

Psychiatry and the Death Penalty: The Landmark Supreme Court Cases and Their Ethical Implications for the Profession

Ebrahim J. Kermani, MD and Jay E. Kantor, PhD

The U.S. Supreme Court has made a number of recent rulings in regard to the death penalty that will likely have the effect of increasing the use of psychiatry during the trial and sentencing process in capital cases. Any such changes are bound to increase the number of ethical dilemmas faced by psychiatrists involved in such work. The rulings affecting psychiatry include: (1) The Eighth Amendment forbids the execution of persons who are mentally incompetent in regard to their ability to appreciate the reasons for punishment. (2) A mentally-ill prisoner may be forcibly given neuroleptics if he presents a danger to himself or others. (3) Forced medication may not be used during the trial and sentencing phase if it has the potential to change the defendant's demeanor significantly enough to affect his defense. (4) Aggravating psychological factors affecting a convict may be balanced against mitigating factors in considering whether death sentence should be imposed. (5) The psychosocial impact of the crime upon the victim's family may be presented during the sentencing phase as factors relevant to sentencing. (6) Adolescents and retarded individuals are not immune from the death penalty simply by virtue of their age or level of intelligence.

There is a strong tradition in medicine, going back at least to Hippocrates, that physicians are obliged to do no intentional harm to their patients. More than that negative duty to refrain from harm, physicians are thought to be bound by a

positive obligation to do good for those in their charge—to work for their patients' best interests. Those obligations may be odds with some of the goals of our criminal justice system, which may include a goal of causing harm (punishment). The ethical dilemmas seem more dramatic if the end result of psychiatric input is long-term imprisonment or even death by execution, but the issues exist whenever the psychiatrist becomes involved in the corrections system. In

Dr. Kermani is clinical professor of psychiatry, New York University School of Medicine. Dr. Kantor is adjunct associate professor of psychiatry (Medical Humanities), New York University School of Medicine, and philosopher-in-residence, Forensic Psychiatry Services, Bellevue Hospital. Address correspondence to: Ebrahim J. Kermani, M.D., New York University Medical Center, 550 First Avenue, New York, NY 10016.

this paper, we focus on some recent U.S. Supreme Court rulings on capital punishment that raise important ethical problems for the psychiatric profession.

Incompetency to be Executed

The courts have held that convicts who have been sentenced to death should not be executed if they are currently incompetent to appreciate the reasons for execution. Professional organizations such as the American Psychiatric Association and American Bar Association concur with that opinion.^{1, 2} The execution of such an individual should be stayed if, as a result of mental illness or mental retardation, he cannot understand the nature of the pending proceeding or understand the nature and reasons for the punishment.³ *Ford v. Wainwright*⁴ is the case that became the present benchmark for this issue. Alvin B. Ford was convicted of murder and sentenced to death. While incarcerated, Ford began manifesting behavior changes and delusional thinking indicative of psychosis. It was determined that he was unable to make any connection between the homicide of which he had been convicted, and the death penalty that he was supposed to receive as punishment. The *Ford* case was heard by the Supreme Court, which decided that execution of a person such as Ford was not permissible because: (1) It would have questionable retributive value, because he could not appreciate the reasons for his punishment; (2) it would present no example to others and thus have no deterrence value; (3) it would simply offend humanity; (4) it would be

a violation of the Eighth Amendment to the Constitution as an instance of cruel and unusual punishment.

*Evans*⁵ noted that the U.S. Supreme Court has reviewed the execution of mentally incompetent persons on five occasions since the time of inception of the Court. Although in each case the Court used different principles and different reasons, the consistent conclusion was that the Constitution forbids the execution of a mentally incompetent person.^{4, 6-9}

In *Ford*, the Court expressed no opinion about the constitutionality of forcibly restoring the prisoner's competency to be executed. This raises one of many ethical dilemmas for psychiatrists: In such a situation, is it ethical for a psychiatrist to attempt to restore a condemned's competency in order to prepare him for execution? The debate among mental health professionals and behavioral scientists about this issue continues to be extensively discussed in the literature.⁴

Forcible Psychiatric Treatment for State Interests

Fueling the debate about the role of mental health professionals in the criminal justice system, are two landmark Supreme Court cases, *Perry v. Louisiana*¹⁰ and *Riggins v. Nevada*.¹¹ In *Perry*, at issue was whether the state may forcibly treat an incompetent inmate with antipsychotic drugs in order to make him competent for execution. In *Riggins*, the issue was whether the state may forcibly medicate a mentally ill defendant in order to restore his compe-

tency to stand trial for charges in which a guilty verdict might result in his execution. In both cases, the state could not proceed without the participation of psychiatrists both to prescribe appropriate medications and to evaluate their efficacy and safety.

Perry was found competent to stand trial and subsequently convicted of five counts of first degree murder and sentenced to death. In the course of his imprisonment he became psychotic. On a subsequent hearing, the Louisiana State Court observed that Perry was competent for execution only when he was on antipsychotic medication. The court ordered that Perry's competency should be maintained by administering medication to him, even if by force, until the time of his execution.

The U.S. Supreme Court heard the arguments both from the state's and Perry's point of view. The justices did not render any opinion, instead they returned the case back to the Louisiana Court and advised Louisiana to decide Perry's case in light of the Court's decision that was made earlier in *Washington v. Harper*.¹²

Under the *Harper* precedent, states can forcibly medicate an incompetent prisoner, but first the state must establish that (1) the incompetent prisoner is dangerous to himself or others, or is seriously disruptive to the functioning of the penal institution and (2) that treatment is in the inmate's medical interest.

In comparing *Perry* to *Harper*, the U.S. Supreme Court appears to have created new ethical dilemmas rather than shedding light on those that already

existed. *Harper* was not a case involving competency for execution. He was convicted of robbery and was forcibly medicated because he was disruptive in prison. In contrast, the goal in *Perry*'s case was to groom the inmate with medication for the specific purpose of preparing him for execution. Of course, it might be argued that an incompetent prisoner who remains unexecutable because of his mental condition can be said to seriously disrupt the running of the penal institution.

The *Riggins* case differs from both *Harper* and *Perry*. The issue in *Riggins* was whether antipsychotic medication that alters the defendant's attitude, appearance and demeanor can be forced upon him during the trial and sentencing phase.

Riggins was found guilty of murder and robbery, and was sentenced to death. In his appeal to the U.S. Supreme Court, he argued that he was forced to take an antipsychotic medication (Mellaril) during the trial, which affected his appearance and demeanor sufficiently to influence the verdict. The U.S. Supreme Court sided with *Riggins* and concluded that there "is a strong possibility that *Riggins*' defense was impaired due to the administration of Mellaril" and that was a violation of the defendant's rights under the Sixth and Fourteenth Amendments to the U.S. Constitution.

Yet, even if the courts find such forced restorations of competency legally permissible, ethical questions about the participation of psychiatrists would remain. The psychiatrist would still be faced with

his/her obligations of nonmaleficence and beneficence toward the patient.

Restoration of Competency— Ethical Analysis

Ethical Objections Appelbaum¹³ has noted that society is profoundly ambivalent about the death penalty, and may have a tendency to look to psychiatry for “an easy way out.” This societal expectation creates ethical conflicts when practitioners in the healing professions such as psychiatry are asked to participate in the punishment process, particularly when execution of the convicted is a possibility and rehabilitation or effective treatment no longer is on the agenda.

Some believe that it would be unethical for psychiatrists to take part in any such tasks.^{14, 15} On the face of it, psychiatric intervention in these cases would seem to violate the Hippocratic Oath, and, as well, seems contrary to directives of various medical societies that have held to the principle that a physician should be dedicated to the preservation of life and should avoid participating in legally authorized executions. Some professional societies have gone as far to recommend that their members also should avoid evaluating a prisoner’s mental and physical fitness for execution.^{16, 17}

The American Psychiatric Association (APA)¹⁶ has argued against medicating an inmate in order to prepare him for execution. In its view, his sentence should be commuted to life imprisonment, and then he should be provided with the necessary treatment for his ill-

ness. The APA has claimed that a physician involuntarily medicating someone in such cases is hardly different from participating in the execution itself and is in clear violation of traditional and contemporary ethical codes of psychiatric and medical associations.

Those who object to psychiatric participation offer a number of interrelated arguments to support their position. For example, it has been argued that helping in any way to bring a person to execution is inconsistent with the general professional requirements of being a physician as well as conflicting with the specific professional requirements for the practice of psychiatry. According to this line of thinking, the personal attitudes of a physician for or against capital punishment are irrelevant. Regardless of the psychiatrists’ own beliefs about capital punishment, as a psychiatrist *qua* psychiatrist, any participation in enabling capital punishment would be inconsistent with the defining characteristics of the profession.¹⁴

Similarly, these objectors may appeal to professional codes of ethics to justify their claim that there is a moral obligation to refrain from participation. The rules appealed to here are primarily *ethical* rules for the profession rather than rules that attempt to guide or define claims about what the tools of medicine or psychiatry can actually accomplish.

Thus, it may be argued that practices such as making convicts competent to be executed may be consistent with the therapeutic capabilities, methods, skills, and goals of psychiatry (treating psychoses, for example), but are profession-

ally impermissible because such practices are inconsistent with overriding professional ethical principles that place limit on the ways and situations in which effective psychiatry ought to be used. Typically, these arguments start with the moral principle of "First, do no harm."^{14, 15} Successful psychiatric restoration of competency to be executed is possible, but wrong and hence impermissible because it would violate the overriding moral obligation to do no harm to patients.

However, there are many problems with simple reliance on the dicta of codes of ethics for moral direction. The dicta are often stated in general and ambiguous terms that may leave us with uncertainty when we try to apply them. For example, we are in a time in which we can no longer simply claim that "Do no harm" always means "Keep the patient alive as long as possible." Many believe that there are cases in which more harm may be done to a terminally ill patient by keeping him alive rather than allowing him to die. In fact, it is no longer certain that "Do no harm" would be inconsistent with policies that permitted physicians to directly cause the death of such suffering patients.

"Do no harm" in the context of correctional medicine is ambiguous. It is not clear why adherence to the "Do no harm" principle should not enjoin physicians from participating in any process that helps enable *any* sort of punishment for patients, capital or not. Presumably, any punishment meted out to a convicted criminal could be construed as harm to the person punished. This

same objection might be presented to those^{18, 19} who would be willing to participate in making condemned convicts competent if they could be assured that the prisoner's punishment by execution would be commuted to life imprisonment.

Clinical Objections Objectors to psychiatric participation in enabling competency to be executed may argue that such participation would be inconsistent with the clinical treatment goals of psychiatry. Unlike those who believe that participation could be consistent with performing effective psychiatry but would violate overriding ethical principles, these claim that participation could never be seen as effective clinical psychiatry. The appeal here is also based on ethical grounds but directed at a professional's obligation to do psychiatry that is consistent with the standards of clinical practice. Partially underlying this argument is a view that the aims of therapy must include the goal of bringing the patient to a state of mental well-being.

That argument has its own difficulties. The recent general acceptance of autonomy theory approaches to health care²⁰⁻²² has had effects on the concepts of health and illness as well as having effects upon the definition of the physician-patient relationship.^{23, 24} Helping a patient to achieve the capacity to have appropriate feelings of guilt or even to achieve the capacity to appreciate and accept appropriate punishment may not conflict with the healer's duty to "Do no harm." The goal of psychiatry may be to restore a patient's capacity to be a autonomous responsible being, rather

than to be a happy being. In this view, the psychiatrist who willfully fails to restore his patient's autonomy has violated his duty of beneficence. Being beneficent and acting in the patient's best interest can no longer be seen simply as providing happiness for the patient. In principle, that goal of psychiatry to restore autonomy may be quite consistent with helping to make a person competent to be executed.^{25, 26}

Other Objections However, there are at least three complicating factors that may weigh the moral balance against a psychiatrist taking part in tasks that are causal factors leading to execution: (1) If the psychiatrist believes that the institution of capital punishment is morally wrong, whether or not its implementation requires the help of psychiatrists. (2) If the goal of the "treatment" of the individual prisoner is specifically to enable execution. (3) If the task is being undertaken contrary to the convict's wishes.

If a psychiatrist believes that capital punishment is morally wrong, he may be faced with a moral dilemma, but a dilemma that has sources external to the moral or professional demands of the profession. We have argued that participation may, in fact, be theoretically consistent both with the obligation to perform effective treatment, and may be consistent with the moral obligation not to do harm. Those who disagree should carefully consider whether their objections derive from their moral beliefs as citizens, or their beliefs about the moral demands of their profession.

If their objections to capital punish-

ment really are based on reasons external to the professional demands of psychiatry, they must decide whether they will do their cause more good by working within the criminal justice system, or refusing to participate. The main problem weighing against the psychiatrist working toward the restoration of competency for execution is the likelihood that such "treatment" is likely going to be done counter to the "consent" of the "patient."

Under autonomy-based approaches to the physician-patient relationship, there are some situations in which medical intervention may be justifiable in spite of the patient's refusal to give direct consent, these include:

1. When a patient is too disturbed to understand or appreciate the need and purposes of treatment, especially if the patient is in imminent danger. However, this seeming overriding of the person's right to self-determination may be more apparent than real. Justifying this "forced" treatment is the assumption that we are actually conforming to the "real" wishes of the patient. That is, we assume that most persons in that condition would believe treatment to be in their best interests and would consent if they had the full capacity and time to make informed decisions.^{22, 27} However, while we can presume having consent to treat those who, because of their mental status, are unable to appreciate that they are in need of treatment, we may not force treatment on them if we have convincing evidence (a living will, or advanced directive, or designated proxy) they would not have wanted treatment.²⁷

Too, the more risks attendant with the treatment, and, especially, the less probable a beneficial outcome and the less likely that treatment is in the patient's best interests, the less justification can be offered for dispensing even emergency treatment without the consent of the patient.

In these cases of prisoners incompetent to be executed, it would be hard to draw an inference that they, or any reasonable person, would consent to therapy specifically aimed at making them competent to be executed. Consent issues aside, it would be difficult to draw the further inference that interventions aimed specifically at restoration of competency to be executed could be thought of as "treatment" that could be forcibly given because it would be "in the best interests" of the patient.

These may be the strongest arguments against psychiatrists forcibly "treating" convicts specifically to restore their competency to be executed. However, this argument fails if we are convinced that the prisoner, if he were decisionally capable, would have consented to such intervention.

2. Unconsenting medical intervention may be justifiable when a compelling public interest overrides the patient's refusal.²⁸ The most often cited psychiatric examples of this are instances in which a person's mental illness causes him to be a danger to others. This justification was among those cited by the majority in *Washington v. Harper*¹² in upholding his forcible medication. However, as some have argued,²⁹ absent the consent of the person to such intervention, the

primary purpose of "medicating" in cases in which a person is a danger to others or is disruptive to the running of an institution is not treatment for the sake of the individual, but is restraint, behavior management, or social control for the sake of others. It seems to us that the minority in *Harper* was correct in claiming that the majority in *Harper*, and other courts as well, sometimes miss the real purpose for the administration of neuroleptic drugs to patients like Harper. Characterizing the administration of neuroleptics for such purposes as "medicating" may be an inappropriate smokescreen. In that light, the *Harper* majority has not really dealt with the issue of the extent of a prisoner's right to refuse *treatment*, it has dealt with the limitations of a prisoner's right to refuse *restraints* administered not for his sake, but for the sake of others.

In that major respect, the *Washington v. Harper*¹² and *Riggins v. Nevada*¹¹ cases differ considerably. In *Harper*, the purpose of involuntary medication was to insure the safety of the prisoner and others in the prison. In *Riggins*, safety and imminent dangerousness were not directly at issue. The purpose of medication was to treat a person with a grave psychiatric disorder to enable him to be competent to stand trial.

Death Penalty for Minors and the Mentally Retarded

Minors Another of the controversial issues being debated involves the imposition of the death penalty on juveniles who commit heinous crimes. Mental health professionals who oppose execu-

tion of adolescents have relied heavily on the work of researchers who claim to have found that the development of "formal operation thought" as described by Piaget and others³⁰ often occurs later than the early teens. Schowalter³¹ has pointed to the *Diagnostic and Statistical Manual of Mental Disorders*, saying that the manual has prohibited the diagnosis of antisocial personality disorder until a person is at least 18 years of age, and this was done precisely because adolescents are still undergoing significant cognitive and emotional changes. For example, this type of cognitive immaturity causes adolescents to believe that while death happens to others, it cannot happen to them. Other behavioral scientists, to the contrary, believe that cognitive and moral development are closely affiliated and may progress through a series of discrete phases.³² Therefore, there is little to justify shielding all adolescent criminals from the range of penalties facing adults.

Behind this heated debate is a landmark case considered by the Supreme Court, *Thompson v. Oklahoma*,³³ which was decided by a plurality opinion. The Court barred execution of inmates who were under the age of 16 at the time of their offense. Thompson was 15 years old when he actively participated in a brutal murder and killed his former brother-in-law. Four of the U.S. Supreme Court justices concluded that the Eighth Amendment prohibits the execution of a person who was under 16 years of age at the time of the offense. One justice agreed that Thompson's death sentence must be set aside, but on

the grounds that the state may not execute persons for crimes committed at the age of 15 or younger if the state has not specified a minimum age for the death penalty.

The Court noted that the death penalty is meant to serve two main social purposes; retribution, and deterrence of capital crimes by prospective offenders. The Court argued that the lesser culpability of juvenile offenders makes the retribution rationale simply inapplicable.

The deterrence rationale also has minimal force when we note that 98 percent of arrests for willful homicide involved persons who were over 16 at the time of the offense. Thus, the justices went on to say that excluding younger persons from the class that is eligible for the death penalty will not diminish the deterrence value of capital punishment for the vast majority of potential offenders. In short, the majority of five were not persuaded that the imposition of the death penalty for offenses committed by persons under 16 years of age has made, or can be expected to make, any measurable contribution to the goals that capital punishment is intended to achieve. Moreover, four of the justices added that it would be contrary to societal "standards of decency."

Persons with Mental Retardation-

Individuals with mental retardation, like minors, belong to a special group for which society shows special qualms about imposition of the death penalty. However, unlike minors, the U.S. Supreme Court found that persons with mental retardation were not automati-

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cally precluded from being executed upon a conviction for a capital crime.³⁴

In the case of mental retardation, the jury must weigh the defendant's mental status as indicative of a possibility that there may have been related circumstances that may mitigate against capital punishment. Relevant mitigating factors could include poor moral reasoning and lack of ability to understand basic relationships between actions and their consequences.

The defendant, Johnny Penry, in the case of *Penry v. Lynaugh*,³⁴ confessed to the rape and murder of a woman and was charged accordingly. He had an IQ between 50 and 63, which is indicative of mild to moderate mental retardation. He was found to be competent to stand trial. In the sentencing procedure, the jury, in accordance with state law, confirmed that the murder was deliberate and that there was probability that Penry would commit further violent crimes. In that jurisdiction, being a continuing threat to society meant that he must be sentenced to death. When the case came before the U.S. Supreme Court, the justices were confronted with two questions: One, whether Penry's rights were violated because the jury was not adequately instructed to take all of the mitigating circumstances, including his mental retardation, into consideration. Secondly, whether it would be cruel and unusual punishment under the Eighth Amendment to execute a person with mental retardation with Penry's reasoning ability.

In their plurality decision, four justices plus one concluded that state law

(Texas) was deficient in not allowing the jury to give consideration to the defendant's mental retardation as a mitigating circumstances in determining sentencing for capital murder. In the view of the Court, punishment should be directly related to the personal culpability of the criminal defendant, and any emotional and mental problem that may him less culpable should be taken into consideration.

The Court also had to decide the general question of whether execution of a person with retardation is always in violation of the Eighth Amendment. This time, four judges plus one formed a new plurality which concluded that it would not necessarily be cruel and unusual punishment to execute a person with mental retardation who, like Penry, had the reasoning capacity of a seven-year-old. Penry's life was saved, not because he was mentally retarded, but because the jury were not instructed to consider whether, in his particular case, his retardation was a mitigating factor.

Children, Persons with Retardation, and the Death Penalty—Ethical Analysis

The onset of adulthood in nonhuman animals is usually taken to be the onset of the animal's capacity to reproduce. With humans, adulthood is defined in terms of mental rather than sexual maturity. Mental maturity involves an ability to be responsible for one's own actions. It involves having a capacity to appreciate the possible consequences of one's behavior, and the capacity to be driven by reasons rather than impulses.

The age of onset of those competencies may vary from individual to individual and also may vary according to the context. Some children with severe developmental disabilities or mental disturbances may never attain competency in any or all areas of functioning.

Confronted with the overwhelming task that would be needed to determine each individual's competencies in each individual case, legal systems make utilitarian generalizations about the ages when competency or lack of competency may be presumed in contexts such as the capacity to make financial contracts, to be licensed to drive, to be eligible to vote, to give consent for medical treatment, and to be presumed to be an adult offender held fully responsible for consequences of illegal behaviors.

The U.S. Supreme Court has recognized that individuals with mental retardation "have a reduced ability to cope with and function in the everyday world."³⁵ If this "reduced ability" affects moral action and rational thinking, then the affected individual cannot be held wholly culpable for his actions. In a roundabout way, the Supreme Court has recognized some need for the courts to carry an extra burden to prove that these individuals are culpable. Hence, the death penalty can be imposed on minors and persons with retardation as long as there was an opportunity to present and consider mitigating factors.

When psychiatrists are called upon for their testimony in such cases, they should realize that there is substantial variation in regard to moral develop-

ment and rational thinking among individuals classified as "retarded."³⁶

Aggravating and Mitigating Factors and Testimony about Victim Impact in the Sentencing Phase

Aggravating and Mitigating Factors

The death sentence is not automatically imposed upon conviction for certain types of murder, but imposed only after a determination that aggravating circumstances outweigh the mitigating ones. The relevance and weight of these factors are considered in regard to the "particular crime committed by the particular defendant" (*Blystone v. Pennsylvania*).³⁷ In every capital sentencing procedure the prosecution and the defense must be permitted to introduce aggravating and mitigating evidence (*Lockett v. Ohio*).³⁸ In such circumstances, psychiatrists may play a pivotal role, the troubled background of a defendant, the defendant's mental illness or retardation, evidence of organicity, childhood deprivation or abuse, all can be presented as mitigating factors. On the other hand, evidence of antisocial personality, dangerousness, inability to be rehabilitated, can be presented as aggravating factors. A psychiatrist's testimony about such factors may affect the outcome of sentencing.

Victim Impact Testimony A recent development in interpretation of constitutional law is the trend toward admitting testimony about the impact of a crime upon the victim's family and, as well, the admission of testimony about the character of the victim. There are

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general ethical questions about the morality and fairness of permitting such testimony. Most of these questions have to do with putting relative value on victims. There are also more specific moral questions about the place of psychiatrists in such proceedings. Some have argued that allowing the impact of a crime upon "indirect" victims to affect the severity of punishment is unjust. It is argued that allowing those factors to bear on the severity of punishment denies equal protection to direct victims of crime who lack friends or family. That is particularly true if emphasis is put on the general deterrent purpose of punishment.²⁶ For the calculating criminal will know that he has a better chance at lesser punishment if he kills the friendless and unliked member of society, than if he kills a well-liked individual who is well-connected in society.

What role, if any, should a psychiatrist play in such proceedings, particularly when a death sentence may be in the offing? In earlier Supreme Court decisions such evidence was barred (*Booth v. Maryland*)³⁹ (*South Carolina v. Gathers*).⁴⁰ In both *Booth* and *Gathers*, the majority of five to four noted that the Eighth Amendment's prohibition against cruel and unusual punishment required that "a sentence of death must be related to the moral culpability of the defendants." Statements about the victim's personal characteristics fail to provide proof of culpability, and information about the victim should be excluded in the sentencing phase of a murder trial. As the Court shifted toward conservatism, and the cry of the public for "vic-

tim's rights" was raised higher, the Supreme Court, in one of those rare occasions, reversed itself. The Court found that in *Booth*²³ and *Gathers*²⁴ it had "unfairly weighted the scales in a capital trial" in favor of the defendant and against the state (*Payne v. Tennessee*).⁴¹ In this case, Payne was convicted by a jury on two counts of first degree murder and one count of assault with intent to commit murder. He was sentenced to death by the jury. The victims of Payne's offenses were a 28-year-old mother and her young child. During the trial, the state presented emotional testimony by the child's grandmother about the impact of the crime on the rest of the family, including the surviving child. The majority of justices in their review of the case found that evidence about the impact of the crime served entirely legitimate purposes. Such evidence about the victim and the impact of the murder on the victim's family is now legally recognized as relevant to the jury's deliberations to whether the death penalty should be imposed. Stone⁴² forecasts that victim impact statements may create adversarial situations among mental health professionals. For example, the prosecutor might call experts to testify about victim impact and to find out whether the victim's family suffers from "posttraumatic stress disorder." By the same token, the defense is entitled to produce its own experts to reexamine the victim's family. The admission of such testimony may easily lead to "hired gun" issues, and may give rise to more ethical dilemmas for professionals.⁴²

We have argued that testifying about

aggravating or mitigating factors does not necessarily violate the overriding professional obligations of nonmaleficence and beneficence. We have also argued that those who are willing to testify in such cases only when execution is not a possible outcome should probably look for their rationale in their general ethical beliefs about capital punishment rather than in their beliefs about the specific ethical requirements of their profession.

These cases always raise ethical issues about warning an evaluatee about the possible consequences of a nontreatment directed evaluation, as well as issues about "hired gun" testimony. Both important issues have been well discussed in the literature.⁴³⁻⁴⁵

On a more fundamental level, psychiatric testimony about the causal factors that led a noninsane convicted criminal to commit a crime always raises the theoretical issues about free will that we have described earlier. Before agreeing to testify about these matters, psychiatrists should think very carefully about the theoretical assumptions about persons' abilities to control their actions that underlie any claims about mitigating and aggravating factors. If the psychiatrist is willing to testify about these matters, he/she has an obligation to make mention of any serious theoretical controversy that may cast doubt on the certainty of their testimony.

Psychiatric participation in victim impact sentencing hearings raises fewer unique professional ethical issues than does participation in bringing convicts to competency to be executed. Although

the psychiatric evaluation and testimony may have an impact on the severity of the sentence, there is not the same direct causal connection between the psychiatric participation and punishment as exists in instances in which the psychiatrist's direct goal is to bring the convicted to a mental state that will enable execution.

Stone⁴² notes that the scope of capital sentencing falls into three different categories: (1) character of the criminal, (2) character of the crime, and (3) character of the victim. The third category is problematic because the criminal might not have knowledge of his victim's identity and should not be punished for consequences that were not foreseeable.

At any rate, there is the strong possibility that a psychiatrist will be invited by both parties to rebut each other in regard to victim impact. The *Payne* case paved the road for those psychiatrists who wish to present psychological evidence about the impact of a crime upon on the patient's family.

The psychiatrist who believes it is unjust to admit victim impact testimony into the sentencing process must look outside of professional ethics and toward general ethical theories of justice and fairness in punishment when deciding whether or not to participate in these proceedings.

Conclusion

One can hardly imagine what Dr. Benjamin Rush, one of the framers of our Constitution, and whose picture symbolizes the seal of the American Psychiatric Association, would have

thought if he knew that one day psychiatry would play such prominent, if sometimes controversial roles in the law.

Today, psychiatrists and professional organizations are debating various aspects of the participation of mental health professionals in criminal trials, including those mentioned here; restoring the competency for the purpose of execution, and whether or not minors or individuals with retardation should be punished as adults.

The ethical codes of the APA and AMA in their present forms condemn physicians who forcibly medicate an inmate for the purpose of grooming him for execution. The same codes of ethics also dictates that minor and individuals with retardation should not be punished by the death sentence. Yet, the U.S. Supreme Court through its interpretation of constitutional amendments gives increasing weight to the state's interest in implementing punishment. Some of those rulings appear to conflict with the ethical standards set in professional ethical codes.

At any rate, these recent Supreme Court rulings exacerbated existing ethical issues and created new ethical dilemmas for psychiatry. The moral principle of nonmaleficence and beneficence appears inconsistent both with some of the interests of the justice system and with the desires of a society which would prefer to bring violators to quick and final punishment.

Psychiatrists who intend to participate in the implementation of justice, have an obligation to weigh several factors, including their own beliefs about the

institution of punishment, their moral obligations as physicians, their civic duties as citizens, and their beliefs about a patient-defendant's rights in regard to consent for medical care. Decisions whether or not to participate in such processes should be based on well-considered personal principles and moral values, rather than on blind obedience to professional codes of ethics or institutional job descriptions.

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