

# *Perry v. Louisiana*: Can a State Treat an Incompetent Prisoner to Ready Him for Execution?

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From 1967 to 1977, the Supreme Court upheld a *de facto* moratorium on executions in the United States.<sup>1</sup> In 1972, the Court vacated the sentence of three capital defendants in *Furman v. Georgia*,<sup>2</sup> ruling that the sentences inflicted cruel and unusual punishment in violation of the Eighth and Fourteenth Amendments. The *Furman* court's concern with the arbitrary and discriminatory application of the death penalty eventually prompted state legislatures to refine their capital punishment statutes.<sup>3</sup> Four years after *Furman*, the Court upheld the first group of revised death penalty statutes in *Gregg v. Georgia*,<sup>4</sup> and a majority of states copied those statutes, reenacting the death penalty.<sup>5</sup> The newly condemned inmates slowly began to be executed; finally, in 1984, more than 20 prisoners were executed, twice as many as in the previous 20 years combined.<sup>6</sup> The nation's death row population swelled because the tedious appeals process meant that prisoners were condemned to death faster than the judicial system could dispose of their cases.<sup>7</sup> Today, with the appeals process taking as

long as a decade, states have begun to encounter a phenomenon of some condemned inmates asserting that their prolonged confinement awaiting the death penalty has left them mentally incompetent to be executed.<sup>8</sup>

As a matter of statute<sup>9</sup> or common law,<sup>10</sup> and now as a matter of constitutional law,<sup>11</sup> every death penalty jurisdiction forbids the execution of the incompetent condemned.<sup>12</sup> Prohibiting the execution of the incompetent condemned, however, does not end the debate. During the 1990 fall term, the Court, in *Perry v. Louisiana*,<sup>13</sup> was confronted with one of the most troublesome problems involving incompetent death row inmates. The issue in *Perry* was whether or not the state forcibly could treat an incompetent inmate with antipsychotic drugs in order to make him competent for execution.<sup>14</sup> After receiving briefs and hearing oral arguments, the Supreme Court vacated certiorari in *Perry* and instructed the Louisiana state courts to decide the case in light of the Court's recent decision in *Washington v. Harper*.<sup>15</sup>

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The *Perry* case raises difficult legal and ethical questions. This paper attempts to answer some of these questions by analyzing the legal grounds on which an inmate can be found incompetent for execution. It continues by looking at *Ford v. Wainwright* and *Washington v. Harper* and then attempts to apply the *Harper* decision to the facts of *Perry*. In this paper I argue that the Court should have given the state courts more guidelines to apply the *Harper* balancing test. I also contend that *Perry* should be decided under the Eighth Amendment's prohibition on cruel and unusual punishment. The paper concludes with a discussion of some of the ethical issues *Perry* raises for the medical profession.

### The Perry Case

During the early morning hours of July 17, 1983, Michael Owen Perry entered the unlocked house of his cousins, Randy Perry and Brian LeBlanc, at 639 Louisiana Street in Lake Arthur, Louisiana.<sup>16</sup> He walked first into the living room where Randy Perry lay asleep on the couch. From a distance of only a few feet, Perry fired a single fatal shot into the left eye of his cousin.<sup>17</sup> He next moved to the bedroom where Brian LeBlanc slept, and again fired a single fatal shot into the victim's head.<sup>18</sup>

After these gruesome killings, Perry walked across the yard to his parent's home and broke into the house. He listened to music, waiting on his parents' arrival home from an out of town trip.<sup>19</sup> Entering the house after their return, his father came through the front door first,

followed by Anthony Bonin, Perry's two-year-old nephew, and Perry's mother. Perry opened fire on the trio, shooting his father first, then his mother, and finally the child.<sup>20</sup> Since his first attempt did not kill either of his parents, Perry shot both of them a second time in the head;<sup>21</sup> not being sure the child was dead, he shot him a second time also. After dragging his mother's body away from the front door so he could shut it, Perry took his father's wallet containing \$3,000 cash and a strongbox belonging to his mother.<sup>22</sup> He fled from the scene in his father's car.

Perry arrived in Washington, DC, on July 18, 1983, the day after the murders, and checked into the Annex Hotel.<sup>23</sup> While at the hotel, he paid his rent in advance, giving the clerk five \$100 bills, and purchased several items from a local television store.<sup>24</sup> On July 31st, Perry had an altercation with another guest at the hotel that led to the police being called. An officer ran a routine check on Perry and learned he was wanted in Louisiana for five counts of homicide.<sup>25</sup> Among the evidence seized at his arrest was \$1,100 cash and a television set with the names of the five victims written on the side.

Michael Perry became a suspect because of his bad relationship with his parents. Perry lived in a trailer behind his parents' home and was not allowed to enter their home without permission.<sup>26</sup> Perry's parents took him to a mental hospital in Galveston for examination when he was 16.<sup>27</sup> They had him committed to the Central State Hospital at Pineville two years later.<sup>28</sup> During this

admission, Perry showed delusional thinking and paranoid ideation. According to testimony, Perry was infuriated at his parents for committing him and consequently had threatened to kill them.<sup>29</sup> In a statement to police after his arrest, Perry admitted his relationship with his parents was bad and stated he "couldn't take it anymore."<sup>30</sup>

After apprehending Perry, the state conducted two sanity commission hearings regarding his ability to stand trial; the first was held on September 26, 1983, and the second on March 1, 1984.<sup>31</sup> The first commission was composed of Dr. Louis E. Shirley, a general practitioner with some experience in treating psychiatric disorders, and Dr. Young Hee Kang, a general practitioner who completed a residency in psychiatry.<sup>32</sup> After brief interviews in the parish jail on September 26, 1983, both physicians were of the opinion that Perry needed further psychiatric evaluation.<sup>33</sup> They summarized their findings:

[w]e find that he has a long history of paranoid schizophrenia and at this time is not in complete contact with reality and may be dangerous to himself or others. We were not able to ascertain his mental state at the time of the alleged offense(s). We feel that he needs complete psychiatric evaluation and therapy at this time.<sup>34</sup>

As a result of this evaluation, Perry was sent to the Feliciana Forensic Facility for evaluation and treatment.<sup>35</sup>

The second sanity commission was appointed upon motion of the state.<sup>36</sup> This commission was composed of the same two physicians who were on the first commission, plus an additional physician, Dr. Aretta J. Rathmell, a spe-

cialist in psychiatry. At the second commission hearing, the three physicians unanimously agreed that Perry was mentally competent and could assist his counsel in his defense as required by the Sixth Amendment.<sup>37</sup> Finding the evidence clear, the trial court agreed and ruled accordingly.<sup>38</sup>

In October 1984, Perry was unanimously convicted of five counts of first degree murder.<sup>39</sup> Following the presentation of evidence during the sentencing portion of the trial, the jury unanimously recommended that Perry be sentenced to death on each count. The jury found the same two aggravating circumstances existed for each crime: (1) the offender knowingly created a risk of death or great bodily harm to more than one person and (2) the offense was committed in an especially heinous, atrocious, or cruel manner.<sup>40</sup> The trial judge subsequently imposed the death sentence.<sup>41</sup>

After sentencing, Perry was sent to the Louisiana State Penitentiary on December 20, 1985. From the outset, prison physicians were aware of his mental condition. During his stay at the prison, Perry continually has been medicated with Haldol.<sup>42</sup> He has been committed to the prison hospital on numerous occasions and experienced extreme mood swings from depression to episodes of uncontrolled yelling and screaming.<sup>43</sup> State psychiatrists have concluded that Perry is a chronic schizophrenic and can only be controlled through medication.<sup>44</sup>

In 1987, the Louisiana Supreme Court heard Perry's case on direct ap-

peal. While affirming the conviction and sentence,<sup>45</sup> the court encouraged the state and defense counsel to inquire into Perry's current mental state and competency to be executed:

[t]he State of Louisiana will not execute one who has become insane subsequent to his conviction of a capital crime. The state will not impose the penalty on Michael Owen Perry if a court determines he has become insane subsequent to his conviction for first degree murder and lacks the capacity to understand the death penalty. Counsel for the defendant may apply to the trial court for an appointment of a sanity commission to make such determination. Indeed, the allegations of mental capacity may be raised by the court or the prosecutor.<sup>46</sup>

On January 14, 1988, the trial court ordered such a hearing. The court appointed three psychiatrists and a psychologist to examine Perry. Each expert interviewed him between January and April 1988.

On April 20, 1988, the experts presented their findings to the court.<sup>47</sup> The experts unanimously agreed on the diagnosis of schizo-affective disorder.<sup>48</sup> One of the experts, Dr. Jiminez, testified that schizo-affective disorder is a major mental illness that is incurable. She stated that although the symptoms may get better, the underlying illness remains.<sup>49</sup> Jiminez also testified that she was most concerned about Perry's ambivalence or inconsistency in his thinking. Two of the experts, Dr. Cox and Dr. Vincent, testified that Perry is "at best a moving target,"<sup>50</sup> stating that his competency changes frequently, "sometimes he is competent and sometimes he is not."<sup>51</sup> Concurring with the testimony of the others, Dr. Estes, the last expert,

stated that Perry "was not completely aware of the nature of the proceedings against him even though he was able to acknowledge that he was on death row. . . ."<sup>52</sup> The state did not present any evidence at the hearing or introduce any experts to question the findings of the sanity commission.<sup>53</sup> The court scheduled the ruling on Perry's competence for August 1988.<sup>54</sup>

Between April and August, the court received *ex parte* reports concerning Perry's condition. At the hearing on August 26, 1988, the trial court introduced these reports into the record over the objections of defense counsel.<sup>55</sup> Based on these reports, the court concluded Perry's condition probably had changed from April. Therefore, the court ordered Dr. Jiminez and Dr. Cox to reexamine Perry.<sup>56</sup> Pending that hearing, the court ordered that the Department of Public Safety and Corrections provide treatment and medication for Perry. The court stated this forcible medication should continue until at least September 30, 1988, when it would render a final decision on the issues.<sup>57</sup>

At the September hearing, the trial court called as its witness, Dr. Kay Kovac, a family practitioner who is the Medical Director of the Louisiana State Penitentiary.<sup>58</sup> Dr. Kovac talked with Perry on one occasion for approximately 15 minutes. Based on this interview, she described Perry as "appropriate and not delusional," although he did make a claim of hearing voices. She testified that she was aware of antipsychotic medication but, because she is not a psychiatrist, had no in-depth knowledge of

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whether these drugs could help Perry.<sup>59</sup> Based on his interview of Perry, Dr. Cox concluded that “[Perry] was getting worse, even on the medication.”<sup>60</sup> Dr. Cox reiterated his “moving target” description of Perry’s competence and summarized his findings by stating that, based on his last interview, Perry was incompetent for execution.<sup>61</sup> The final witness, Dr. Jiminez, testified that during the interview Perry “was aware of the crime and the death penalty.”<sup>62</sup> Dr. Jiminez acknowledged, however, that this stability was solely the result of Haldol.

Immediately following Dr. Jiminez’s testimony, the court rendered its order:

It is obvious to this court that the defendant is competent for execution. It is further obvious from the testimony that he is competent only when maintained on psychotropic medication in the form of Haldol. . . . Michael Owen Perry is mentally competent for purposes of execution, and that he is aware of the punishment he is about to suffer said punishment. Since the defendant’s competency is achieved through the use of antipsychotic drugs, it is further ordered that the Louisiana Department of Public Safety and Corrections is to maintain the defendant on this medication as to be prescribed by the medical staff of said Department, and, if necessary, to administer said medication forcibly to defendant and over his objection.<sup>63</sup>

After this ruling, Perry sought writs of certiorari and alternatively, an appeal to the Louisiana Supreme Court. The Louisiana Supreme Court denied all motions; however, the United States Supreme Court granted certiorari.<sup>64</sup> After receiving briefs and hearing oral arguments during the fall 1990 term, the Court vacated certiorari, stating this case should be decided in light of the Court’s

recent decision in *Harper v. Washington*.<sup>65</sup>

### Legal Issues Concerning Competency For Execution

Although the law in every state with a death penalty forbids the execution of an incompetent person,<sup>66</sup> the United States Supreme Court has considered the issue only five times.<sup>67</sup> While it is beyond the scope of this paper to explore each of these cases in detail, a brief discussion is warranted. In constitutional law, the nature of the right—whether it constitutes a liberty or property interest implicated by the Fourteenth Amendment<sup>68</sup>—determines what process is due; therefore, it is necessary to examine briefly the legal dilemmas underlying the issue of competency for execution.<sup>69</sup> These Eighth Amendment and due process problems profoundly influence the legal and psychiatric issues such as how a claim of insanity is initially evaluated, who may raise such a claim, whether a denial of the claim is appealable, how extensive the evaluations of the purported incompetency must be, who evaluates the inmate and by what standard, the adversarial character of the evaluation, who ultimately decides the question, the degree of deference to medical opinion, the reliability of psychiatric examinations conducted in a prison setting, and the implementation of the legal standard of competency by the evaluators and trier of fact.<sup>70</sup> The answers to these questions in turn raise serious ethical issues concerning whether psychiatrists should participate

at all in competency for execution proceedings.<sup>71</sup>

**Historical Background** In 1897, the Court considered for the first time the question of competency for execution in *Nobles v. Georgia*.<sup>72</sup> The inmate, Nobles, asserted that the claim of insanity had to be determined by a jury in an ordinary judicial proceeding with all the common law safeguards. The Court rejected this argument, reasoning that such a process would give the inmate ultimate control over the execution, with its indefinite postponement depending “solely upon his fecundity in making suggestion after suggestion of insanity, to be followed by trial upon trial.”<sup>73</sup> The Court stated that the exemption of the incompetent from execution was not a right but a mere privilege: “[h]e has had the benefit of a jury trial, and it is now the court only that must be satisfied on the score of humanity.”<sup>74</sup> Since the inmate had no absolute right to a jury trial on the issue of supervening insanity under the common law, the Court ruled that the legislature was free to prescribe the proper procedure for evaluating inmates’ claims of post-sentencing insanity.<sup>75</sup>

Over 50 years later in *Solesbee v. Balkcom*,<sup>76</sup> the Court again inspected the due process requirements surrounding the competency for execution issue. The inmate in *Solesbee* argued that he was entitled to notice and an adversarial hearing at which he could have counsel, cross-examine witnesses, and present evidence. Citing the danger of repeated false claims of insanity,<sup>77</sup> the Court rejected the inmate’s argument, finding

that the state procedure did not deny due process and comparing it to a reprieve or grant of clemency, powers generally vested in the executive branch and free from judicial review. According to the Court, the state procedure, which vested ultimate authority in the governor, was “motivated solely by a sense of public propriety and decency—an act of grace which could be bestowed or withheld by the state at will and therefore not subject to due process requirements.”<sup>78</sup> Rejecting the analogy to sentencing and gubernatorial reprieves, Justice Frankfurter dissented. He argued that a reprieve from execution while insane was not solely a matter of executive discretion but was instead subject to due process safeguards which require that the inmate have at least the right to make a presentation on his own behalf.<sup>79</sup>

In *Caritativo v. California*,<sup>80</sup> the Court considered a challenge to a statute that vested in the prison warden sole responsibility for initiating judicial proceedings about an inmate’s competency for execution. Citing *Solesbee*, the Court upheld the California Supreme Court’s decision that stated the courts lacked jurisdiction to consider an inmate’s sanity or review a warden’s decision unless the warden initiated the sanity inquiry. Justice Frankfurter again dissented, joined by Justices Brennan and Douglas. Without stating that the Due Process Clause required a formal adversarial hearing or judicial proceeding, Justice Frankfurter suggested that “some procedure be established for assuring that the warden give ear to [such a claim].”<sup>81</sup> Because the initial evaluation by the warden was fi-

nal and *ex parte*, Justice Frankfurter believed that the Due Process Clause required a better opportunity for a hearing.<sup>82</sup>

**The Ford Case** In *Ford v. Wainwright*,<sup>83</sup> the Court considered an inmate's argument that the Eighth Amendment's prohibition against cruel and unusual punishment precluded the state from executing the incompetent condemned.<sup>84</sup> Ford also argued that due process jurisprudence had changed so dramatically in the past 30 years that *Solesbee* and its progeny no longer dictated what process is due an inmate claiming post-sentencing insanity.<sup>85</sup> Deciding, for the first time, a competency for execution case under the Eighth Amendment, the Court agreed with the defendant, holding the execution of the incompetent condemned constituted "cruel and unusual" punishment. Writing for the majority, Justice Marshall stated that "whether [the prohibition's] aim be to protect the condemned from fear and pain without comfort of understanding, or to protect the dignity of society itself from the barbarity of exacting mindless vengeance, the restriction finds enforcement in the Eighth Amendment."<sup>86</sup> Justice Marshall also wrote a plurality opinion, joined by Justices Brennan, Blackmun, and Stevens, holding that the state due process procedures were inadequate and that Ford was entitled to an evidentiary hearing in federal district court, *de novo*, on the question of his competency for execution.<sup>87</sup> Although not agreeing with Court's constitutional analysis, Justices O'Connor and

White agreed with the majority that the state procedures were inadequate.<sup>88</sup>

The *Ford* Court did not address the issue of medical involvement in the competency determination. Instead, the majority recognized the inmate's interest in presenting medical testimony to rebut or support the state's findings on the issue of insanity, highlighting "the value to be derived from a factfinder's consideration of differing psychiatric opinions when resolving contested issues of mental state."<sup>89</sup> The Court also did not question the propriety of state statutes that provide for execution following the restoration of competency by physicians.<sup>90</sup> Further, the *Ford* Court did not specify any particular mental state that would result in a finding of incompetence,<sup>91</sup> leaving intact state definitions.

**The Harper Case** In *Washington v. Harper*,<sup>92</sup> the Court returned to a due process analysis similar to *Solesbee*, concluding that an inmate did not have an absolute right to refuse medical treatment.<sup>93</sup> The inmate in *Harper* was convicted of robbery and incarcerated at the Washington State Special Offender Center where he voluntarily received anti-psychotic drugs to treat a manic depressive disorder.<sup>94</sup> In 1982, he refused treatment and the state physician sought to forcibly medicate him pursuant to a state statute.<sup>95</sup>

The *Harper* Court broke its due process analysis into two parts, first considering the substantive issue of what facts must exist before the state can forcibly medicate and then determining the procedural issue of whether the state's non-judicial process was sufficient.<sup>96</sup> After a

review of the Washington statute permitting forcible medication of inmates, the Court concluded that, as a matter of state law, Harper had the "right to be free from the arbitrary administration of antipsychotic medication."<sup>97</sup> Citing its decision in *Vitek v. Jones*,<sup>98</sup> the Court also held that the inmate had a significant liberty interest in avoiding the "unwanted administration of antipsychotic drugs" under the Due Process Clause of the Fourteenth Amendment.<sup>99</sup> The Court, however, rejected the inmate's argument that he had an absolute right to refuse treatment, finding the Due Process Clause conferred upon the inmate no greater right than that recognized under state law.<sup>100</sup>

Stating that the prisoner's right under the Clause to "avoid the unwanted administration of antipsychotic drugs must be defined in the context of the inmate's confinement,"<sup>101</sup> the Court concluded that the proper test for determining the constitutional validity of any prison regulation is whether it is "reasonably related to legitimate penological interests."<sup>102</sup> The Court considered three factors in deciding the reasonableness of Washington's forcible medication statute: (1) a rational connection between the prison regulation and a legitimate governmental interest, (2) the impact accommodation of the asserted constitutional right would have on guards and other inmates, and (3) the existence of ready alternatives.<sup>103</sup> In holding the state statute reasonable under this constitutional standard, the Court noted that "there are few cases in which the [s]tate's interest in combating the danger posed

by a person to both himself and others is greater than in a prison environment. . . ."<sup>104</sup> Moreover, the Court stated that when the "inmate's mental disability is the root cause of the threat he poses to the inmate population, the state's interest in decreasing the danger necessarily encompasses an interest in providing him with medical treatment for his illness."<sup>105</sup> Rejecting the inmate's alternatives for accommodating the state's interest,<sup>106</sup> the Court concluded that "the Due Process Clause permits the [s]tate to treat a prison inmate who has a serious mental illness with antipsychotic drugs against his will, if the inmate is dangerous to himself or others and the treatment is in the inmate's medical interest."<sup>107</sup>

In the procedural part of its due process analysis, the *Harper* Court stated that the Due Process Clause has never been interpreted to require the neutral trier of fact be "law trained or a judicial or administrative officer."<sup>108</sup> Upholding the state procedure,<sup>109</sup> the Court noted "that an inmate's interests are adequately protected, and perhaps better served, by allowing the decision to medicate to be made by medical professionals rather than a judge."<sup>110</sup> Citing *Parham v. J.R.*<sup>111</sup> and *Vitek v. Jones*,<sup>112</sup> the Court concluded that the procedural requirements would be met as long as the decisionmaker is independent of those treating the inmate and the inmate is given a full and fair hearing.

***Applying Harper To Perry*** After receiving briefs and hearing oral arguments, the Supreme Court vacated cer-

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tiorari and remanded the *Perry* case to the state courts for determination in light of its decision in *Harper*.<sup>113</sup> This order is puzzling for several reasons. First, the *Harper* decision was issued prior to the Court granting certiorari in *Perry*.<sup>114</sup> If *Harper* clearly controls the decision in *Perry*, the Court could have refused certiorari and sent the case back to the state courts for reconsideration rather than accept jurisdiction. When *Perry* was argued on October 2, 1990, Justice David Souter had not joined the Court and, therefore, did not participate in this case. A second possible explanation for the Court's actions is that it was deadlocked 4 to 4 and could not decide the case. As a procedural matter, a tie automatically would uphold the state court order permitting the inmate to be medicated and executed. By contrast, the Court's action vacates the lower court's decision and bars the execution until the constitutional question is resolved in a new round of appeals.

While the result in *Perry* may hinge on state court determinations (such as whether treatment is in the inmate's medical interest), the *Harper* Court clearly established an inmate's right under the Due Process Clause to remain free from the unwanted administration of antipsychotic drugs. Although this is not an absolute right to refuse treatment, the Court envisioned the forced medication of an incompetent inmate under the Due Process Clause only when the state could show future dangerousness and that medication is in the prisoner's medical interest. Permitting an inmate's forced medication if the procedure is

"reasonably related to valid penological interests," the Court sought to balance the inmate's rights against the state's interest. By using a reasonable relation standard, the Court focused on the state's interests, avoiding the difficult issues a higher standard, such as strict scrutiny, would entail and minimizing the effects of such a substantial interference on the inmate's well-being. Regardless of the propriety of the *Harper* Court's balancing of interests, its decision does present significant adverse precedent for *Perry* by establishing that an inmate does not have an absolute right to forego treatment and that a state may forcibly treat a prisoner under certain conditions. *Harper*, however, does not present an absolute bar for *Perry* to challenge the reasonableness of the Louisiana order requiring his forced medication.

Under *Harper*, a forcible medication statute will not be reasonable unless the state can show a rational connection between the regulation and a legitimate state interest. The *Harper* Court identified two state interests that would make such a statute reasonable and tip the scales in the state's favor, thereby permitting the treatment of an incompetent inmate against his will. According to the Court, the state must establish both of the following interests before forcibly treating an incompetent prisoner: (1) that the inmate is dangerous to himself or others (a police power interest) and (2) that treatment is in the inmate's medical interest (a *parens patriae* interest). In its brief to the Supreme Court, Louisiana justified its interest in treating

Perry against his will under three theories: (1) a police power interest in protecting other inmates and prison officials from the danger posed by Perry, (2) a *parens patriae* interest in providing for Perry's medical interest, and (3) a penal interest in carrying out the sentences imposed by its courts.<sup>115</sup> While each of these theories represent a state interest in the case, none of them represents a "legitimate state interest" as required by *Harper* that would justify the "grooming" of Perry for execution.

From *Harper*, the state must establish both a police power and *parens patriae* interest in forcibly administering psychotropic drugs to an incompetent inmate. Under a police power theory, the state would have the power to forcibly medicate Perry because he poses an immediate danger to other inmates or prison officials. In *Harper*, the Court was concerned about protecting the inmate and others from harm, noting the inmate had tried to attack prison guards and other inmates on several occasions.<sup>116</sup> The *Harper* Court held that when the inmate is dangerous the state may invoke its police power interest as a legitimate basis for forcibly medicating an inmate. While the state has a similar interest in *Perry*, the state's brief to the Supreme Court did not cite any evidence in the record of the threat Perry posed to others if he was not medicated or any incidents of violence during his seven years of incarceration. Although the *Harper* Court did not quantify this dangerousness requirement in exact terms, the Court clearly required evidence of actual attacks or physical harm, mere

threats likely would not be enough.<sup>117</sup> Without evidence that Perry is a threat to himself and others, Louisiana's police power interest would not qualify as a legitimate interest for forcibly medicating Perry under *Harper*.

Assuming the state can meet the first part of the *Harper* test by establishing a police power interest, it must still prove a *parens patriae* interest, showing that treatment is in Perry's medical interest. Under a *parens patriae* theory, the state may act to preserve and promote the welfare of those who can not care for themselves.<sup>118</sup> In this case, Louisiana aims not at benefiting Perry as a ward of the state but instead seeks to facilitate his death in order to serve other state interests. In cases where medication does not lead to death, such as *Harper*, the state may have a legitimate *parens patriae* interest sufficient to overcome an inmate's right to forego treatment. When the inmate is sentenced to death however, the balance is clear: the state has no *parens patriae* justification for facilitating an incompetent prisoner's death.

Since *Harper* did not deal with a condemned inmate, the Court did not shed much light on how to balance the *parens patriae* interests in death penalty case. The *Harper* Court, however, did consider the potential negative side effects psychotropic drugs may have on the inmate. Although treatment may provide temporary relief for the inmate's problems, the medication often results in unpleasant side effects such as acute dystonia, akathisia, and tardive dyskinesia. In Perry's case, these side effects include

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excessive sleep, drooling, and impaired motor skills. While the *Harper* Court was concerned about these potential negative side effects, it recognized these drugs as useful tools in treating incompetent prisoners, stating that the medical professional should consider the side effects before recommending the use of psychotropic drugs. In effect, the Court left the treatment of the inmate to the physician, understanding that the inmate's medical interests may be served by discontinuing treatment if the side effects are too severe. Although the precise meaning of "medical interest" remains unclear, this Note argues that the court order in *Perry* forcing treatment is a clear violation of *Harper*. The court did not consider the inmate's interests and looked only to the state's interest in carrying out the execution. At the least, the order likely is too broad. It provides for medication until *Perry* is competent for execution. It does not provide for any subsequent review or relief even if treatment is causing *Perry* physical harm.

While no court has upheld the involuntary administration of psychotropic drugs unless based on a *parens patriae* interest,<sup>119</sup> Louisiana might argue a penal interest as justification for such action. Under a penal interest approach, the state is allowed to act in order to carry out the sentences of its courts. While Louisiana may have a strong state interest in carrying out *Perry*'s execution, the state does not have a legitimate state interest in executing an insane person. Executions of the insane are unconstitutional, and the state has no legiti-

mate interest in attempting to carry out an unconstitutional sentence. As stated by the *Ford* Court, such a sentence is invalid and prohibited by the Eighth Amendment. Using a means, particularly one as drastic as forced psychotropic medication, to achieve something that is an illegitimate end does not justify the destruction of *Perry*'s rights. Louisiana has imposed the death penalty, but no statute authorizes the infliction of forced medication to achieve that end. Moreover, even assuming Louisiana has a legitimate penal interest, such an interest would not justify the execution of *Perry*. The *Harper* Court established the state's police power and *parens patriae* interests as the only valid interests that could outweigh the inmate's interest under the Due Process Clause. Therefore, Louisiana's alleged penal interest, by itself, would be insufficient to tip the scales in the state's favor and permit treatment.

Although *Harper* set up minimal due process requirements under the Due Process Clause, it left open the possibility that an inmate may receive more protection under a state constitution. Louisiana law permits forcible medication for no longer than 15 days and then only when (1) the inmate is mentally ill or retarded and (2) a physician certifies that medication is necessary to prevent harm to the inmate or others.<sup>120</sup> Medication beyond 15 days is permitted only if (1) a petition has been filed with the court, (2) the petition sets forth reasons for the treatment, (3) there is a hearing at which the inmate has a right to counsel, and (4) the court determines that the

inmate is incompetent. Louisiana law on the use of medication states that no medication may be administered to a patient except on the order of a physician. It continues that medication shall not be used for nonmedical reasons such as punishment or for convenience of the medical staff.<sup>121</sup> From these statutes, treatment appears to be the only justification in Louisiana for forced medication. Moreover, it can be argued that these statutes—written in mandatory language—create a liberty interest greater than either the interest under the federal constitution or the state statute in *Harper*. If so, *Harper* may prevent the use of drugs on Perry except for treatment.<sup>122</sup>

In *Harper* the Court refused to require a finding of incompetence before the state could forcibly medicate the prisoner. Determining that neither the state statute nor the Due Process Clause required such a determination, the Court permitted the state to forcibly medicate a prisoner on a committee's finding that the inmate is dangerous to himself or others and that the treatment is in the inmate's medical interest. In contrast, under Louisiana law an inmate must be adjudicated incompetent for a period more than 15 days before he can be medicated against his will. Such a mandatory state requirement likely grants the inmate both substantive and procedural rights exceeding those discussed in *Harper*. From a substantive standpoint, the state must show the incompetent prisoner would choose to receive treatment if he was competent to make the decision (i.e., a substituted judgment

standard). In a procedural context, the state would need court approval, instead of a committee recommendation, before medicating an incompetent inmate against his will. While these requirements are not an absolute bar to the forcible medication of an inmate, they provide substantial rights not enjoyed under the statute in *Harper* and would permit a Louisiana court to prohibit the forced medication of Perry.

As a final matter, it appears that *Perry* would have been better decided under an Eighth Amendment analysis. As the psychiatrist at his initial competency for execution hearings stated, Perry is at best a moving target. Finding him competent for execution today does not insure that he would be competent tomorrow. This instability creates a substantial risk that Perry could be executed on a day when he is not competent. Such an execution would violate the Eighth Amendment's prohibition on cruel and unusual punishment as decided by the *Ford* Court. Moreover, such a process arguably is arbitrary and capricious, also a violation of the Eighth Amendment as enunciated by the Court in *Furman v. Georgia*.<sup>123</sup> If *Perry* had been decided under the Eighth Amendment, the Court could have established a firm rule against grooming inmates for execution. In the event an inmate was found incompetent for execution, the Court could have prescribed that his sentence would automatically be converted to life in prison without parole.<sup>124</sup> Such a rule would accommodate the interests of all parties. By providing for a life term without parole, society's interests in punishment and retribution

would be satisfied without chancing the cruel and barbaric execution of an incompetent inmate who does not understand his punishment. The inmate could pay his "debt to society" through a life sentence and receive prompt medical attention without the fear of the executioner's imminent arrival. Finally, such a rule would alleviate many of the ethical considerations that currently plague the medical profession in the treatment of the incompetent condemned.<sup>125</sup>

### Ethical Considerations

Medical ethics may be implicated whenever psychiatric participation is required in a capital proceeding. From a medical standpoint, the psychiatrist is bound by a fundamental ethical principle to do no harm and to preserve life. Moreover, the psychiatrist is under an ethical duty to heal the sick and prevent suffering.<sup>126</sup> In competency to be executed proceedings, the state's interest in executing the condemned forces these two principles of medical ethics into conflict.

*The Ethical Dilemma Facing Psychiatrists After Harper* While *Harper* left several legal issues unresolved, the Court clearly contemplated the participation of the medical profession in the competency determination. Psychiatrists traditionally have been involved with capital proceedings in such areas as assessing competency to stand trial,<sup>127</sup> predicting future dangerousness,<sup>128</sup> and determining competency to waive appeal.<sup>129</sup> In these proceedings, medical ethics are often examined in the context of the forensic psychiatrist,<sup>130</sup> who may

owe "dual allegiances" to the state and the profession,<sup>131</sup> thus creating substantial concern that the medical well-being of the patient may be subordinate to duties owed the employer.<sup>132</sup> While any psychiatric participation in capital proceedings arguably violates the physician's ethical duty not to take a life, total psychiatric abstention would have a significant adverse effect on the exercise of individual rights associated with the criminal justice system. For example, the constitutional right to a fair trial requires that the defendant be competent to stand trial.<sup>133</sup> If psychiatrists completely refused to make competency determinations in capital proceedings, many incompetent defendants would be convicted and sentenced to death in violation of their constitutional rights. Furthermore, the psychiatrist's responsibility at the competency to stand trial stage for an inmate's eventual execution is extremely attenuated.<sup>134</sup> At the competency determination, the defendant still enjoys the presumption of innocence, or he may plead guilty to avoid the death penalty. Even if the accused is convicted, the jury may not choose to impose a sentence of death or the judge may vacate the sentence.<sup>135</sup> Furthermore, in competency to waive appeal proceedings, the inmate may be making a conscious choice to forgo potentially life-sparing action, analogous to the situation where a physician respects a competent patient's right to die.<sup>136</sup> Therefore, psychiatrists generally will agree to participate in capital proceedings as long as their involvement is limited to the traditional determinations such as com-

petency to stand trial, competency to waive appeal, and future dangerousness.

The ethical dilemmas facing a psychiatrist after an inmate has been found incompetent for execution, however, are somewhat different. The first issue is whether the psychiatrist should agree to treat the incompetent prisoner to make him ready for execution.<sup>137</sup> Even assuming that the treating psychiatrist was not involved in the initial certification of incompetence and thus is not subject to a conflict of interest, the ethical issues are not easily resolved. From one perspective, the psychiatrist has a duty to treat illness. Although a psychiatrist may oppose the death penalty on moral grounds, refusing to treat a mentally ill death row inmate transgresses his medical duty.<sup>138</sup> While a failure to treat may cheat the executioner, such a refusal implicitly denies that mental illness causes great suffering.<sup>139</sup> Some commentators argue the most humane action is to treat the incompetent condemned, thereby allowing him to prepare for and meet his death with equanimity.<sup>140</sup> Others believe the best way to resolve the psychiatrist's dilemma is to separate the medical from the legal or political issues, recognizing that it is the physician's duty to treat illness, and that capital punishment is a social or legal question not within the realm of medicine.<sup>141</sup>

Assuming a psychiatrist agrees to treat such a patient, the second ethical question is whether he should be involved in the recertification process. Again, eliminating the problem of conflict of interest by assuming that the psychiatrists who participated in the initial certifi-

cation or treatment proceedings are not the same as those who participate in the recertification determination, is such involvement an ethical performance of a physician's duty? The problem is clear: "if incompetence is found, a later assessment of competence by psychiatrists is tantamount to imposing a new death sentence. In the first evaluation nonintervention leads to death; here intervention by psychiatrists is required for death."<sup>142</sup> At the recertification phase, the proximity of the psychiatrist's actions is such that "but for" for the physician's conduct, the prisoner likely would not die. The incompetent inmate benefits from a stay of execution that can only expire upon a restoration of sanity. Therefore, the treatment and restoration of sanity are the only conditions precedent for the prisoner's execution.

Some commentators<sup>143</sup> argue that psychiatric involvement in the recertification process is a clear violation of medical ethics.<sup>144</sup> The supporters of this view draw an analogy to the doctrine of causality in the criminal law with regard to homicide. They argue that under the Model Penal Code § 2.03 (1989), "[c]onduct is the cause of a result when: (a) it is an antecedent but for which the result in question would not have occurred . . . ."<sup>145</sup> The Code also defines murder as "purposely or knowingly" causing the death of another human being.<sup>146</sup> Moreover, this intent requirement is satisfied when death was within the purpose or the contemplation of the actor. Those opposed to psychiatric involvement point out that "but for" recertification the state can not renew the

inmate's death warrant.<sup>147</sup> Since the psychiatrist understands the consequences of his actions, they argue his recertification is tantamount to homicide under the Code.<sup>148</sup> Although state exoneration insulates the psychiatrist from legal liability, supporters of this view do not believe this exemption in any way diminishes the ethical violation.<sup>149</sup>

Other commentators would allow psychiatric participation in recertification determinations on a consequentialist basis.<sup>150</sup> In evaluating this pragmatic approach, we must consider the tremendous popular support the death penalty receives in many states. If psychiatrists adopted a completely principled approach to the treatment and recertification phases, their position likely would have little effect.<sup>151</sup> The probable response would be for state legislatures to amend their capital punishment statutes and allow a hospital official to perform the recertification.<sup>152</sup> Since there surely is no lack of pro-death penalty psychiatrists, supporters of psychiatric involvement recognize this reality and argue for more stringent criteria, with the hope that more liberal-thinking psychiatrists will recognize the stakes and participate, applying higher standards of professional competence. While this argument does not answer the principled position, it does point out that opinions on competency for execution issues are affected not only by one's position on the death penalty but also by perceived political reality.<sup>153</sup>

***Proposed Solutions To The Ethical Dilemma*** By enacting statutes that codify the common law rule against ex-

ecuting the insane, and by implementing these statutes with a process that uses psychiatrists, the state apparently has posed an insolvable ethical dilemma for psychiatrists. Requiring a psychiatrist to treat a condemned inmate pursuant to one of these statutes pits the role of healer, which is the essence of being a physician, squarely against the medical principles to do no harm and to take no life.<sup>154</sup> Although the state clearly has an interest in executing the condemned, such an interest is not a legitimate reason for the state to enact statutes that alternatively invite, or in the case of state employees, coerce psychiatrists to breach their medical ethics.<sup>155</sup>

One potential solution to this quandary would be for the state to accord the status of conscientious objector to state psychiatrists troubled by the prospects of treating these individuals.<sup>156</sup> Such a legislative exemption would insulate the psychiatrist from the retaliatory and coercive powers of the state. Although this solution does not rescue the physician from the dilemma the state has created, it does allow the psychiatrist to choose either prong of the conflict without fear of state retribution. Recognizing the essential role psychiatrists play in the competency determination, this solution rests on the notion that statutes which can not be implemented without causing a profession to transgress its ethical code are permissible if the state does not punish either of the difficult choices it permits.<sup>157</sup> The propriety of setting up the conflict in the first place, however, remains problematic. In considering this approach, the state should also be aware

that by relying on volunteer psychiatrists to render treatment, it is dealing with a group of physicians who practice near the fringe of what the profession has defined as ethical conduct.<sup>158</sup>

Another solution to this ethical dilemma would be for the state to use other professionals to fulfill the statutory obligation. Nurses, psychologists, and social workers on the staff of state hospitals are experienced in the diagnosis, treatment, and care of mentally ill patients.<sup>159</sup> Illnesses that rise to the level of incompetence, however, are generally treated with psychotropic drugs,<sup>160</sup> which require doctors for administration.<sup>161</sup> Moreover, this solution is not wholly satisfying because it merely passes the problem to another profession rather than solving it. Further, it is possible that the ethical codes of nurses, psychologists, and social workers would also prohibit treatment under these circumstances.<sup>162</sup>

A final solution is to follow the current procedure and allow the state, subsequent to a finding of incompetency for execution, to involve the medical profession in the prisoner's treatment.<sup>163</sup> If the state selects this course of action, I would argue that it should not do so at the expense of the ethical integrity of the medical profession. Instead, the state should defer to the medical profession and avoid the potential breach of professional ethics associated with this decision. The only way to reach this result is to specify in the statute that subsequent to a finding of incompetence for execution and prior to treatment by a psychiatrist, the incompetent inmate's

sentence would be commuted to life imprisonment.<sup>164</sup> Since treating the inmate and restoring his sanity could no longer be equated with doing harm to the patient or taking a life, the psychiatrist could heal the inmate without betraying any ethical obligations.

### Conclusion

By vacating certiorari on *Perry*, the Supreme Court has left the determination of an important legal issue to state court's interpretation of the *Harper* decision. At the present, it is unclear how the state courts will resolve these difficult legal issues and perform the balancing of interests that *Harper* requires. A better solution to this dilemma would have been to prohibit the treatment and subsequent execution of an incompetent condemned inmate under the Eighth Amendment. By commuting these incompetent inmates' sentences to life in prison without parole, the state would have a clear rule to apply. Such a sentence would better serve the interests of both society and the inmate, by providing for an appropriate sentence without chancing the possible transgression of a constitutional limit. Moreover, such a rule would permit the medical profession to treat the incompetent condemned inmate without the fear of transgressing any ethical obligations.

### References

1. See Ward, Competency for execution: Problems in Law and Psychiatry, 14 Fla St U L Rev 35, 37 (1986) (citing Bureau of Justice Statistics, U.S. Dep't of Justice, Bulletin on Capital Punishment, 1984 at 7 (1985)).
2. *Furman v. Georgia*, 408 U.S. 238 (1972).
3. Ward, *supra* note 1, at 37.

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4. *Gregg v. Georgia*, 428 U.S. 153 (1976) (*Gregg* upheld the capital punishment statute of Georgia.). *See also* *Proffitt v. Florida*, 428 U.S. 242 (1976) (upholding Florida's revised death penalty statute); *Jurek v. Texas*, 428 U.S. 262 (1976) (upholding Texas' revised death penalty statute). *But see* *Woodson v. North Carolina*, 428 U.S. 280 (1976) (holding North Carolina's death penalty statute unconstitutional); *Roberts v. Louisiana*, 428 U.S. 325 (1976) (holding Louisiana's death penalty statute unconstitutional).
5. *Ward*, *supra* note 1, at 37.
6. *Id.* at 38 (citing Pace of Executions in U.S. Quicken, N.Y. Times, Dec. 13, 1984, at A18, col. 1).
7. *Id.* at 37 (by 1986, there were 1,714 inmates on death row).
8. *Id.*
9. More than 20 states have enacted provisions prohibiting the execution of the incompetent condemned. *See* Ala. Code § 15-16-23 (1982); Ariz. Rev. Stat. Ann. § 13-4021 (1982); Ark. Code Ann. § 16-90-506 (1987); (1977); Cal. Penal Code §§ 3700-3704 (West 1982); Conn. Gen. Stat. § 54-101 (1985); Fla. Stat. Ann. § 922.07 (West 1985); Ga. Code Ann. § 17-10-61 to -63 (Harrison 1990); Ill. Rev. Stat. ch. 38, ¶1005-2-3 (1982); Kan. Stat. Ann. § 22-4006 (1988); Md. Ann. Code art. 27, § 75(a) (1987); Mass. Gen. Laws Ann. ch. 279, § 62 (West Supp. 1986); Miss. Code Ann. § 99-19-57 (Supp. 1985); Mo. Ann. Stat. § 552.060 (Vernon 1987); Mont. Code Ann. § 46-19-201 to -202 (1985); Neb. Rev. Stat. § 29-2537 to -2538 (1978); Nev. Rev. Stat. § 176.425 to 455 (1986); N.M. Stat. Ann. § 31-14-4 to -14-7 (1984); N.Y. Correct. Law §§ 655-57 (McKinney 1987); Ohio Rev. Code Ann. § 2949.28-30 (Anderson 1987); Okla. Stat. Ann. tit. 22, § 1005-1008 (1986); Utah Code Ann. § 77-19-13 (1982); Wyo. Stat. § 7-13-901 to -903 (1987). Other states provide for transfer of all mentally incompetent prisoners to the state hospital. *See* Del. Code Ann. tit. 11, § 406 (1987); Ind. Code Ann. § 11-10-4-1 to 4-5 (Burns 1988); N.C. Gen. Stat. § 15A-1001 to 1002 (1988); S.C. Code Ann. § 44-23-210 (Law. Co-op. 1985); Va. Code § 19.2-177.1 (1990).
10. Four states have adopted, by case law, the common law rule prohibiting the execution of the presently incompetent. *State v. Allen*, 204 La. 513, 15 So.2d 870 (1943); Commonwealth v. Moon, 383 Pa. 18, 117 A.2d 96 (1955); *Jordan v. State*, 124 Tenn. 81, 135 S.W. 327 (1911); *State v. Davis*, 6 Wash. 2d 696, 108 P.2d 641 (1940) (dictum). Idaho has a statute that provides for the adoption of the common law absent an explicit statutory provision. Idaho Code § 73-116 (1989). Therefore, the common law rule against executing the insane should apply.
11. *Ford v. Wainwright*, 477 U.S. 399 (1986) (execution of the insane violates the Eighth Amendment proscription against cruel and unusual punishment).
12. The term "incompetent condemned" or "insane condemned" refers to inmates under a sentence of death who become insane after conviction but prior to execution. The state in this instance is concerned with competency only at the time of the execution; competency at the time of the crime or trial is assumed.
13. *Perry v. Louisiana*, 111 S. Ct. 449 (1990).
14. *Id.*
15. *Washington v. Harper*, 110 S. Ct. 1028 (1990).
16. *State v. Perry*, 502 So.2d 543, 546 (La. 1986).
17. *Id.*
18. *Id.*
19. *Id.*
20. *Id.*
21. *Id.* (There appeared to be some struggle with his father, whose body was found crouching behind the television in the living room.).
22. *Id.* (After his apprehension, Perry gave a statement to a deputy, admitting to the five murders. This statement of the facts is based on Perry's confession.).
23. *Id.* at 547.
24. *Id.*
25. *Id.*
26. *Id.* at 546.
27. At this time, Michael Perry was diagnosed as a paranoid schizophrenic. The doctor found that he had no insight into his illness and might not know right from wrong. Brief for the Petitioner at 3, *Perry v. Louisiana*, 111 S. Ct. 449 (1990) (No. 89-5120).
28. *Perry*, 502 So.2d at 546-47. The doctors again diagnosed Perry as a paranoid schizophrenic. This admission was prompted by Perry's mother who gave a history of his bizarre behavior such as burning his clothes and living in his automobile. Brief for the Petitioner at 3, *Perry v. Louisiana*, 111 S. Ct. 449 (1990) (No. 89-5120).

29. *Perry*, 502 So.2d at 546-47.
30. *Id.* After interviewing Perry, Deputy Durkes gave this account of the defendant's statement:  
 "Why did you kill all those people? The boys threw me out of my grandmother's house, stole money from me all the time, and harassed me constantly. My mother and father wouldn't leave me alone. They made me live in that trailer behind their house by all those stinking dog pens. They took all my money all the time, wouldn't let me in their house when I wanted. I couldn't take it anymore.  
 I asked him why he killed the child. The kid was evil, some sort of devil, witch of some sort. . . . I said that the child was too young to do him any harm or even talk, so why kill him? He was a very smart kid, he said, too too smart for his age. I had to make sure he was dead." *Id.*
31. *Id.* at 547.
32. *Id.*
33. *Id.*
34. *Id.* at 547-48.
35. Upon his admission to Feliciana, Perry was delusional. He stated that he "didn't have enough blood" and reported hearing voices. He said that robots, the president, and the CIA were controlling his actions. The robots told him to kill his family. He exhibited manic behavior and pressured speech. He complained of being fed body parts and stated that if shot in the head, he would not die. Brief for the Petitioner at 4, *Perry v. Louisiana*, 111 S. Ct. 449 (1990) (No. 89-5120).  
 Perry's delusional thinking continued throughout his stay at Feliciana. He believed that his parents were still alive, that other patients wished to kill him, and that another patient had bitten his tongue. He explained the murders as a need to break all ten commandments and that this was the last commandment that "he had to break." Two days after expressing this "need," Perry denied even being in Louisiana at the time of the murders. *Id.*
36. *Perry*, 502 So.2d at 548.
37. *Id.* This determination was supported by Perry's physician at Feliciana, Dr. Jiminez. Although Perry was still delusional at his release from Feliciana in March 1984, Dr. Jiminez stated in her exit evaluation that Perry was "able to give his rights as a defendant and [understand] the nature of the charges against him. Brief at 5, *Perry* (No. 89-5120).
38. *Perry*, 502 So.2d at 548.
39. *Id.* at 545.
40. *Id.*
41. *Id.*
42. Brief at 6 (While in prison, Perry has taken between 20 and 50 mg of Haldol daily.)
43. *Id.* at 7-13. While in prison, Perry has been in and out of the hospital on a regular basis, never staying more than six to eight weeks at the prison. During his stays at the hospital, he is medicated and watched carefully. He generally responds to medication such as Haldol or Thorazine; however, he has experienced some significant side effects, often sleeping in excess of 20 hours per day when medicated. *Id.* at 6. Although the medication helps alleviate his mood swings, Perry only experiences brief interludes of sanity, appearing sane one day only to be in a wild rage the next.
44. *Id.* at 13.
45. On appeal, Perry raised several issues questioning the propriety of his conviction and sentence. For example, he maintained the police had searched his parents home in violation of the Fourth Amendment and, therefore, could not use the illegally obtained evidence. *Perry*, 502 So.2d at 556-58. Perry also objected to the admission of certain hearsay statements, specifically his confession after being apprehended and his aunt's testimony regarding statements Perry made about wanting to kill his parents. *Id.* at 551-55. Furthermore, Perry objected to certain alleged prejudicial statements made by the prosecutor concerning the death penalty and to the admission into evidence of certain explicit photographs depicting the gruesome nature of the crime. *Id.* at 558-62. Of particular importance to this note, Perry questioned the state's determination that he was competent to stand trial. *Id.* at 547-50. The court ruled against Perry not only on his competency objection but also on all the other issues.
46. *Id.* at 563-64.
47. Brief at 14.
48. *Id.* at 14. One of the psychiatrists who testified, Dr. Jiminez, defined schizo-affective disorder as: "An illness wherein the patient has a problem with thinking disorder and at the same time with his feeling tone or the affective component. When they are in the state of acute illness they are usually in a manic phase and very paranoid. Now if they are also in the depressed state, they could

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- be very withdrawn and would be manifesting symptoms like not wanting to sleep, not wanting to talk, or having crying adversity. The problem is also that they would have some distortion in their thinking and that would be the schizophrenic component of the illness." *Id.*
49. *Id.*
  50. *Id.* at 17–18 (testimony of Dr. Cox and Dr. Vincent).
  51. *Id.* at 17.
  52. *Id.* at 20.
  53. *Id.* Although all four experts agreed that Perry suffered from schizo-affective disorder, only three of them would have deemed him incompetent for execution based on their interviews. The fourth, Dr. Cox, testified that on the day of his interview Perry "was functioning about as well as I've ever seen him function." *Id.* at 17. He also stated, however, that Perry was a "moving target," subject to severe mood swings that could make him incompetent at any time. *Id.*
  54. *Id.* (The original date was May 26th but was later changed to August 26th).
  55. *Id.* at 21 (Defense counsel was not informed of or given copies of these *ex parte* reports. Moreover, these reports contained statements by state employees who had not been called as witnesses during the April 1988 hearings.).
  56. *Id.*
  57. *Id.*
  58. *Id.* at 22.
  59. *Id.*
  60. *Id.*
  61. *Id.*
  62. *Id.* at 23.
  63. *Id.*
  64. 110 S.Ct. 1317 (1990).
  65. *Harper v. Washington*, 110 S.Ct. 1028 (1990).
  66. *See supra* notes 9–12 and accompanying text.
  67. *Ford v. Wainwright*, 477 U.S. 399 (1986); *Caritativo v. California*, 357 U.S. 549 (1958); *Solesbee v. Balkcom*, 339 U.S. 9 (1950); *Phyle v. Duffy*, 334 U.S. 431 (1948); *Nobles v. Georgia*, 168 U.S. 398 (1897).
  68. U.S. Const. amend. XIV, § 1; *Morrissey v. Brewer*, 408 U.S. 471, 481 (1972) (whether procedural protections are due depends on the weight of the individual's interest, and whether the interest is one within the contemplation of the "liberty or property" language of the Fourteenth Amendment).
  69. *Ward, supra* note 1, at 69.
  70. *Id.*
  71. *See* Part III of this article for a discussion of the general ethical issues facing psychiatrists in these cases.
  72. *Nobles v. Georgia*, 168 U.S. 398 (1897).
  73. *Id.* at 406.
  74. *Id.* at 407.
  75. *Id.* at 409 (In this case, the legislature delegated the power to make an initial ruling on an inmate's sanity to the Sheriff.).
  76. *Solesbee v. Balkcom*, 339 U.S. 9 (1950).
  77. *Id.* at 12.
  78. *Id.* at 11.
  79. *Id.* at 14–26 (Frankfurter, J., dissenting).
  80. *Caritativo v. California*, 357 U.S. 549 (1958) (*per curiam*).
  81. *Id.* at 557 (Frankfurter, J., dissenting).
  82. *Id.* at 556–59 (Frankfurter, J., dissenting).
  83. *Ford v. Wainwright*, 477 U.S. 399 (1986).
  84. The *Ford* case is factually similar to *Perry*. In 1974, Ford was convicted of murder and sentenced to death. His sanity during the commission of the crime, at trial, or at sentencing was not an issue. He began to manifest bizarre changes in behavior in late 1981. *Id.* at 403. Ford's counsel engaged two psychiatrists to evaluate the inmate. After both concluded that Ford suffered from paranoid schizophrenia, Ford's attorney invoked the review procedures under Fla. Stat. Ann. § 922.07 (1985 and Supp. 1986).
  85. *Ford*, 477 U.S. at 412.
  86. *Id.* at 410.
  87. *Id.* at 425.
  88. *Id.* at 430–431 (O'Connor, J., concurring in part and dissenting in part). In her opinion, Justice O'Connor stated that the statute created only a protected liberty interest, and did not rise to the level of a constitutionally protected right. *Id.*
  89. *Id.* at 414 (Marshall, J., plurality opinion).
  90. If the inmate "is cured of his disease, the state is free to execute him." *Id.* at 425 (Powell, J., concurring in part and concurring in judgment).
  91. In his opinion, Justice Powell stated that the standard must forbid "the execution only of those who are unaware of the punishment they are about to suffer and why they are to suffer it." *Id.* at 422 (Powell, J., concurring in part and concurring in judgment).
  92. *Washington v. Harper*, 110 S.Ct. 1028 (1990).
  93. Under common law, the doctor must honor a patient's informed, voluntary decision.

- This "informed consent" doctrine imposes liability on doctors who do not obtain informed consent for nonemergency treatment. However, when the treatment is psychiatric in nature and the patient is thought to be suffering from a serious mental illness, the informed consent doctrine has not found uniform acceptance. Until the 1970s people who were civilly committed or hospitalized as incompetent to stand trial or criminally insane could be forcibly medicated regardless of their ability to make treatment decisions. The assumption apparently was that since these people were subject to involuntary institutionalization, they were not competent to veto treatment decisions. At the same time, they were not competent to insist on certain types of treatment. These practices continue today in some jurisdictions. Several courts, however, have recognized a "right to refuse" psychotropic medication for institutionalized populations, thereby constitutionalizing a version of the informed consent doctrine in that setting. Reisner R and Slobogin C. *Law and The Mental Health System: Civil and Criminal Aspects* 848 (ed 2). St. Paul. West Pub., 1990 at 848.
94. *Harper*, 110 S.Ct. at 1030.
  95. *Id.* (The Washington statute permitted medication against an inmate's will 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.)
  96. *Id.* at 1036.
  97. *Id.* The inmate's right was created in the mandatory language of the state statute. *Id.* Allowing a psychiatrist to treat an inmate with antipsychotic drugs against his will only if he is found to be "(1) mentally ill and (2) gravely disabled or dangerous, the [statute] creates justifiable expectation on the part of the inmate that the drugs will not be administered unless those conditions exist." *Id.*
  98. *Vitek v. Jones*, 445 U.S. 480 (1980).
  99. *Harper*, 110 S.Ct. at 1036.
  100. *Id.* at 1037. Harper argued that the state could not forcibly medicate him unless he was adjudicated incompetent, and then only if the factfinder made a substituted judgment that, if competent, he would consent to drug treatment. *Id.*
  101. *Id.*
  102. *Id.* (citing *Turner v. Safley*, 482 U.S. 78 (1987)). The Court stated that the reasonable relation test is the proper standard of review even when the inmate alleges infringement on a fundamental right. *Id.* In cases of infringement on fundamental rights, the state is usually required to satisfy a more rigorous standard of review, such as a strict scrutiny test. *Id.*
  103. *Id.* at 1038 (citing *Turner v. Safley*, 482 U.S. 78, 89-91 (1987)).
  104. *Id.* at 1038-39.
  105. *Id.* at 1039.
  106. *Id.* The inmate argued that the state's interest could be achieved through physical restraints at de minimis cost. He further argued that before the state could forcibly medicate him, it must find him incompetent and then obtain court approval using a substituted basis standard. *Id.*
  107. *Id.* at 1040.
  108. *Id.* at 1042.
  109. *Id.* at 1040. The Washington policy required that the decision whether to medicate an inmate against his will be made by a hearing committee composed of a psychiatrist, psychologist, and the Center's Associate Superintendent. *Id.* At the time of the hearing, none of the committee members may be involved in the inmate's treatment or diagnosis. Committee members are not disqualified, however, if they have treated or diagnosed the inmate in the past. *Id.* The committee's decision is subject to review by the Center's Superintendent: if the inmate desires, he may seek judicial review of the decision in state court. *Id.*
  110. *Id.* at 1042.
  111. *Parham v. J. R.*, 442 U.S. 584 (1979) (allowing temporary involuntary commitments of children upon application by a parent or guardian and approval by the hospital superintendent).
  112. *Vitek*, 445 U.S. 480 (1980) (holding that due process requirements are met so long as an inmate facing involuntary transfer to a mental hospital is provided with qualified and independent assistance—i.e., an attorney is not required).
  113. *Perry v. Louisiana*, 111 S.Ct. 449 (1990).
  114. The *Harper* decision was handed down in February 1990; the *Perry* case was granted certiorari on March 5, 1990.
  115. Brief in Opposition at 14-15, *Perry v. Louisiana*, 111 S. Ct. 449 (No. 89-5120).
  116. *Harper*, 110 S. Ct. at 1040.
  117. Considering the anger that Perry often displays during his mood swings, the state may have substantial evidence to meet this re-

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- quirement. While more information is needed to accurately evaluate Perry's threat to himself and others, the state must come forth with this evidence under *Harper*.
118. Schall v. Martin, 467 U.S. 253, 265–66 (1984).
  119. See Bee v. Greaves, 744 F.2d 1387, 1395 (10th Cir. 1984), cert. denied, 469 U.S. 1214 (1985) (requiring a *parens patriae* interest before the state could administer psychotropic drugs).
  120. La. Rev. Stat. Ann. § 15:830.1(A) (West Supp. 1991).
  121. La. Rev. Stat. Ann. § 28:171 (West 1989 and Supp. 1991).
  122. See also Hewitt v. Helms, 459 U.S. 460 (1983) (holding that mandatory prison regulations created a protected liberty interest on the part of prisoners to avoid administrative segregation except under certain circumstances).
  123. 408 U.S. 238 (1972).
  124. All commentators obviously would not be satisfied with this rule. Many would argue that death row inmates would try to fake being incompetent to avoid the death penalty. This is a valid concern; however, with psychiatric examinations and full hearings on the issue, many of these problems could be resolved.
  125. See *infra* notes 119–57 and accompanying text for an explanation of the ethical problems facing psychiatrists in competency for execution proceedings.
  126. Veatch R. A Theory of Medical Ethics. New York, Basic Books, 1981 at 25. (quoting American Medical Association, Code of Ethics (1848)) (The code of ethics required physicians “to minister to the sick with due impressions of the importance of their office; reflecting that the ease, the health, and the lives of those committed to their charge, depend on their skill, attention, and fidelity.”).
  127. See Insanity Defense Reform Act of 1984, 18 U.S.C. § 4241 (1988) (psychiatrist required for assisting in determination of incompetency to stand trial).
  128. This role emerges from capital punishment statutes that require the jury to determine whether there is a probability the defendant would commit criminal acts of violence that would constitute a continuing threat to society. See, e.g., Texas Crim. Proc. Code Ann. 37.071 (Vernon Supp. 1991). In these jurisdictions, psychiatric testimony becomes desirable and necessary from the viewpoint of the prosecution and the defense.
  129. See Gilmore v. Utah, 429 U.S. 1012, 1015–16 nn. 4–5 (1976) (defendant made “knowing and intelligent waiver” of federal rights after death sentence imposed). Rees v. Peyton, 384 U.S. 312 (1966) (*per curiam*) (judicial determination of inmate's mental competence to refuse assistance of counsel and terminate legal proceedings required).
  130. Forensic psychiatrists use psychiatric principles and techniques to enable courts to reach legal determinations.
  131. In the traditional doctor-patient relationship, the physician gathers confidential information from the patient for therapeutic purposes. Conversely, the forensic psychiatrist obtains information for non-therapeutic purposes—i.e., for the benefit of their third-party employers. For this reason, the practice of forensic psychiatry has provoked heated debate about the appropriate medical ethics and roles.
  132. See, e.g., Bazelon. The Law, the Psychiatrist, and the Patient, Man and Med. 81 (1980) (“The question of divided loyalties is of direct relevance when psychiatrists are called upon, as they are continually, to make important decisions in a legal setting.”).
  133. Dusky v. United States, 362 U.S. 402 (1960) (*per curiam*).
  134. Note, Medical ethics and competency to be executed, 96 Yale L J 96:167–86. 1986 at 176.
  135. *Id.*
  136. See Byrn RM, Compulsory lifesaving treatment for the competent adult, Fordham L Rev 44:1–36, 1975 (analyzing right to die cases).
  137. Ward, *supra* note 1, at 90. Under the informed consent doctrine, the doctor, in the ordinary doctor-patient relationship, explains the medical problem to the patient, including prognosis and treatment. Thereafter, the patient is given a chance to weigh the benefits and consequences of treatment, coming to a rational, logical conclusion based on all the information, which the doctor must accept. In situations such as *Perry*, the informed consent doctrine complicates the issues because the patient may not be able to make a rational decision. The problem becomes who should make the treatment decision and whether the physician should abide by it.
  138. *Id.*

139. *Id.*
140. *Id.*
141. See National Medical Ass'n Section on Psychiatry and Behavioral Sciences, Position Statement on the Role of the Psychiatrist in Evaluating and Treating "Death Row" Inmates 3-4 (undated).
142. Radelet ML, Barnard GW: Ethics and the psychiatric determination of competency to be executed. *Bull Am Acad Psychiatry Law* 14:37-53, 1986.
143. Some psychiatrists argue that even the initial evaluation of an inmate for competency in a capital proceeding implicates the taking of life and is thus prohibited. Note, *supra* note 127, at 175 (citing interview with Dr. Paul Applebaum, *Nightline: Catch 22: Curing Prisoners . . . To Die*, (ABC television broadcast, Mar. 6, 1986)) ("Psychiatrists really as physicians, as healers, have no place anywhere near these determinations."). However, in evaluating an inmate, the role of the psychiatrist as a healer is not necessarily implicated. "[T]o pretend that the usual doctor-patient role is in effect during a forensic examination is patently dishonest and unethical." Rapoport, *Ethics and Forensic Psychiatry*, in *Psychiatric Ethics* 263. Regardless of the psychiatrist's close proximity to the execution process, if he properly informs the inmate of the purpose of the evaluation and the lack of confidentiality, his function is that of a court consultant, which is ethically permissible. Rapoport, *supra* at 262 ("It is imperative that the patient be informed clearly whose servant the interviewer is."). While a diagnosis of incompetency presents the possibility of a stay of execution, refusing to evaluate may lead to death. *Id.* (Absent a finding of incompetency, the inmate will be executed.) The inmate is under a sentence of death; the psychiatrist can either affirm it, in which case nothing has changed, or delay it through a finding of incompetency, thereby preserving an inmate's life. See Radelet and Barnard, *supra* note 143, at 49-50.
144. Note, *supra* note 135, at 174.
145. *Id.* (citing Model Penal Code § 2.03 (1989)).
146. *Id.* (citing Model Penal Code §§ 210.1, 210.2 (1989)).
147. *Id.* at 178.
148. *Id.*
149. *Id.*
150. M. Radelet and G. Barnard, *supra* note 143, at 61.
151. Ward, *supra* note 1, at 92.
152. *Id.*
153. *Id.*
154. Note, *supra* note 135, at 184.
155. *Id.*
156. *Id.*
157. *Id.*
158. *Id.* at 185. The problem with this approach is that a small number of psychiatrists who are willing to testify can dominate and distort the process. One study involving testimony on future dangerousness illustrates this point. In 20 cases, a total of 29 witnesses testified on future dangerousness: eight testified once, and two others testified in 12 and 9 cases, respectively. *Id.* (citing Dix, *Participation by mental health professionals in capital murder sentencing*, *Int'l. J. Law Psychiatry* 1:283-91 (1978)).
159. *Id.*
160. For example, phenothiazines are used to treat such symptoms as hallucinations, psychotic thought processes, bizarre responses, and paranoia. Davis, *Antipsychotic drugs*, in *The Comprehensive Textbook of Psychiatry*, III. Edited by Kaplan HI, Freedman AM, Sadock BJ. Baltimore, Williams & Wilkins, 1980, pp. 2257-9. Lithium is the most effective treatment available for manic-depressive disorders, acting on the "grandiosity . . . paranoid rages . . . and religious delusions" typical of this disorder. Fieve, *Lithium therapy*, in *The Comprehensive Textbook of Psychiatry* 1980, p. 2348. Federal prescription laws require that only licensed physicians may prescribe medicine for human consumption.
161. Note, *supra* note 135, at 185.
162. *Id.*
163. *Id.*
164. *Id.* at 186.