14 The Insane

Introduction

The insane present a special case from the standpoint of every recognized purpose of criminal punishment but one: the truly insane are impossible to deter. They cannot be taught a lesson for the purpose of specific deterrence; it is doubtful whether punishing the insane sends a useful message to others. For retributivists, it is difficult to argue that the deranged deserve to be punished because desert is premised on free will, which is not present with the insane or present in a markedly different way. The only commonality with the sane criminal is the need for incapacitation. On the premise that the insane present a special case, there is unanimous agreement. Each of the states and the federal government recognizes some version of the insanity defense.

Every state and the federal government also bars the execution of a condemned prisoner who is in good mind at the time of the crime but subsequently becomes insane. This is a unique situation. If a condemned person were insane at the time of his offense he would have been found not guilty by reason of insanity. If he were insane at the time of trial, he would have been found incompetent to stand trial because he could not participate in his defense. Here, the condemned is rational at the time of the crime and trial, but subsequently becomes insane.

There is unanimity that the insane should not be executed, but in the case of criminals who are sane at the time of the offense, the policy arguments against execution on the basis of subsequent insanity are not as clear. Most religious teachings militate against dispatching an offender "into another world, when he is not of a capacity to fit himself for it." From the standpoint of specific deterrence, there is little reason to carry out the sentence because the insane cannot be taught any further lesson. However, one might argue that there is a general deterrence benefit to carrying out the sentence. Failing to execute might contribute to a perception that the state is not serious about carrying out sentences. This effect is surely minimal. Deterrence theory presumes rationality on the part of the criminal. The thought would have to be that the potential criminal makes the marginal decision to commit a crime based on the chance that he will be caught, tried, and convicted, but that the sentence will never be carried out because the court concludes that he is insane—mistakenly, he hopes; otherwise, the criminal will enjoy very little benefit indeed.

The truly problematic question is whether criminals who become insane after trial deserve to be punished. The requirements of retribution are not obvious. Consider the hypothetical and strange case of Llewelyn, sentenced by a jury to die for the brutal murder and rape of a teenage girl. On the way out of the courtroom, an anvil falls on Llewelyn's head. He falls into a coma for 30 years. When Llewelyn awakens, he is sweet and docile, a changed man. When told of his crimes by his doctors, Llewelyn is horrified. He has no recollection of the crime; in his changed state he does not seem capable of such a violent act. The doctors testify that the anvil has miraculously corrected organic damage to Llewelyn's brain. Whereas before he had frontal lobe damage that limited his impulse control, now he is able to comport himself according to society's demands. Fit for execution, prison officials arrive to take Llewelyn from the hospital to the electric chair. His lawyers appeal for clemency. The governor wonders whether it is just to execute Llewelyn.

On one view, retribution demands that he be executed. It is Llewelyn who committed the murder; therefore, he should be held accountable. But the philosopher Derek Parfit argues that it makes as much sense to execute the reformed Llewelyn as it would to execute Llewelyn's son for his father's crimes. The reformed Llewelyn is essentially a new man. We have all done things as teenagers that we would never do again as adults and would feel rather put upon if we were forced to answer for them today. So it is with Llewelyn. Who counts in the calculation of desert—the offender as constituted at the time of offense or at the time the sentence is carried out?

The Supreme Court has offered different answers in different contexts. In *Skipper v. South Carolina*, the Supreme Court held that, under *Lockett*, a defendant must be allowed to present evidence of his adjustment to prison, even though this behavior is after the fact of his offense. In *Evans v. Muncy*, on the other hand, the Court let stand the denial of *habeas* relief to the petitioner, sentenced to die on the basis of a future dangerousness aggravator, who later helped to stop a prison riot and by all accounts saved the lives of several guards. These inconsistencies are discussed at greater length on the subject of symmetry and victim impact evidence in Chapter 16.

Yet, every state has implicitly taken the view that, at least as far as subsequent insanity is concerned, what counts is the condition of the offender at the time the sentence is carried out and that punishment is not deserved by the insane. In *Ford v. Wainwright*, excerpted in the Critical Documents section of this chapter, the Supreme Court found that contemporary standards of decency do not tolerate the execution of the insane. The Court applied the traditional *Coker* test. In this instance the evidence was overwhelming—no state allowed for the execution of the insane.

Why then was there a case at all? If no state would tolerate the execution of the insane, why was Ford forced to appeal to the Supreme Court to stay his execution? Although no state tolerates the execution of the insane by statute and practice and, after *Ford*, by constitutional mandate, it remains for the individual state to determine the process by which insanity is judged. Florida allowed sanity to be determined through a nonadversarial process entirely within the executive branch. The Court favorably cited the procedures used in determining competency to stand trial and in involuntary commitment proceedings, but it did not articulate the precise procedures to be followed.

The amount of process guaranteed a defendant claiming insanity remains unclear. In *Lowenfeld v. Butler*, a 1988 case, the Supreme Court declined to stay Lowenfeld's execution, though he had submitted the affidavit of a clinical psychologist who believed it highly probable that Lowenfeld suffered from paranoid schizophrenia. The majority did not publish an opinion. The implication of the decision may be that the defendant had a constitutional right to a fair adjudication of insanity, not to be free from execution if actually insane. This may seem peculiar, but it parallels the Court's approach to dealing with residual questions of innocence as discussed in Chapter 20. In *Herrera v. Collins*, the Supreme Court places greater emphasis on the process by which guilt and innocence are judged rather than actual innocence. This is problematic, especially from a retributive standpoint if it allows undeserving people to be punished, but it has some obvious practical appeal. Only God knows whether a defendant is truly innocent or insane—the best that can be done in the corporeal world is to ensure a fair adjudication.

Another question, and the subject of the following debate, is whether an insane defendant can be compulsorily medicated to be made competent for execution. It is a vicious dilemma for the defendant—or the defendant's attorney—when the defendant must either voluntarily take medication and facilitate his own execution or refuse the medication and remain insane.

Outside the realm of capital punishment, the Supreme Court has held that a defendant may be treated with antipsychotic drugs against his will if the prisoner has been found to be dangerous to himself or others and if the treatment is determined to be in the prisoner's medical interest. State and federal courts have split in determining whether *Washington v. Harper* allows the medication of prisoners for the purpose of execution. In *Perry v. Louisiana*, the Louisiana Supreme Court found that, under the Louisiana state constitution, it is unconstitutional to force a defendant to take medication so that he can be executed. The Eighth Circuit Court of Appeals,

however, allowed Arkansas officials to force Charles Singleton to take drugs to make him sane enough to be executed. In October 2003, the Supreme Court let that ruling stand, declining to grant *certiorari* in Singleton's case.

Later, Charles Ewing argues that any participation by physicians in the capital punishment process is antithetical to their professional obligation. Barry Latzer contends that whether an execution ultimately occurs is a matter of speculation—there is the possibility of an appeal or clemency. The relevant consideration for the physician, he says, is whether his assistance diminishes the immediate suffering of the patient.

Critical Documents

Ford v. Wainwright

477 U.S. 399 (1986)

Mr. Justice Marshall announced the judgment of the Court and delivered the opinion of the Court with respect to Parts I and II and an opinion with respect to Parts III, IV, and V, in which Justice Brennan, Justice Blackmun, and Justice Stevens join.

For centuries no jurisdiction has countenanced the execution of the insane, yet this Court has never decided whether the Constitution forbids the practice. Today we keep faith with our common-law heritage in holding that it does.

I

Alvin Bernard Ford was convicted of murder in 1974 and sentenced to death. There is no suggestion that he was incompetent at the time of his offense, at trial, or at sentencing. In early 1982, however, 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.

Counsel for Ford asked a psychiatrist who had examined Ford earlier, Dr. Jamal Amin, to continue seeing him and to recommend appropriate treatment. On the basis of roughly 14 months of evaluation, taped conversations between Ford and his attorneys, letters written by Ford, interviews with Ford's acquaintances, and various medical records, Dr. Amin concluded in 1983 that Ford suffered from "a severe, uncontrollable, mental disease which closely resembles 'Paranoid Schizophrenia With Suicide Potential'"—a "major mental disorder severe enough to substantially affect Mr. Ford's present ability to assist in the defense of his life."

Ford subsequently refused to see Dr. Amin again, believing him to have joined the conspiracy against him, and Ford's counsel sought assistance from Dr. Harold Kaufman, who

interviewed Ford in November 1983. Ford told Dr. Kaufman 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. Dr. Kaufman concluded that Ford had no understanding of why he was being executed, made no connection between the homicide of which he had been convicted and the death penalty, and indeed sincerely believed that he would not be executed because he owned the prisons and could control the Governor through mind waves. Dr. Kaufman found that there was "no reasonable possibility that Mr. Ford was dissembling, malingering or otherwise putting on a performance." 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."

Counsel for Ford invoked the procedures of Florida law governing the determination of competency of a condemned inmate. Following the procedures set forth in the statute, the Governor of Florida appointed a panel of three psychiatrists to evaluate whether Ford had "the mental capacity to understand the nature of the death penalty and the reasons why it was imposed upon him." At a single meeting, the three psychiatrists together interviewed Ford for approximately 30 minutes. One doctor concluded that Ford suffered from "psychosis with paranoia" but had "enough cognitive functioning to understand the nature and the effects of the death penalty, and why it is to be imposed on him." Another found that, although Ford was "psychotic," he did "know fully what can happen to him." The third concluded that Ford had a "severe adaptational disorder," but did "comprehend his total situation including being sentenced to death, and all of the implications of that penalty." He believed that Ford's disorder, "although severe, seemed contrived and recently learned." The interview produced three different diagnoses, but accord on the question of sanity as defined by state law.

This Court granted Ford's petition for *certiorari* in order to resolve the important issue whether the Eighth Amendment prohibits the execution of the insane.

II

A

We begin with the common law. The bar against executing a prisoner who has lost his sanity bears impressive historical credentials; the practice consistently has been branded "savage and inhuman." Blackstone explained:

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

As is often true of common-law principles, the reasons for the rule are less sure and less uniform than the rule itself. One explanation is that the execution of an insane person simply offends humanity; another, that it provides no example to others and thus contributes nothing to whatever deterrence value is intended to be served by capital punishment. Other commentators postulate religious underpinnings: that it is uncharitable to dispatch an offender "into another world, when he is not of a capacity to fit himself for it." It is also said that execution serves no

purpose in these cases because madness is its own punishment: *furiosus solo furore punitur*. More recent commentators opine that the community's quest for "retribution"—the need to offset a criminal act by a punishment of equivalent "moral quality"—is not served by execution of an insane person, which has a "lesser value" than that of the crime for which he is to be punished. Unanimity of rationale, therefore, we do not find. "But whatever the reason of the law is, it is plain the law is so." We know of virtually no authority condoning the execution of the insane at English common law.

Further indications suggest that this solid proscription was carried to America, where it was early observed that "the judge is bound" to stay the execution upon insanity of the prisoner.

B

This ancestral legacy has not outlived its time. Today, no State in the Union permits the execution of the insane. It is clear that the ancient and humane limitation upon the State's ability to execute its sentences has as firm a hold upon the jurisprudence of today as it had centuries ago in England. The various reasons put forth in support of the common-law restriction have no less logical, moral, and practical force than they did when first voiced. For today, no less than before, we may seriously question the retributive value of executing a person who has no comprehension of why he has been singled out and stripped of his fundamental right to life. Similarly, the natural abhorrence civilized societies feel at killing one who has no capacity to come to grips with his own conscience or deity is still vivid today. And the intuition that such an execution simply offends humanity is evidently shared across this Nation. Faced with such widespread evidence of a restriction upon sovereign power, this Court is compelled to conclude that the Eighth Amendment prohibits a State from carrying out a sentence of death upon a prisoner who is insane. Whether its aim be to protect the condemned from fear and pain without comfort of understanding, or to protect the dignity of society itself from the barbarity of exacting mindless vengeance, the restriction finds enforcement in the Eighth Amendment.

V

[The Court deemed Florida's non-adversarial procedure for determining insanity unsatisfactory.] We do not here suggest that only a full trial on the issue of sanity will suffice to protect the federal interests; we leave to the State the task of developing appropriate ways to enforce the constitutional restriction upon its execution of sentences. It may be that some high threshold showing on behalf of the prisoner will be found a necessary means to control the number of nonmeritorious or repetitive claims of insanity.

Yet the lodestar of any effort to devise a procedure must be the overriding dual imperative of providing redress for those with substantial claims and of encouraging accuracy in the factfinding determination. The stakes are high, and the "evidence" will always be imprecise. It is all the more important that the adversary presentation of relevant information be as unrestricted as possible. Also essential is that the manner of selecting and using the experts responsible for producing that "evidence" be conducive to the formation of neutral, sound, and professional judgments as to the prisoner's ability to comprehend the nature of the penalty. Fidelity to these principles is the solemn obligation of a civilized society.

The judgment of the Court of Appeals is reversed, and the case is remanded for further proceedings consistent with this opinion.

Justice Powell, concurring in part and concurring in the judgment.

The more general concern of the common law—that executions of the insane are simply cruel—retains its vitality. It is as true today as when Coker lived that most men and women value the opportunity to prepare, mentally and spiritually, for their death. Moreover, today as at common law, one of the death penalty's critical justifications, its retributive force, depends on the defendant's awareness of the penalty's existence and purpose. Thus, it remains true that executions of the insane both impose a uniquely cruel penalty and are inconsistent with one

of the chief purposes of executions generally. For precisely these reasons, Florida requires the Governor to stay executions of those who "do not have the mental capacity to understand the nature of the death penalty and why it was imposed" on them.

Such a standard appropriately defines the kind of mental deficiency that should trigger the Eighth Amendment prohibition. If the defendant perceives the connection between his crime and his punishment, the retributive goal of the criminal law is satisfied. And only if the defendant is aware that his death is approaching can he prepare himself for his passing. Accordingly, 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.

Petitioner's claim of insanity plainly fits within this standard. According to petitioner's proffered psychiatric examination, petitioner does not know that he is to be executed, but rather believes that the death penalty has been invalidated. The question in this case is whether Florida's procedures for determining petitioner's sanity comport with the requirements of due process. I would hold that they do not.

Justice O'Connor, with whom Justice White joins, concurring in the result in part and dissenting in part.

I am in full agreement with Justice Rehnquist's conclusion that the Eighth Amendment does not create a substantive right not to be executed while insane. Accordingly, I do not join the Court's reasoning or opinion. Because, however, the conclusion is for me inescapable that Florida positive law has created a protected liberty interest in avoiding execution while incompetent, and because Florida does not provide even those minimal procedural protections required by due process in this area, I would vacate the judgment and remand to the Court of Appeals with directions that the case be returned to the Florida system so that a hearing can be held in a manner consistent with the requirements of the Due Process Clause. I cannot agree, however, that the federal courts should have any role whatever in the substantive determination of a defendant's competency to be executed.

I believe that one aspect of the Florida procedure for determining competency to be executed renders that procedure constitutionally deficient. If there is one "fundamental requisite" of due process, it is that an individual is entitled to an "opportunity to be heard." As currently implemented, the Florida procedure for determining competency violates this bedrock principle.

Because Florida's procedures are inadequate to satisfy even the minimal requirements of due process in this context, I would vacate the judgment below with instructions that the case be returned to Florida so that it might assess petitioner's competency in a manner that accords with the command of the Fourteenth Amendment.

Justice Rehnquist, with whom The Chief Justice joins, dissenting.

The Court today holds that the Eighth Amendment prohibits a State from carrying out a lawfully imposed sentence of death upon a person who is currently insane. This holding is based almost entirely on two unremarkable observations. First, the Court states that it "knows of virtually no authority condoning the execution of the insane at English common law." Second, it notes that "today, no State in the Union permits the execution of the insane." Armed with these facts, and shielded by the claim that it is simply "keeping faith with our common-law heritage," the Court proceeds to cast aside settled precedent and to significantly alter both the common-law and current practice of not executing the insane. It manages this feat by carefully ignoring the fact that the Florida scheme it finds unconstitutional, in which the Governor is assigned the ultimate responsibility of deciding whether a condemned prisoner is currently insane, is fully consistent with the "common-law heritage" and current practice on which the Court purports to rely.

The Court places great weight on the "impressive historical credentials" of the common-law bar against executing a prisoner who has lost his sanity. What it fails to mention, however, is

the equally important and unchallenged fact that at common law it was the executive who passed upon the sanity of the condemned. So when the Court today creates a constitutional right to a determination of sanity outside of the executive branch, it does so not in keeping with but at the expense of "our common-law heritage."

Creating a constitutional right to a judicial determination of sanity before that sentence may be carried out, whether through the Eighth Amendment or the Due Process Clause, needlessly complicates and postpones still further any finality in this area of the law. The defendant has already had a full trial on the issue of guilt, and a trial on the issue of penalty; the requirement of still a third adjudication offers an invitation to those who have nothing to lose by accepting it to advance entirely spurious claims of insanity. A claim of insanity may be made at any time before sentence and, once rejected, may be raised again; a prisoner found sane two days before execution might claim to have lost his sanity the next day, thus necessitating another judicial determination of his sanity and presumably another stay of his execution.

Since no State sanctions execution of the insane, the real battle being fought in this case is over what procedures must accompany the inquiry into sanity. The Court reaches the result it does by examining the common law, creating a constitutional right that no State seeks to violate, and then concluding that the common-law procedures are inadequate to protect the newly created but common-law based right. I find it unnecessary to "constitutionalize" the already uniform view that the insane should not be executed, and inappropriate to "selectively incorporate" the common-law practice. I therefore dissent.

Perspectives

Issue—Is It Ethical to Medicate the Insane for the Purpose of Execution?

Charles Patrick Ewing, "Diagnosing and Treating 'Insanity' on Death Row: Legal and Ethical Perspectives"

5 *Behavioral Sciences and Law* 175 (1987)

The Supreme Court's decision in *Ford* clearly heightens the procedural protections afforded the condemned inmate who claims to be insane and thus not fit for execution. No longer can such a claim be adjudicated solely on the basis of the unchallenged conclusions of the State's mental health experts. The conclusions of psychologists and psychiatrists regarding an inmate's sanity can and undoubtedly will be challenged in some legal forum. Otherwise, however, *Ford* will have little if any impact upon the roles currently played by these mental health professionals in this phase of the death penalty process. The legal, now constitutionally mandated, rule banning execution of the insane will continue to demand the participation of psychologists and psychiatrists in at least two ethically questionable roles—one diagnostic, the other therapeutic.

First, wherever sufficient doubt is raised regarding a convicted capital defendant's sanity, these mental health professionals will be called upon to evaluate the prisoner's mental functioning and to report their conclusions to the governmental officer or body charged with making the ultimate decision. Moreover, psychologists and psychiatrists will be called upon to help determine whether and when an insane convicted capital defendant has been restored to sanity and is thus legally fit to be executed. Second, psychologists and psychiatrists will be called upon to provide treatment for those condemned inmates found to be insane and thus unfit for execution. The goal of such treatment, of course, will be to restore the sanity of these inmates, thus rendering them fit for execution.

Can psychologists and psychiatrists fulfill these roles and, at the same time, meet their professional ethical obligations?

I. The "Diagnostic" Role

Psychologists and psychiatrists who accept this role agree to help decide whether a condemned inmate is to live or die. Of course, they might argue that their conclusions with regard to an inmate's sanity do not seal the inmate's fate. Usually, a panel of mental health professionals is asked to evaluate the inmate and the ultimate determination always rests with a legal, rather than psychological or psychiatric decision-maker. Additionally, under *Ford*, the conclusions reached by psychologists and psychiatrists regarding the inmate's "sanity" will be subject to challenge and the inmate will be able to present evidence which might contradict those conclusions.

As a practical matter, however, the conclusions of psychologists and psychiatrists will carry significant weight. Indeed, if their conclusions are in accord with those reached by other colleagues who have examined the inmate, for all practical purposes the decision will be made by the examining mental health professionals. In some instances, psychologists and psychiatrists may conclude that the condemned inmate is insane and thus spare him or her from execution, at least temporarily. In other instances, however, they will conclude that the condemned inmate is "sane" and thus participate in a process which paves the way for the inmate's death. If they do their jobs honestly and objectively, psychologists and psychiatrists who participate in this function have no way of telling in advance what, if any, conclusions they will reach.

The ethical objection to such participation seems clear. Psychiatry and clinical psychology are, above all else, healing professions. From the ancient Hippocratic Oath ("The health of my patient will be my primary preoccupation") to the Principles of Medical Ethics adopted by the American Medical Association (AMA) and endorsed by the American Psychiatric Association, physicians consistently have professed their primary commitment to healing and the preservation of life. As the AMA has put it, a physician is a "member of a profession dedicated to preserving life where there is hope of doing so." Clinical psychology, though not a branch of medicine, is similarly devoted to healing and the relief of human suffering. According to the American Psychological Association, provision of clinical psychological services involves "the application of principles, methods, and procedures for understanding, predicting, and alleviating intellectual, emotional, psychological, and behavioral disability and discomfort."

To render a clinical judgment which has the practical effect of authorizing the execution of a convicted capital defendant is clearly contrary to the fundamental ethical commitments of psychology and psychiatry to healing and the relief of human suffering.

II. The Therapeutic Role

Unlike the diagnostic role, the therapeutic role seems to involve professional practice arguably consistent with the ethical commitment of psychiatrists and psychologists to healing and the relief of suffering. Psychologists and psychiatrists who accept this role provide therapeutic services aimed at restoring the condemned inmate's mental health.

Beyond the first glance, however, it seems clear that assumption of the therapeutic role in this unique psycholegal context also violates the fundamental ethical principles of these healing professions. The ultimate purpose of providing psychological or psychiatric treatment of the "insane" condemned inmate is not to heal or relieve the suffering of that inmate, but to enable the state to take the inmate's life. If such treatment is successful, the end result will be the inmate's death. Professional acts that facilitate such a result are clearly incompatible with "preserving life where there is hope of doing so."

It must be recognized, of course, that refusal to provide psychological or psychiatric treatment to an "insane" condemned inmate also raises ethical and legal questions. As a legal matter, all penal inmates are entitled to necessary psychiatric and psychological treatment, and prison psychologists and psychiatrists have a legal if not ethical duty to provide such treatment. Thus, in this unique context, it would appear that these mental health professionals are caught between a rock and a hard place. Whether they refuse or agree to treat an insane condemned inmate, they would seem to betray their professional ethical commitment to healing practice. Moreover, if they refuse to treat such an inmate, they arguably violate the law.

From a legal perspective, the dilemma posed for these psychologists and psychiatrists seems susceptible to rather easy resolution. As state-licensed health care professionals, psychologists and psychiatrists are required by law to adhere to the ethical principles of their respective professions. The state, as both licensing authority and employer, cannot have it both ways. The state cannot, on the one hand, demand that these professionals practice ethically and yet, on the other hand, require them to engage in unethical practice.

As a purely ethical matter, the dilemma faced by psychologists and psychiatrists in this context may seem somewhat more troubling. In fact, however, this ethical dilemma is more apparent than real. Denying treatment to an insane condemned inmate may have the effect of prolonging the inmate's psychopathology and mental suffering, thus arguably violating the ethical norm of healing. Yet providing treatment may well lead to his or her death. The ultimate purpose in treating the insane condemned inmate is not to heal the inmate, but to enable the state to take his or her life.

A significant, if not the most significant, component of the ethical commitment to healing practice lies in the imperative to "preserve life where there is hope of doing so." Only an absolutist would invoke this imperative without qualification. There are of course, instances in which passive or even active euthanasia might be regarded as ethically appropriate. But where the healing professional's choice is between providing treatment which relieves psychological suffering but results in the death of an otherwise healthy human being, and refusing to provide such treatment, there can be little if any doubt that the latter course of (in)action is the ethically proper one.

III. Conclusion

Psychologists and psychiatrists who participate in these legal functions violate the fundamental ethical norms of the healing professions to which they belong. Moreover, they do so for no good reason. The humanitarian motive advanced by laws forbidding execution of the presently insane is laudable, but that motive would be no less well-served were psychologists and psychiatrists to boycott these functions altogether.

The diagnostic function referred to earlier is a legal rather than psychological or psychiatric one. Psychological and psychiatric input, though generally desired by those who make and enforce these laws, is not essential. The decision regarding an inmate's insanity in this particular context could be made just as well—if not better—on the basis of lay evidence provided by those who know the inmate best and have had the greatest opportunity to observe him or her over time. Such a process might require greater procedural safeguards than those mandated by the Supreme Court. But given what is at stake, a heightened concern with due process in this context hardly seems unreasonable.

The "treatment" function now performed by psychologists and psychiatrists in this context is likewise not essential. In Great Britain, the law provides that once found to be presently insane, a condemned inmate is "exempted from execution altogether." If all American psychologists and psychiatrists refused to treat presently insane, condemned inmates until they were exempted from execution, the same humanitarian instinct that underlies the ban on executing the insane might well lead American legislatures to follow the example set by the British.

Ideally, psychologists and psychiatrists should voluntarily and individually relinquish both of these ethically objectionable roles.

Barry Latzer, "Between Madness and Death: The Medicate-to-Execute Controversy"

22 *Criminal Justice Ethics* 3 (2004)

I. Introduction

The evidence is overwhelming that Charles Laverne Singleton stabbed a grocery clerk to death in the course of a robbery. The victim knew him. She told the police officer who first arrived at the bloody scene, as well as the physician who unsuccessfully treated her, that Charles Singleton

"came in the store, said this is a robbery, grabbed her around the neck, and went to stabbing her." Singleton was convicted and sentenced to death for the murder. Many years later (far too many), the Eighth Circuit Court of Appeals resolved an intriguing legal issue raised by this sad and deceptively simple case. May the state compel a mentally ill death row inmate to take medicine for his disorder where the beneficial effects of the treatment also make him sane enough to be executed?

For most of his time on death row, Charles Singleton has been taking psychotropic medication. It was first prescribed for anxiety and depression, but when, in 1987, Singleton's mental health began to deteriorate, he was medicated—sometimes voluntarily, sometimes forcibly—to control the symptoms of psychosis. Some of the Eighth Circuit judges described his situation as follows:

> *He started to believe that his cell was possessed by demons and had "demon blood" in it. He reported that his brother would come to his locked prison cell and take him out of it for walks. He was under the impression that a prison doctor had planted some type of device in his right ear and that his thoughts were being stolen from him when he read the Bible.*
>
> *Singleton was diagnosed as likely schizophrenic and placed on antipsychotic medication. He initially took it on his own, but when he refused, he was forcibly medicated. For the next several years, Singleton continued to be treated for his psychosis. His medication was administered voluntarily at times, and at times it was administered forcibly. Whenever he was off his medication, his symptoms would resurface, and he would again experience hallucinations.*

Two major U.S. Supreme Court decisions set the stage for the instant controversy. In 1986, in *Ford v. Wainwright*, the Court ruled that a capitally-sentenced inmate who has become "insane" may not be executed. Meanwhile, in 1990, in *Washington v. Harper*, the Court permitted prison authorities to order forcible administration of antipsychotic drugs on the condition that three requirements were met: the prisoner must have a serious mental illness, he must be dangerous to himself or others, and the treatment must be in the inmate's medical interest. *Harper*, however, involved a non-death-sentenced inmate. As the Eighth Circuit put it, the issues in Singelton's case are "whether the State may forcibly administer antipsychotic medication to a prisoner whose date of execution has been set and whether the State may execute a prisoner who has been involuntarily medicated under a *Harper* procedure."

By a 5–4 vote, the Eighth Circuit court answered both questions in the affirmative. At the heart of the court's ruling is the assertion that medication was in Singleton's interests even after the execution date was set and that, in effect, *Harper* applies to capital inmates.

The Eighth Circuit got it right. So long as the three *Harper* requirements—essentially, psychosis, dangerousness, and treatability—are satisfied, the state's compelling interest in the administration of justice outweighs the death row inmate's interest in avoiding both medication and execution.

II. Three Policy Options

When a capitally-sentenced inmate becomes insane, yet treatable, three policy options are available:

- **A.** *Medicate and Execute*. The state would medicate the inmate, forcibly if necessary, and if sanity is restored, impose the authorized punishment—the death sentence.
- **B.** *Don't Medicate, Don't Execute*. Should the inmate refuse treatment the state would accede to his wishes, withhold the medication, and if he becomes incompetent, postpone indefinitely the imposition of the death sentence.
- **C.** *Medicate, Don't Execute*. The state would remit the death sentence and, with the inmate's consent, provide treatment.

Option A seems bizarre: we treat the prisoner so that we may kill him. However, as I will try to show, this alternative turns out, upon reflection, to be the soundest of the three options—provided that one considers the death penalty to be morally justified.

By contrast, Option B—withhold treatment and suspend execution—would seem to be the least defensible of the three alternatives. It places the inmate in a cruel dilemma, a Hobson's choice between madness and death. Choosing needed medication, he prepares the way for his execution; eschewing medication, he faces continuing psychotic episodes.

One might object, however, that putting a prisoner in such a dilemma is no more cruel than the execution itself. In other words, if the death penalty is not unacceptably cruel, then neither is Option B. I would answer such an argument in the following way (while acknowledging that many would not accept this response): The death penalty is not cruel because it is imposed on a moral agent for having unlawfully and violently taken the life of an innocent fellow human being. The penalty is society's attempt to balance the moral disequilibrium created by the prisoner's murderous conduct. In short, the death penalty is supported by traditional retributive principles.

Option B, on the other hand, is unacceptably cruel because it turns illness into a virtual penological sanction. It accomplishes this by inducing the prisoner to exchange leniency for treatment. Thus the inmate's nearly inevitable mental breakdown is substituted for his authorized punishment. The bargain is struck: he trades his affliction for his life.

Option C would be justified if capital punishment, though legal, were immoral, for then it would never be morally preferable to execute anyone. This is, of course, the view of abolitionists, which probably explains why Option C is the favorite of the academy. If, however, one accepts (as this essay does) the premise that capital punishment is not inherently immoral, then Option C is difficult to defend. It is especially untenable in cases of exceptionally brutal or heinous crimes, where the claims of justice are hard to deny.

The most compelling argument for supporting Option C would seem to be based on mercy, or compassion, for the offender. Just as we sometimes reduce punishments for the elderly or those suffering from physical illness or injury, we might shorten the sentences of those afflicted by mental illness.

While every humane criminal justice system should provide for mercy, no rational criminal justice system that seeks justice for criminals can make mercy the principal component of sentencing policy. Mercy, by definition, seeks to alleviate the suffering which comes as a result of the offender's punishment, while justice is the very ground for that punishment and its concomitant suffering. Thus, mercy and justice are antipodal, which is why we sometimes speak of justice tempered by mercy. Insofar as general rules for sentencing are aimed at providing justice, mercy cannot be the basis for those rules. Consequently, Option C—which is based on mercy—cannot serve as the general rule for sentencing policy.

III. The Ethics of Medicating Death Row Inmates for Purposes of Execution

The American Psychiatric Association's Principles of Medical Ethics say: "A psychiatrist should not be a participant in a legally authorized execution." However, the Principles do not say what constitutes a "participant," which could range from direct involvement at the time of the execution, such as by certifying competence, to much more indirect involvement, such as treatment of the death row inmate well before the imposition of sentence.

A clarifying statement was issued by the Council on Ethical and Judicial Affairs of the AMA, the pertinent portion of which states:

> *When a condemned prisoner has been declared incompetent to be executed, physicians should not treat the prisoner for the purpose of restoring competence unless a commutation order is issued before treatment begins. If the incompetent prisoner is undergoing extreme suffering as a result of psychosis or any other illness, medical intervention intended to mitigate the level of suffering is ethically permissible.*

This statement measures the physician's ethical duty by the purpose of his or her conduct. If the purpose is to restore competence for execution, then treatment is disapproved. If, on the other hand, the incompetent death row inmate is experiencing "extreme suffering," then treatment is permitted.

In the ordinary state of affairs, the AMA statement is self-contradictory. The psychotic condemned inmate probably is suffering very greatly, which, according to the AMA statement, makes treatment ethical. However, treating such a patient also may be expected to make him competent, thus rendering the treatment unethical. Perhaps the way out of this is to adopt a subjective interpretation of the statement. If the psychiatrist's purpose is to alleviate the suffering and not to establish competence that would, from a subjectivist perspective, justify treatment.

Perhaps at the root of the AMA/APA contradiction is a more profound, and perhaps unresolvable, ethical dilemma: treat the death row inmate and contravene the mandate to preserve life; deny treatment and violate the duty to heal the sick and prevent suffering. As one analyst, Rochelle Salguero, puts it:

> *The physician cannot make an ethical choice. To comply with the interests of the state by providing treatment, the physician must violate a fundamental ethical prohibition, for without her treatment of the condemned, no execution would take place. Yet by refusing to treat the patient and thereby avoiding participation in the execution, the physician must forego her countervailing ethical duty to heal the sick and prevent suffering.*

However, there are compelling reasons to prefer treatment to non-treatment. The negative consequences of non-treatment are certain, immediate, and directly attributable to the doctor's intentional conduct. Denied antipsychotic medicine, the inmate/patient is nearly certain to become hallucinatory, delusional, disordered, incoherent, and manic. The symptoms will be clear and present and probably continue for as long as the physician withholds treatment. Moreover, the symptoms are a direct product of the doctor's failure to provide care.

By contrast, the negative consequence of treatment, that is, death by execution, is uncertain, remote, and not directly caused by the doctor. There is a good chance that the execution will not take place. Judicial reversals in last-minute appeals or gubernatorial clemency rulings make the application of capital penalties uncertain. The undesirable consequence may never occur at all. If it does occur, it probably will take place after a long lapse of time, perhaps months or years. Even if the patient ultimately is executed, the doctor is not directly causing his death. The execution is the act of the state, not the physician. The doctor's treatment is too remote in time and effect to be considered the immediate cause of death.

One might argue, however, that although the negative consequence of treatment is uncertain, remote, and indirect, it is so catastrophic to the patient that any other option is preferable. This may or may not be so. Is a life of madness—unremitting and relentless—better than death? I am not sure which I would choose were I faced with such a devastating choice. At the least, the preferred option certainly is not obvious.

Here is an analogy that demonstrates the physician's nonresponsibility for the inmate's death. Suppose a psychotic prison inmate has many enemies, perhaps because his crime or his institutional behavior violated some informal prisoner code of conduct. Suppose too that the authorities get wind of a threat to the inmate's life and they tell this to the psychiatrist hired to treat prisoners. Assume that the psychiatrist in turn tells the corrections administrators that if treatment is not forthcoming, the inmate will quickly deteriorate to the point at which hospitalization will be necessary. The authorities reply that in the hospital, the inmate will be safe from his fellow prisoners, whereas if successfully treated, he will remain in the prison and run a risk of being murdered. If the psychiatrist provides treatment, and sometime thereafter, the inmate is indeed murdered, can the physician be blamed for his death? Clearly not, because the death

was uncertain, remote, and not directly caused by the doctor, whereas his duty to heal was clear and present. The same may be said in the death penalty situation.

I conclude that if a physician has the means to treat a patient's disorder, and especially if those means are relatively safe, low-cost and effective—as present-day antipsychotic medication usually is—then he or she has an overriding duty to provide treatment. This remains true even if in treating the patient, the physician exposes the patient to a risk of death due to causes other than the treatment. If, however, as Salguero's quotation above contends, the physician's moral dilemma cannot be resolved and he must violate an ethical canon whichever option he takes, then I do not see how he could be faulted. Where the choice is between evils—in this case, preserving life or alleviating suffering—the medical practitioner should not be blamed for choosing one bad alternative rather than another.

In sum, I believe that it is more ethical to treat the psychotic death row inmate than to withhold treatment and condemn him to madness.

Discussion Question

1. Barry Latzer and Charles Ewing disagree about the fundamental view of the physician. Professor Latzer says the physician should attend to the immediate needs of the patient, regardless of the long-term consequences. Is he right? Would the answer be different with respect to a coal miner who has broken his leg and who also has a nascent condition of black lung disease? Successful treatment of the fracture would allow the miner to return to work but would virtually certainly worsen his lung condition. Should this be considered by the physician?