

## Medicate-to-Execute: Current Trends in Death Penalty Jurisprudence and the Perils of Dual Loyalty

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# COMMENT

## MEDICATE-TO-EXECUTE: CURRENT TRENDS IN DEATH PENALTY JURISPRUDENCE AND THE PERILS OF DUAL LOYALTY

DANIEL S. SHAIVITZ\*

### I. INTRODUCTION

Health care professionals fulfill many roles during a criminal prosecution. Caring for defendants throughout the process is critical to the success of our criminal justice system. Because our justice system is largely based on principles of “just desserts,” retribution, and deterrence, persons who cannot comprehend certain acts as wrongful should not receive the same punitive treatment as persons who can. Likewise, individuals lacking the competence to understand principles of wrongfulness should be spared the most severe sanctions. The process begins when defense counsel, the government, or the court detects behavior indicative of mental illness. Next, one of the parties, through a motion, or the court acting *sua sponte*, must request a psychological evaluation of the defendant and a subsequent evaluation that confirms the belief of the movant that the defendant is not competent.<sup>1</sup> Examinations may be ordered for myriad reasons.<sup>2</sup> A defendant may lose and regain competence throughout the various stages of the prosecution. That a defendant’s competence may fluctuate is especially significant when a defendant receives a death penalty sentence.

Individuals deemed incompetent may not be executed.<sup>3</sup> However, the law is beginning to permit the involuntary medication of persons who lack competence

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1. See Charles Patrick Ewing, “Above All, Do No Harm:” *The Role of Health and Mental Health Professionals in the Capital Punishment Process*, in AMERICA’S EXPERIMENT WITH CAPITAL PUNISHMENT 461, 463 (James R. Acker et al. eds., 1998).

2. See *id.* Generally, defense counsel tends to raise this issue *pro forma*, or it may stem from a genuine judicial concern regarding the mental health of the defendant. The government may raise this issue merely as the machinery of discovery. A court would normally desire such an inquiry be made due to the nature of the offense or the prospective punishments sought by the prosecution. *Id.*

3. See *Ford v. Wainwright*, 477 U.S. 399, 410 (1986).

at various points in the criminal justice system.<sup>4</sup> Most commonly, involuntary medication occurs during the trial phase. However, courts have recently developed a willingness to involuntarily medicate persons specifically to re-establish competence for execution.<sup>5</sup> This judicially created doctrine fails to address the moral and ethical responsibilities of health care professionals who serve the criminal justice system. Health care professionals experience complex conflicts of interest when they make determinations of competence in these circumstances. It is the responsibility of the health care professional to consider the prospect of medicating the convicted offender in order to restore the offender's competence for execution. Health care professionals should never be required to cause the death of a patient, directly or indirectly, regardless of the patient's criminal history.

The Supreme Court recently denied *certiorari* to the Eighth Circuit in *Singleton v. Norris*.<sup>6</sup> With that denial, the Court unfortunately yielded the opportunity to resolve this hotly debated issue. As a result, brewing conflicts between fundamentally relied upon principles of medical ethics and currently unfolding death penalty jurisprudence will likely reach a critical mass as medicate-to-execute schemes gain acceptance through practice. By the time the next opportunity arises in which a state involuntarily medicates a death row inmate and the Court has occasion to review it, medicate-to-execute schemes may have developed more widespread support rendering their opponents more helpless than they currently are. Moreover, the Court should have taken the opportunity to settle the building conflict between the states.<sup>7</sup>

By passing on *Singleton*, the Court endangered the future influential power of medical ethics over the integrity of the medical professional and the safety of patients. While the legal issues surrounding *Singleton* are controversial on their face, the underlying conflict between criminal jurisprudence and accepted standards of medical professionals poses a much greater threat. Medical professionals, as common participants in the judicial process, should not be alienated by conflicting ethical and legal directives. If the Court continues to favor the decision of the Eighth Circuit enunciated in *Singleton*,<sup>8</sup> the judiciary will be in danger of developing roles for health care professionals that directly contradict the established, fundamental moral and ethical principles of their profession. When

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4. *E.g.*, *Washington v. Harper*, 494 U.S. 210, 227 (1990).

5. *See, e.g.*, *Singleton v. Norris*, 319 F.3d 1018 (8th Cir. 2003).

6. 124 S.Ct. 74 (2003).

7. In two states of differing circuits, this issue has risen to the highest court in the state – Louisiana and South Carolina. *See, e.g.*, *State v. Perry*, 610 So.2d 764 (La. 1992); *Singleton v. State*, 437 S.E.2d 53 (S.C. 1993); *Singleton v. State*, 623 S.W.2d 180 (Ark. 1981), *cert denied* 456 U.S. 938; *Singleton v. Lockhart*, 871 F.2d 1395 (8th Cir. 1989), *cert. denied* 493 U.S. 874 (1989); *Singleton v. Lockhard*, 962 F.2d 1315 (8th Cir. 1992), *cert denied* 506 U.S. 964 (1992); *Singleton v. Endell*, 870 S.W.2d 742 (Ark. 1994), *cert denied sub nom. Singleton v. Norris*, 513 U.S. 960 (1994); *Singleton v. Norris, cert denied* 522 U.S. 840 (1997).

8. *Singleton*, 319 F.3d 1018.

given the opportunity, the Court must reverse the Eighth Circuit to prevent the further erosion of the ethical standards of health care practitioners.

This comment addresses the mounting conflict between health care professionals and medicate-to-execute schemes. Part II introduces the evolving nature of the Court's protection of mentally ill defendants, and addresses the increased and diversified use of medication throughout the criminal prosecution process. In addition, Part II introduces *Singleton* and illustrates the gravity of the holding. Part III explores the most recognized codes of medical ethics, evaluating their origins, current impact, and endangered future. Further, Part III identifies the underlying conflict at issue in *Singleton* by developing upon the roles of health care professionals and the conflicts of interest that occur as a result of their dual loyalty to their patients and the criminal justice system in which they are forced to operate.

## II. LEGAL BACKGROUND

Until *Singleton*, the Supreme Court had been progressive in its continual acknowledgement of the need to protect mentally incompetent persons throughout the criminal prosecution process. Despite the Court's increased respect for the effects of mental illness on offenders during all stages of the criminal justice system, increasingly physicians have experienced a judicial interference with their practice. By granting certiorari in *Singleton*, the Court should have halted the constriction of the medical practice that has taken place of late. An investigation of the controlling case law will provide the necessary understanding of what protections the Supreme Court has established for the mentally ill and how this current issue challenges that law.

### *A. The Controlling Case Law*

The Court has protected mentally ill persons convicted of capital offenses from execution.<sup>9</sup> By protecting mentally ill individuals, the Court has demonstrated an increased understanding of mental illness and its effects on offenders. Among the circumstances discussed by the courts are when the state can medicate mentally ill defendants to render them competent to stand trial, when the state can medicate mentally ill defendants during incarceration, and when the state can medicate mentally ill defendants to render them competent for execution. In each of these circumstances, a unique standard is utilized to determine competence.

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9. See *Ford*, 477 U.S. 399 (1986) (holding that the state must afford a "full and fair hearing" when a petitioner challenges his competence to be executed). The holding was made in light of a Florida statute that did not provide an adequate fact-finding procedure. *Id.*

Since 1960, the Supreme Court has recognized the plight of mentally incompetent defendants.<sup>10</sup> In *Dusky*, the Court changed the standard used to assess competence to stand trial.<sup>11</sup> According to the Court, a person must have “sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding – and ... ha[ve] a rational as well as factual understanding of the proceedings against him.”<sup>12</sup> In order to gauge this ability, a licensed or certified health care professional, by court order, must perform a psychological examination of the defendant.<sup>13</sup> The health care professional’s report must discuss the defendant’s medical history and present symptoms, a record of the tests employed in the examination, the health care professional’s findings, statements of opinion as to diagnosis and prognosis, and most importantly, whether the health professional believes that the defendant is competent under the language set forth in *Dusky*.<sup>14</sup> In these instances, health care professionals are called upon to make quasi-judicial determinations.

In *Ford v. Wainwright*,<sup>15</sup> the Court prohibited states from executing prisoners lacking mental competence; a decision in line with common law jurisprudence.<sup>16</sup> Ford was sentenced to death for murder in 1974.<sup>17</sup> After several years of incarceration, he developed a psychological disorder that led to the progressive deterioration of his mental competence.<sup>18</sup> A habeas corpus petition was filed on behalf of Ford, asking the Court to stay his execution.<sup>19</sup> In considering this petition, the Supreme Court addressed whether the Eighth Amendment prevented the execution of an insane defendant.<sup>20</sup> Justice Marshall, writing for the majority, recognized the parallel practices in historic records and current national trends and found that the practice of executing the insane “simply offends humanity.”<sup>21</sup> The *Ford* doctrine provides that when a prisoner challenges his or her own competence via a federal habeas corpus proceeding, a *de novo* evidentiary hearing in federal district court is available.<sup>22</sup> The *Ford* decision was a success for its extension of humanitarianism to mentally incompetent persons, and

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10. See *Dusky v. U.S.*, 362 U.S. 402 (1960).

11. *Id.* at 402.

12. *Id.*

13. 18 U.S.C. § 4247 (2000).

14. *Id.*

15. 477 U.S. 399 (1986).

16. *Id.* at 401, 406-408.

17. *Id.* at 401.

18. *Id.* at 402.

19. *Id.* at 404.

20. *Id.* at 404; “Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted.” U.S. CONST. amend VIII.

21. *Ford*, 477 U.S., at 408, 409.

22. *Id.* at 418.

it set the stage for the current issue by acknowledging the potentially fluctuating mental status of death row inmates.

The Court considered procedural due process protections afforded to incompetent persons in *Washington v. Harper*,<sup>23</sup> specifically, whether a hearing was necessary under the Fourteenth Amendment before a mentally ill prisoner could be involuntarily medicated.<sup>24</sup> Harper was incarcerated initially for robbery, during which time he consented to the administration of psychotropic medication.<sup>25</sup> As a condition of his parole, the court forced Harper to receive psychiatric treatment.<sup>26</sup> Despite his treatment, Harper assaulted two nurses and the court revoked his parole.<sup>27</sup> Upon his return to state custody, Harper was sent to the Special Offender Center where psychiatrists diagnosed him with “a manic-depressive disorder.”<sup>28</sup> Initially, Harper consented to treatment, including the use of antipsychotic medications, but later refused medical treatment.<sup>29</sup> Pursuant to Special Offender Center Policy 600.30, the physicians who treated Harper attempted to administer medication over his objections.<sup>30</sup>

The Court found that Policy 600.30 comported with procedural and substantive due process.<sup>31</sup> Policy 600.30 provided the following protections to defendants in Harper’s situation:

First, if a psychiatrist determines that an inmate should be treated with antipsychotic drugs but the inmate does not consent, the inmate may be subjected to involuntary treatment with the drugs only if [the inmate] (1) suffers from a “mental disorder” and (2) is “gravely disabled” or poses a “likelihood of serious harm” to himself, others, or their property. Only a psychiatrist may order or approve the medication. Second an inmate who refuses to take the medication voluntarily is entitled to a hearing before a special committee consisting of a psychiatrist, a psychologist, and the Associate Superintendent of the Center, none of whom may be, at the time of the hearing, involved in the inmate’s treatment or diagnosis. If the committee determines by a majority vote that the inmate suffers from a mental disorder and is gravely disabled or dangerous, the inmate may be medicated against his will, provided the psychiatrist is in the majority. Third, the inmate has certain procedural rights before, during, and after the hearing. . . . Fourth, after the initial

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23. 494 U.S. 210 (1990).

24. *Id.* at 213.

25. *Id.*

26. *Id.* at 214.

27. *Id.*

28. *Harper*, 494 U.S. at 214.

29. *Id.*

30. *Id.*

31. *Id.* at 227.

hearing, involuntary medication can continue only with periodic review.<sup>32</sup>

By following this Policy, the state fulfilled its obligations to provide mentally ill inmates with treatment and protect those surrounding them in an institutional setting.<sup>33</sup> The test enunciated in *Harper* made it clear that an inmate can be involuntarily medicated “if the inmate is dangerous to himself or others and the treatment is in the inmate’s medical interest.”<sup>34</sup> While appreciating the importance of the liberty interest at stake, the Court opined that the prison environment, considered in concert with the dangerousness of the defendant, constituted a serious enough threat to approve the treatment of a patient with antipsychotic drugs without the defendant’s consent.<sup>35</sup>

The *Harper* Court held that the Policy satisfied the requirements of procedural due process, and reasoned that the adjudicatory process within the Policy did not require a judicial decision maker.<sup>36</sup> Instead, the Court imposed this balancing role upon a medical professional. At this “full judicial hearing,” where the patient has the right to counsel,<sup>37</sup> the decision maker conducts two inquiries: (1) “whether the inmate suffers from a ‘mental disorder;’” and (2) “whether, as a result of that disorder, he is dangerous to himself, others, or their property.”<sup>38</sup> While the Court “allowed” medical professionals to perform a judicial role,<sup>39</sup> it failed to consider the awkward position medical professionals would be subjected to when making adjudications regarding their own patients.

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32. *Id.* at 215-16. The rights granted the inmate included the right to notice of the Center’s intent to convene an involuntary medication hearing, the right to attend the hearing, present evidence and cross-examine witnesses, and the right to assistance from a lay adviser who has not been involved in the case and who understands the psychiatric issues involved. The court also granted the inmate the right to appeal and seek judicial review of a committee decision. *Id.* at 216. In addition, the time period specified for periodic review of involuntary medication was determined to be a term of fourteen days. *Id.* at 216 n.4.

33. *Id.* at 225-26.

34. *Harper*, 494 U.S. at 227.

35. *Id.* The Court stated that “[t]he extent of a prisoner’s right under the [Due Process] Clause to avoid the unwanted administration of antipsychotic drugs must be defined in the context of the inmate’s confinement.” *Id.* at 222.

36. *Id.* at 231. The Court opined that a patient may be “better served” by such an arrangement. *Id.* That point was especially so when the “patient is mentally disturbed, [and] his own intentions will be difficult to assess and will be changeable in any event.” *Id.* Also, the Court stated that the “risks associated with antipsychotic drugs are for the most part medical ones, best assessed by medical professionals.” *Id.* at 233.

37. *Id.* at 228.

38. *Id.* at 232.

39. *Id.* at 231. More accurately, the Court imposed this role upon medical professionals. The Court may have been motivated by the fact that such adjudications are inefficient with regards to judicial economy and scarce prison resources. *See id.* at 232.

In *Riggins v. Nevada*,<sup>40</sup> the Court firmly stated that, when a state medicates persons for the purpose of rendering them competent to stand trial, due process requires that the proposed treatment be “medically appropriate and, considering less intrusive alternatives, essential for the sake of [the defendant’s] own safety or the safety of others.”<sup>41</sup> Writing for the Court in *Riggins*, Justice O’Connor created a test favoring the rights of defendants to be free from unwanted antipsychotic medication during trial.<sup>42</sup> In a concurring opinion, Justice Kennedy stated that a test closely resembling strict scrutiny<sup>43</sup> makes it abundantly clear that states cannot involuntarily medicate individuals, except when faced with exceptional circumstances.<sup>44</sup> In a nearly unanimous reversal of the Nevada Supreme Court’s affirmation of the defendant’s conviction and death sentence,<sup>45</sup> the Court bolstered its protection of mentally ill defendants.

David Riggins was convicted of the November 20, 1987 murder and robbery of Paul Wade.<sup>46</sup> Soon after his arrest, Riggins complained that he was hearing voices and that he was experiencing difficulty sleeping.<sup>47</sup> The physicians who treated Riggins gradually increased his prescription of Mellaril, an antipsychotic drug, from 100 milligrams per day to 800 milligrams per day.<sup>48</sup> After a series of inconsistent psychiatric examinations, Riggins stood trial, and he petitioned the trial court to suspend the administration of antipsychotic medications until the end of the trial.<sup>49</sup>

After the district court held an evidentiary hearing which barely satisfied procedural due process requirements, Riggins’ motion was denied.<sup>50</sup> Although the District Court heard evidence with respect to Riggins’ competency and the effects

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40. 504 U.S. 127 (1992).

41. *Id.* at 135.

42. *Id.* at 135-36.

43. While the majority refutes the dissent’s argument that this test is in fact strict scrutiny, it is hard to believe that it is not. *See id.* at 136.

44. *Id.* at 145. Justice Kennedy stated that “[i]f the State cannot render the defendant competent without involuntary medication, then it must resort to civil commitment, if appropriate, unless the defendant becomes competent through other means. If the defendant cannot be tried without his behavior and demeanor being affected in this substantial way by involuntary treatment . . . the Constitution requires that society bear this cost in order to preserve the integrity of the trial process.” *Id.* (Kennedy, J., concurring).

45. *See id.* at 128. Justices Thomas and Scalia dissented. *Id.* at 146.

46. *Riggins*, 504 U.S. at 129.

47. *Id.*

48. *Id.*

49. *Id.* at 130.

50. *See id.* at 130-31. The effect of suspending the administration of the medication was the subject of speculation by the psychiatrists who evaluated Riggins for the purposes of determining his competence to stand trial. *Id.* Additionally, the District Court’s denial of Riggins’ motion was composed of a one-page order that provided no indication of how the Court reached its conclusion. *Id.* at 131.



of the medication from four physicians, the court made no mention of any relevant findings of fact when it denied Riggins' motion to terminate medication.<sup>51</sup> As indicated by Justice O'Connor, at least two of those physicians relied on guesswork when evaluating Riggins' case.<sup>52</sup> In addition, the physicians each came to different, and equally uncertain, conclusions.<sup>53</sup> Despite the inconsistencies, the District Court ordered Riggins to be medicated until the end of the trial.<sup>54</sup>

The Supreme Court decided *Riggins* by applying the *Harper* test.<sup>55</sup> The Court restated the *Harper* test simply: the state cannot force antipsychotic drugs on a convicted prisoner absent (1) "a finding of overriding justification;" and (2) "a determination of medical appropriateness."<sup>56</sup> The Court reasoned that "once Riggins moved to terminate administration of antipsychotic medication, the State became obligated to establish the need for Mellaril and the medical appropriateness of the drug."<sup>57</sup> In *Riggins*, the Court unfortunately did little to further define the meaning of "medical appropriateness." The Court instead presumed the medical appropriateness of the treatment despite the fact that Riggins "received a very high dose" of Mellaril.<sup>58</sup> The definition of medical appropriateness still requires further development by the Court.

The Court also held that both the Sixth and Fourteenth Amendments prohibited the involuntary administration of antipsychotic medication without applying the proper procedural test and substantive inquiry.<sup>59</sup> What is unfortunate, however, is that the Court made its determination without separating these individual analyses.<sup>60</sup> The Court first stated that "the Fourteenth Amendment affords at least as much protection to persons the State detains for trial" as it affords convicts.<sup>61</sup> As for the remainder of the jumbled analysis, the Court reasoned that "[e]fforts to prove or disprove actual prejudice . . . would be futile, and guesses whether the outcome of the trial might have been different if Riggins' motion had been granted would be purely speculative."<sup>62</sup> The Court acknowledged, however, the strong possibility that "Riggins' defense was impaired

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51. *Riggins*, 504 U.S. at 131.

52. *Id.*

53. *See id.*

54. *Id.*

55. *Id.* at 133-35. The Court specifically distinguished *Riggins* from *Harper*, however, on the grounds that *Harper* applied specifically to inmates, as opposed to criminal defendants at the time of trial. *Id.* at 134-35.

56. *Riggins*, 504 U.S. at 135.

57. *Id.*

58. *Id.* at 133.

59. *See id.* at 137-38.

60. *See id.*

61. *Riggins*, 504 U.S. at 135.

62. *Id.* at 137.

due to the administration of Mellaril.”<sup>63</sup> Further, the Court stated that expert testimony to that effect would have little impact, if any, on the prejudice caused by the forced administration of Mellaril.<sup>64</sup> Despite the clarity of the test stated in *Riggins*, the Court provided little guidance for future courts dealing with the minutiae of similarly situated defendants.

In 1995, a squeamish Fifth Circuit denied judicial review to a death row inmate suffering from paranoid schizophrenia on the issue of whether he could be involuntarily medicated to preserve his competence for execution.<sup>65</sup> The court faltered when given the opportunity to review the merits of the petitioner’s last-minute claim that his rights were being violated by the involuntary administration of Haldol by the state. Instead of concerning itself with the issue at hand, the court deferred to procedural rules that, in effect, disallowed petitioner’s claim.<sup>66</sup> Though the facts of the case and the grounds under which the claims were brought are admittedly suspect,<sup>67</sup> the court ultimately wavered in the face of this opportunity to consider the involuntary medication of a prisoner for execution. This is amplified by the fact that the court largely ignored the testimony of a medical professional.<sup>68</sup>

The Court of Appeals for the District of Columbia attempted to elaborate on the “medical appropriateness” prong of the *Harper* test in *U.S. v. Weston*.<sup>69</sup> In 1998, Weston stormed the U.S. Capitol armed with a .38 caliber firearm.<sup>70</sup> Weston shot and killed two U.S. Capitol Police officers and seriously wounded a third.<sup>71</sup> After the District Court found Weston incompetent to stand trial, he spent time at the Federal Corrections Institute in Butner, North Carolina, during which time he was placed in solitary confinement in lieu of receiving treatment for mental illness.<sup>72</sup> Because Weston refused the medical treatment offered to him by the physicians at the federal facility, administrators placed him in solitary confinement

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63. *Id.*

64. *Id.* at 137-38.

65. *See Fearance v. Scott*, 56 F.3d 633, 642 (5th Cir. 1995).

66. *Id.* at 642. The Fifth Circuit commented:

Albeit an interesting and important issue, Fearance has no vehicle to present it for our determination at this last moment . . . . [T]here is no question that a claim for forcible medication could have arisen from these treatments before his first state hearing, and certainly prior to his second state petition in 1992.

*Id.* at 642, 643.

67. *See id.* at 635. Fearance brought this group of claims as a last-minute attempt to have his execution stayed. *Id.*

68. *See id.* at 641. “This court specifically held that a doctor’s ‘conclusion’ that the petitioner ‘suffers from paranoid schizophrenia falls woefully short of a finding that petitioner is so deranged that he is unaware that he is about to be put to death as a result of his earlier conviction and sentence for murder.’” *Id.*

69. 255 F.3d 873 (D.C. Cir. 2001).

70. *Id.* at 874.

71. *Id.* Weston was also seriously wounded by gunfire during the attempt to arrest him. *Id.*

72. *Id.* at 874-75.

to “mitigate his dangerousness.”<sup>73</sup> In accordance with the established requirements of due process, the government obtained an order to administer anti-psychotic medication against Weston’s will.<sup>74</sup> The Court of Appeals affirmed the trial court’s ruling that it was appropriate to forcibly medicate Weston.<sup>75</sup>

Under the precedent set forth in *Riggins* and *Harper*, the Court of Appeals was forced to determine whether the proposed medication was “medically appropriate.”<sup>76</sup> The test for “medical appropriateness” enunciated by the District Court in *Weston* required the decision maker to balance the potential benefits of the treatment against the potential detriments of treatment.<sup>77</sup> The Court of Appeals ultimately concluded that the determination of “medical appropriateness” relies heavily on “the judgment of medical professionals.”<sup>78</sup> While this definition of “medical appropriateness” is of limited value as precedent, it is valuable nonetheless because it attempts to address a concept that has been left largely undeveloped by the courts.

The Eighth Circuit incorporated the *Weston* definition of “medical appropriateness” in *U.S. v. Sell*.<sup>79</sup> Charles Sell was charged with health care fraud, attempted murder, conspiracy, and solicitation to commit violence.<sup>80</sup> Most of that conduct related to the false claims for services Sell submitted to Medicaid in the course of his dental practice.<sup>81</sup> Sell was initially found to be competent, but a rapid deterioration in his mental state became evident during his various bond proceedings and throughout the pretrial process.<sup>82</sup> On a motion by the defense counsel, Sell was evaluated and diagnosed with delusional disorder, persecutory type, by both the defendant’s and prosecution’s psychologists.<sup>83</sup> In light of those evaluations, the district court found that Sell was incompetent to stand trial.<sup>84</sup> A magistrate judge then permitted Sell’s forcible medication for the purposes of treatment and restoring his competence to stand trial.<sup>85</sup> That order was later upheld

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73. *Id.* at 875.

74. *Weston*, 255 F.3d at 875.

75. *Id.* at 876.

76. *Id.*

77. *Id.* at 876-78. The court employed more technical jargon, stating that the physician must weigh “the capacity of antipsychotic drugs to alleviate [defendant’s condition] (the medical benefits) against their capacity to produce harm (the medical costs, or side effects).” *Id.* at 876-77.

78. *Id.* at 876.

79. 282 F.3d 560, 567 (8th Cir. 2002).

80. *Id.* at 562.

81. *Id.*

82. *Id.* at 562-63.

83. *Id.* at 563. The persecutory subtype of delusional disorder is characterized by a person’s belief that he is being conspired against, cheated, spied on, followed, and generally obstructed in the pursuit of long term goals. *Id.* at 563 n.3 (citing the *Diagnostic and Statistical Manual of Mental Disorders IV*).

84. *Sell*, 282 F.3d at 563.

85. *Id.* at 564-65.

by the district court.<sup>86</sup> Sell appealed the holding, asking the Eighth Circuit to determine whether he could be forcibly medicated “for the sole purpose of restoring his competence to stand trial.”<sup>87</sup>

The Eighth Circuit Court of Appeals affirmed the decision of the district court, stating that “Sell may be involuntarily medicated for the purpose of rendering him competent to stand trial.”<sup>88</sup> The court entered its judgment with the following caveat:

[T]his is a limited holding. We do not believe this standard will be met in all circumstances in which the government wishes to restore competence. Furthermore, we note that an entirely different case is presented when the government wishes to medicate a prisoner in order to render him competent for execution.<sup>89</sup>

Using the precedent previously discussed, the Eighth Circuit considered Sixth and Fourteenth Amendment challenges to involuntary medication.<sup>90</sup>

The Eighth Circuit modeled its decision after the aforementioned legal precedent, especially *Harper* and *Riggins*. First, the Eighth Circuit concurred with the district court when it found that there was insufficient evidence to prove that Sell posed a danger to himself or others.<sup>91</sup> Second, the Eighth Circuit considered whether Sell could be forcibly medicated solely to render him competent to stand trial.<sup>92</sup> For the purposes of that determination, the Eighth Circuit relied on the tests developed in *Harper* and *Riggins*.<sup>93</sup> Relying on those cases, the Eighth Circuit held that it was permissible to medicate for the sole purpose of rendering Sell competent to stand trial.<sup>94</sup> Next, at Sell’s urging, the Eighth Circuit considered whether strict scrutiny was the appropriate standard of review.<sup>95</sup> Refusing to adopt strict scrutiny, the Eighth Circuit found that the charges against Sell were serious enough for the state to justify bringing him to trial.<sup>96</sup> Additionally, the Eighth

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86. *Id.* at 565. The order to forcibly medicate was upheld, though the magistrate’s reasoning was considered faulty by the District Court. The District Court found that there was insufficient evidence to support a finding that Sell posed a danger to himself or others and that the state’s interest in restoring Sell’s competence for trial was sufficient to warrant the holding. *Id.*

87. *Id.*

88. *Id.* at 572.

89. *Sell*, 282 F.3d at 571.

90. *See id.* at 565-73.

91. *Id.* at 565.

92. *Id.*

93. *Id.* at 565-66.

94. *Sell*, 282 F.3d at 566.

95. *Id.* at 567.

96. *Id.* at 568. The Eighth Circuit reasoned that “[d]espite Sell’s significant liberty interest in refusing antipsychotic medication, in view of the seriousness of the charges, we believe that the government’s interest in restoring his competence so that he may be brought to trial is paramount.” *Id.*

Circuit found that “there were no less intrusive means.”<sup>97</sup> Lastly, the Eighth Circuit did not believe that the district court “committed clear error in finding that the government proved medical appropriateness by clear and convincing evidence.”<sup>98</sup> The Eighth Circuit also determined that Sell’s Sixth Amendment rights had been sufficiently provided for in this instance. Overall, *Sell* was a well-reasoned, well-written demonstration of the applicable precedent.

The Supreme Court has created a barrage of common law standards and tests for competence that are dedicated to the protection of mentally ill defendants. The Court also balances this protection with the interests of the state in prosecuting and punishing criminal offenders. Some courts have tested the strength of those protections to find that the Supreme Court’s protection is not absolute. If *certiorari* had been granted, *Singleton* would have tested the Court in this regard.

### B. *Singleton v. Norris*

A study of *Singleton v. Norris*<sup>99</sup> illustrates the fragility of the Court’s protection of mentally ill defendants. Though the Eighth Circuit anticipated this case in *Sell*,<sup>100</sup> the current body of jurisprudence has not answered the question of whether a state violates the Eighth Amendment when it involuntarily medicates a person in order to render him competent for execution. Interpreting the current law, the Eighth Circuit has decided to limit the protections afforded by the U.S. Supreme Court. The Court has not delivered an opinion to the contrary.<sup>101</sup>

In *Singleton*, the Eighth Circuit held that a person’s Eighth Amendment rights, as enunciated in *Ford*, are not violated when the State executes a prisoner “who became incompetent during his long stay on death row but who subsequently regained competency through appropriate medical care.”<sup>102</sup> As a result, the Eighth Circuit, *en banc*, denied Singleton’s petition for writ of habeas corpus and vacated Singleton’s stay of execution.<sup>103</sup> The court’s reasoning followed the tests enunciated in *Ford*, *Harper*, and *Riggins*.<sup>104</sup> The *Singleton* court was persuaded by the state’s argument that it had an “essential,” overriding interest in “carrying out a

97. *Id.* at 568.

98. *Id.* at 570. However, the Eighth Circuit did “acknowledge that there [was] a difference of opinion on the efficacy of using antipsychotic drugs to treat delusional disorder.” *Id.* In making this determination, the Eighth Circuit reviewed volumes of medical testimony and research. *See id.* at 569-71.

99. 319 F.3d 1018 (8th Cir. 2003).

100. *U.S. v. Sell*, 282 F.3d 560, 571 (8th Cir. 2002).

101. The Court denied *certiorari* and, as such, has not addressed this issue to any degree of satisfaction. 124 S.Ct. 74 (2003) (Oct. 6, 2003).

102. *Singleton v. Norris*, 319 F.3d 1018, 1027 (8th Cir. 2003).

103. *Id.*

104. *Id.* at 1023-24.

lawfully imposed sentence.”<sup>105</sup> Moreover, the court found the state’s argument especially compelling in a death penalty case.<sup>106</sup> The court found that Singleton’s interest in remaining free from medication was the inferior interest in this case because (1) Singleton had preferred taking the medicine on prior occasions, and (2) Singleton did not experience any side effects from taking the medications.<sup>107</sup>

Charles Laverne Singleton was sentenced to death for the June 1, 1979 murder of Mary Lou York.<sup>108</sup> Singleton entered a grocery store, grabbed York by her neck and proceeded to stab her.<sup>109</sup> A witness, Patti Franklin, then heard York scream that she was being killed by Singleton.<sup>110</sup> After Franklin ran off for help, Lenora Howard witnessed Singleton exiting the store and observed a bloody and crying York<sup>111</sup> emerge from the store.<sup>112</sup> Soon thereafter, Police Officer Strother arrived to find York in the rear of the store lying in a pool of her blood.<sup>113</sup> York was accompanied by her physician, Dr. J.D. Rankin, in the ambulance as she was transported to the hospital.<sup>114</sup> York relayed a description of the events to Dr. Rankin before she died.<sup>115</sup>

The Court of Appeals reacted viscerally in *Singleton* stating that “[s]ociety’s interest in punishing offenders is at its greatest in the narrow class of capital murder cases in which aggravating factors justify imposition of the death penalty.”<sup>116</sup> In furtherance of its decision, the Eighth Circuit found that treating Singleton with antipsychotic drugs satisfied the test of medical appropriateness. Specifically, the court was unable to find a less obtrusive means of accomplishing the State’s goals;<sup>117</sup> “the medication [was] effective and . . . the expected side effects [did] not overwhelm the benefits of the medicine.”<sup>118</sup> The court also reasoned that in light of the determination that “the best medical interests of the prisoner must be determined without regard to whether there is a pending date of

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105. *Id.* at 1025.

106. *Id.*

107. *Id.*

108. *Singleton*, 319 F.3d at 1020. Singleton also received a life sentence for the robbery he perpetrated in the same exchange. *Id.*

109. *Singleton v. State*, 623 S.W.2d 180, 181 (1981). York recounted the details of the attack to her physician shortly before her death. *Id.*

110. *Id.*

111. *Id.*

112. *Id.* The money bag contained about \$2.00 in change and the register in the store had a “small amount of change in it.” *Id.*

113. *Id.* York also told Officer Strother what had transpired. *Id.*

114. *Id.*

115. *Singleton*, 623 S.W.2d at 181. York died before she reached the emergency room. *Id.*

116. *Singleton*, 319 F.3d at 1025.

117. *Id.*

118. *Id.* at 1026.

execution,” the treatment was in the best medical interests of Singleton.<sup>119</sup> On those grounds, the Eighth Circuit held that “the mandatory medication regime, valid under the pendency of a stay of execution, does not become unconstitutional under *Harper* when an execution date is set.”<sup>120</sup>

As a result of the Eighth Circuit’s decision, the ethics of medical professionals are placed in conflict. In essence, a medical professional may treat an incompetent prisoner with psychotropic drugs, rendering the prisoner competent to be executed. On the other hand, the medical professional may deny treatment desperately needed to control the imbalanced mind of a prisoner in order to preserve the afflicted life of the prisoner. Neither option fits neatly into the ethics that medical professionals take an oath to uphold. That conflict should have been resolved by the Supreme Court on *certiorari*, however it was not.

### III. HEALTH CARE PROFESSIONALS AND DUAL LOYALTY

Health care professionals play an increasingly large role in the criminal justice system. Though the roles of health care professionals are in flux, their respective codes of ethics remain reasonably static. As such, conflicts between professional ethics and professional practice are likely to occur more often now than ever. To understand the prevailing trends in medical ethics, it is necessary to explore not only contemporary codes of ethics, but ancient codes as well. Because of the ties that exist between current and historic codes of ethics, some current principles are under attack because of tradition. As will be demonstrated, that is the case with the Oath of Hippocrates and its successors. Due to the specific involvement of psychiatrists in the criminal justice system, the press releases of the American Psychiatric Association are studied as well as the Code of Medical Ethics published by the American Medical Association. In this specific instance, physicians face a particularly difficult conflict: dual loyalty. Dual loyalty negatively affects the ability of physicians to perform their duty without controversy.

#### *A. The Roles of Health Care Professionals in the Criminal Justice System*

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119. *Id.* The Eighth Circuit had some difficulty reconciling the ultimate effect of the “medical appropriateness” consideration in this instance. *See id.* at 1025-26.

120. *Id.* at 1026.

The criminal justice system has increased its awareness of mental health issues in the last half century.<sup>121</sup> This increased awareness by the judiciary and the legislature of the necessary role that health care professionals play is an advanced version of mid-1800s thinking, when insanity was considered a disease.<sup>122</sup> By the late 19<sup>th</sup> century, some already considered the insanity defense overused.<sup>123</sup> Only recently has the Court prohibited the execution of the insane.<sup>124</sup> What these social developments have in common is that they each implicate the need for health care professionals to perform increasingly important roles in criminal proceedings. *Singleton* now provides another opportunity to increase the role of physicians by providing more circumstances in which psychological evaluations are allowed, as well as increasing the offenders' opportunities for treatment.

The most important step for mentally incompetent defendants in the criminal justice system is the initial assessment as to whether that defendant is in fact incompetent.<sup>125</sup> In furtherance of that end, *Dusky* delegated a great role to health care professionals that has since been codified.<sup>126</sup> The health care professional may examine the defendant for a reasonable period not to exceed thirty days in the health care facility nearest to the court.<sup>127</sup> As discussed in Part II of this comment, court ordered examinations call for considerable analysis. The decisions of the health care professional may trigger an indeterminate period of commitment or continued participation in a criminal trial that might not be in the defendant's best interest.

The determination regarding competence to stand trial is unlike most determinations made in criminal jurisprudence. A defendant is found incompetent if "by a preponderance of the evidence . . . the defendant is presently suffering from mental disease or defect rendering him mentally incompetent . . ." <sup>128</sup> This is likely the result of the legislature's sensitivity to the needs of the mentally incompetent. If the court finds that the defendant is competent, the prosecution continues.<sup>129</sup> Defendants who are found to lack competence to stand trial are free,

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121. *See supra* Part II.

122. *See* STUART BANNER, *THE DEATH PENALTY* 119 (2002).

123. *Id.* at 214.

124. *Id.* at 285.

125. It is at this point in the criminal proceedings that criminal culpability is either pursued by the prosecutor or abandoned in light of the physician's determination. In the latter case, the species of proceedings varies greatly from those taking place as a result of the former because the interest of the state is no longer predominantly punishment of the defendant, but rather emphasizes others' safety from the defendant as well as the defendant's own safety.

126. 18 U.S.C. § 4247 (2000).

127. *Id.*

128. 18 U.S.C. § 4241 (2000).

129. *Id.*



at least temporarily, from penal incarceration; however, their progress is monitored during a period of court-ordered institutional commitment.<sup>130</sup>

Defendants lacking competence keep the close attention of the jurisdiction that has an interest in prosecuting them. The state commits such persons to the custody of the Attorney General who, in turn, hospitalizes them.<sup>131</sup> This hospitalization term may last for a reasonable amount of time not to exceed four months, during which further inquiries are made into the defendant's mental health.<sup>132</sup> Instead of determining whether illness and disease exist, the health professional must determine prospectively whether the condition will persist interminably.<sup>133</sup> In that instance, health care professionals are forced to make quasi-judicial determinations that are outside the scope of their traditional duties.

In light of recent decisions, health care professionals must determine whether medication would restore the defendant's competence. They must also engage in the prescription and administration processes of treatment methods. It is unclear what standards prevail when the health care professional balances the likely success of the medication and the ensuing trial. These factors are weighed against the pursuit of other means of patient treatment that would not result in probable incarceration.

### *B. Ancient Sources of Medical Ethics*

Two historic sources are responsible for the content of most current medical codes of ethics. Those materials may be riddled with archaic expressions, however, they are still of great use to medical organizations as a quasi-legislative history for their current codes. The Oath of Hippocrates<sup>134</sup> and The Prayer of Maimonides<sup>135</sup> provide valuable information as to what activities modern codes of ethics mean to restrict, despite the fact that those activities and the social issues surrounding them had not yet taken shape.

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130. *Id.*

131. *Id.*

132. *Id.* According to the statute, this period of examination may continue for additional reasonable periods until,

(A) [the defendant's] mental condition is so improved that trial may proceed, if the court finds that there is a substantial probability that within such additional period of time he will attain the competence to permit the trial to proceed; or (B) the pending charges against him are disposed of according to law; whichever is earlier. *Id.*

133. *Id.*

134. HIPPOCRATIC OATH – CLASSICAL VERSION (*Translation from Greek by Ludwig Edelstein*, LUDWIG EDELSTEIN, *THE HIPPOCRATIC OATH: TEXT, TRANSLATION, AND INTERPRETATION* (1943)), available at [http://www.pbs.org/wgbh/nova/doctors/oath\\_classical.html](http://www.pbs.org/wgbh/nova/doctors/oath_classical.html) (last updated Mar. 2001).

135. PRAYER OF MOSES MAIMONIDES, available at <http://www.phrusa.org/research/methics/methicsoath.html#1> (last visited Jan. 31, 2004).

The Oath of Hippocrates states:

I SWEAR ... to ... follow that system of regimen which, according to my ability and judgement [sic], I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous. I will give no deadly medicine to any one if asked, nor suggest any such counsel; and in like manner I will not give to a woman a pessary to produce abortion. With purity and with holiness I will pass my life and practice my Art .... Into whatever houses I enter, I will go into them for the benefit of the sick, and will abstain from every voluntary act of mischief and corruption; and, further, from the seduction of females or males, of freemen and slaves. Whatever, in connection with my professional service, or not in connection with it, I see or hear, in the life of men, which ought not to be spoken of abroad, I will not divulge, as reckoning that all such should be kept secret. While I continue to keep this Oath unviolated, may it be granted to me to enjoy life and the practice of the art, respected by all men, in all times.<sup>136</sup>

At medical school graduation ceremonies, students take the Hippocratic Oath before beginning careers as medical professionals.<sup>137</sup> Among the plethora of promises included in the Oath, students pledge to practice the art of medicine within the boundaries of the practitioner's ability and experience, to practice medicine without corruption of any kind, and to keep the confidentiality of persons treated.<sup>138</sup> Within the laundry list of professional responsibilities, several appear ancient and outdated in contrast with others. For example, students must consider their instructors as parents, the children of those instructors as brethren, and share with this extended family the practitioner's income as necessary.<sup>139</sup> Obviously, some of the oath is outdated.<sup>140</sup> Although changing social norms render some features of a historic text obsolete, it does not nullify the underlying principles that guide the profession.

The Hippocratic Oath is reliable as an ethics measuring stick despite its unofficial legal status. Calling the Oath an "embarrassment"<sup>141</sup> is a hypercritical oversight and a failure to recognize that many of the standards by which people live and act are not codified. The Ten Commandments clearly rebut such arguments that the principle of "Do No Harm" is weightless because of its non-

136. HIPPOCRATIC OATH, *supra* note 134.

137. NOVA ONLINE, THE HIPPOCRATIC OATH TODAY: MEANINGLESS RELIC OR INVALUABLE MORAL GUIDE?, at [http://www.pbs.org/wgbh/nova/doctors/oath\\_today.html](http://www.pbs.org/wgbh/nova/doctors/oath_today.html) (last updated Mar. 2001).

138. See HIPPOCRATIC OATH, *supra* note 134.

139. *Id.*

140. See MICHAEL DAVIS, JUSTICE IN THE SHADOW OF DEATH 73-74 (1996).

141. *Id.*

legal status.<sup>142</sup> The Commandments are not a legally cognizable body of law.<sup>143</sup> It could not be argued that honoring one's parents is a legal requisite,<sup>144</sup> particularly in cases of abuse and abandonment where obedience would not serve the best interest of the child. However, on the whole, people still act with a certain respect for their parents. What about adultery? Some states, such as Maine, treat adultery only as a recognized reason for divorce.<sup>145</sup> Other states criminalize adultery as a misdemeanor punishable by a \$10 dollar fine.<sup>146</sup> While the penalty is not sizeable, there must be some form of consensus that holds that adultery is not ethical. Moreover, the fact that the Ten Commandments include an outdated provision regarding the crafting of graven images of the Lord,<sup>147</sup> the underlying principles of the Ten Commandments are not nullified.

Michael Davis further argues that the principle of "Do No Harm" is weightless due to current, conventional medical practice.<sup>148</sup> He claims that physicians violate the Hippocratic Oath every day by performing tests on animals, healing soldiers, prescribing dangerous drugs, and performing clinical trials on patients.<sup>149</sup> He concludes that this principle cannot limit physicians from participating in executions because physicians can perpetrate harm without violating the Oath.<sup>150</sup> This logic is faulty. His arguments are based wholly upon instances cast in an overly cynical light that forces physicians to engage in backtalk. Taking Davis' example of amputation, physicians must remove a limb from a patient to prevent the spread of disease throughout the entire body.<sup>151</sup> Choosing between a reduced, though significant harm (loss of a limb), and the gravest of harms (loss of life) physicians must logically choose a course of action that will harm a patient if only to achieve a greater good.<sup>152</sup> In the case of a physician treating a mentally ill patient who is sentenced to death, the physician's decision to treat the patient with medication provides minimal benefit to the patient in comparison with the result of that treatment – the patient's execution. In effect,

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142. The complete text of the Ten Commandments can be found in the Bible at *Exodus* 20:1-17 (New Revised Standard Version).

143. Some of the Commandments have been codified in every state, e.g., "You Shall Not Murder." See e.g., MD. CODE ANN. CRIM. LAW § 2-201 (2002); MASS. GEN. LAWS ch. 265, § 1 (2003).

144. Though, on some occasions such respect may be ordered in juvenile court as a means of adjudicating a sentence.

145. ME. REV. STAT. ANN. tit. 19-A, § 902 (West 2002).

146. E.g., MD. CODE ANN. CRIM. LAW § 10-501 (2002) (prescribing the criminal penalty for adultery).

147. *Exodus* 20:4.

148. DAVIS, *supra* note 140, at 74-75.

149. DAVIS, *supra* note 140, at 74-75.

150. DAVIS, *supra* note 140, at 75.

151. DAVIS, *supra* note 140, at 74.

152. DAVIS, *supra* note 140, at 75. Although Davis notes that physicians don't always choose courses of action that operate to achieve a greater good (e.g. plastic surgery, sex change operations, etc.). *Id.*

the current dilemma proposes a scenario that directly contradicts Davis' example. Thus, participating in an execution has no such foreseeable good.

The Prayer of Maimonides provides another strong influence on modern ethics.<sup>153</sup> This 12<sup>th</sup> century statement of professional ethics, second only to the Oath of Hippocrates in its influence on modern ethics, owes its origin to Islam.<sup>154</sup> As one might expect, every passage in the Prayer praises God in some way.<sup>155</sup> Of particular interest, the Prayer of Maimonides thanks "Almighty God" for "endow[ing] man with the wisdom to relieve the sufferings of his brother, [and] to recognize his disorders."<sup>156</sup> According to the precepts contained therein, it is the duty of the physician to "watch over the life and health of . . . creatures . . . rich and poor, good and bad, enemy as well as friend."<sup>157</sup> An arguable interpretation of this medley is that those who subscribe to this Prayer are bound ethically to protect mentally ill prisoners from execution.

### C. Current Trends in Medical Ethics

The American Medical Association (AMA) publishes a Code of Medical Ethics and Current Opinions of the Council on Ethical and Judicial Affairs that outlines the basic principles of ethics that effect health care professionals.<sup>158</sup> The authors of the Code explicitly state that the Oath of Hippocrates exists as a "living statement of ideals to be cherished by the physician."<sup>159</sup> Despite the early origin of the Oath, probably in the 5<sup>th</sup> century B.C., it has remained as "an expression of ideal conduct for the physician."<sup>160</sup> The Opinions contained in the AMA Code provide illumination on the official perspectives on current social policy and act as necessary commentary on the code as affected by that sentiment.

Opinion 2.06 on Capital Punishment<sup>161</sup> demonstrates the AMA's scathing response to the death penalty. In the Opinion, the AMA recognizes the internal conflict that may exist for health care professionals.<sup>162</sup> The AMA explicitly denounces participation by a health care professional in state sanctioned

153. PRAYER OF MAIMONIDES, *supra* note 135.

154. PRAYER OF MAIMONIDES, *supra* note 135.

155. PRAYER OF MAIMONIDES, *supra* note 135.

156. PRAYER OF MAIMONIDES, *supra* note 135.

157. PRAYER OF MAIMONIDES, *supra* note 135.

158. AMA, COUNCIL ON ETHICAL & JUDICIAL AFFAIRS, CODE OF MEDICAL ETHICS (2002-2003 ed.).

159. *Id.* at x.

160. *Id.*

161. *Id.* at 17.

162. *See id.* at 18.

executions.<sup>163</sup> While activities are categorized for the purpose of this classification, the categorization defines activities too generally.<sup>164</sup> Because the term “participate” is open to broad interpretation, the AMA describes some activities that the definition may encompass in explicit detail.<sup>165</sup> The Opinion emphatically states that “[w]hen a condemned prisoner has been declared incompetent to be executed, physicians should not treat the prisoner for the purpose of restoring competence unless a commutation order is issued before treatment begins.”<sup>166</sup>

The AMA continues to reinforce its organizational disapproval of the death penalty and, specifically, the participation of health care professionals in state sanctioned executions. In Resolution 5, the AMA supports a death penalty moratorium.<sup>167</sup> Resolution 6 extends the AMA crusade by formally opposing laws and administrative rules that might require physician participation in executions and that might attempt to protect the identity of physicians who participate in executions.<sup>168</sup> Physician participation includes direct conduct, such as administering drug cocktails in lethal injections or examining pulmonary activity after an electrocution, and indirect conduct, such as evaluation of competency, that leads to the death of a prisoner.<sup>169</sup> These resolutions and the above Opinion clearly demonstrate that the AMA strictly condemns physician participation in legal executions.

The American Psychiatric Association (APA) issued a position statement similarly endorsing a moratorium on the death penalty.<sup>170</sup> In the statement, the APA commented on evidence witnessed specifically by the APA and evidence

163. AMA, COUNCIL ON ETHICAL & JUDICIAL AFFAIRS, CODE OF MEDICAL ETHICS 17 (2002-2003 ed.).

164. *Id.* The categories specified in the Opinion are: “(1) an action which would directly cause the death of the condemned; (2) an action which would assist, supervise, or contribute to the ability of another individual to directly cause the death of the condemned; (3) an action which could automatically cause an execution to be carried out on a condemned prisoner.” *Id.*

165. *Id.* The AMA expressly includes the following as activities included in their definition of “participate:”

[P]rescribing or administering tranquilizers and other psychotropic agents and medications that are part of the execution procedure; monitoring vital signs on site or remotely (including monitoring electrocardiograms); attending or observing an execution as a physician; ... rendering of technical advice regarding execution[;] ... selecting injection sites; starting intravenous lines as a port for a lethal injection device; prescribing, preparing, administering, or supervising injection drugs or their doses or types; inspecting, testing, or maintaining lethal injection devices; and consulting with or supervising lethal injection personnel.

*Id.*

166. *Id.* at 18.

167. AMA House of Delegates, Resolution 5 (received Apr. 14, 2003).

168. AMA Resolution 6 (H-140.963 reaffirmed 2001).

169. See AMA, COUNCIL ON ETHICAL & JUDICIAL AFFAIRS, *supra* note 163, at 17.

170. APA, DOC. NO. 200006, MORATORIUM ON CAPITAL PUNISHMENT IN THE UNITED STATES: POSITION STATEMENT (Oct. 2000) [hereinafter APA POSITION STATEMENT 2000].

noted by the American Bar Association.<sup>171</sup> According to the statement, the APA was concerned chiefly with the treatment of the “mentally ill and developmentally disabled” by the criminal justice system in current capital sentencing processes.<sup>172</sup> Because APA membership consists largely (if not entirely) of physicians, in a postscript the APA did not denounce the death penalty as an institution.<sup>173</sup> The APA position that the death penalty “is administered in an unfair and arbitrary manner” is more politically correct than the sentiment expressed twenty years earlier.<sup>174</sup> In its earlier statement, the APA likened physicians who participate in executions to the physicians who committed violent atrocities in Nazi Germany.<sup>175</sup> Though the APA apparently has refocused its energy on the procedural applications of capital punishment, its message has not faded – physicians are ethically forbidden from participating in state sanctioned executions.

#### *D. The Problem of Dual Loyalty*

The problem of dual loyalty affects medical professionals who treat incarcerated criminals.<sup>176</sup> As apparent in the codes of ethics already discussed, a physician’s first responsibility is to the health of the patient.<sup>177</sup> Practical applications tend to complicate matters, though. Dual loyalty is defined as “clinical role conflict between professional duties to a patient and obligation, express or implied, real or perceived, to the interests of a third party such as an employer, an insurer or the state.”<sup>178</sup> In the case of an execution, the physician is forced to answer to the interests of the state, which may potentially be the

171. *Id.* (“Whereas the American Bar Association has concluded that the death penalty is administered in an unfair and arbitrary manner and has recommended a moratorium on executions until proper reforms are implemented . . .”).

172. *See id.*

173. *Id.*

174. *Compare id. with* APA, DOC. NO. 800002, MEDICAL PARTICIPATION IN CAPITAL PUNISHMENT: POSITION STATEMENT (June 1980) [hereinafter APA POSITION STATEMENT 1980].

175. APA POSITION STATEMENT 1980, *supra* note 174.

176. *See* ROCHELLE GRAFF SALGUERO, MEDICAL ETHICS AND COMPETENCY TO BE EXECUTED, 96 YALE L.J. 167, 176 (1986). Salguero refers to this conflict as “dual allegiances,” describing the resulting “concern that that the medical well-being of a patient is subordinate to duties to the employer.”

176. *Id.* In her article, Salguero discusses the involvement of medical practitioners in the criminal justice system in the wake of the *Ford* decision.

177. *See supra* text accompanying notes 155-69.

178. PHYSICIANS FOR HUMAN RIGHTS, UNIV. OF CAPE TOWN, DUAL LOYALTY AND HUMAN RIGHTS (2002)[hereinafter, DUAL LOYALTY], available at [http://www.phrusa.org/healthrights/dual\\_loyalty.html](http://www.phrusa.org/healthrights/dual_loyalty.html) (last visited Jan. 31, 2004).

physician's employer.<sup>179</sup> In cases of mere incarceration, the state's elevation of its interests over those of physician employees may serve important social purposes and may be considered justifiable.<sup>180</sup> However, what is the outcome when the patient is mentally ill? More importantly, to whom is the physician more responsible in such a case?

Dual loyalty includes the duties of the health care professional to various parties in addition to the patient. Generally, the health care professional may be responsible to the community, family members, employers, insurance companies and governments.<sup>181</sup> In some cases, responsibilities to these third parties conflict with the responsibilities of the health professional to the patient.<sup>182</sup> Departures from the loyalty owed to the principle beneficiary of treatment may include evaluating the patient, breaching the confidentiality owed to a patient to protect others from violence or communicative diseases, and involuntarily medicating patients.<sup>183</sup> Overall, such departures require a finding that the conflicting interest is (1) justifiable, and (2) consistent with human rights.<sup>184</sup> The Eighth Circuit apparently reasoned that its "medicate-to-execute" scheme is such an acceptable departure.

Conflicts in loyalty may arise for several reasons. Routine pressures include "legal requirements, threats of professional or personal harm for non-compliance, the culture of the institution or society where the professional practices, or even the professional's own sense of duty to the state."<sup>185</sup> These consequences may be extremely severe for the professional, especially those employed in institutions such as prisons and jails.<sup>186</sup> State-based pressures are likely to be insurmountable in capital punishment cases where the nature of the crime and the community response call for the execution to take place.

The two greatest causes of the dual loyalty problem, which also contribute immeasurably to the persistence of the problem, are lack of training and structural flaws.<sup>187</sup> Generally, health care professionals do not receive the training needed to

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179. See generally Stacy A. Ragon, Comment: *A Doctor's Dilemma: Resolving the Conflict Between Physician Participation in Executions and the AMA's Code of Medical Ethics*, 20 U. DAYTON L. REV. 975 (1995). In her discussion of this conflict, Ragon takes an historic approach to show that physicians have actively participated in capital punishment. *Id.* at 976-77. She further develops how the AMA is ill-equipped to combat this problem. *See id.* at 991. In her conclusion, she opines that states should not create situations in which this conflict of interest occurs. *Id.* at 1007.

180. *Id.*

181. *Id.*

182. *Id.*

183. *Id.*

184. DUAL LOYALTY, *supra* note 178.

185. DUAL LOYALTY, *supra* note 178.

186. DUAL LOYALTY, *supra* note 178. This may be due, in part, to the fact that these institutions are closed to the public in most senses. DUAL LOYALTY, *supra* note 178.

187. DUAL LOYALTY, *supra* note 178.

identify and overcome these situations.<sup>188</sup> While codes of ethics exist, they do not provide protocol for assessing third party demands.<sup>189</sup> This leaves the health care professional stranded to evaluate the justifications of the state on his or her own.<sup>190</sup> Left to a passive role, the professional is unable to advocate effectively for the patient's rights.<sup>191</sup> In order to defeat this element of the problem, mentoring programs must be established in which burgeoning professionals may look to more respected physicians for examples of how to respond to these pressures. It will also be necessary for medical organizations to lobby more aggressively for the creation of standard regulations that will guide their actions when put in professional jeopardy.

The second cause of the dual loyalty problem, structural flaws, is grounded in the nature of the relationships between health care professionals and third parties. The four most recognized flaws include: "the nature of employment relationships with the state; administrative mechanisms that lack procedures for contesting state demands; disincentives to promote human rights; and licensing and professional organizations that play no part in providing support to health care professionals when they are challenged in meeting their human rights obligations."<sup>192</sup> Propositions made in response to this problem include relationship restructuring, creation of administrative mechanisms, and collective action.<sup>193</sup> Health care professionals need to proactively pursue the establishment of these systems if future pressures are to be disarmed.

The Eighth Circuit enunciated the problems flowing from dual loyalty with its decision in *Singleton*. The court reasoned that society's interest in carrying out the imposed sentence outweighs Singleton's interest in remaining free from unwanted medication.<sup>194</sup> However failing to consider the eventual responsibility that the treating health care professional will bear, the court has ordered participating physicians to violate their codes of ethics. In other words, the court chooses to put the professional's relationship with the state ahead of the professional's responsibility to the patient. More precisely, the health care professional must condemn the patient because the state so commands. The Supreme Court failed to recognize the gravity of this conflict. Most importantly, the Supreme Court balked at the opportunity to head off a steamrolling debate with a demonstration of pragmatic decisiveness. While the Court could have summarily resolved these conflicts by eliminating their occurrence altogether, instead it acquiesced, allowing the problem to develop further.

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188. DUAL LOYALTY, *supra* note 178.

189. DUAL LOYALTY, *supra* note 178.

190. DUAL LOYALTY, *supra* note 178.

191. DUAL LOYALTY, *supra* note 178.

192. DUAL LOYALTY, *supra* note 178.

193. DUAL LOYALTY, *supra* note 178.

194. See *Singleton v. Norris*, 319 F.3d 1018, 1026 (8th Cir. 2003).



### *E. Bridging the Gap*

The Court should have addressed the issue of dual loyalty by considering *Singleton* and its progeny on *certiorari* and eliminating circumstances in which physicians are forced to condemn patients to state sanctioned executions because of treatment with psychotropic medication. Though the Court is not bound by the Hippocratic Oath when drafting opinions, it has shown consideration of physicians' ethics in the past.<sup>195</sup> In this instance, the Court could have chosen to categorically foreclose the availability of the death penalty for persons who may become competent as a result of the administration of medication. An opinion to this effect would surely be in line with the precedent set forth in *Ford v. Wainwright*.<sup>196</sup>

By eliminating the death penalty in involuntary medication cases, the Court would remove ethical concerns from the minds of physicians treating incompetent defendants and would allow those physicians to act exclusively according to their obligations to their patients. *Singleton* raised these concerns in his discussion of the Eighth Amendment when he argued that "the medical profession recoils from participation in executions."<sup>197</sup> Appellant urges the Court of Appeals to adopt the commutation approach to this solution.<sup>198</sup> The commutation approach, in which the death sentence is displaced en lieu of a life sentence without the possibility of parole, resolves this inherent conflict.<sup>199</sup> If the commutation approach is adopted, physicians could freely treat incompetent prisoners without the added concern that the treatment rendered would precipitate the execution of the patient.

Conservative jurisdictions would be unlikely to adopt the commutation approach as imagined by *Singleton*. First, a court arguably should not act solely in the interest of third parties, such as treating physicians, when determining how to punish a criminal offender. While this argument almost certainly would alienate physicians employed to treat criminal offenders, it is not without merit. Second, a

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195. See, e.g., *Roe v. Wade*, 410 U.S. 113, 130-32 (1973).

196. 477 U.S. 399, 410 (1986) (holding that the Eighth Amendment prohibits execution of the insane).

197. Appellant's Brief at 32, *Singleton v. Norris*, 319 F.3d 1018 (8th Cir. 2003) [Hereinafter Appellant's Brief], available at 2000 WL 33983423.

198. *Id.* at 33-34. Appellant cites another brief and the Maryland statutory approach to support his "simple" answer to this conflict in ethics and treatment. *Id.*

199. *Id.* The inherent conflict is enunciated by *Singleton* as the following: "if the state requests treatment specifically so that the prisoner's competence for execution can be reevaluated, the intent of the treatment is quite different. No longer to promote the health of the prisoner, the purpose of treatment is to allow execution." *Id.* at 33. As an aside, the commutation approach would not likely trigger anti-abolitionist aggression in more conservative jurisdictions because it creates this commutation exception only in these extreme instances.

conservative bench would not likely be disposed to create an exception for persons who may be competent at any point in the criminal justice process – from commission of the crime through the execution. It would be highly unlikely to expect the most conservative jurisdictions to promote progressive safe harbors when the Supreme Court has created more uniformity across age of majority death penalty jurisprudence.<sup>200</sup> Third, conservative courts would likely be more concerned with the prospect of being duped by offenders who are trying to manipulate the system to have their lives spared.<sup>201</sup> Though not exclusive, the above arguments illustrate the potential breadth of opposition to the commutation approach.

Physicians' ethics set forth a standard of decency by which criminal punishment should be measured. Singleton argued that the "punishment must not be unacceptable to contemporary society."<sup>202</sup> Despite the ancient origins of ethical codes of professional conduct, the same codes are updated nearly as often as conflicts arise.<sup>203</sup> As such, the opinions and resolutions that flow from the AMA and similar medical entities act as modern measures of social standards. The opinions and resolutions are drafted by persons who encounter these conflicts often enough to understand the dilemmas they raise, and the proposed solutions are drafted with current trends in ethics and social norms in mind. For these reasons, these resources are appropriate materials for the Court to consider when deciding how to deal with the ethical implications of medicate-to-execute scenarios.

### III. CONCLUSION

As a general principle of constitutional law, states are permitted to provide more protection for their citizens than is provided in the U.S. Constitution. It is not permissible for states to impinge the minimum protections given to citizens. Though public support for the death penalty may wax and wane, the law must strive to be more static. The Supreme Court must take its jurisprudence a step further to provide an impenetrable defense for individuals lacking competence to be executed. When presented with the opportunity to do so, the Court must hold

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200. For example, conservative courts have narrowed the exceptions that once existed for persons suffering from mental retardation and minors who are charged as adults. *See Atkins v. Virginia*, 536 U.S. 304 (2002) (reversing the Virginia Supreme Court and holding that the execution of the mentally retarded is "cruel and unusual punishment" prohibited by the Eighth Amendment); *Stanford v. Kentucky*, 492 U.S. 361 (1989) (holding that the imposition of the death penalty on an individual who was 16 at the time of the commission of the crime is not cruel and unusual under the Eighth Amendment).

201. Singleton makes a brief attempt to address this concern. Appellant's Brief, *supra* note 184 at 29.

202. Appellant's Brief, *supra* note 197 at 32. Again, Appellant makes this argument in his brief discussing the Eighth Amendment. Appellant's Brief, *supra* note 197 at 32.

203. *See* discussion *supra* Part III.C.

that it is cruel and unusual to execute persons who are forcibly medicated. The current standard allows for unacceptable inconsistency.

The current standard similarly binds the hands of health care professionals who are willing to treat mentally ill defendants. Until health care professionals can remove themselves from the shadow of the state, dual loyalty will continue to be a problem. Physicians must be able to practice without having to combat the pressures of the state and society. Instead of extending the role of the health professional, it may be best to perfect the roles already created and focus on how best to serve the patient in those capacities. The Court must overturn *Singleton* in order to preserve the medical profession's ethical standards. The bottom line is that physicians should not be forced to breach the principles of modern ethics by participating in the "medicate-to-execute" scheme of justice ordered by the Eighth Circuit.