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Robert T.M. Phillips M.D., Ph.D

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ROBERT T.M. PHILLIPS, M.D., PH.D.*

In the past decade, nothing has sparked more intense debate among psychiatrists than their role in capital sentencing proceedings.[1] Unfortunately, the discussions thus far have been characterized far too often by impassioned rhetoric rather than by informed reason. The controversy is also inherently more appropriately characterized as a conflict of moral position rather than one of ethical dilemma. An individual's personal belief regarding the propriety of capital punishment is, in fact, a personal, moral opinion held by an individual. If the individual happens to be a physician, it may be logically assumed that, as a member of a profession dedicated to preserving life, participation in a legally authorized execution would be a direct violation of ethical standards of conduct.[2]

What then defines physician participation in capital sentencing proceedings, and how does one understand the appropriate or inappropriate roles that physicians may play in an execution? There are three categories that define physician participation in executions: (1) actions that directly cause the death of an individual;[3] (2) actions that

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* Deputy Medical Director, American Psychiatric Association, Washington, D.C.

1. *See generally* M. Gregg Bloche, *Psychiatry, Capital Punishment, and the Purpose of Medicine*, 16 INT'L J.L. & PSYCHIATRY 301 (1993); Fred Bonner et al., *Physician Involvement in Capital Punishment*, 91 N.Y. ST. J. MED. 15 (1991); Richard J. Bonnie, *The Death Penalty: When Doctors Must Say No*, 305 BRIT. MED. J. 381 (1992); William J. Curran, *Psychiatric Evaluations and Mitigating Circumstances in Capital-Punishment Sentencing*, 307 NEW ENG. J. MED. 1431 (1982); Charles Patrick Ewing, *Diagnosing and Treating "Insanity" on Death Row: Legal and Ethical Perspectives*, 5 BEHAV. SCI. & L. 175 (1987); Ebrahim J. Kermani & Jay E. Kantor, *Psychiatry and the Death Penalty: The Landmark Supreme Court Cases and Their Ethical Implications for the Profession*, 22 BULL. AM. ACAD. PSYCHIATRY & L. 95 (1994); Douglas Mossman, *Denouement of an Execution Competency Case: Is Perry Pyrrhic?*, 23 BULL. AM. ACAD. PSYCHIATRY & L. 269 (1995); Douglas Mossman, *The Psychiatrist and Execution Competency: Fording Murky Ethical Waters*, 43 CASE W. RES. L. REV. 1 (1992); Robert D. Truog & Troyen A. Brennan, *Participation of Physicians in Capital Punishment*, 329 NEW ENG. J. MED. 1346 (1993); Barbara A. Ward, *Competence for Execution: Problems in Law and Psychiatry*, 14 FLA. ST. U. L. REV. 35 (1986); Howard Wolinsky, *US Physicians Debate Capital Punishment*, 346 LANCET 43 (1995).

2. *See* Council on Ethical & Judicial Affairs, American Med. Ass'n, *Physician Participation in Capital Punishment*, 270 JAMA 365, 365-68 (1993) [hereinafter CEJA Report].

3. *See id.* at 368.

assist, supervise, or contribute to the ability of another individual to directly cause the death of the condemned;[4] and (3) actions that automatically cause an execution to be carried out on a condemned prisoner.[5] There is little disagreement within the profession that any action that directly contributes to the death of a condemned individual is inherently unethical.[6] Activities that would be considered participation in an execution include prescribing or administering medications that are part of an execution protocol, selecting injection sites, starting intravenous lines as ports for lethal injection devices, or prescribing, preparing, administering, or even supervising the injection of drugs for the purpose of lethal injection by nonmedical personnel.[7] Additionally, the American Medical Association (AMA) Policy Compendium[8] suggests that participation in an execution also includes, but is not limited to, the monitoring of vital signs (on site or remotely), attending or observing an execution in the role of physician, and rendering technical advice regarding the execution process.[9]

It would seem, then, that part of the controversy rests with the interpretation or definition of what actions essentially assist or contribute to the ability of another individual to directly cause the death of a condemned prisoner, and, to a lesser extent, what actions could automatically cause an execution to be carried out.[10] It is the position of those who espouse a moral opposition to psychiatrists participating in capital sentencing proceedings that assisting or aiding another to conduct an execution or performing a task that automatically causes an execution to be carried out violates the canons of medical ethics.[11] The position is grounded in the fundamental ethical concept of *primum non nocere* (above all, do no harm)[12] and is the foundation for arguments for abstention by psychiatrists from these legal proceedings.[13] Setting aside for the moment the clinical implications of abstention, the assumption of such

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4. *See id.*

5. *See id.*

6. *See id.* at 366.

7. *See id.* at 366, 368; AMERICAN MED. ASS'N, POLICY COMPENDIUM § 2.06 (1996).

8. AMERICAN MED. ASS'N, *supra* note 7.

9. *Id.*; *see* CEJA Report, *supra* note 2, at 366, 368.

10. *See* CEJA Report, *supra* note 2, at 366-68.

11. *See* Bonnie, *supra* note 1, at 381.

12. *See* Bloche, *supra* note 1, at 310 & nn.46-47; CEJA Report, *supra* note 2, at 365.

13. *See* CEJA Report, *supra* note 2, at 366.

posture could have profound implications for the legal system as a matter of public policy.[14]

There are three areas of potential involvement for psychiatrists in capital cases.[15] The first encompasses pre-sentence evaluations, including competency to stand trial, the provision of expert psychiatric testimony during a trial, and psychiatric opinions regarding relevant issues of aggravation or mitigation during the penalty phase of a trial.[16] The second is during the evaluation of a condemned prisoner's competency to be executed.[17] Finally, physicians might be involved in psychiatric treatment of a condemned inmate on death row in response to an acute emergence of symptoms or to restore an incompetent inmate to competency for execution.[18] The balance of this article will examine two of these activities—specifically, pre-sentence evaluations and the treatment of inmates to restore competence to be executed—in the context of the ethical and moral objections that are raised by this controversy.

Regarding pre-sentence evaluations, to assume the abstention position would have a profound impact on the lives of the condemned. It would deny the accused their Eighth[19] and Fourteenth Amendment[20] rights and greatly underestimates the importance of competent and reliable

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14. *See generally* James C. Beck, M.D., *The Role of Psychiatry in Death Penalty Defense*, 21 BULL. AM. ACAD. PSYCHIATRY & L. 453, 455 (1993) (stating that "[p]sychiatric assistance is essential in preparing adequately for a sentencing trial" and that the "purpose of [psychiatric] testimony is to help the sentencing jury see the defendant as a person, rather than solely as an incarnation of evil").

15. Others have described as many as eight potential roles for the psychiatrist. *See* Bloche, *supra* note 1, at 311-16 & nn.51-78.

16. *See* CEJA Report, *supra* note 2, at 367; *see also* Harvey Bluestone et al., *A Study of Criminal Defendants Referred for Multiple Psychiatric Evaluations Regarding Their Competency to Stand Trial*, 26 J. FORENSIC SCI. 416 (1981) (discussing forensic psychiatry's role in the determination of a defendant's competency to stand trial); Barbara Bolsen, *Strange Bedfellows: Death Penalty and Medicine*, 248 JAMA 518, 519 (1982) (noting that a physician's testimony can play a key role in capital cases).

17. *See* CEJA Report, *supra* note 2, at 367.

18. *See id.*

19. "Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments be inflicted." U.S. CONST. amend. VIII.

20. "No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny any person within its jurisdiction the equal protection of the laws." U.S. CONST. amend. XIV, § 1.

psychiatric testimony as a function of due process.[21] Absence of competent and reliable psychiatric testimony would substantially weaken the ability of a defendant to provide substantive evidence in matters concerning sanity, competence, and mitigation.[22] Issues of specific intent, diminished capacity and duress, and domination by others are viewed by the court through the psychiatrist's eyes.[23] Psychiatric opinions have profound implications for defense challenges to events surrounding arrest and subsequent issues of contention, such as consent to search, Miranda waiver, and the reliability of confession.[24] The devastating impact on due process is overshadowed only by the

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21. *See* Nancy S. Horton, Comment, *Restoration of Competency for Execution: Furiosus Solo Furore Punitur*, 44 SW. L.J. 1191, 1195-1200 (1990); *see also* G. Linn Evans, *Perry v. Louisiana: Can a State Treat an Incompetent Prisoner to Ready Him for Execution?*, 19 BULL. AM. ACAD. PSYCHIATRY & L. 249, 253-54 (1991) (noting that every death penalty jurisdiction prohibits the execution of the incompetent condemned as a matter of Constitutional law); Marianne Kastrup, *Psychiatry and the Death Penalty*, 14 J. MED. ETHICS 179, 179-83 (1988) (noting that it is unconstitutional to execute a prisoner who becomes insane while awaiting execution); William T. Pizzi, *Waiver of Rights in the Interrogation Room: The Court's Dilemma*, 23 CONN. L. REV. 229, 239 (1991) (discussing *Colorado v. Connelly*, 479 U.S. 157 (1986), where a psychiatrist testified as to defendant's understanding of Miranda warning despite impaired volitional capacity). *But see* Michael L. Radelet & George W. Barnard, *Ethics and the Psychiatric Determination of Competency to be Executed*, 14 BULL. AM. ACAD. PSYCHIATRY & L. 37, 47-48 (1986) (stating that a psychiatrist's opinion about a prisoner's competency to be executed cannot be challenged in an adversarial judicial process, and is therefore unlike testimony in a competency to stand trial hearing).

22. *See* Horton, *supra* note 21, at 1201-02; *see also* Bloche, *supra* note 1, at 312 (discussing central role of psychiatric testimony and diminished capacity plea); Curran, *supra* note 1 (noting that psychiatric evidence can be used to establish mitigating circumstances); Peter R. Dahl, *Legal and Psychiatric Concepts and the Use of Psychiatric Evidence in Criminal Trials*, 73 CAL. L. REV. 411 (1985) (asserting the essential involvement of psychiatrists in establishing required mental states of diminished capacity defense). *But see* Karen Huey, *A Mental Health Law Symposium on the Insanity Defense and Civil Commitment*, 29 HOSP. & COMMUNITY PSYCHIATRY 443, 446 (1978) (stating that the determination of competency to stand trial is "essentially a legal one").

23. *See generally* Dahl, *supra* note 22 (discussing psychiatric concepts as related to the law); John F. Fitzgerald et al., *Competency Evaluations in Connecticut*, 29 HOSP. & COMMUNITY PSYCHIATRY 450 (1978) (discussing procedures for conducting competency evaluations); William T. Pizzi, *supra* note 21.

24. *See* John Blume, *Mental Health Issues in Criminal Cases*, ADVOCATE, Aug. 1990, at 42; Richard J. Bonnie, *Dilemmas in Administering the Death Penalty: Conscientious Abstention, Professional Ethics, and the Needs of the Legal System*, 14 LAW & HUM. BEHAV. 67, 68 (1990); Dahl, *supra* note 22; Pizzi, *supra* note 21.

extraordinary naïveté of those who believe that abstention will bring a halt to capital punishment.[25]

If one truly assumes that the principal of non-maleficence should be rigidly adhered to by the psychiatric profession, then one must conclude that psychiatric participation in any form of legal proceeding would be ethically objectionable.[26] The absence of outrage regarding other forms of forensic psychiatric activity suggests that those who oppose psychiatric involvement in capital sentencing cases do so on the ground that the death penalty is somehow only different in degree from other punishments.[27] As such, one must conclude that clinical participation in capital cases is, in principal, no more or less problematic than forensic participation in any criminal case. Professor Richard Bonnie[28] poignantly argues that,

> [t]he question then, is whether the distinction between death and other harms has a categorical force in ethical terms. Contemporary discussion of ethical issues in the withholding or withdrawal of life-sustaining treatment suggests that it does not, and that preservation of life is not always the paramount ethical value, even in the context of the physician-patient relationship.[29]

While many hold strong opinions about the propriety of involvement of a psychiatrist that may lead to execution, there is no ethical barrier to testifying at the pre-trial, trial, or sentencing phase in a capital case.[30] Despite the heavy reliance on psychiatric testimony, the psychiatrist is

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25. *See* Louis Jolyon West, M.D., *Psychiatric Reflections on the Death Penalty*, 45 AM. J. ORTHOPSYCHIATRY 689, 700 (1975) (advocating "doctor's boycott of executions" as a means of abolishing the death penalty).

26. *See* Paul S. Appelbaum, *Competence to be Executed: Another Conundrum for Mental Health Professionals*, 37 HOSP. & COMMUNITY PSYCHIATRY 682, 683 (1986); Bonnie, *supra* note 1, at 381; Bonnie, *supra* note 24, at 75-76; Kastrup, *supra* note 21, at 180.

27. *See* Richard J. Bonnie, *Healing-Killing Conflicts: Medical Ethics and the Death Penalty*, 20 HASTINGS CENTER REP. 12, 13 (1990); *see also* Bloche, *supra* note 1, at 329 (questioning the differences between death and other sanctions); Bonnie, *supra* note 1, at 381 (noting that it is "difficult to sustain the argument that medical testimony that might lead a judge to impose a death sentence violates medical ethics even though testimony that might lead the court to impose long term, and often debilitating, imprisonment does not").

28. John S. Battle Professor of Law and Director, Institute of Law, Psychiatry and Public Policy, University of Virginia, Charlottesville, VA.

29. Bonnie, *supra* note 27, at 13.

30. *See generally* Bonnie, *supra* note 24, at 76-77; Kastrup, *supra* note 21, at 179, 181.

neither the judge nor the executioner.[31] The psychiatrist does not make the formal determination of competence that results in the ability to stand trial or to be sentenced to execution.[32] The judge or jury plays that critical role in the adjudicatory process; the psychiatrist offers an opinion. It should also be noted that, given the adversarial nature of our judicial system, a contrary clinical opinion may, in all likelihood, be offered by another psychiatrist.[33]

Testimony regarding competence to be executed, however, raises related but unique issues. First is the presumption that execution competency evaluations transcend mere participation in the administration of justice,[34] which would seem to characterize all other forensic activity,[35] and place the practitioner in the new role of participating in the administration of punishment.[36] The former would be characterized as ethically permissible, the latter as ethically objectionable.[37] Execution competency evaluations are not clearly distinguishable from other modes of clinical participation in the correctional process.[38] Forensic evaluators are frequently called upon to conduct evaluations for the purpose of classification, triage and institutional assignment, and transfer to psychiatric facilities.[39] These evaluations have provided the underpinnings for parole board determinations for decades.[40] There is inherently nothing different in assessing someone's competency to be executed from performing an evaluation of someone's competency to stand trial, competency to execute a will, or competency to remain at liberty in society in the face of acute mental illness.[41]

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31. *See* Bloche, *supra* note 1, at 316-17; CEJA Report, *supra* note 2, at 367.

32. *See* Bloche, *supra* note 1, at 316-17; CEJA Report, *supra* note 2, at 367.

33. *See, e.g.*, Barefoot v. Estelle, 463 U.S. 880, 934 (1983) (Blackmun, J., dissenting) (noting that "the presentation of defense psychiatrists [may] convert the death sentence hearing into a battle of the experts"); *see also* Appelbaum, *supra* note 26, at 683 (noting that "[p]sychiatrists may be asked by the defense, the prosecution, or the court to evaluate the defendant and to testify at trial regarding the relationship between the alleged crime and the defendant's mental state at that time"); Bloche, *supra* note 1, at 312 (discussing the need for clarification regarding a prisoner's right to call his own experts at a competency hearing).

34. *See* Appelbaum, *supra* note 26, at 682-83; Bonnie, *supra* note 1, at 381.

35. *See* Appelbaum, *supra* note 26, at 682-83; Bonnie, *supra* note 1, at 381.

36. *See* Appelbaum, *supra* note 26, at 682-83.

37. *See* Bonnie, *supra* note 24, at 79.

38. *See id.* at 79-80.

39. *See id.* at 80.

40. *See id.*

41. *See* Appelbaum, *supra* note 26, at 682.

What does unequivocally distinguish these evaluations from other forms of forensic evaluation is the immediacy of the link between the evaluator's opinion and the decision as to whether the person being evaluated will live or die.[42] As in pre-sentence activity, the physician's role in this process is supportive rather than causal.[43] Again, the physician acts as an advocate of justice, not as a source of punishment.[44] The opinion regarding competence to be executed will be weighed by a finder of fact and a decision will be made within the appropriate jurisprudential framework.[45] The psychiatric evaluation is only one piece of a complicated matrix that is taken into account by the ultimate decision maker who is respectful of constitutionally guaranteed rights of due process in the most critical aspect of the adjudicatory spectrum.[46]

Undoubtedly, the most complicated ethical dilemma is posed when a physician is asked to treat an individual for the express purpose of restoring them to competency for execution.[47] Indeed, these individuals are often severely mentally ill and experience acute psychosis that manifests as self-destructive behavior, which poses great potential harm

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42. *See* Bonnie, *supra* note 24, at 80-81.

43. *See id.* at 79-80.

44. *See* Paul S. Appelbaum, *The Parable of the Forensic Psychiatrist: Ethics and the Problem of Doing Harm*, 13 INT'L J.L. & PSYCHIATRY 249, 257 (1990); Bonnie, *supra* note 24, at 80.

45. *See* CEJA Report, *supra* note 2, at 367.

46. *See id.*

47. *See* Bonnie, *supra* note 24, at 82-83 (stating that most difficult ethical questions arise after prisoner has been declared incompetent to be executed); *see also* Evans, *supra* note 21, at 263 (recognizing that psychiatrists have an ethical dilemma in treating condemned inmates); Kirk Heilbrun et al., *The Debate on Treating Individuals Incompetent for Execution*, 149 AM. J. PSYCHIATRY 596, 604 (1992) (stating that competency for execution presents complex ethical and moral problems); Kastrup, *supra* note 21, at 181 (recognizing that there is no easy answer to dilemma of treating incompetent prisoner when treatment may result in prisoner's execution); Radelet & Barnard, *supra* note 21, at 49 (discussing the ethical issues in treating a man so that he can be restored to competency to be executed); Michael L. Radelet & George W. Barnard, *Treating Those Found Incompetent for Execution: Ethical Chaos with Only One Solution*, 16 BULL. AM. ACAD. PSYCHIATRY & L. 297, 305-06 (1988) (suggesting that the issue of treating mentally incompetent death row prisoners creates conflict in the minds of treatment staff); Ptolemy H. Taylor, *Execution of the "Artificially Competent": Cruel and Unusual?*, 66 TUL. L. REV. 1045, 1063 (1992) (noting that all psychiatrists must reconcile the ethical dilemma).

to themselves and others.[48] Three positions have emerged regarding the treatment of persons deemed incompetent for execution: never treat, sometimes treat, and always treat.[49]

Those that espouse the "never treat" philosophy believe that the relief of suffering is not a sufficient justification for providing treatment in large measure because such treatment would allow the infliction of greater harm.[50] Critics of this position, however, immediately point to the flaw in such reasoning.[51] They suggest that by not treating, one de facto creates a greater state of harm to the individual because their suffering escalates as they are subject to the ravages of their mental illness.[52] The "sometimes treat" position, the most widely adopted position among those engaged in this debate, suggests that treatment should be provided only when the inmate wants to be treated.[53] While this position seems most consistent with other ways of approaching clinical matters within the rubric of informed consent, it, by definition, raises the obvious question of the ability of an incompetent prisoner to give informed consent for treatment.[54] The law has, however, addressed such dilemmas outside the arena of capital punishment with legal procedures such as living wills and substituted judgements, including next friend determinations.[55] The "always treat" position functionally disregards the consequence of treatment by focusing solely on the delivery of clinical service as the appropriate and singular responsibility of the mental health practitioner.[56] In this context, there is an adherence to the belief that the psychiatrist's primary role as a physician is to relieve pain and suffering whenever and wherever it presents itself,[57] and therefore, this position removes itself

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48. *See* Dorothy Otnow Lewis et al., *Psychiatric, Neurological, and Psychoeducational Characteristics of 15 Death Row Inmates in the United States*, 143 AM. J. PSYCHIATRY 838, 840 (1986); *see also* Kastrup, *supra* note 21, at 181-82 (discussing psychiatric problems of death row prisoners).

49. *See, e.g.*, Appelbaum, *supra* note 44, at 256; Bloche, *supra* note 1, at 345-51; Bonnie, *supra* note 24, at 83; Heilbrun, *supra* note 47, at 598.

50. *See* Appelbaum, *supra* note 44, at 683; Ewing, *supra* note 1, at 183.

51. *See* Ewing, *supra* note 1, at 183-84.

52. *See id.*

53. *See* Bonnie, *supra* note 24, at 83; Heilbrun, *supra* note 47, at 601, 604.

54. *See* Bonnie, *supra* note 24, at 83-84; Heilbrun, *supra* note 47, at 604.

55. *See, e.g.*, *In re* Tavel, 661 A.2d 1061, 1066-69 (Del. 1995) (describing Delaware's Death With Dignity Act, 16 DEL. CODE ANN. tit. 16, § 2501 (1993), established to provide for termination of medical treatment or life support for incompetent individuals).

56. *See* Heilbrun, *supra* note 47, at 598.

57. *See id.*

from entrapment in the political discussion.[58] This is also the position espoused by the Section of Psychiatry and Behavioral Sciences of the National Medical Association (NMA):

> [T]he treatment of a "death row" inmate's mental illness does not imply that the treating psychiatrist agrees with capital punishment but rather is committed to the adequate health care of the correctional population, and realizes the nature of the sentence the inmate has to serve is a legal issue in the purview of jurisprudence and not psychiatry. . . .
>
> The Section also asserts that an inmate facing execution deserves the same type of psychotherapy that a terminally ill patient deserves, i.e. psychotherapy designed to work through the psychological issues everyone grapples with when knowingly facing death (shock, anger, denial, depression, and acceptance). The fact that "death row" inmates would not be given the opportunity to engage in either psychiatric and/or religious counseling to prepare for their death is reprehensible.[59]

The position of the NMA essentially is one that presumes the "always treat" posture is rooted in a commitment towards the provision of clinical care and the restoration of human dignity.[60]

It should also be understood that the Section of Psychiatry of the NMA is mindful of the disproportionate representation of persons of color on death row and their particular commitment to the service of that population.[61] These issues, though somewhat tangential to the points under consideration in this discussion, are worthy of mention. The death penalty is the harshest manifestation of discrimination against persons of color in this country.[62] In all of my years of conducting forensic evaluations in capital sentencing proceedings, it has become clear that the

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58. *See id.*

59. National Med. Ass'n Section on Psychiatry & Behavioral Sciences, Position Statement on the Role of the Psychiatrist in Evaluating and Treating "Death Row" Inmates 3 (1986) [hereinafter National Med. Ass'n] (on file with *The New York Law School Law Review*).

60. *See* Heilbrun, *supra* note 47, at 598.

61. *See* National Med. Ass'n, *supra* note 59, at 2 (noting that "a vast number of inmates on 'death row' are members of minority groups").

62. *See generally* Furman v. Georgia, 408 U.S. 238, 364 (1972) (Marshall, J., concurring) (stating that "Negroes [are] executed far more often than whites in proportion to their percentage of the population" and that "while the higher rate of execution among Negroes is partially due to a higher rate of crime, there is evidence of racial discrimination").

color of one's skin, the amount of money one has for an attorney, and the passions of the moment, play a much greater role in determining who dies than the circumstances of the crime involved or the background of the person on trial.[63] There are nearly 3000 persons confined on death row in the United States today.[64] A disproportionate number of them are persons of color[65] and almost all of them are poor.[66] The quality of legal assistance, or the lack of it, is a critical problem for the poor who comprise the vast majority of those sentenced to die.[67] The issues of race and poverty are at play whenever the state seeks the death penalty.[68] It is likely, then, that these issues also complicate, consciously or unconsciously, positions that are assumed regarding psychiatry's role in capital sentencing proceedings and, most particularly, the role of psychiatrists in the context of treating persons incompetent for execution.[69]

In the most recent report of the Council on Ethical and Judicial Affairs (CEJA) of the AMA entitled *Physician Participation in Capital Punishment: Evaluations of Prisoner Competence to be Executed; Treatment to Restore Competence to be Executed*,[70] CEJA concluded that it is acceptable for physicians to provide testimony regarding competence to be executed. The CEJA report stated that physician participation in evaluations of a prisoner's competence to be executed may be ethical when the physician's medical opinion is just one aspect of the information taken

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63. *See* Douglas W. Vick, *Poorhouse Justice: Underfunded Indigent Defense Services and Arbitrary Death Sentences*, 43 BUFF. L. REV. 329, 410-12 (1995) (discussing the relationship between socioeconomic factors, such as race and poverty, and death sentencing); *see also* Stephen B. Bright, *Counsel for the Poor: The Death Sentence Not for the Worst Crime but for the Worst Lawyer*, 103 YALE L.J. 1835, 1836 (1994) (noting that "[p]oor people accused of capital crimes are often defended by lawyers who lack the skills, resources, and commitment to handle such serious matters").

64. *See* BUREAU OF JUSTICE STATISTICS, U.S. DEP'T OF JUSTICE, SOURCEBOOK OF CRIMINAL JUSTICE STATISTICS—1994, at 587-99 (Kathleen Maguire & Ann L. Pastor eds., 1995).

65. *See id.*

66. *See* Vick, *supra* note 63, at 410-12.

67. *See id.*

68. *See id.* at 335 & n.24.

69. *See supra* notes 47-49 and accompanying text.

70. Council on Ethical & Judicial Affairs, American Med. Ass'n, *Physician Participation in Capital Punishment: Evaluations of Prisoner Competence to be Executed; Treatment to Restore Competence to be Executed*, CEJA Report 6-A-95 (1995) (on file with *New York Law School Law Review*).

into account by the ultimate decision maker, a role that legally should be assumed by a judge or hearing officer.[71]

Regarding the more complex issue, when a condemned prisoner has been declared incompetent to be executed, the AMA takes the following position:

> [P]hysicians should not treat the prisoner to restore competence unless a commutation order is issued . . . .
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> . . . [However, i]f 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. . . .
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> . . . [Reevaluation of] the prisoner's competence to be executed should be performed by an independent physician examiner.[72]

Additionally, a physician cannot be compelled to participate in this evaluative process if it is contrary to the physician's personal beliefs.[73]

The conflict of conscience that arises when psychiatrists are engaged in both evaluation and treatment of individuals on, and en route to, death row may be likened to the balancing of the principles of beneficence and non-maleficence resting on the fulcrum of one's personal beliefs. Such an analysis, then, would render this a discussion of moral acceptability, as viewed by the practitioner, rather than ethical conduct, as defined by a profession.

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71. *See id.* at 2.

72. *Id.* at 4.

73. *See id.*