Treating Those Found Incompetent for Execution: Ethical Chaos with Only One Solution

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In early 1988 the population on America's death rows climbed above the 2,000 mark for the first time in history. In 1986 the United States Supreme Court firmly stated that the Constitution will have been violated if any of these prisoners is put to death while mentally incompetent for execution. In this article we discuss the case of Gary Alvord, the only inmate to be formally found incompetent for execution in modern times. Interviews with psychiatrists and mental health professionals at the Florida psychiatric hospital where Alvord was treated between 1984 and 1987 reveal much ambivalence and anger about the case. We conclude that, out of respect for the rights of these mental health professionals and the ethical codes of their professions, any prisoner found incompetent for execution should have his or her death sentence commuted to long-term imprisonment before treatment is requested or given.

In 1986 the United States Supreme Court firmly declared that the Eighth Amendment ban on cruel and unusual punishment prohibits execution of the mentally ill.[1] Before that decision, every state using the death penalty had provisions of one sort or another that allegedly prevented execution of the insane,[2] but exemption from execution was treated as a subject for executive grace, not a matter of constitutional right. Because they were left to the discretion of the executive, the procedures used to determine who was mentally incompetent had any number of ambiguities, irregularities, and other shortcomings. The Florida statute under review in *Ford v. Wainwright*[1] was invalidated on three grounds: (1) it excluded the prisoner from the proceedings in which his competency was determined, (2) it denied the prisoner any right to challenge the findings of the psychiatrists appointed by the state to evaluate competency, and (3) it left the final decision of whether or not to temporarily postpone the execution, pending recovery of competency, in the hands of the less-than-neutral Governor.

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It remains to be seen how the federal courts will react to the attempts of various states to amend their rules in accordance with the *Ford* ruling. Florida, in the wake of *Ford*, now puts the decision of whether or not the prisoner is competent in the hands of a judge from the same circuit in which the state's electric chair is housed. While that judge may listen to evidence of incompetency presented by the defense, he or she is not required to do so. In the first case in which this procedure was used (in November 1987), a psychiatrist who had spent an hour evaluating a prisoner for competency for execution at the request of the Governor testified in court that he had "no doubts" that the prisoner was indeed competent to be executed.[3] This determination and the procedures through which it was reached are now being challenged in federal courts, and other states are awaiting the rulings to sort out what can be learned from Florida's example.

In an earlier report[4] we reviewed some of the major ethical problems facing psychiatrists who are asked by the state to participate in evaluations of competency for execution. Other authors have also recently addressed this issue.[5-7] Some, but not all, of the concerns we raised were also voiced in the Court's opinion in *Ford*. In this article we focus our attention on a slightly different ethical problem. As currently mandated by the legislative, judicial, and executive branches of government, exemptions from execution because of mental incompetence are temporary, not permanent. If the prisoner is given adequate mental health treatment and recovers mental competence, he or she will also regain eligibility for execution and will be put to death. In effect, the stay of execution expires when the medical and/or mental health treatment succeeds. We therefore ask: Can a physician or health care professional ethically deliver medical care knowing that the success of that care will result in the death of the patient? We discuss the issue from a framework of medical ethics but view the issues for other health care professionals as identical to those faced by the physician.

Ethical Principles Involved

Several ethical principles are involved in this dilemma. Most central are beneficence and confidentiality.

The principle of beneficence requires health care professionals to refrain from injuring patients and to help them further their interests by preventing or removing possible harms (i.e., primum non nocere—"first, do no harm"). This important guideline (but no longer a part of the official AMA Principles of Medical Ethics) may require physicians to act paternalistically in some cases. In the case of children and incompetent individuals, some form of paternalism is unavoidable: physicians, guardians, the courts, or other decision-makers must choose on behalf of the patients and must determine their best interests.[17] Even deception by the physician, some would argue, may be justified by paternalistic concerns about the best interests of the patient.[19] Because treating a patient so that he or she can be executed

is almost never in the best interests of the patient,[20] can other principles override the principle of beneficence? Alternatively, are paternalistic efforts *required* of the physician to shield the patient from harm?

A second ethical principle raised in these cases is confidentiality. As expressed in the Hippocratic Oath, "And whatsoever I shall see or hear in the course of my profession, as well as outside my profession in my intercourse with men, if it be what should not be published abroad, I will never divulge, holding such things to be holy secrets."[21] Should health care personnel be required to divulge information learned in the course of treating incompetent death row prisoners to those whose job is to determine whether the patient's competence for execution has been restored? What quality or quantity of information should be recorded in the patient's medical records?

We know that confidentiality in physician-patient encounters is not an absolute right; but whether it can or should be violated by therapists who treat incompetent death row prisoners presents a major dilemma. Physicians must inform public authorities about gunshot wounds, certain sexually transmitted diseases, child or sexual abuse, and other possible dangers to third parties. In such cases the interests of the community in self-protection are given precedence over the interests of the patient. Although it would be difficult to support the argument that there is a community interest in self-protection in cases of mentally ill death row prisoners, it still could be argued that the state's interest in carrying out its lawfully imposed death sentence, standing alone, legitimizes breaches of confidentiality. The hospital staff is serving two very different masters: the patient and the state, and questions concerning confidentiality cannot be answered by pleasing both.

At the heart of the ethical dilemma faced by mental health professionals who are asked to treat mentally incompetent death row prisoners is the threat to the fiduciary nature of the physician-patient or therapist-patient relationship that such treatment poses. An atmosphere of trust, confidence, and veracity is essential to establishing open communication and fostering the healing process. If the physician violates this trust by a misuse of paternalism or by exposing the patient to harm, other patients of that physician (or hospital) may be less trustful, less open, and thus more difficult to treat. In this sense, one could argue that executing the prisoner once he or she is successfully treated requires violating the relationship of trust that is a necessary prerequisite for successful treatment.

Appelbaum outlines three positions that mental health professionals might take in reaction to a request to treat incompetent death row prisoners.[22] First, some clinicians may feel obligated to treat mental illness whenever possible, regardless of the consequences, and would treat the patient and let others argue about his or her fate. But as Sargent argues in condemning such treat-

ment, "Any therapy not grounded in the patient's welfare is inherently dishonest."[23] The question for physicians considering this option therefore becomes whether other concerns can be identified that outweigh the obligation of honesty. Second, physicians may choose to treat some prisoners—but only those who request treatment. The problem with this position is that inmates incompetent for execution may also be incompetent to give an informed consent for treatment, and thus close consultation between the doctor and the inmate's attorney is called for. A third position is outright refusal to treat any patient when the goal of those demanding the treatment (i.e., the state) is to shorten the patient's life.

Although such arguments are instructive in the abstract, it is quite a different matter to decide what to do when an incompetent death row prisoner is literally delivered to a hospital's doorsteps for treatment. In the United States today, only one of the 2,048 inmates currently under a sentence of death has been found incompetent to be executed.[24] With the pace of executions in this country promising to increase, and the undoubtedly high (although unknown) prevalence of mental impairment on death row,[25] the psychiatric and related mental health professions will no doubt be confronted by similar cases in the future. We therefore collected data for this article through interviews with a dozen mental health professionals who, over the last four years, have been forced to decide whether or not to become involved in treating an inmate to restore his competency for execution.

The Case of Gary Alvord

In 1974 Gary Eldon Alvord was convicted of strangling three women to death during the course of a 1973 burglary in Tampa. One of the victims was also sexually assaulted. Alvord had first been incarcerated at age 7, and at age 13 was diagnosed as a paranoid schizophrenic and admitted to a Michigan psychiatric hospital. He later escaped from that hospital and others; in 1970 he was charged in Michigan with kidnapping and raping a young girl and found not guilty by reason of insanity. In 1973 Alvord again escaped and this time headed for Florida, where later that year the killings that led to his death sentence took place.

In 1975 Alvord's conviction and death sentence were upheld by the Florida Supreme Court.[26] A further appeal to the Florida Supreme Court, contending that he was denied effective assistance of counsel because his attorney failed to convince him to plead not guilty by reason of insanity, was also denied.[27] However, in 1983 a United States district court vacated Alvord's sentence because the trial judge had based it in part on an inappropriate aggravating factor: future dangerousness.[28] This order was subsequently reversed by the United States Circuit Court of Appeals,[29] which later that year refused to reconsider its decision.[30]

Alvord was scheduled to be executed on November 29, 1984. Shortly before that date, his attorneys raised the issue of whether the inmate was mentally competent to be executed. They had

briefly addressed this issue in 1979 but had decided to await resolution of other issues in the case before pursuing it. This time, a team of three psychiatrists was appointed by the Governor to assess Alvord's competency, and three days before the scheduled execution, the prisoner was evaluated. After the psychiatrists dictated a five-sentence report in the prison parking lot stating their belief that Alvord was indeed incompetent to be executed, the governor stayed the execution and ordered the prisoner transferred to a state psychiatric hospital in Chattahoochee. We note in passing that the psychiatrists' report simply offered the conclusion that Alvord was incompetent for execution; no details were given as to how the examination was conducted or what medical impairments were found. In short, it was really the psychiatrists, not the governor, who made the decision that Alvord was incompetent. As in every other case in which the issue of competency has been raised in Florida death penalty cases, the physicians in the Alvord case acted as both experts and judges.

Alvord's arrival at Florida State Hospital in Chattahoochee, on December 10, 1984, sparked immediate controversy. Almost immediately the hospital's Human Rights Advocacy Committee issued a statement saying that the presence of the death row inmate "would negatively impact upon the morale of both the patients and the staff of the unit." The committee expressed support for any staff members who would refuse to participate in Alvord's treatment, and called for Florida law to be changed, so that a commutation to life imprisonment would be required when death row inmates are found incompetent for execution. They also joined the Florida Mental Health Association in calling for a boycott by mental health professionals of assessments of competency to be executed.[31]

For the first ten months after his arrival at Chattahoochee, Alvord was housed in the hospital's forensic unit, a division of the hospital with 450 beds which delivers services primarily to prisoners found incompetent to stand trial. In October 1985 he was transferred to the newly opened Corrections Mental Health Institution (CMHI), also on the grounds of the Chattahoochee hospital. This unit, then six months old, was designed for 150 convicted felons serving time in the Florida prison system who suffer from chronic mental illness. It is jointly operated by the state's health agency (Health and Rehabilitative Services) and the state's corrections department. The residents of the facility are called inmates (not patients), but they live in rooms (not cells).[32,33] Alvord remained in that unit until 1987.

Staff Options and Reactions

The Florida statute requires that a mentally incompetent death row prisoner remains at the state hospital "until the proper official of the hospital determines that he has been restored to sanity." When the prisoner has been restored to sanity, "the hospital official shall notify the Governor of his determination, and the Governor shall appoint another commission [to formally

reevaluate the prisoner's competence for execution]."[34]

Despite their long experience in forensic work, the Chattahoochee staff found that the existing procedures and models, which had been used in other cases in striking a delicate balance between medical and legal roles, proved to be of little help in figuring out how to handle the Alvord case. During the prisoner's 31 months at Chattahoochee, the staff gradually moved through three different models in reacting to the state's mandate. They are:

Incompetent to Stand Trial Model The first idea, developed (and rejected) before Alvord's arrival at Chattahoochee, was to treat him like those prisoners found incompetent to stand trial. Prisoners found incompetent to stand trial are assigned to a treatment team. One member of that team, a psychologist, is designated as the assessor of the legal issue. When the assessor feels that the inmate is competent to stand trial, he or she reports this opinion to the trial court, which then conducts a formal hearing on the issue. This model was immediately rejected for the Alvord case, primarily because it lay all the responsibility for directing the prisoner's fate on the shoulders of one assessor. A shared-responsibility model was preferred.

Team Approach Model This model was adopted when Alvord first arrived at Chattahoochee. Instead of the burden of assessment of competency falling on the shoulders of one health professional, the whole treatment team (psychiatrist, psychologist, and social worker) would assume the roles of both treater and evaluator. A unanimous decision would be required before the Governor's office would be informed that, in the opinion of the hospital, the prisoner's competency had been restored. This model was eventually rejected because it failed to separate the role of therapist from that of evaluator, and the staff quickly saw how the demands of those two roles sharply conflicted.

Split Model Once CMHI opened, it was decided that the roles of treater and assessor were in hopeless conflict, and that the assessor should be completely removed from the treatment team. This solution, however, did not completely resolve the assessor's feelings that he (by serving as an assessor) was undermining the goals of the institution, which were to further the welfare of the patients. The assessor tried to make clear to the patient that he was not in a treating role but expressed some discomfort about how well his explanation was understood. Furthermore, a complete separation of the assessor from the case proved to be impossible. The assessor still knew the treaters and worked with them on other cases; they were still friends and socialized together, and avoiding all verbal and nonverbal communication about the case was impossible.

Under this model the assessor does not give opinions on the ultimate issue of the inmate's competency for execution, and does not discuss the criteria for competence in any written medical records. The assessor writes reports that describe the inmate's behavior, but leaves interpretation of these reports to

administrators within the institution. The assessor does give opinions on the patient's need to remain hospitalized; and of course an opinion that maximum benefits of hospitalization have been reached would imply an indirect judgment on the issue of competence to be executed.

In our interviews with the mental health professionals who were involved with the Alvord case, the most common reactions we found were confusion and anger. Especially when Alvord first arrived at Chattahoochee, the staff felt a powerful ambivalence about the case. They reported feeling continual emotional conflicts over how to deal with the inmate, and even when we visited the staff two years after Alvord first arrived, these conflicts had not been resolved or eased. One psychiatrist reported first approaching Alvord as one would approach the terminally ill; then thinking the inmate needed to be restored to competency so he could defend himself; then trying to empathize with the victims' family; then feeling very paternal toward the inmate; and then, finally, abandoning the hope of finding an approach that "worked" or "felt comfortable." This psychiatrist was at first criticized by other staff members for feeling emotionally torn, which only fueled the psychiatrist's anger at having been placed in such a difficult position. The psychiatrist *was* emotionally torn, and *was* paying a high personal price for involvement. The psychiatrist finally concluded not only that the dilemma was unresolvable but that it was simply not worth the energy required to try to find a justification for even minimal involvement.

Some staff members suggested that they often felt the inmate should be granted access to at least one therapist in whom he could confide and trust. These workers felt that nothing that Alvord did or said could be regarded as confidential.[35] Some reported worrying that even if they told Alvord not to confide in them, the patient's basic need for human contact might be so great that he might—against his own interests—divulge information that could be used against him. Some staff felt caught in a bind between wanting to keep their distance, on the one hand, and wanting to help the inmate (as any other patient), on the other. Recognizing his isolation and humanity, they also recognized the contradiction inherent in the fact that even if confidentiality could be guaranteed, it may help Alvord recover and bring him nearer to his demise in the electric chair.

The prisoner was not the only person feeling isolation. We found that many staff members welcomed the opportunity to share their feelings about this case with us. They usually felt it best not to discuss the case with anyone, inasmuch as whatever was said could be given a political interpretation and could be used to fuel the conflict. Because of this concern, the rural location of the hospital, and the fact that staff disputes over this case could easily be covered and distorted by the press, the case and the dilemmas it presented made some staff members feel quite isolated.

After a two-hour meeting with a dozen

mental health professionals who had been involved with this case, we asked how many would be involved with the next inmate who was found incompetent for execution. Not one said he or she would. To be sure, CMHI undoubtedly has other therapists who might, but the lesson these therapists learned from their experiences is sobering. Even the therapists who themselves had found a way to feel somewhat comfortable with the case had a high degree of respect for other therapists who did not share their feelings, and they seemed to want Alvord removed simply out of deference to the principled feelings of their colleagues.

On March 23, 1987, a psychiatrist, psychologist, and hospital administrator signed a 10-page single-spaced clinical summary of Alvord, summarizing his social and medical history and his mental status (and changes therein) since being hospitalized. They specifically refused to offer an opinion on competency for execution but recommended that a panel of experts (from outside of CMHI) be appointed to reassess Alvord's competence. On July 24 the Governor appointed a panel of three psychiatrists to conduct a reassessment. On August 4 a two-page addendum to the March 23 report was signed by the three members of the Chattahoochee staff. This addendum concluded that Alvord was "in a substantial state of remission for a chronic schizophrenic major mental illness [*sic*]" and that "he has received maximum benefit from his hospitalization at Corrections Mental Health Institution."

Alvord was transferred 150 miles east to Florida State Prison for his competency exam, which was scheduled for September 29. On that date, however, Alvord's attorney instructed him not to cooperate with the exam, based on the beliefs that (1) the proceedings were a direct violation of the Supreme Court's decision in *Ford*, and that (2) if Alvord's death sentence were vacated because of other legal issues (unrelated to mental competency), the material uncovered in the exam might be used against him at resentencing. The transcript of the exam reveals that Alvord had "no response" to 64 questions posed by the psychiatrists, who did not warn the prisoner of any right to remain silent. The three psychiatrists then wrote to the Governor, on prison letterhead, saying that Alvord's refusal to be interviewed showed that he could "respond appropriately" but that they could not "render an opinion within reasonable medical probability as to his competency to be executed." On October 15, 1987 the Governor lifted the stay of execution that had been granted to Alvord in 1984 when he was originally found incompetent for execution. Today Alvord remains at Florida State Prison, and his death warrant could be signed at any time.

Conclusions

The case of Gary Alvord is far from over. However, the chapters of his story that concern his treatment at Chattahoochee have now been written, and several lessons can be learned.

The first lesson learned from this case

lies in the hospital administration's wisdom in permitting its mental health professionals to opt out of treating incompetent death row prisoners. Although at first some of the staff did feel somewhat pressured to treat Alvord, it was quickly decided that all involvement with the prisoner would always be on a voluntary basis. The issue of treating mentally incompetent death row prisoners is not clear-cut (at least to some), and reasonable therapists will differ as to what they feel their personal and collective reactions should be. The staff at this hospital unquestionably have grown by listening to each other and learning to respect each other's conscientious decisions. The case has been divisive, but the administration's willingness to allow therapists to remain uninvolved has no doubt reduced the tension and prevented large-scale staff infighting.

Second, this case presents a lesson for legislators, judges, and members of the state's executive branch. To our knowledge, none of these parties ever solicited the opinions of mental health professionals before asking—indeed mandating—that they provide evaluations and treatment for mentally incompetent death row prisoners. Similarly, in the wake of the 1986 *Ford* decision, although the Florida Supreme Court solicited input from members of the Bar on revising Florida's incompetency statute, as far as we know no opinions were solicited from psychiatrists or other mental health professionals to see whether and how competency for execution could be evaluated, and whether or not treatment should be delivered if any exemptions from execution are not permanent. The state's policy-makers apparently assume that at least some psychiatrists and mental health professionals will be found who will do exactly what the policy-makers tell them to do. Thus far this assumption has proved to be correct. Not unlike the occasional judge who is shocked when he or she visits a prison, the policy-makers might learn something if they solicited input from those whom they have asked to treat inmates so that they can be executed.

Third, requests to treat mentally incompetent death row prisoners inevitably produce conflict in the minds of the treatment staff. This conflict stems from the necessity to please several audiences in a zero-sum game in which not all allegiances can be honored. The patient, the government, the hospital administration, and the victim's family all may demand allegiance from the therapist, and even the most determined and confident therapist will feel pressures from opposing directions. Conflict may also brew from the fact that, because the patient's life is at stake, manipulation of the staff by the patient can be expected to occur routinely. The staff, who typically want to be in control, need to discuss their feelings about being manipulated and about any resentment that might ensue.

Fourth, the major source of conflict in the minds of the staff was not felt as a theoretical battle between conflicting principles of medical ethics, nor was it a matter of overworked and underpaid state employees trying to avoid challeng-

ing and difficult cases. Instead it was (and is now, through bitter experience) felt as a simple realization that the competency for execution dilemma was one they could do without under existing circumstances. The staff recognized that to see Alvord return to the prison and be executed would be emotionally difficult for some of them. If the issue of Alvord's competency eventually ends up in court (as it will if other legal issues in the case do not moot the competency issue), a courtroom battle might pit staff against staff and friend against friend to decide Alvord's fate.

Finally, the amount of staff time consumed by this case, especially given the large number of unmet demands for mental health services in the state, is yet another reason why many on the staff would prefer not being placed in the awkward position of providing treatment so that the patient can be put to death. Questions of individual ethics aside, from this point of view the absence of a commutation of sentence necessitates a ridiculous waste of scarce medical resources.

We conclude that the ethical dilemma created by the demand to treat prisoners so that they can be executed can only be resolved by commuting the sentence of mentally incompetent death row prisoners to long-term imprisonment. This solution has in fact been adopted in Maryland.[36] But Maryland's solution is not without problems: it may increase the chances of malingering and may also increase the temptation of those physicians opposed to the death penalty to find everyone they evaluate incompetent. As we see it, however, the first problem is reduced by allowing only the most highly-skilled physicians to participate in these life-and-death decisions. The rare inmate who, in theory, may escape the executioner by feigning insanity would still be punished by long-term imprisonment, and we do not see the benefits of execution *over and above those of long-term imprisonment* as outweighing the ethical and emotional costs outlined above. Furthermore, the second objection to commuting death sentences for incompetent inmates is not convincing. Physicians whose feelings against the death penalty would influence their competency evaluations (at most a small number, and not the sort whom governors would ask to conduct evaluations in the first place) would be no less motivated by the prospect of a permanent exemption from execution than by the prospect of a temporary exemption. In short, we find the arguments for automatic commutation to be strong and persuasive.

Precedent for executive clemency in this type of case is abundant and strong.[37–39] From the *Ford* decision we know that mentally incompetent inmates have a constitutional right not to be executed. From the Alvord experience we conclude that mental health professionals should be given some guarantee that *they* have a right not to be faced with the predicament of working in hospitals where people are being treated with medical skills in order to hasten their deaths.

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22. Appelbaum: supra note 5
23. Sargent: supra note 14 at p 5
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