68 (1997).

immediately as members of a commonwealth."[231] Living in civil society does not require us to sacrifice personal freedom; rather, civil society secures personal freedom by transforming it from a "wild, lawless" condition into freedom under law, from freedom without the possibility of rights into freedom in which rights can be asserted and protected.[232]

Kant has thus succeeded in "deducing" the concept of civil society, with its attendant laws and coercive power, as a condition of the possibility of the freedom assumed in the exercise of practical reason. The notion of mutual, consensual obligation achieved through a hypothetical social contract enables reason to rationally order concepts such as lawfulness and rightful ownership, which are necessary components of freedom in any world where people cannot avoid having contact with one another.[233]

D. The Role of Retribution

As we have seen, central to Kant's understanding of a political constitution is the possibility of legitimate state coercion, one attribute of which is "penal justice."[234] But this leaves open the question of what types of punishments may justly be imposed on wrongdoers. One option might be to create a set of uniform punishments based on what scientific experiments might indicate, or on what experience has taught us, is necessary to deter various crimes. This procedure would satisfy the purpose of punishment as Kant defines it—assuring mutual respect for various individual rights through coercive measures that deter violations of those rights. Yet on Kant's view, such a procedure can be neither correct nor just because respect for the humanity of others requires that whatever principle we use to set punishments must be stipulated (or "deduced") a priori as a condition of the possibility of freedom in a civil society, the primary legal function of which is preserving just relationships between its members. What experience (that is, information obtained a posteriori), might teach us about suppressing crime cannot, therefore, be used to determine what punishments are fair or just.[235]

Instead, says Kant, the degree of punishment must be guided by "the principle of equality . . . , that is, the principle of not treating one side more favorably than the other."[236] This principle requires us to recognize that we

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231. RECHTSLEHRE at 80 [315]. As Kant uses the term, a commonwealth is "a union proceeding from the common interest of all in having a juridical condition of society." RECHTSLEHRE at 75 [311].

232. RECHTSLEHRE at 80-81 [316].

233. Thompson, *supra* note 205, at 76-77.

234. RECHTSLEHRE at 151 [362].

235. RECHTSLEHRE at 132 [363].

236. RECHTSLEHRE at 101 [332].

must treat the humanity of the criminal and the humanity of the victim equally, and may only inflict on the criminal what he has, in his criminal act, inflicted on another person. Admission of other considerations, such as using the criminal as an example to others, is potentially unfair to the criminal, who must always be treated as an end in himself. "The only time a criminal cannot [rationally] complain that he is treated unjustly is when he draws the evil deed back onto himself. . .and suffers that which according to the spirit of the penal law—even if not to the letter thereof—is the same as what he has inflicted on others."[237]

Considerations of justice thus require the state to impose punishments that are strictly retributive. The theoretical (philosophical) justification for having a system of punishment in civil society is coercive (*i.e.*, to deter would-be miscreants from violating laws that protect freedom by preserving just relationships among people[238]). Yet punishment as actually carried must be strictly retributive with the criminal's guilt being the necessary and sufficient condition for a court's imposing a sentence. To coerce (through "punishment") someone for a reason other than his having committed of a crime—for example, to punish him in order "to promote some other good for the criminal himself or for civil society"—would be to manipulate him "merely as a means to the purposes of someone else." The innate personhood of any individual, even an accused criminal, "protects him against such treatment . . . He must first be found to be deserving of punishment before any consideration is given to the utility of this punishment for himself or for his fellow citizens."[239]

As a system of coercive threats, the institution of punishment would be meaningless if punishments were not carried out, and the a priori deduction of justification of punishment precludes selective considerations based on individual circumstances. Failing to carry out a punishment for a crime that the criminal had a fair opportunity to avoid would favor the criminal and ignore the harm he has done. This would not merely be unfair; it would also constitute a failure to treat the criminal as an end in himself. Punishment is society's means for respecting the criminal's rationality, the means through which the criminal experiences the rational consequences of his freely chosen course of action. This is the case because punishment is a social practice that all of us, including offenders themselves, would endorse if we considered the rational justification of criminal justice from a neutral standpoint and regarded the interests of others as equal to our own desires.[240]

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237. RECHTSLEHRE at 133 [363].

238. Hill, *supra* note 199, at 430.

239. RECHTSLEHRE at 100 [331].

240. Hill, *supra* note 199, at 430.

For Kant, just punishment is also literally *retributive.* Most rational persons will respond to a set of coercive measures by obeying the law, thereby "paying back" (*i.e.*, re-tributing) fellow citizens for their obedience to law through reciprocation. When criminals choose to break laws, however, they are also choosing to undergo punishment as an alternative means of repaying fellow citizens for upholding the law.[241] This is another reason why the wrong that the criminal commits determines his punishment: punishment must be determined only by considering how the criminal can properly repay society for his transgression:

Accordingly, any undeserved evil that you inflict on someone else among the people is one that you do to yourself.... Only the Law of retribution (*jus talionis*) can determine exactly the kind and degree of punishment... [as determined by] a court of justice (and not in your own judgment). All other standards fluctuate back and forth and, because extraneous considerations are mixed with them, they cannot be compatible with the principle of pure and strict justice.[242]

Kant's way of thinking about the role of punishment in society has features that should appeal to physicians who treat accused criminals and are concerned about their fate. Although someone who receives punishment likely also receives the moral condemnation of the community, moral condemnation is not the point of punishment. Rather, punishment is a rationally necessary consequence of our enjoying rights in civil society. It is administered because it is what fairness and disinterestedness require. Society should not punish to make an example of the criminal, and sentencing should not be an occasion for making gratuitous judgments about the criminal's moral worth. Determining that someone deserves punishment does not permit us to regard him "as worthless scum, utterly incapable of reform."[243]

Kant's theory also forbids us from regarding deterrence or rehabilitation

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241. Murphy, KANT, *supra* note 205, at 142-43. *Cf.* U.S. v. Bergman, 416 F. Supp. 496, 499-500 (S.D. N.Y. 1976).

242. RECHTSLEHRE at 101 [332]. This limitation on punishment, states Professor Susan Meld Shell of Boston College, debars the criminal from protesting his punishment or arguing that he is being treated only as a means.

> Injury arises whenever more is imposed upon my will than I am able to impose on others.... But the criminal has, through the commission of his crime, placed a real hindrance on the external freedom of another, a limit that exceeds the point equilibrium of by which justice (or the system of external freedom) is itself defined. To place a comparable hindrance on the freedom of the criminal is to impose a bond on him that he cannot, in principle, claim as an injury, for it imposes no more on him than he has imposed on others.

Susan Meld Shell, *Kant on Punishment*, 1 KANTIAN REVIEW 115, 121 (1997).

243. Hill, *supra* note 199, at 439.

as necessary or sufficient reasons to punish someone, and thereby precludes the legal system from making judgments about the criminal's potential for reform, his likelihood of future misbehaving, or his inner worthiness. Punishment is a legitimate practice simply and precisely because society requires coercive measure to preserve freedom, and because punishment affirms everyone's humanity and autonomy, including the criminal's. Through punishment, a criminal experiences the logical consequences of his lawbreaking behavior. Legal denunciation through conviction and punishment expresses civil society's belief in, and respect for, the criminal's worthiness as a rational being, and affirms his moral value as a responsible person.[244]

VIII. IMPLICATIONS

A. The Value of Competence-Restoring Treatment and the Obligation to Accept It

To summarize: whenever individuals live together, a reasonably fair[245] criminal justice system, with rules that specify infliction of punishment as the response to crime, is a condition of the possibility of exercising practical freedom and having rights. Making criminals undergo punishment is an obligation of civil society, and a just legal system will assure that the lawbreaker is dealt with only in ways that respect his rationality and autonomy. These obligations provide two ways to understand why psychiatrists whose actions may make possible a criminal's conviction or punishment are not violating their obligations to help patients and avoid harming them.[246]

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244. Michael S. Moore, *The Moral Worth of Retribution*, *in* RESPONSIBILITY, CHARACTER, AND THE EMOTIONS 179, 198-217 (Ferdinand Schoeman ed. 1987).

245. Those who have suggested that treating Weston is unethical have not claimed that it is the *unfairness* of the criminal justice system—including, in Weston's case, the possibility of the death penalty—that makes treatment wrong (although I suspect that opposition to the death penalty may lurk behind their objections). For a short discussion of this problem, *see* Mossman, *Fording*, *supra* note 196, at 56-59. I return to this matter *infra*, Section IX.

246. It should be noted that although physicians have special means and skills through which they can fulfill obligations of beneficence and nonmaleficence, these obligations are ones that are not peculiar to physicians. LEVITICUS 19:18 instructs Jews and Christians, "Thou shalt love thy neighbor as thyself." Secular ethical schemes tell us that it is in everyone's enlightened self-interest to be good to each other (*see, e.g.*, JOHN STUART MILL, UTILITARIANISM Chs. II, III (1863), *in* ETHICAL THEORIES: A BOOK OF READINGS 395, 412 (A. I. Melden ed. 1967)) and that absent any generally-accepted justification, is it never morally acceptable for any one to do another harm. *See, e.g*, PAUL H. ROBINSON, CRIMINAL LAW DEFENSES 121-28 (1984) for a discussion of the extent to which justification, among

First, for an incompetent defendant who faces prosecution by a fair criminal justice system, *competence-restoring treatment represents a potential benefit, even if the likely outcome of treatment is the defendant's conviction and punishment.* The benefit derives from the peculiar circumstances and needs of that incompetent defendant. With regard to the possible consequences of criminal prosecution, accused criminals, like all of us, are bound by the demands of reason. Reason requires me to recognize that I can enjoy autonomy in a world where I must interact with other persons only by participating in civil society where judicially imposed punishment is the response to violations of rights. What preserves practical freedom in civil society are not the things that accused criminals in fact say they want after their arrest, but what reason tells us is needed when the social phenomenon of criminal behavior, and the threat it poses to autonomy, are viewed from a disinterested standpoint.

If I become a criminal, it is unlikely that I will ask to be punished, and my receiving punishment certainly should not depend on whether I think I am guilty or what I think I deserve for my transgression. Rather, says Kant, "it is the pure juridical legislative reason . . . in me that submits myself to the penal law as a person capable of committing a crime, that is, as another person along with all the others in the civil union who submit themselves to this law."[247] Not to regard an accused criminal as similarly submitting himself to law would require me to treat him as less than my moral equal. This a physician must not do, for it demeans the defendant as less than an end in himself.

What does this tell us about defendants Charles Sell or Russell Weston, who suffer from mental disorders that preclude their going to trial? Having recognized that bringing accused persons to justice is a crucial[248] and logically required function of civil society (as well as an affirmation of the accused's right to autonomous decision-making), competence-restoring psychiatric treatment then becomes one desirable feature of a legal system that treats everyone as an end in himself. Because competence-restoring medical treatment makes prosecution allowable, it preserves the autonomy and humanity of accused criminals by letting them satisfy their obligations

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other criminal defenses, is exculpatory as a product of society's acceptance of the behavior in general.

If, then, *all* citizens have obligations to do others good or at least to avoid harming others, then punishment poses a potential moral problem for everyone, not just physicians. Thus the same arguments that would justify physician actions in competence restoration must all justify, *mutatis mutandem*, the actions of jurors who convict, judges who sentence, jailers who effectuate sentences, and a society that, as a whole, collectively imposes suffering on its members through the actions of the criminal justice system.

247. RECHTSLEHRE at 105 [335].

248. For a discussion of this as a legal matter, *see* U.S. v. Weston, 255 F.3d at 880-81.

under the social contract. For criminal defendants undergoing competence restoration, treatment thus does not violate a psychiatrist's obligation to help patients and not harm them, even if successful treatment will allow those patients to be tried, convicted, and punished. Indeed the opposite is the case: safe, effective, competence-restoring treatment is medically appropriate because it is the incompetent defendant's vehicle for exercising rationality and vindicating his autonomy. For a psychiatrist not to administer such treatment would be an affront to the defendant's personhood because the psychiatrist would regard the defendant-patient in a way that the psychiatrist would not wish to be regarded: as an object to control rather than as a responsible individual, as a thing rather than an end in himself.[249]

This leads to a second way of understanding the value of treatment, inspired by what one might call a Kantian critique of how the *Sell* decision tells trial courts to evaluate proposals for involuntary medication. Trial courts, *Sell* states, should consider the seriousness of the defendant's charges, any period of confinement that could count against the defendant's sentence, and whether the defendant might, if not treated, be confined to a psychiatric hospital for a lengthy period, which "would diminish the risks that ordinarily attach to freeing without punishment one who has committed a serious crime."[250] Here, the Supreme Court seems to contemplate what are, from a Kantian standpoint, three troubling prospects. First, the Court appears to endorse a practice of tacitly assuming – without a trial – that an accused defendant has committed an illegal act, followed by use of civil commitment proceedings to confine that not-yet-found-guilty defendant if the factfinder thinks the defendant committed the act charged. Second, trial courts are given constitutional imprimatur to somehow calculate the added practical value of pursuing justice through prosecuting someone, rather than simply isolating him from society without

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249. Loyola University Professor Gary Herbert comments:

> Accusing the miscreant of having injured a *person* means recognizing the miscreant, too, *as* a person, as a being who is defined by his relationship with persons rather than mere things. By implication, the person who asserts the right of humanity in his own person acknowledges his freedom, his humanity, his rights, his capacity to obligate others, and, coincidentally, but not unimportantly, the legitimacy of his [own] punishment when he fails to act according to the law. Failure to punish would be to recognize him as nothing more than an animal will whose responsibility for what he does is precluded by the fact that he is a mere creature of inclinations to which he is bound, and of which he is not the author. He must be held responsible.

Gary B. Herbert, *Immanuel Kant: Punishment and the Political Preconditions of Moral Existence*, 23 INTERPRETATION 61, 66 (1995).

250. *Id.* at 180.

a criminal trial. Third, the Court provides a mechanism for creating a class of psychiatric hospital inmates who have been accused of crimes, for whom treatment to allow prosecution has been ruled out, but who are nonetheless confined because they are deemed dangerous.

Of course, legal decisions to punish criminals typically lead to confinement, which coincidentally protects the public from the criminals' future acts. But punishment in these cases is justified as society's promised-in-advance response to any miscreant's act. Punishment, then, is merely a just, retributive response to a proven misdeed. It contains no value judgment about the miscreant's liberty or possible future behavior. It is (and must be) carried out to make credible the system of coercive threats that preserves individual freedom. By contrast, to deprive an accused criminal of a trial, to deem him dangerous, and to make him an inmate in a psychiatric hospital because he is a threat to society simply treats him as an object. Handled this way, the accused criminal becomes merely a means to an end rather than a responsible end in himself. Had he instead been punished for doing something that violated others' rights and thereby threatened society, the criminal would have had the opportunity to consider and acknowledge matters that each offender should rationally acknowledge: his own misdeed and the need for law enforcement to preserve freedom. Punishment thus gives offenders the chance, at least, to identify their personal failings and accept responsibility for them. By contrast, mere confinement of a psychotic individual without giving him competence-restoring treatment robs him of the chance to appreciate what he has done and why his alleged act should merit criminal sanction.

B. Application to Actual, Treatment-Refusing Defendants

Thus, as a corollary of their participation in civil society, persons accused or convicted of crimes should be regarded as having given their *hypothetical,* rational consent to a social contract that provides for bringing accused criminals to trial and that includes procedures for giving psychiatric treatment to those defendants whose mental problems would otherwise preclude their being prosecuted fairly. But what about *actual* situations with real pretrial detainees? What should psychiatrists do when confronted with defendants (or their attorneys) who, like Sell and Weston, are opposed to competence-restoring treatment? How does hypothetical consent to treatment affect actual treatment refusals?

These questions have a two-part answer. First, Kant's deduction of consent to the conditions of a social contract, including the condition to undergo punishment, would be meaningless unless deducted consent outweighed a defendant's actual desire to circumvent punishment. To a criminal defendant who protested, "Who cares about Kant's theory or any other theory? I don't want to be punished!", we would respond that Kant's

theory tells us what desires and other considerations count when deciding how to treat criminals. As University of Illinois Professor Samuel Fleischacker puts it, the criminal may choose to ignore laws and the consequences of breaking them, but society does not, and society may therefore hold the criminal responsible "whether or not he wants to acknowledge those laws . . . . Civil society runs on the principle 'every citizen shall live under his own,' whether he chooses rational or irrational law for himself."[251] Or, as Professor Jeffrie Murphy explains,

> 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 . . . 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.[252]

Thomas Hill makes a similar point:

> The law's threat of punishment is to each citizen, but once offenders have ignored it[,] what is relevant is the relation between the law and the individual offenders. They disregarded the legitimate threat addressed to them [*i.e.*, the prospect of punishment for crimes], and the law has, in general, a morally justifiable right to carry out what it has threatened *to them*. By hypothesis, they have no complaint against the system . . . The court imposes the punishment on individuals because that is the law, not because it is a means to frighten others. . . . [T]he courts thereby respect the humanity of offenders as an end, though this provides the offenders no escape from the legitimate sanction that, by their free choice, they willfully incurred.[253]

Second, medical ethics recognizes that explicit consent is not the only valid basis for treatment. When most of us seek medical care, we do not give our doctors explicit verbal or written consent for being examined, nor do we explicitly consent to taking prescribed medication. Instead, we signify our consent for treatment by going to the doctor's office or having the pharmacist fill a prescription. When doctors treat unconscious or delirious patients in emergencies, the treatment is ethically permissible because it is the sort of thing to which most reasonable persons would

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251. Samuel Fleischacker, *Kant's Theory of Punishment*, 79 KANT-STUDIEN 434, 442-43 (1988) (footnote omitted).

252. Murphy, *Does Kant, supra* note 196, at 528.

253. Hill, *supra* note 199, at 441 (italics in original).

consent if they could.[254]

These answers illuminate how hypothetical rational consent bears on the problem of giving competence-restoring treatment to a defendant who either explicitly refuses medication or is too impaired to express a valid wish about getting medication. A defendant's consent to treatment is one aspect of his larger consent to freedom under law within the original contract. Given the existence of mentally disordered defendants, one feature of a criminal justice system consistent with this contract is a means for providing competence-restoring treatment to those defendants who otherwise could not participate in their own legal proceedings. In effect, all members of civil society agree to fair, impartial procedures that permit conscientious administration of competence-restoring treatment as a way to allow society to treat us as ends in ourselves (that is, as a human beings who may answer for wrongdoing through punishment) and not merely as a means (as irrational creatures to be confined because of dangerousness). This is not to say that clinicians should not obtain legal clarification – a court's written approval – before treating incompetent defendants who do not or cannot explicitly consent to treatment. Recognizing the presence of consent under a social contract simply clarifies how medical ethics applies to patients for whom punishment could well follow successful treatment.

If a physician believes that the legal system will treat a defendant-patient fairly, then the extra-medical, prosecution-enabling consequences of competence-restoring treatment do not conflict with Hippocratic obligations of beneficence and nonmaleficence. Defendants are entitled to psychiatric treatment that may permit prosecution, and by providing defendants with such treatment, doctors assure that civil society will fulfill its obligation to respect the rationality and humanity of all persons.

IX. THE POTENTIAL DEATH PENALTY

The above discussion assumes that, whatever the overall merits of the United States criminal justice system, a physician believes that the system will treat his defendant-patient fairly. In the case of Charles Sell, who was able to bring his case all the way to the Supreme Court, this assumption seems reasonable, but it may not hold true in all cases or in all aspects of every case. Russell Weston's situation provides a good example of the issues here. On the one hand, despite his being indigent, Weston has been represented by highly-skilled, publicly funded attorneys whose budget has allowed them, among other things, to retain nationally-recognized forensic psychiatrists as defense consultants and potential experts. On the other hand, features of Weston's situation – the distorting effects of the high publicity his case has and may continue to receive, and (especially) the

254. *See, e.g.*, GUTHEIL & APPELBAUM, *supra* note 12, at 158-59, 161-62.

possibility of capital punishment[255] will for some readers invalidate the assumption of fair treatment.

Kant saw nothing wrong with capital punishment,[256] but many U.S. psychiatrists do. They oppose the death penalty either because they believe it is intrinsically wrong to execute criminals or because they believe that the United States cannot administer capital punishment equitably. These psychiatrists could argue that Kant was wrong about the death penalty,[257] and that even if one generally accepts Kant's views about the humanity-respecting function of punishment, treating Weston and restoring his competence involuntarily would be lending tacit approval to, and would constitute participation in, an unjust or immoral process, a process in which no psychiatrist should engage. For psychiatrists who hold this view, the possibility of the death penalty seems a valid reason for arguing that administering competence-restoring treatment is "medically inappropriate," and that *all* psychiatrists should be barred from restoring the competence of Weston and of any other death penalty defendant.[258]

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255. Weston's case is far from the only one in which a defendant faces the prospect of receiving competence-restoring treatment that may allow conviction and a death sentence. *See, e.g.*, William C. Lhotka, *Medicating Suspect in 3 Killings Is Argued: Judge Refuses to Weigh Potential Death Penalty*, ST. LOUIS POST-DISPATCH, June 2, 2004 (judge states possibility of death penalty is not a factor in deciding whether to forcibly administer medication for competence restoration), Janice Morse, *Murder Suspect's Sanity at Issue: If Medication Forced, Death Trial in Future,* CINCINNATI ENQUIRER, Aug. 6, 2004, at B1 (trial court to hold hearing on forcing incompetent defendant to take medication so he can be tried on capital murder charges), Matthew B. Stannard, *Forced Medication of Suspect Sought; Man Could Stand Trial with Drugs*, S.F. CHRON., Apr. 20, 2002, at A17 (prosecutor to file motion ordering psychotropic medication for potential death penalty defendant), and Mike Tolson, *Yates Found Guilty; What's in Store for Yates in Prison?*, HOUS. CHRON., Mar. 13, 2002, at A1 (woman who voluntarily received antipsychotic medication before trial faced possible death penalty).

256. For example, Kant argued that execution was the only appropriate punishment for murder because there could be "no sameness in kind [as the principle of equality requires] between death and remaining alive even under the most miserable conditions." RECHTSLEHRE at 101 [332].

257. *See, e.g.*, Sarver, *supra* note 230, at 470-71 (arguing that irreversibility and possible errors in administration of the death penalty is incompatible with Kant's overall theory of respect for humanity). For a discussion of how respect for humanity and capital punishment are consistent under Kant's theory, *see* J. Angelo Corlett, *Foundations of a Kantian Theory of Punishment*, 31 S. J. PHIL. 263, 275-76 (1993).

258. For a recent overview of this debate within the American Academy of Psychiatry and the Law, *see* Michael A. Norko, *Organized Psychiatry and the Death Penalty: An Introduction to the Special Section*, 32 J. AM. ACAD. PSYCHIATRY LAW 178 (2004) (describing proposed referenda concerning capital punishment), Abraham L. Halpern et al., *Now Is the Time for AAPL to Demonstrate Leadership by Advocating Positions of Social Importance*, 32 J. AM. ACAD. PSYCHIATRY LAW 180, 180-81 (2004) (arguing that most

Yet to argue this is to suggest that these defendants' own feelings about what should happen to them—feelings that, while incompetent, they cannot articulate because they do not comprehend their situations—should never come to light. As the existence of death row "volunteers" for execution shows,[259] some persons convicted of capital crimes prefer execution to life in prison.

But arguing for a general bar to restoration of capital defendants raises a much larger issue, for it suggests that psychiatrists have some special moral status that obligates them, when opportunities present themselves, to use or withhold their medical privileges and skills in ways that interfere with the workings of the criminal justice system. If such a special status were conceded, it could surely justify psychiatric opposition to (and interference with) treatment in many more cases than Weston's. In *any* criminal case—capital or noncapital—where a psychiatrist believed the potential legal events following successful treatment of a mentally ill defendant were less desirable than having his patient remain incompetent to stand trial, or in any case where a psychiatrist believed his patient might not receive optimal treatment by the legal system, this special status would obligate the physician to block or withhold competence-restoring treatment. To concede "special status" obligations for psychiatrists also suggests that doctors might rightfully lie about a pre-trial detainee's mental condition to help a patient-defendant avoid a possibly unfair legal result. Or, doctors could interpret George Annas's suggestion to make "an independent judgment that treatment is in the patient's best medical interests"[260] as an invitation to conclude that antipsychotic therapy is "medically inappropriate," and offer testimony accordingly.

If courts knew that doctors might behave in these ways, there would be ample reason to limit, disregard, or even eliminate physician participation in legal proceedings. But leaving such consequences aside, it seems arrogant for psychiatrists to suggest that their professional ethics and status

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AAPL members support an official organizational stance against capital punishment, and that only the abolition of capital punishment will stop physicians from assisting with actual executions), Roy O'Shaughnessy, *AAPL and Sociopolitical Policy*, 32 J. AM. ACAD. PSYCHIATRY LAW 184 (2004) (reviewing history of referenda, and holding that by alienating a minority of members, an official sociopolitical position would undermine educational and scientific goals), and John Gunn, *The Royal College of Psychiatrists and the Death Penalty*, 32 J. AM. ACAD. PSYCHIATRY LAW 188, 190 (2004) (noting that within the British medical profession, official opposition to capital punishment is noncontroversial).

259. For discussions of recent examples in Ohio, *see* Alan Johnson, *Inmates' Death Wish Raises Ethical Questions*, COLUMBUS DISPATCH, July 6, 2004, at 1A (discussing three cases), and Jim DeBrosse, *Ferguson Gets Wished-For Death Penalty*, DAYTON DAILY NEWS, Sept. 13, 2003, at A1 (capital defendant requests and receives death sentence, notwithstanding advice of his attorneys).

260. Annas, *supra* note 182, at 2301.

as medical doctors require them to interfere with administration of democratically enacted laws. A psychiatrist who believes the death penalty is immoral might understandably wish to avoid participating in court-ordered restoration of a capital defendant's trial competence, and no physician should be required to ignore what his conscience dictates. But an individual psychiatrist's principled objection to the death penalty does not support an ethical argument that all psychiatrists should be barred from giving any capital defendant competence-restoring treatment.