Psychiatry and the death penalty†

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Ninety-five countries throughout the world retain the death penalty. All make provision for excluding the 'insane' from liability to capital punishment (Hood, 1990). Psychiatrists and other mental health professionals are therefore involved in the process leading up to capital sentencing and execution in many of these countries. Such involvement may take many forms though, with the notable exception of the USA, very little is known of its nature or extent in practice. Whatever form psychiatric involvement takes, and however much it may be shaped in different places by social, economic and cultural variables, as well as the configuration of particular criminal justice systems, certain fundamental ethical questions arise which do not admit of simple answers. It might be argued that these ethical dilemmas no longer have relevance to European countries because they have all effectively abolished capital punishment. However, others may claim that the death penalty, as the most spectacular example of the extra clinical harm to which a psychiatrist's dealings with patients may contribute, ought to be of central concern when practitioners come to consider the uncertain balance between their duty to an individual patient and society at large.

The death penalty in context

There has been a world-wide trend towards abolition of capital punishment over the past quarter of a century, though no authoritative account of the extent of its continued use has been possible. Amnesty International have reported that in 1996, a total of 7107 death sentences were passed and 4272 executions carried out throughout the world (Amnesty International, 1997, Facts and Figures on the Death Penalty AI Index Act 50/10/97). This figure is probably an underestimate.

In the USA, where executions resumed in 1977 after a five-year moratorium, the number of inmates on death row has now risen to more than 3100 (Amnesty International, 1997, United States of America – Death Penalty Developments in 1996 AI Index AMR 51/01/97). Although initially the actual number of executions carried out was low (less than 25 per annum), since 1992 at least 30 prisoners have been executed each year.

Psychiatrist involvement

In the eighteenth century, an English jurist, Hawkins (1716), reported:

> And it seems agreed at this Day, That if one who had committed a capital offence, become Non Compos before conviction, he shall not be arraigned; and if after conviction, that he shall not be executed.

The effectiveness of modern treatment for mental illness has complicated this consensus because the 'Non Compos' may become 'Compos(mentis)' with treatment. Early on in the process this may make possible the arraignment and trial of the previously incompetent defendant; later, where incompetency has arisen on death row, 'successful' treatment may result in his execution.

Therefore, not only may the psychiatrist be called upon to give evidence in court almost anywhere between the beginning and the end of criminal justice proceedings involving capital defendants, he may also be called upon to treat a defendant, thereby indirectly facilitating his death.

The clamour of debate within the psychiatric profession in the USA has been most intense in relation to, first psychiatrists evaluating and testifying concerning a defendant's competency to be executed, and second, giving treatment to restore a defendant's competency to be executed. Nowadays no psychiatrist, and especially no forensic psychiatrist, can realistically claim absolute allegiance to that ancient ethical prescription '*Primum non nocere*'. Even if no harm is intended, the clinical activities of psychiatrists routinely, if indirectly, bring about (extra-clinical) harm to their patients. Examples range from the denial of workman's compensation to the return to the battlefield of the traumatised or wounded soldier declared fit once more for active duty. A good example within the field of forensic psychiatry in this country might be a pre-sentence evaluation which emphasises both the future dangerousness and untreatability of a personality disordered defendant, thereby contributing to a lengthy prison sentence. In this

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situation the patient may suffer harm in order that society may not. Observers such as Stone (1984) have criticised forensic psychiatry as an enterprise too morally risky for physicians to engage in. For him, balancing the good of a particular patient against the general good of society, is really not compatible with the physician's allegiance to the patient, as made explicit in the Hippocratic oath.

Nowhere is the collision between service to the state (or society) and Hippocratic loyalty to the patient so violent and obvious as when treatment of a patient on death row results in the restoration of competency, which in turn leads to the patient's death at the hands of the state. The practitioner is painfully reminded that, here at least, he or she cannot serve two masters. Now the ethical relevance of this admittedly extreme set of circumstances could be great indeed if this reminder was seen to be related to most of a forensic psychiatrist's work. Were it to be argued that the example of death row simply throws into sharp relief conflicts which lie at the heart of the forensic practitioner's work, then it may threaten "to morally deconstruct his awkward professional identity" (Bloche, 1993).

American forensic psychiatrists have attempted to resolve this dilemma by espousing the notion of 'objectivity' or 'truth' in clinical work. This entails the practitioner being open about the nature of his or her loyalties, in so doing making it plain that the examination may not benefit the patient, and obtaining consent for it on those terms. One problem with this approach is that, in many circumstances where mental illness is found, the clinician may wish to provide treatment and support, thus reverting to the role of physician helper, trying simultaneously to see him or her self as both an objective agent of the justice system and a compassionate physician.

It is clearly the close proximity to the act of execution that has made evaluation and treatment of the incompetent death row prisoner so contentious. This has been suggested as a basis for deciding which forms of involvement may be ethically acceptable and which not. Invoking the image of the doctor as executioner, Bloche (1993) has argued that we might make such judgements by asking to what extent a particular form of involvement invokes the impression that the doctor is primarily working for the executioner. Almost without exception, treatment that restores or maintains competency to be executed clearly assists the executioner at the condemned patient's expense, the more so if it is given involuntarily, therefore, according to this analysis, it should be ethically proscribed.

One obvious objection to the above is that proximity is not necessarily correlated directly with causality. More important is a consequentialist objection to the notion of psychiatrists absenting themselves from death row. This is simply that in a country where increasing numbers of defendants are being sentenced to death and spending an average of some 10 years on death row (where psychiatric morbidity is high) substantial numbers of people who need it will be deprived of expert psychiatric care. To these prospective patients, the knowledge that the psychiatrists have departed with their ethical integrity intact may be of cold comfort.

While international medical and human rights organisations have paid much attention to the issue of physician involvement in capital punishment (for example, examining potential sites for lethal injection), very little detailed consideration has been given to specific questions surrounding psychiatric involvement. Included in a declaration made by the World Psychiatric Association (1989) was the statement that the participation of psychiatrists "in any action connected to executions" is a violation of professional ethics. The problem is in knowing just what this means. In the UK both the British Medical Association (1992) and the Royal College of Psychiatrists (1992) have commendably been more specific, addressing both testimony concerning competence to be executed and treatment to restore it.

In 1992 the American Medical Association (AMA), through its Council on Ethical and Judicial affairs, decided to define which specific behaviours should qualify as (physician) participation and therefore be proscribed. Although the AMA's directive identified both these forms of psychiatric involvement as requiring proscription, it deferred action to allow input from the American Psychiatric Association. As influential lobby groups with opposing opinions attempted to sway the outcome, the matter dragged on until June 1995 when a report was finally produced which concluded first, that participation in evaluation of competence to be executed is not unethical *per se* and second, the report stated that treatment to restore competence to be executed is ethically unacceptable, and that the incompetent may justifiably receive treatment only to relieve extreme suffering (American Medical Association, 1995). Examples might include attempts at self-castration, enucleation of the eyes, or persistent food and fluid refusal by psychotic death row inmates.

Considerable weight will attach to these decisions, not least because the AMA's positions on ethical matters are binding upon members of the American Psychiatric Association. However, it is already clear that the debate is far from over, and there may be those who feel that the report has inevitably failed the impossible task of squaring an ethical circle.

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As distant observers of these disputed and complicated proceedings, psychiatrists in this and other European countries may wish to count themselves fortunate that they practise in countries where the death penalty has been abolished.

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