Coping With the Ethical Conundra of Forensic Psychiatry: A Tribute to Howard Zonana, MD

Paul S. Appelbaum, MD

As part of the Festschrift in honor of Howard Zonana, MD, this article reviews two important concerns that emerged in the ethics of forensic psychiatry in the resolution of which he played critical roles. In the late 1980s and early 1990s, the question arose of what role, if any, was proper for psychiatrists to play with regard to evaluations of competence to be executed and treatment of incompetent prisoners. Dr. Zonana was a major force in developing the American Psychiatric Association's position, in which the rights of prisoners were balanced with protection of the integrity of the medical profession. He was then deeply involved in helping to persuade the American Medical Association to reject a more extreme position and to adopt this approach. Similarly, in the mid-2000s, Dr. Zonana brought to the attention of the American Psychiatric Association (APA) the participation of psychiatrists in interrogation of detainees in national security settings. The policy that he subsequently helped to craft was adopted by APA and influenced the subsequent, very similar AMA policy. These two examples, of the many that could have been chosen, illustrate the profound impact that Howard Zonana has had on the ethics of psychiatry as a whole and on the ethics of forensic psychiatry in particular.

J Am Acad Psychiatry Law 38:551–8, 2010

I would like to begin my contribution to this Festschrift for Howard Zonana with some personal recollections. Howard has been a colleague and friend since the early 1980s, when we first met through our mutual activities in the American Psychiatric Association (APA) and the American Academy of Psychiatry and the Law (AAPL). From his position as leader of one of the preeminent forensic psychiatry training programs in the United States, he has played a critical role in the history of American forensic psychiatry and, pertinent to my focus in this article, in the development of the ethics of our field. He has had that impact in his roles as Chair of the APA Council on Psychiatry and Law and of the APA Commission on Judicial Action, as AAPL President and its second Medical Director, and as a consummate forensic psychiatrist and teacher.

In these various positions, Howard Zonana has helped to formulate policy on every major aspect of forensic ethics over the past 30 years. Moreover, as a psychiatrist of exceptional ethical stature in his own work, he has constituted an outstanding role model for his trainees and his colleagues in all of forensic psychiatry. To review the entire range of forensic ethics that bears Howard's mark is well beyond the scope of a single paper. Instead, I will focus my attention on two of the controversies on the ethics of forensic psychiatry that I know of firsthand, in which Howard played a leading part in different decades of his career. From the late 1980s and early 1990s, what involvement, if any, should forensic psychiatrists have in capital proceedings; and from the mid-2000s, what role, if any, should psychiatrists play in interrogation of detainees? Both dealt with the proper scope of activity for psychiatrists in the forensic realm.

Participation in Capital Proceedings

The origins of the knotty dilemmas associated with psychiatrists' involvement with the death penalty can be traced to the historic doctrine that an insane person should not be subject to execution. Traditionally, the states that retained the death penalty had a variety of ways of addressing death row

Dr. Appelbaum is Elizabeth K. Dollard Professor of Psychiatry, Medicine, and Law, and Director, Division of Law, Ethics and Psychiatry, Columbia University and New York State Psychiatric Institute, New York, NY. Address correspondence to: Paul S. Appelbaum, MD, New York State Psychiatric Institute, 1051 Riverside Drive, Unit 122, New York, NY 10032. E-mail: psa21@columbia.edu.

Disclosures of financial or other potential conflicts of interest: None.

prisoners' assertions that they were incompetent to be executed (or more accurately, the assertions of their legal counsel), but such cases came along infrequently. Most psychiatrists were unaware that a prisoner had to be competent to be executed and the profession had never grappled with the ethics of that legal doctrine. However, in 1986, the U.S. Supreme Court decided *Ford v. Wainwright*,[1] holding that there is a constitutional right under the Eighth Amendment not to be executed while incompetent. Although the standard for competence to be executed was left uncertain, the role of psychiatrists in the process seemed central.

Indeed, *Ford* called attention to the variety of roles that psychiatrists may be asked to play in capital cases. These include assessment of a detainee's competence to waive *Miranda* rights and offer a confession, competence to stand trial, mental state at the time of the crime (which may be relevant to mental state defenses such as insanity and diminished capacity), competence to waive appeals, and competence to be executed. Other decisions by the Court emphasizing the broad scope of admissible evidence at capital sentencing hearings invited greater participation by psychiatrists at that stage of the proceedings as well.[2,3] Given that many indigent capital defendants could not afford to engage a psychiatrist to work with the defense team, the Court's holding in *Ake v. Oklahoma*[4] in 1985 that states were required to cover the costs of a defense psychiatrist in such circumstances further opened the door to their utilization when the death penalty was in play.

Some opponents of the death penalty maintained that psychiatrists should not be involved at any stage of capital proceedings, since such participation is antithetical to the medical role. Both the American Medical Association (AMA)[5] and the American Psychiatric Association (APA)[6] took positions rejecting physicians' participation in capital punishment, but they appeared to be directed toward involvement in the executions themselves; where the line should be drawn along the spectrum of potential roles in the process that led to the death chamber was not clear. At one end of the spectrum, it was clear that physicians should not be flipping the switch on the electric chair or injecting a lethal dose of medication; at the other end, it was less obvious that assessment of the competence of a defendant to stand trial on a capital charge, when there was only a slight statistical possibility that the defendant would be sentenced to death, constituted "participation in capital punishment." Wherever one stood on the line-drawing question, however, it was apparent that assessment of competence to be executed had the potential to be particularly problematic. Not only could the evaluating psychiatrist be seen as the gatekeeper to the death chamber, but a finding of incompetence led inevitably to the question of what happens next (i.e., should the prisoner be treated to restore competence, and is evaluating that competence in such cases a legitimate function for a psychiatrist to undertake?).

In the aftermath of the Supreme Court's decision in *Ford v. Wainwright*, these issues were discussed by the APA Council on Psychiatry and Law while Howard Zonana was chair of the group. As chair of the APA Commission on Judicial Action, I sat in on meetings of the Council. The members of the Council generally held the view that evaluation of competence to be executed is more like than unlike other forensic functions. That is, as is generally true in forensic psychiatry, the role of the psychiatrist is to offer medical evidence about the evaluee's mental state to a legal decision maker who determines whether the prisoner is competent. Indeed, in many cases it seems likely that the contribution of the psychiatrist might help a judge conclude that the prisoner is incompetent, and hence should not be executed. The consensus in the Council was that this function is sufficiently different in an ethically important way from administering lethal medication or determining whether a prisoner has succumbed to an initial dose of the medications intended to end his life that it should not be seen as constituting direct participation in capital punishment.

Treatment of incompetent death row prisoners after such an evaluation, however, appeared to raise different concerns. The role of a forensic evaluator is guided by considerations that generally fall into the categories of honesty and objectivity[7] (or as I have called them elsewhere, subjective and objective truthfulness[8]) and a desire to avoid gratuitous harm (which can be considered under the broader category of respect for the person being evaluated). When psychiatrists provide treatment, however, they return to a more traditional physician's role in which the ethics of beneficence and nonmaleficence—doing good for and avoiding harm to the patient—are primary.[8] Thus, treatment of prisoners to restore their competence to be executed is generally unethical, because

the treatment is not for their benefit but primarily for the purpose of enabling the state to end their lives.

No formal APA policy on participation in treatment or evaluations of competence to be executed was drafted as result of these discussions, in part because the Court's decision was so new that there had been insufficient time for a consensus among psychiatrists to crystallize. Nor, until mid-1992, did the AMA act. To be sure, as mentioned, since 1980 the AMA had endorsed the position that "A physician . . . should not be a participant in a legally authorized execution." However, AMA had never clarified what constitutes "participation." By 1992, AMA decided to remedy that omission. In the middle of that year, APA received a draft report from the AMA Council on Ethical and Judicial Affairs (CEJA) elaborating in detail on which actions were equivalent to participation in executions. The AMA draft indicated that psychiatrists' assessments of competence to be executed and treatment of incompetent prisoners were unethical.[9]

From the APA perspective, receipt of the draft report raised several points. The first was procedural: it was bad precedent for AMA to make policy affecting psychiatrists without consulting APA, the specialty's major professional organization. Beyond that, of course, the Council on Psychiatry and Law, to which the AMA draft was referred, was concerned with the substantive problem that CEJA might not fully have thought through all of the complexities of the situation in reaching its conclusion and thus had arrived at an unreasonable result. The language of the report, which alluded to the variety of evaluations that psychiatrists perform in the process of adjudicating capital cases, appeared to open the door to the argument that no psychiatrist should be involved at any point in capital proceedings. That, in turn, raised questions about the impact that such a position would have on the ability of capital defendants, with so much at stake, to mount a reasonable defense. In addition, the impact on mentally ill death row prisoners of banning psychiatric evaluations for competence to be executed was not likely to be salutary. Incompetent prisoners would be left without a means of demonstrating their incapacity, and might—notwithstanding the Court's decision in *Ford*—end up being executed while in an incompetent state. Finally, by absolutely precluding psychiatric treatment of incompetent prisoners, the AMA position would not have permitted interventions to relieve extreme suffering or to stop life-threatening behavior. Thus, the AMA draft position risked purchasing ethical purity only at the cost of harm to death row prisoners themselves.

Sometime before the AMA draft arrived, I had taken over as chair of the Council on Psychiatry and Law from Howard Zonana, who was now chair of the Commission on Judicial Action. The Council formulated a response to the AMA, asking that all discussion of the psychiatric assessment of competence to be executed and treatment of incompetent prisoners be deleted from the draft.[10] We offered to consult with the AMA to discuss our concerns. In May 1993, APA formally communicated to AMA its recommendations for alternative language that Howard and I had drafted, in consultation with the APA Ethics Committee, which was approved by the APA Board of Trustees,[11] and requested an opportunity to meet with CEJA. Although there was no direct response from the AMA, in June 1993 an AMA position was adopted by the House of Delegates that included this wording:

> Given the complexity of the ethical issues and the importance of the role of psychiatrists, the Council [i.e., CEJA] will defer guidelines on physician involvement in evaluations of a prisoner's competence to be executed [and treatment to restore competence] until the Council has consulted further with the ethics committee of the American Psychiatric Association.[12]

In August 1993, CEJA sent APA its follow-up report, which embodied only minor modifications to its initial approach, and invited APA input.[13] Thus, it came about that the next year (1994), Howard Zonana, Ken Hoge (to whom I was soon to pass the reins as chair of the Council), and I flew to Chicago to represent APA in a meeting with the AMA's CEJA to explain our concerns about the original position. Richard Bonnie, professor of law at the University of Virginia and long-time consultant to the Council, had played an important role in developing the Council's position and helping us to prepare for the meeting.

We left Chicago that day without any promises from the AMA and without an assurance that they would adopt our suggestions. In September 1994, we received a revised draft from CEJA that essentially reflected the APA's approach.[14] We made further suggestions about this draft and a subsequent one. The following year (1995), the AMA House of Delegates was asked to approve additional recommendations concerning physician participation in capital

proceedings. Included in the list of additional recommendations:

> Evaluation of competence to be executed is ethical, so long as appropriate due process protections are in place and the psychiatrist is not the ultimate decision maker.
>
> Treatment of an incompetent-to-be-executed prisoner is generally unethical unless commutation takes place.
>
> Treatment can occur if the prisoner is experiencing extreme suffering as a result of psychosis—but only to mitigate such suffering.
>
> Physicians should have the right to opt out of assessment of competence to be executed or treatment of incompetence because of personal beliefs involving the death penalty.

In essence, CEJA had adopted the position advocated by APA, and the resulting document was passed by the House of Delegates and became (and remains) AMA policy.[15] Some years later, APA adopted the AMA policy as its own formal position.[16]

Reflecting on this episode from the perspective of organized psychiatry, the interaction with AMA was successful in two ways. First, procedurally, it established the proposition that when considering questions of ethics that affect psychiatry, AMA will not act without consulting APA, the umbrella organization that speaks for our field as a whole. Second, substantively, the result of the process was the development of a more reasonable set of guidelines for psychiatrists involved in these very difficult situations. Howard Zonana played a major role in shaping the APA's position and persuading the AMA to go along with it.

Psychiatry and National Security Interrogations

A second conundrum of ethics that faced forensic psychiatry in which Howard played a crucial role was raised by reports from Iraq, Afghanistan, and Guantánamo Bay, Cuba, that physicians and psychologists had been involved in abusive national security interrogations.[17,18] Howard was the first to bring the nature of these interrogations to the attention of the APA Council on Psychiatry and Law and to lay out the complexities involved. In particular, allegations were being made that physicians (including psychiatrists) had played the following roles with regard to interrogations of detainees:

> Training of interrogators;
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> Screening of detainees before interrogation to determine suitable techniques of pressure;
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> Disclosure of information from medical records to identify weaknesses of detainees;
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> Oversight of sleep deprivation, dietary manipulation, and sensory deprivation;
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> Approval of interrogation plans;
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> Presence during interrogations;
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> Providing feedback on interrogation techniques;
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> Failure to report abusive techniques.

Similar allegations in the popular and professional media implicated psychologists as the primary mental health professionals who were relied on for these purposes; the American Psychological Association responded by putting together a task force that issued a report in June 2005.[19] The report concluded that:

> Psychologists should not be involved with, and should report, torture or cruel, inhuman, or degrading treatment.
>
> Psychologists should not use information from a medical record "to the detriment of the individual's safety or well-being," but may use it to "ensure that an interrogation process remains safe."[19]
>
> "Psychologists may serve in various national security-related roles, such as a consultant to an interrogation."[19]

The report concluded that, when psychologists were involved with interrogations, the Ethics Code of the American Psychological Association applies to their behavior, although how it applies was left unstated. The report also noted a lack of consensus on whether psychologists may "ethically disguise the nature and purpose of their work."[19]

The psychologists' report received a great deal of criticism in the popular media and from within the psychological profession (e.g., Refs. 20, 21). Much of that criticism argued that it was inappropriate for psychologists, as a helping profession, to participate in interrogations that were coercive or even abusive and that their presence appeared to lend legitimacy to these problematic tactics. Given that psychiatrists, as well, were alleged to be involved in national security interrogations, albeit to a lesser extent, it was natural to ask what APA's position on such involvement might be. In fact, APA had not previously had to confront this question, and although an APA statement issued in response to queries in June 2005 made reference to several provisions in the organization's Annotations to the Principles of Medical Ethics, their application to interrogation situations was not clear (i.e., it was not readily evident what was permitted or excluded). The one clear statement on the record was a 1985 joint position statement of APA and the American Psychological Association re-

jecting any complicity in torture.[22] Beyond that, however, the question simply remained unexplored.

In September 2004, APA began investigating the issue. With Howard Zonana's help, the APA Council on Psychiatry and Law (which I was again chairing) and the Committee on Judicial Action met jointly with psychiatrists involved in national security and public safety consultation to discuss the ethics-related conflicts they faced in their various roles, including interrogation, hostage negotiation, and other functions. Howard made the initial presentation to the group, laying out the concerns. The following September, the Council and the Committee jointly invited representatives from APA's Ethics Committee, Committee on Misuse and Abuse of Psychiatry, and the Board, along with several leaders in military psychiatry to a three-hour session to discuss the concerns and begin development of a draft position statement for the organization. Howard was one of the people around the table who played an important part in shaping the discussion. The document arising from that meeting was subsequently refined with the entire group by e-mail.

The draft document addressed three subjects: first, it restated and expanded on APA's previous opposition to the involvement of psychiatrists in torture:

> The American Psychiatric Association reiterates its position that psychiatrists should not participate in, or otherwise assist or facilitate, the commission of torture of any person. Psychiatrists who become aware that torture has occurred, is occurring, or has been planned must report it promptly to a person or persons in a position to take corrective action.

This part of the statement expanded on the 1985 joint statement with the psychologists by adding the obligation to report torture, when psychiatrists become aware that it is occurring. There was no dissent in the group to this requirement, and the military psychiatrists present reported that this was already required by the armed forces' own rules of conduct.

Second, the statement addressed the possible conflict in psychiatrists' roles as treaters and as consultants to an interrogation process:

> Every person in military or civilian detention, whether in the United States or elsewhere, is entitled to adequate medical care under domestic and international humanitarian law. Psychiatrists providing medical care to individual detainees owe their primary obligation to the well-being of their patients and should not participate or assist in any way, whether directly or indirectly, overtly or covertly, in the interrogation of their patients on behalf of military or civilian agencies. Nor should any part of the medical records of any patient, or information derived from the treatment relationship, be disclosed to persons conducting interrogation of the detainee.

Once again, there was no disagreement among the members of the group that treating psychiatrists should not be involved in interrogating their patients. Some questions were raised about the use of medical information to clear people for interrogation, in the belief that this could be protective of impaired detainees. However, the threat that psychiatrists would become gatekeepers to the interrogation process, deciding when detainees could be turned over for abusive interrogations, precluded adoption of that approach.

Finally, the working group tackled the most difficult aspect, participation in interrogations themselves:

> Psychiatrists should not participate in the interrogation of persons held in custody by military or civilian investigative or law enforcement authorities, whether in the U.S. or elsewhere. Nor should they provide information or advice to military or civilian investigative or law enforcement authorities regarding the likely consequences of specific techniques of interrogation that is in any way particularized in its application to an individual detainee.

Since it made little sense to indicate that participation in interrogations was out of bounds without indicating what constituted an interrogation, the following definition was developed:

> As used in this statement, "interrogation" refers to a deliberate attempt to elicit information from a detainee for the purposes of incriminating the detainee, identifying other persons who have committed or may be planning to commit acts of violence or other crimes, or otherwise obtaining information that is believed to be of value for criminal justice or national security purposes. Interrogation does not include interactions with judges or attorneys in connection with adjudication or preparation for adjudication; interviews or other interactions with a detainee authorized by a court or by counsel for the detainee; or interviews or other interactions with a prisoner serving a sentence conducted by or on behalf of correctional authorities.

Support for a ban on participation in interrogations was based on two rationales. First, interrogations are inherently coercive and deceptive. With regard to coercion, at the simplest level, it seems obvious that detainees who want to speak freely about the information they know do not need to be interrogated formally. Moreover, detainees overseas—where *Miranda* rights do not apply—are typically not free to terminate interrogations at will, and they are often subject to noxious interrogation conditions. As for deception, persons being interrogated are often fed false information about the situation or

about what others have said (e.g., that they have implicated the detainee in activities that could lead to criminal punishment, unless the detainee cooperates and tells his captors what he knows). The inappropriateness of physicians becoming involved in either coercion or deception speaks strongly against their having a role in the interrogation process.

A second reason to be wary of involvement in interrogation is that facilitating questioning undercuts the role of psychiatrists as treaters, because detainees are unlikely to trust physicians when they know that physicians participate in interrogations. Thus, detainees' rights to adequate medical care, especially to psychiatric treatment, may be compromised by their fear that information communicated in a treatment context (e.g., about their phobias or their concerns regarding the well-being of family members) might be used against them in interrogations.

Support for a position that ruled out psychiatric involvement was not unanimous. There was substantial (though minority) support for an approach that focused on eliminating physician involvement only in "coercive" interrogations, involving, for example, sleep deprivation, uncomfortable positions, and the like. A majority of the group, however, believed that this distinction would be impossible to adhere to in practice, since a psychiatrist who provided information to facilitate interrogation would have no way of knowing in what kind of interrogation that information would be used. Even if present in or near the interrogation room, it would be unlikely that a physician could determine how an interrogation was conducted. Although offered in the draft report as an alternative approach, both the APA Joint Reference Committee and the Board of Trustees, which later reviewed the document, opted for a complete bar on participation favored by the majority of the working group.

A remaining consideration was the possibility of indirect involvement in interrogation. Psychiatrists, for example, might be asked to provide general training (e.g., on interviewing techniques) to interrogators, or advice regarding the interrogation of a specific person (e.g., "This detainee is terrified of being left alone, and can likely be broken by prolonged isolation."). Was either of those functions permissible? The group recognized that general training for interrogators may be desirable in certain situations—for example, teaching interrogators how to interview people with mental illnesses or how to interview juveniles, without causing needless trauma. More direct advice about specific detainees was seen as implicating psychiatrists too directly in the interrogation process. Hence, the line was drawn at providing information "that is in any way particularized in its application to an individual detainee."

After review by the APA Joint Reference Committee and preliminary approval by the Board of Trustees, the document went to the Assembly, which under APA rules is required to approve position statements before final approval by the Board. There was some pushback from a subset of military psychiatrists who were concerned that a statement by APA opposing participation in interrogations might put them in an awkward situation were they to face countervailing orders by their superiors. Although many military psychiatrists felt that the statement would be protective, that is, it would give them a basis to decline to participate in activities about which they had substantial qualms, when the question was raised at the Assembly in November 2005, the document was changed to preclude participation only in coercive interrogations. Thus, the rather unusual situation now existed that the APA Board and Assembly had endorsed different versions of a position statement. When the Assembly version went back to the Board in December 2005, the Board strongly reaffirmed its original stance.

In January 2006, as chair of a joint Board and Assembly workgroup appointed to resolve the conflict, I went to a meeting of the Assembly Committee on Planning in Tucson to discuss the matter. After negotiation and some changes, including clearer specification of those roles for psychiatrists that were precluded by the statement and those that remained permissible (e.g., training on the medical and psychological effects of particular interrogation conditions), the document returned to the Assembly at its next meeting in May 2006 and was approved with the crucial bar on psychiatric participation in all interrogations in place. Shortly thereafter, it was put on the agenda of the Board of Trustees and adopted as APA policy.[23]

Two codas to this account are of note. The much more permissive position on interrogation of the American Psychological Association attracted so much negative response from the membership of that organization that it ultimately was overturned in a membership referendum,[24] although the organiza-

tion's leadership has refused to embrace the new position as formal policy. Within months of approval of the APA's position statement and after APA input to a preliminary draft,[25] the AMA adopted its own position, which was almost identical in its stance.[26] Hence, a timely and positive response by APA led and shaped AMA policy, establishing a principled position on participation in interrogation for American medicine as a whole and leading the way for the mental health professions as well. Once more, Howard Zonana had played a pivotal role in alerting psychiatry to a critical problem of ethics and in helping to craft the solution.

A Leader for American Psychiatry

It should be clear from this account how, in two of many similar situations, Howard Zonana was a key contributor to the development of the ethics of forensic psychiatry and indeed of psychiatry as a whole. I chose as illustrations two episodes with which I was also involved and hence knew well. I might, however, have selected the excellent series of practice guidelines for forensic psychiatry that have been produced by AAPL under Howard's guidance,[27–29] or I might have discussed the role that Howard has played representing AAPL at the AMA House of Delegates and the influence that he has garnered for forensic psychiatry as a consequence of his thoughtful and measured responses to a wide range of difficult problems. In fact, I could have focused on any one of a large number of other examples.

It is invaluable for any profession to have within it leaders who have immense practical experience, detailed knowledge of the relevant data, and a strong moral compass. Howard Zonana has played that role within APA, AAPL, and AMA, and I have no question that he will continue to do so for many more years. Thus, it is a particular privilege to be part of the well-deserved honor that this Festschrift represents. It has been a special pleasure to know and work with him. Thank you, Howard.

Acknowledgments

I am grateful to Richard Bonnie for access to his archives of materials on the APA-AMA interaction on the questions of competence to be executed and to Prof. Bonnie and Ken Hoge, MD, for sharing their recollections of the process.

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