FORUM - PSYCHIATRISTS AND THE DEATH PENALTY: SOME ETHICAL DILEMMAS

A crisis in the ethical and moral behavior of psychiatrists

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A critical controversy is occurring in the USA in regard to physician participation in legal execution that has worldwide implications for ethics and morality in medicine [1]. It is disconcerting that efforts are being made in the USA to permit psychiatrists to participate in legal executions. This is surprising, as many national and international organizations have passed resolutions prohibiting such participation. In particular, it should be noted that at the World Psychiatric Association Congress in Madrid, in August 1996, the General Assembly unanimously passed the Declaration of Madrid that included the statement: `Under no circumstances should psychiatrists participate in legally authorized executions nor participate in assessments of competence to be executed'.

Many of the arguments of those who propose to make it ethically permissible for psychiatrists to participate in legal executions are troublesome if not fallacious. For example, they confuse the propriety of a physician's testimony regarding a defendant's competence to stand trial, that is a defendant who has not yet been found guilty, let alone sentenced, with the ethically impermissible testimony regarding the competence of a condemned prisoner to be executed. The question of competence to be executed arises only after a court sentences a person to death and not infrequently after the final decision to execute has been made. It is at this point that the forensic psychiatrist is invited to engage in the ethically prohibited participation in a legally authorized execution. The proximity of this participation and the act of killing casts doctors, metaphorically, as hangmen's accomplices [2].

Even more troublesome is a proposal for `forensic psychiatry exceptionalism' that should dismay psychiatrists internationally. This notion asserts that a forensic psychiatrist is not a psychiatrist when performing evaluations for a court and thus not bound by the ethical principles formulated by various psychiatric societies. To obfuscate the departure from psychiatric ethics, the forensic psychiatrist is referred to as an `advocate of justice' or an assistant in `the administration of justice', or simply as `an agent of the state'. A leading proponent of this belief stated, `forensic psychiatrists, however, work in a different ethical framework, one built around the legitimate needs of the justice system' [3] and has suggested calling a forensic psychiatrist a `forensicist'. This is a dangerous notion that opens the door to any sort of behavior by a physician participating in executions, torture or managed care administration by declaring in this role `I am not committed to traditional medical ethics'. This notion has had its application in the state of Illinois, USA, where legislation permits physicians to participate in executions, including injection of lethal substances, without losing their license, because in that role they are not acting as physicians and are not subject to the ethical constraints of physicians.

Equally perturbing is the issue of psychiatric treatment that restores competence to be executed. The prohibition against this sort of treatment has been weakened by permitting interventions in the case of `extreme suffering' without adequately defining suffering; thus relief of suffering could be facilely invoked by psychiatrists or prison physicians to effectuate the restoration of competence and facilitate execution. In 1992 the Royal College of Psychiatrists published guidelines for the situation where the necessity of intervention and treatment are compelling in which it was stated `on no account should the psychiatrist agree to state, after treatment that the person is fit for execution'. In the state of Maryland, USA, the sentence of a seriously mentally ill death-row inmate who requires treatment is commuted to life imprisonment without parole. This is a wise procedure that should be made universal.

Psychiatrists today are indeed torn between traditional ethical principles and strong pressures from society, particularly certain segments of the legal profession, to make compromises and become collaborators in the demands of the law. Rather than look for compromises, one must adhere to traditional concepts. Psychiatrists and other physicians must join in the struggle to uphold ethical and moral principles or they will in time reap a whirlwind of public condemnation. When confronted with major changes in the ethical guidelines promulgated by the American Medical Association, the American Psychiatric Association Board of Trustees in July 1995 deferred action in order to have the components of the American Psychiatric Association enter into discussion and hold a debate on the subject in San Diego in May 1997. So far, the issue remains unresolved. We are gratified that further American Psychiatric Association review is under way, and the Council on Ethical and Judicial Affairs of the American Medical Association has been requested by its House of Delegates to reconsider its position in regard to the issue of psychiatrists' participation in legally authorized executions.

While some may wish to redefine themselves as `agents of the state', such rationalizations constitute complicity in immoral and unethical behavior.

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Comments

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In 1975 a working group from the Regional Office for Europe of the WHO met in Siena, Italy. The subject for discussion was forensic psychiatry. The discussion inevitably embraced ethical matters. One of the important conclusions from the meeting was that `general medical ethics applied to forensic psychiatry in exactly the same way as they apply to other parts of the medical profession, and, in particular, a forensic psychiatrist should see his first duty as to his patient, and should not operate as a part of the state control systems'.

Contemporaneously there were persistent allegations that political dissidents in the Soviet Union were locked up as mentally abnormal and were `treated' with psychotropic drugs in order to change their opinions [1,2).

The Soviet Union was forced to resign from the World Psychiatric Association for a few years because of this pressure. Eventually the Soviet government allowed western observers to inspect their hospitals. The USA sent an official delegation in 1989. A further visit was conducted in 1991 on behalf of the World Psychiatric Association. This team was chaired by James Birley from the UK and included Loren Roth, the medical leader of the previous US delegation.

Different concerns have led to pressure on the Japanese government [3,4]. From 1968, reports of violence to patients, including patient deaths, began to emerge. In 1984 the director of a Japanese hospital was sent to prison for putting profits before patient care. Totsuka and his group campaigned via the United Nations Commission on Human Rights and in 1988 a new Mental Health Act became law in Japan.

In such ethical matters, many of us look to the USA for support and for leadership. The USA has a remarkable written constitution (the oldest in the world) based on liberal principles and is genuinely democratic. In this context it is difficult for European people, who have (with the notable exception of some countries of the old USSR) effectively given up the death penalty, to understand why a civilised nation indulges in the ritualised cold-blooded killing of individuals it has cast out from its midst. It is harder still for European doctors to understand a contemporary debate about the involvement of the medical profession in such a process. It is widely assumed that, should the worst happen and capital punishment were reintroduced into western European countries, the medical profession would set its face against such a political catastrophe and not partake in it. Surely, the public would expect nothing less from the medical profession. The public knows that doctors are bound by the ethics of their profession to comfort, to try to preserve life, and to never harm anyone. The privileges, the responsibilities, the status of medical practice, come from a clear understanding that this is what doctors are like, and that if individuals lapse from these high standards they will be, in one way or another, disciplined within their own profession or may be ejected from it.

From the eastern shore of the Atlantic ocean, therefore, the debate which has been going on for some time in the USA and which is so well encapsulated in the Freedman and Helped article, seems almost incomprehensible. It is difficult to get all the nuances of this debate from afar, and even visits to the USA do not completely clarify the matter as this is essentially an internal American grief. To some extent, non-Americans feel like helpless bystanders hoping that Uncle Sam, or at least Uncle Sam's doctor, will soon come to his senses so that he can join, once again, with 'the rest of the medical profession in the world to try to defeat the distortions of medicine which can so easily occur when it is hijacked for nefarious purposes.

News is emerging chat suggests doctors in China are now active as executioners [5]. It has been reported that one doctor is experimenting with various cocktails, such as a veterinarian would use to put down a pet dog, to find alternatives to the firing squad provided, of course, they do not interfere with the sale of the offender's organs to Hong Kong for transplantation!

The world medical fraternity needs to stand shoulder to shoulder to speak out against such misuse of medical science and the misuse of medical practitioners. Yet, any kind of world protest against China would probably be ineffective and useless without the weight and influence of the medical profession from the USA. US doctors cannot wholeheartedly and properly join in with such a campaign while they are themselves giving approval to their own members who collude with executions and whilst they try to find ways to redefine the medical practitioner as a non-medical practitioner or `forensicist' (an agent of the criminal justice system) when he or she is involved with legal processes.

It is time to restate the 1975 Siena principles [6] and to have these endorsed worldwide. Not just in the interests of patients (although that is paramount), but also in the interests of the medical profession. A profession which strays from the high ideals expected of it will, ultimately, not be tolerated by its paymaster, the public.

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I agree fully with Freedman and Halpern and the World Psychiatric Association 1996 Declaration of Madrid that stated `under no circumstances should psychiatrists participate in legally authorised executions nor participate in assessments of competence to be executed'. This position has been argued well, and in far greater detail, by Bloche [1].

The central issue, I think, is that of participation in execution. To participate too directly in execution creates Legitimate exceptions to some medical procedures that are otherwise ethical. To treat psychosis, for instance, is generally ethical, but to treat a prisoner's psychosis so that he or she can be executed is unethical; so is final evaluation of competence to be executed unethical. In countries that allow capital punishment, such as the USA, such evaluation nearly always occurs after much other psychiatric and legal work has been done, and after a prisoner has been sentenced; thus it is, in time and effect, too directly a part of execution to be ethical for a profession that should protect its therapeutic and compassionate aims and its over-riding value of helping and not harming individuals.

Some see the debate on banning final psychiatric evaluation of competence to be executed as a covert debate on capital punishment. Not so. Opposing capital punishment is relevant, but one can be against physician participation in executions whether one favours capital punishment or not. Some see banning such evaluation as likely to embody or lead to less psychiatric care. Again, not so. I think it would probably lead to better, clearer, and more care.

I find the issue of forensic psychiatrist exceptionalism both troublesome and interesting. Appelbaum and others claim that `the forensic psychiatrist in truth does not act as a physician'. Appelbaum more or less creates a more or less ethic of `truth' and `the legitimate needs of the justice system'. Such roles and values clash with ordinary medical ethics, and do and will harm medicine.

I have suggested chat if any psychiatrist does carry out evaluations of competence to be executed, he or she should be required to wear a police uniform while doing so to make his or her dominant role clear, not just to the psychiatrist but even to a multiply stressed and often less than clear-headed late-stage prisoner.

When the American Psychiatric Association Board of Trustees yielded to its forensic psychiatrists in 1994 and, after too little debate, changed its position and allowed participation in evaluation of competence to be executed, the Board was not adequately aware that in forensic psychiatry (as in other subspecialty groups such as managed-care-company-executive psychiatrists) the expert subgroup will often have vested interests and values and wishes at odds with the values of the larger whole of psychiatry or medicine.

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Freedman and Halpern are thoroughly right in their unequivocal criticism of Appelbaum's twin assertions that (1) psychiatrists judging competency for execution are not practising psychiatry; and that (2) the ethics of medicine as applied to forensic psychiatry should be suited to the needs of the Court. Both assertions are patently illogical, socially deleterious and utterly corrosive to the integrity of medical ethics.

Psychiatry is not defined by the purposes to which we put it. Competency determinations depend on knowledge and methods developed by, and specific to, psychiatry. The Courts do not have this knowledge. That is why they need psychiatric expertise in the first place. Appelbaum's clumsy euphemism, making the psychiatrist a `forensicist', is a bizarre and transparent distortion of reality to give benediction to an ethically illicit act.

Similarly, the ethics of medicine (and psychiatry as a branch of medicine) is not defined by convenience, the needs of the state or the purposes to which we wish to put medical knowledge. Medical ethics derives from the universal predicament of human illness, from the vulnerability, dependence and exploitability of those the physician attends. The ends of medicine are healing, helping, comforting and curing. Every physician pledges to serve those ends when she or he enters the profession. Being an accomplice in the death of a human being is totally inconsistent with the ends of medicine. No act of law or fiat can change that fact.

Appelbaum's elastic logic invites the usurpation of medical power in the name of politics and ideology, and not primarily in the interest of the patient. Totalitarian states do so with gross abandon; democracies with more discretion. The result, in either ease, is to imperil the most vulnerable members of our society.

Physicians must remain the guardians of the moral integrity of the profession and its ethics. Psychiatrists must heed the ethical proscription against assisting in legal executions enunciated by the World Psychiatric Association. In these times, their witness to the integrity of medical ethics is an assurance that some things are not at the disposal of whim, fancy or political power.

Recommended reading

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Freedman and Halpern should be commended for their dogged efforts to focus professional attention on the ethical ambiguity of forensic psychiatry and, more specifically, on the unique ethical dilemmas raised by medical participation in capital cases. Although I do not agree with their position on evaluations of competence of condemned prisoners, I share many of their concerns.

I want to begin by emphasizing that I wholeheartedly agree with Freedman and Halpern about the need for vigilance in maintaining the profession's ethical integrity in the face of political and economic pressures that can undermine public trust in the healing role of the profession. The Nazi experience and the abuses of Soviet psychiatry provide compelling evidence of the dangers to the profession, and to human rights, that arise when the tools of medicine are appropriated co serve the goals of the state. That is why I have joint hands with psychiatrists in the former Soviet Union and other formerly communist nations of central and eastern Europe to help them build the institutional foundations for professional independence, including an autonomous system for promulgating and enforcing ethical norms [1).

I also agree that medical participation in an execution (as by injecting a fatal dose of barbiturates, selecting injection sites, giving technical advice, or monitoring an injection given by someone else) must be unequivocally prohibited. The American Medical Association and the American Psychiatric Association have

condemned such conduct and, as far as I know, nobody within the professional community has argued that it is ethically permissible.

It is helpful to identify the ethical principle that underlies the prohibition against medical participation in executions. Clearly, the objection does not simply lie in the fact that the doctor is serving a non-therapeutic role for the legal system: some non-therapeutic roles are ethically acceptable, for example an assessment of disability for the worker's compensation system or an assessment of competence to stand trial for the criminal justice system. (As these observations suggest, the debate about psychiatric involvement in executions is being carried out in the shadow of a broader controversy concerning the ethical foundations of forensic psychiatry. I will return to this problem below.)

Why, then, is medical participation in executions almost uniformly regarded as unethical? The answer lies not in the logic of therapeutic ethics, but rather in the fundamental idea that serving as an agent of the state's punitive apparatus is not an acceptable social role for a doctor.

Doctors should never use their skills or knowledge for the purpose of facilitating punishment. This principle covers all forms of punishment. For example, some painful punishments, such as isolation in dark cells and whipping, are not categorically prohibited under prevailing international standards of human rights and persist in many parts of the world. Medical assessment of a prisoner's fitness for these punishments and medical monitoring of their administration might be characterized as being beneficial to prisoners because it can prevent injury and suffering more extreme than intended or legally authorized. However, medical assistance in the administration of punishments is nonetheless objectionable because doctors must not align themselves with the punitive aims of the state, either in deciding whether a particular punishment should be carried out or in administering it or directing how it should be administered. So, too, participation in an execution must be categorically forbidden.

Unfortunately, the issue of competence assessment is not so easy to resolve. In some situations, such an assessment would seem co be ethically unacceptable on the same theory I have just outlined. Suppose, for example, that a psychiatrist is assessing the mental status of a condemned prisoner for the sole purpose of telling the warden or director of the prison whether the prisoner is `fit' to be executed. Such an assessment should be forbidden because it aligns the psychiatrist with the execution, implicating him in the process as if he or she had given the `ok' for the execution to go ahead. This is similar to the prohibition against a doctor observing a prisoner being whipped and saying whether he is `fit' to receive any additional lashes.

But consider a different context. Suppose a lawyer representing the condemned prisoner asks a psychiatrist to assess his client's mental state for the purpose of ascertaining whether the mentally disturbed prisoner has the capacity to understand the nature, purpose and consequences of the impending execution. Suppose further that, if the psychiatrist concludes that the prisoner's competence-related abilities are impaired, a hearing on the issue will be held in court, and that the decision whether to stay the execution will be made by a judge. First, the examination is being requested on behalf of the condemned prisoner to ascertain whether there is a clinical basis for raising a legal barrier to an execution that would otherwise occur. Second, the psychiatrist is serving as an expert, not a decision maker.

I recognise that it can still be argued, as Freedman and Halpern do, that the psychiatrist's assessment of the condemned prisoner's competence is so intimately connected with the execution itself that it should be forbidden. However, it can also be argued (as I have done elsewhere [2]) that the psychiatric assessment of competence in this situation does not differ in principle from pretrial forensic assessment of a capital defendant's competence to stand trial and that testifying on the prisoner's competence does not differ in principle from testifying in a capital sentence hearing. In all these settings, testimony by the psychiatrist can be used to establish a legally necessary predicate for a capital conviction and a death sentence. If forensic participation in the earlier stages of a capital case is ethical (and, in the USA, psychiatrists routinely participate in capital cases), a properly structured assessment of competence for execution would also seem to be ethically acceptable, as long as the process is invoked on the prisoner's behalf and as long as the ultimate decision maker is a judge. This approach to the issue may not be indisputable, but it has been embraced by the American Psychiatric Association after years of consideration and debate. I fear chat

Freedman and Halpern have misinterpreted the Association's careful deliberation over a genuinely difficult issue as an unprincipled abdication of the profession's prerogatives to the legal profession.

Specialists in psychiatric ethics also disagree about the conditions, if any, under which it is ethically permissible to treat a condemned prisoner whose deteriorated mental condition may preclude the execution. Some say that a condemned prisoner should never be treated if a possible effect of the treatment is to restore competence and thereby remove a legal barrier to an execution. Others (including myself [3]) argue that such a categorical prohibition is too sweeping. Of course it is unethical to treat a prisoner for the sole purpose of facilitating an execution but, under some circumstances, treatment may be necessary to alleviate a prisoner's torment and suffering. The ethical permissibility of treatment under such circumstances can be demonstrated by imagining (as an heuristic device) that a condemned prisoner, while competent, has executed an advance directive requesting restorative treatment from his own doctor even if one possible consequence of such treatment would be to increase the likelihood of execution. Would it be unethical to treat the prisoner under these~ circumstances? By asking this question, I do not mean to encourage prisons to seek advance treatment directives from condemned prisoners. I mean only to show that therapeutic ethics may sometimes permit, or even require, treatment of the condemned prisoner. Freedman and Halpern seem to concede the ethical permissibility, in principle, of treatment to alleviate extreme suffering, but they rest their objection on the possibility that devious prison psychiatrists could invoke this `vague' exception to justify unethical efforts to facilitate executions. I suppose there is a risk of such abuses, but I think it would be preferable to scrutinise such situations if they arise in practice rather than adopt an admittedly overinclusive ethical prohibition.

Having highlighted an area of continuing disagreement, I want to emphasise two points on which I completely agree with Freedman and Halpern. The issue of treating condemned prisoners puts doctors in an ethical bind. The only sensible way out of the dilemma is for the law to require commutation of the death sentences of prisoners who have been found by a court co be incompetence for execution. Also, even if the possibility of execution remains, the psychiatrist responsible for treatment should play no role whatsoever in the process of competence evaluations; as in other contexts, therapeutic and evaluative roles should be completely separated.

I want to close by emphasising, once again, that I applaud Freedman and Halpern for their vigorous efforts to generate ethical discussion of these issues. At the same time, however, I must also note my suspicion that many physicians who condemn execution competence evaluations are either morally opposed to the death penalty, or have deep ethical qualms about forensic psychiatry. For the record, I will note my own opposition to capital punishment. In my experience, lawyers, judges, doctors, and anyone else who participates in the administration of the death penalty inevitably become mired in ethical quicksand. Unfortunately, professional efforts to evade the quicksand tend to erode the rights and interests of defendants and condemned prisoners. The death penalty should be abolished, but as long as it remains in force neither psychiatric assessment of condemned prisoners nor treatment of incompetent ones should be categorically forbidden.

As for forensic psychiatry, I think Freedman and Halpern have mischaracterized the terms of the debate about the ethics of forensic psychiatry. Nobody argues that psychiatrists serving forensic roles are not bound by psychiatric ethics. What Appelbaum and others have argued, correctly in my view, is that the ethical principles governing forensic psychiatry cannot be derived from the therapeutic ethic that governs chat physician-patient relationship. The challenge is to formulate principles that are designed to govern this particular social role (and so, too, with other social roles) while being rooted in the professional aspirations of medicine, and while forbidding the sorts of abuses that arise when doctors surrender their professional identity and allow themselves to become agents of the state. Freedman and Halpern would serve the profession better by helping to frame the ethic of forensic psychiatry rather then by denying the need to undertake the task.

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More than any other specialty, psychiatry is enmeshed in conflict between the expectations of patients and society. The role of US psychiatry in the determination and restoration of competence for execution presents this conflict in particularly stark form.

The acrimony that characterises the international debate over this role reflects the larger failure of medical ethics discourse to address, in realistic fashion, the tension between physicians' obligations to their patients and their societies. To be sure, some criticism of this role stems from opposition to the death penalty. But the animating ideas behind most such criticism are the Hippocratic ethic of undivided loyalty to patients and the classic injunction, primum non nocere.

In practice, we routinely depart from these ideals, and traditional medical ethics offers us no guidance when we do so [1]. Society maintains contradictory private and public expectations of medicine [2]. As patients, we expect doctors to keep faith with us in moments of medical need, and we take offence when they fail to do so. Yet as citizens, we condition myriad rights, duties, and opportunities upon people's physical and mental health status, and we thereby ask of medicine that it serve multiple gate keeping functions. Employment opportunities, eligibility for disability benefits [3], military service obligations [4], criminal responsibility, child custody, access to abortion [5], and ability co make contracts are among the matters that often hinge on medical evaluation and treatment.

Forensic psychiatrists earn their living by trying to meet these latter public expectations, even when doing so results in harm to the people they attend. Their clinical work on death row, when competence for execution is at stake, poses this contradiction with singular poignancy. But this contradiction suffuses all of forensic practice-and all other exercises of clinical judgement for purposes other than patient care. Thus, the controversy over psychiatric involvement in capital punishment resonates far beyond death row. In this sense, Freedman and Halpern are on to something important in identifying a `crisis' in the ethics of psychiatry.

Should we, then, condemn as unethical all clinical work that serves the state or society or some other third parry at the expense of the well being of individual patients or clinical subjects? In rejecting `compromises' that make physicians into `collaborators in the demands of the law', Freedman and Halpern suggest this. But to do so would be to demand that the medical profession dismiss society’s expressions of need in this regard. The pervasive import of health status in legitimate decision-making about rights, duties and opportunities renders this absolutist position unrealistic.

What, then, of the claim advanced by some forensic psychiatrists, most recently in connection with capital punishment, that the physician who serves the state and/or the legal system `in truth does not act as a physician' [6] and thus need not worry about the Hippocratic duty to keep faith with patients and avoid doing them harm? The recurring appeal of this claim-and its greatest danger-lies in the escape it offers from discomfort occasioned by tension between state expectations and the Hippocratic tradition. To their credit, European forensic psychiatrists have rejected this claim, preferring instead to acknowledge the moral turbulence this tension creates. US forensic practitioners have also generally eschewed this easy answer in favor of the search for balance between their commitments to the justice system and to patient well being [7].

By acknowledging both of these commitments, and the tension between them, forensic psychiatrists accept a healthy measure of restraint on their service to the state. A lack of such restraint opens the way for such abuses as the use of psychiatry to suppress dissent in the former USSR and the attendance of physicians at executions by lethal injection in the USA. The proposition that physicians who serve the state do not act as

physicians is also at odds with the state's reasons for calling upon them. Legal systems look to forensic psychiatry when rights or duties turn on mental health status. Clinical evaluations that bear upon rights and duties make use of medical concepts and categories.

To the extent that these exercises of medical judgement result in harm to clinical subjects, they risk undermining society's expectations about the benevolent use of medical skill. They also violate the expectations of forensic examinees. Even is the psychiatrist clearly says, in advance, that an evaluation will be put to legal use, other, non-cognitive cues confound the examinee's understanding. His or her belief in medical benevolence is unlikely to disappear after such disclosure; on the contrary, the dynamic of transference in the clinical setting may well encourage it. Indeed, that most crucial of. clinical skills-empathic connection with the evaluee-invites trusting feelings that do not reflect the examiner's forensic purposes.

Ethically sensitive forensic practitioners are uncomfortably aware of these difficulties. Neither rigid insistence on the wrongfulness of clinical work that causes harm nor categorical refusal to admit the ethical relevance of such harm moves us toward their resolution. The controversy over clinical ethics on death row presents an opportunity for more productive exploration of this larger problem. In this regard, reports that some US forensic psychiatrists, including Appelbaum, cried behind-the-scenes to reverse US organised medicine's opposition to physician assessment of competence for execution [8] are troubling. Their effort briefly prevailed within the American Psychiatric Association. However, objections by many leading US psychiatrists and ethicists, including Freedman, Halpern, and Hartmann, prompted the Association to revisit the question.

The larger challenge before us is to accommodate psychiatrists' conflicting obligations to their patients and their societies in a manner that respects both the social significance of health status and the fragility of physicians' therapeutic credibility. I have argued elsewhere, in some detail, that such an accommodation requires that we bar clinical work on the state's behalf when it too provocatively and dramatically breaks with society's faith in doctors' benevolence [9]. I believe the ease against psychiatric involvement in the determination and restoration of competence for execution can best be stated in these terms [10].

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Is there a crisis in the ethics of US psychiatry? As managed care challenges physicians' traditional fidelity to patients' interests by encouraging them to place their own economic interests first, there may well be. But the notion of Freedman and Halpern that the crisis has been provoked by psychiatrists' evaluations of death row prisoners whose competence has been questioned would surely surprise most psychiatrists in the USA. Some background on the issue will reveal why.

Thirty-eight of the USA's 50 states allow the death penalty to be imposed, generally for homicides committed under aggravated circumstances. Under US constitutional law, however, prisoners cannot be executed if they are legally incompetent [1]. Generally that requirement has been interpreted to mean that prisoners who fail to understand the nature of the punishment and the reason for its imposition must be spared from execution. In one state (Maryland), such prisoners have their sentences commuted to life in prison and in another (Louisiana), if the state elects to treat the prisoner's incapacity, it can never carry out the death sentence. Although no centralised statistics are kept, evaluations of prisoners' competence to be executed appear to be quite uncommon.

What is it that troubles Freedman and Halpern? They believe that psychiatrists should not participate in evaluations of the competence of death row prisoners. Why they take that stance is not made terribly clear in their piece, other than the assertion that such evaluations constitute physician participation in execution-something that no one believes is ethically permissible. It is worth noting that their view is not supported by the official bodies charged with developing ethical standards for US medicine in general, and psychiatry in particular. The Council on Ethical and Judicial Affairs of the American Medical Association, after studying the issue for years, concluded that conducting such evaluations was not equivalent to participating in an execution. Indeed, “...without physician participation, [incompetent] individuals might be punished unjustifiably” [2]. This conclusion was supported by the American Medical Association's House of Delegates and Board. Similarly, .the American Psychiatric Association's Committee on Ethics ruled that it was permissible for psychiatrists to engage in competence evaluations [3].

These conclusions are consonant with a reasoned view of the psychiatrist’s role in competence evaluations. After assessing the prisoner's capacities, the psychiatrist testifies at a competence hearing regarding his or her conclusions. Other evidence is heard, as well, typically from prison guards and others who have been in contact with the prisoner. The determination regarding the prisoner's competence is left to the official decision maker, usually a judge. Taking part in this process is simply incommensurate with participation in execution.

Not only are such evaluations ethically permissible, but it is the very ban that Freedman and Halpern propose that would create impossible ethical dilemmas for psychiatrists. Envision a psychiatrist treating a prisoner on death row. The psychiatrist believes that the prisoner is psychotic or demented to the point where competence may be in question. As the prisoner is withdrawn and not overtly disruptive, no one else seems to notice. Under the rule proposed by Freedman and Halpern, the psychiatrist would have to stand by silently (because formally evaluating or testifying about a prisoner's competence would be forbidden) and watch the incompetent prisoner go to his death. How anybody could believe that such behavior is ethically justifiable is incomprehensible.

What, then, lies behind efforts to elevate an infrequently performed evaluation, agreed to be ethical by the professional groups that have studied it most closely, to the level of a `crisis' in medical ethics? The death penalty evokes strong feelings among both its supporters and its opponents. Understandably, many opponents will seek any argument available to attempt to delegitimize the process. But it is manifestly unfair to psychiatrists and to death row prisoners themselves to use them as pawns in a game of political posturing over the use of the death penalty.

Although it is not clear from Freedman's and Halpern's piece, it should be noted that no one involved in this debate-not the American Medical Association, the American Psychiatric Association, nor me-argues that psychiatrists should treat persons found incompetent to be executed so that the sentence can be carried out. That is not at issue here. As for my views on the ethics of forensic psychiatry as a whole, which are

misstated by Freedman and Halpern, I have addressed this issue at length elsewhere and refer the interested reader to that discussion [4].

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Medical involvement in the death penalty has, until recently, been an issue that has not received sufficient recognition. Within Amnesty International, a Medical Group against the Death Penalty has been established, with the main objective of fighting against the death penalty by increasing the public's-and in particular physicians'-awareness of the issue. This group, located in Denmark, publishes a regular newsletter and has published a number of papers over the years [1-3] on different aspects of the role of doctors, including psychiatrists [4], in the death penalty.

Among psychiatrists, Appelbaum [5] has highlighted areas of concern to psychiatrists in relation to the death penalty for more than 10 years but has been standing relatively alone in the US debate. Therefore, the recent article by Freedman and Halpern [6] and the present forum are very welcome. Freedman and Halpern mention the clear stand of the World Psychiatric Association in the Declaration of Madrid and the guidelines for specific situations, including the participation of psychiatrists in the death penalty. However, the World Psychiatric Association had previously issued a statement in 1989 in which it is considered a violation of professional ethics for psychiatrists to participate in any action connected to executions. Thus, there is no doubt about the position of the World Psychiatric Association when it comes to the participation of psychiatrists in capital punishment.

Freedman and Halpern focus in particular on the question of competence to be executed, and testimony regarding both competence to be executed and treatment to restore competence. Other aspects also deserve mention, including the role and capacity of psychiatrists in assessing future dangerousness [4]. Here, psychiatric evidence may be influential and indeed play a key role in the jury's decision to vote for the death penalty. Finally, the whole issue of psychiatric problems on death row deserves further attention. This must include the problems present in prisoners on death row as well as the problems that are caused by the conditions on death row.

The death penalty is an issue of concern for the psychiatric community and, as such, further recognition is justified.

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Issues in the relationship between law and psychiatry were present in ancient Greece and Rome over 2000 years ago. The evolution of this relationship cannot be seen as a process of accumulating medical knowledge being made available co the legal system. Nor can it be understood in terms of new legal concepts progressively influencing medicine and, later, psychiatry. Rather, law and psychiatry were subject to mutual adjustments and a continuous exchange of knowledge, techniques and objectives. Over the centuries, the two disciplines seem to have followed general shifts between the care of the individual and the protection of society. Their encounter always brings us back co the duality that exists between our conflicting conceptions of the value of health on the one hand, and our conception of liberty, integrity and autonomy on the other.

The main objective of any physician, the psychiatrist being no exception, is to alleviate suffering and improve the quality of life of patients to allow a better existence. To alleviate suffering and to cure the patient to be competent for execution is against medical ethics. I am privileged to chair the Ethics Committee of the World Psychiatric Association and, with its members, have produced the Declaration of Madrid and the special guidelines for specific situations. The paragraph on the death penalty states that `Under no circumstances should psychiatrists participate in legally authorised execution, nor participate in assessments of competence to be executed'. The declaration was unanimously endorsed by the World Psychiatric Association General Assembly in 1996. The proposal to exclude forensic psychiatrists from this commitment, on the basis that they are advocates of justice or an assistance in the administration of justice, i.e. simply an agent of the state, is ethically unacceptable.

Freedman and Halpern state that `equally perturbing is the issue of psychiatric treatment that restores competence to be executed', allowing intervention in the case of extreme suffering. Here I beg to differ that we should intervene in case of severe suffering from psychotic symptoms or self destructive behaviour, considering that the time between sentencing and actual execution could extend for years, and chat court sentences can and are usually proceeded. However, I do agree with the guidelines of the Royal College of Psychiatrists (1992): `On no account should the psychiatrist agree to state, after treatment, that the person is fit for execution'.

This commitment constitutes a component of the codes of ethics of several national and international medical organisations: the World Medical Association, World Psychiatric Association, American College of Physicians, British Medical Association, Royal College of Psychiatrists and the American Psychiatric Association.

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There are two peculiarities in the US legal system which may wrongly lead readers to chink that the issue raised by Freedman and Halpern may not be of significant interest worldwide.

The first aspect is that the death penalty exists in some states in the USA and the problems are different where it does not. When a psychiatric patient commits an offence and is condemned co death, the insanity defence becomes a life saving issue. Where the death penalty does not exist it can be argued that long term sentences in jail or in a mental institution are equivalent; especially now that psychological rehabilitation is provided in many prisons whereas mental hospitals have deteriorated in many countries. It may even be better to have a limited prison sentence than to be an inmate of a mental institution without time limitation.

Nevertheless, the institutional setting is essential for the job of professionals and an adequate doctor-patient relationship and treatment and rehabilitation procedures are difficult co carry out in prison.

The second peculiarity of the US legal system, and of Anglo-Saxon countries in general, is that the emphasis is placed on procedural law rather than the normative law. The latter is standard in other countries, especially those where Roman law prevails (France, Italy, Spain and Latin American countries). In normative law, the involvement of psychiatrists and other professionals as court experts seems to be easier and is carried out from a certain distance and with little involvement. The expert has two roles: the first is clinical diagnosis of the patient, the second is to evaluate the effects of the derangement of the patient's mind on the offence being judged.

Two recent cases in Spain help to-clarify these points. In both there was an absence of mental disorders but psychiatrists were called to study the accused. In the first, one of a group of adolescents playing a game called `role' brutally killed a sweeper in the early hours of the morning. The game involves the adoption of the role of different people during a normal day and this group adopted the role of `vigilantes' or `racial cleaners' liberating society from weak, old and foreign people. After a few failed attempts the group found the sweeper, aged, fat, and perhaps ugly looking, ac night. During the trial there was a struggle between the psychologists and psychiatrists. The latter were unable to bring forward their argument as none of those involved in the crime, particularly the leader, fulfilled criteria for any psychiatric diagnosis. The psychologists, without the burden of having to provide a psychiatric diagnosis, were much more able to make a description of the personality of the accused and to suggest that they should be considered fully responsible. The psychiatrists, who were appointed by relatives of the accused, supported the notion that the accused were not responsible for their actions based on weak diagnostic formulations. In fact, they were trying an insanity defence without insanity being present. Here the pressures came not from the judicial system itself, but from one of the parties involved.

The other case, in which I participated along with another professor of psychiatry, involved a former head of the police forces in Spain who was accused of corruption and other similar offences. The image of this man in the press and the descriptions by his colleagues in the government as well as his own political party described him as being full of evil and as a psychopath or mentally abnormal person. The study of this person revealed no psychiatric disease and produced a detailed description of his personality and circumstances. The trial is ongoing, but the expert report was able to change the public perception of the accused. Removal of the stigma of mental illness also releases mental patients from the stigma of other social factors.

The lesson from Freedman's and Halpern's paper is that a psychiatrist should, in any circumstance, behave as a psychiatrist and only as a psychiatrist. A thorough reading of the Declaration of Madrid makes the cask of psychiatrists more demanding even in circumstances not as extreme as chose described by Freedman and Halpern.

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FORUM-PSYCHIATRISTS AND THE DEATH PENALTY: SOME ETHICAL DILEMMAS

Response

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We wish to thank all our colleagues who have taken the time to respond with comments to our article `A crisis in the ethical and moral behavior of psychiatrists'. The issues raised in both the article and the commentaries have broad implications and ramifications beyond psychiatry and medicine extending to ethical and moral issues of contemporary society. Thus, discussion can only bring enlightenment in this critical area. We are confident that this aim is well served by the extremely insightful and pertinent observations of the commentators.

Unfortunately, in his comment, Appelbaum does not directly respond to our quoting of his statement delivered at the Annual Meeting of the American Academy of Psychiatry and the Law in 1996, namely that `forensic psychiatrists, however, work in a different ethical framework, one built around the legitimate needs of the justice system'. This notion of forensic exceptionalism is the cornerstone of Appelbaum's arguments and the justification of the sharp departure from psychiatric ethics. This concept that he has put forward in numerous articles, including the one he refers to in his commentary, implies that in the court-related situation the psychiatrist is no longer a psychiatrist but an `advocate of justice', an assistant in `the administration of justice', or a `forensicist' no longer bound by the ethical principles to which psychiatrics are committed. We strongly agree with the statement in Pellegrino's comment that Appelbaum's idea is `patently illogical, socially deleterious and utterly corrosive to the integrity of medical ethics'.

In a recent article, by Stone of the Harvard Medical and Law Schools [1], the departure of some forensic psychiatrists from a strong commitment to preserve confidentiality to acquiescence of a break of confidentiality in court is deplored. Stone attributes this to a need to conform to the needs of the court. We agree, but believe it is an outcome of the above idea that the forensic psychiatrist is no longer a psychiatrist but an agent of the court. Adherence to the ethics of confidentiality is no longer necessary. Forensic psychiatry will suffer immeasurably for this surrender.

Appelbaum cites the report of the Ethics Committee of the American Psychiatric Association (A PA) on 17 February 1996, but fails to mention the clearest statement included in this otherwise ambiguous report, namely that ` ... psychiatrists are physicians and physicians are physicians at all times'...

It must be mentioned further chat ac the June 1997 meeting of the American Medical Association (AMA), the New York State delegation introduced modifications of the 1995 report of the AMA Council on Ethical and Judicial Affairs (which was referred to by Appelbaum). The modifications were sent to the Council for reconsideration. Therefore, this whole issue is still in a state of flux and neither the APA nor the AMA has an unquestioned position at this time.

Both Bonnie and Appelbaum imply that our objection to physician participation in executions is a covert manoeuvre to discredit and eliminate capital punishment. There is no such effort as the issue of capital punishment is, as indicated by Hartmann, unrelated to physician participation. It is noteworthy that when we were collecting signatures at an APA meeting co oppose approval of psychiatrists' participation, a number of those who signed stated that although they were in favor of capital punishment they were strongly opposed to physician participation.

In the matter of treatment of a condemned prisoner's `extreme suffering', we are gratified that Bonnie agrees with us chat the law should require commutation of the death sentence in such cases. Beyond that, however, in the interests of a truly sensible and rational way out of the dilemma, we have made no secret of our strong support for the abolition of capital punishment. We applaud the American Bar Association's call, in February 1997, for a moratorium on capital punishment in the USA. (The reasons given include racially discriminatory application of the death penalty, the grossly inadequate legal representation of the defendants and the restriction on appeals to the federal courts even in cases where new evidence is presented that points to the innocence of the condemned prisoner.) We have also repeatedly endorsed the 1969 resolution of the Board of Trustees of the APA calling for the abolition of the death penalty and declaring that `the best available scientific and expert opinion holds it to be anachronistic, brutalizing, ineffective and contrary to progress in penology and forensic psychiatry'. We must say, again, that we are quite distressed that both Bonnie and Appelbaum imply that we condemn execution competency evaluations solely because we are

morally opposed to the death penalty. It has been our purpose to give indisputably realistic meaning co the ethical canon that prohibits participation by physicians in legally authorized executions and we are gratified that the World Psychiatric Association has clearly proclaimed that psychiatric assessments of competency co be executed fall within the ambit of ethically unacceptable conduct. There is reason to believe that our view in this regard is shared even by physicians who hold that capital punishment has a place in civilized society.

We note that 21 death row prisoners in the USA were exonerated by the courts between 1993 and 1997. These findings of innocence were arrived at over a period of 7 years in almost all of the cases. With the defunding of many federal post-conviction defender organisations last year, the limitations on appeal petitions and the broadening of the federal death penalty, we can expect an acceleration in the number of executions, including the executions of innocent persons. Obviously, there is a distinct risk that psychiatrists will examine innocent prisoners and declare them competent for execution. Unlike Appelbaum, we see this as a crisis.

Bonnie declares that the assessment of a condemned prisoner's competence to be executed, `for the sole purpose of telling the warden or director of the prison whether or not the person is `fit' to be executed', is ethically unacceptable. He nevertheless accepts as ethically sound for a psychiatrist to assess, at the request of a lawyer representing the condemned prisoner, whether the mentally disturbed prisoner `has the capacity to understand the nature, purpose and consequences of the impending execution'. What Bonnie fails to understand is that this ostensibly altruistic participation `on behalf of the condemned prisoner' at once opens the door for the `decision-maker' to invite psychiatrists to evaluate the prisoner's competence and arrive at an assessment contrary to what the prisoner's lawyer desires, with the result that the decision-maker is then free to declare that the execution should take place. This is not merely a theoretical possibility. The recent execution of Pedro L Medina in Florida is a case in point. Here, according to his attorney to whom we spoke, three psychiatrists had been appointed by the Governor to examine Mr. Medina to determine his competency to be executed. They all agreed he was competent and was malingering. An appeal was filed with the Circuit Court judge who appointed three experts -they all found the inmate to be severely psychotic and not malingering. The judge then appointed two psychiatrists who said that Mr. Medina, although `eating his feces and calking crazy', was faking. The lawyer appealed to the judge to send Medina to the state hospital for treatment and/or reassessment. The judge refused and the execution was carried out. (As an additional macabre point of interest, we were cold by the lawyer, who witnessed the execution, that two doctors examined the prisoner after the mask over his face caught fire and the current was turned off; the attorney left with the other witnesses when a Department of Corrections representative announced `sentence carried out-you may leave now'.)

The fact that doctors serve in a non-therapeutic role for the legal system (for example, in assessments of disability for the workers' compensation or social security systems, or of competency to stand trial for the criminal justice system) in areas that no ethical code prohibits in no way justifies, contrary to Bonnie's and Appelbaum's insistence, the participation by psychiatrists in legally authorized executions which is ethically prohibited. We thus take strong exception to Bonnie's assertion that the psychiatric assessment of a death row inmate’s competence to be executed `does not differ, in principle, from pre-trial forensic assessment of a capital defendant’s competence to stand trial' or `from testifying in a capital sentence hearing'.

We would remind Appelbaum of his comments as a member of the affirmative team debating, at the 1987 Annual Meeting of the APA in Chicago, the resolution `It is unethical for psychiatrists to diagnose or treat condemned persons in order to determine their competency to be executed'. Appelbaum pointed out that psychiatric ethics require the psychiatrist co function as a healer and that this role was not compatible with determining that someone was competent to be executed. The role of consultant to the criminal justice system, he said, is secondary and it has co be subordinated to the role of healer, and in rendering an opinion in favor of execution, the physician allows his secondary role co dominate his primary role. Appelbaum stated at that time that an evaluating psychiatrist is `as directly involved as one could imagine, short of flipping the switch, when he serves in this role' [2].

As Appelbaum and Bonnie were the only people to make oppositional comments, we found it necessary to refute their statements. The remainder of the comments were essentially supportive of our position and we

are grateful for the endorsement of our colleagues. Thus, we will make only brief response as their papers speak for themselves.

Gunn makes us aware that the Siena meeting promulgated the declaration that forensic psychiatrists should abjure operating `as part of the state control systems'. He gives proof of the danger of forensic psychiatrists characterizing themselves as `advocates of justice' or `agents of the state' by citing the sad story of psychiatry in the former USSR.

As has been pointed out above, Hartmann vigorously dismisses the contention that opposition to physician participation in executions is a covert way to undermine and do away with capital punishment.

It is to Okasha that we owe credit for his vigorous and wise leadership of the Ethics Committee of the World Psychiatric Association from which the Declaration of Madrid (which we quote above) emerged. We also agree that the 1992 statement of the Royal College of Psychiatry gives us a guideline in regard to intervention in `extreme suffering'.

López-Ibor, as President-Elect of the World Psychiatric Association, was also a critical supporter of the Declaration of Madrid. We are cognizant of the temptations to interpose an insanity plea in capital cases in a humanitarian effort to avoid a death sentence. However, misuse of psychiatry in the presentation of expert witness testimony frequently occurs, resulting in widespread ridicule and criticism of our profession. It should be noted that execution of severely mentally ill inmates is prohibited in the USA. The unwarranted (manufactured?) plea of insanity in capital cases can be nullified by abolition of the death penalty

Kastrup raises an interesting bit of history in regard to Appelbaum's position on physician participation in legal executions. In Appelbaum's 1986 paper cited by Kastrup and in the debate in 1987 referred to by us above, Appelbaum was intransigent in his opposition to physician participation. Regrettably, by 1990 Appelbaum had reversed his position and has continued to this day to favor lifting prohibitions to physician participation as can be seen in his comment.

Pellegrino is one of the outstanding medical ethicists in the USA and his comments demonstrate his rare ability to sum a most commendable position with his strong but spare prose. We have cited above his condemnation of some of the flimflam justifying physicians serving the court or state and thus participating in legal executions. His comment reinforces this position.

Bloche has campaigned for years against physician participation in legal executions and his comment demonstrates his continuing indefatigable commitment.

Thus, a wide-ranging discussion is completed, not just of psychiatrist participation in legal executions but of the very basis of morality and ethics in medicine that is being seriously eroded. It is our hope chat this discussion will raise the consciousness of physicians and psychiatrists to the fragility of our ethical and moral standards chat are now subject to attack. In the words of Pellegrino, `physicians must remain the guardians of the moral integrity of the profession and its ethics. ... In these times, their witness to the integrity of medical ethics is an assurance that some things are not at the disposal of whim, fancy or political power'.

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