Consent in Incompetent Patients

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D.C. May Apply Best-Interests Standard for Surgical Consent in Developmentally Delayed, Incompetent Patients

In *Doe v. District of Columbia*, 489 F.3d 376 (D.C. Cir. 2007), the U.S. Court of Appeals for the District of Columbia ruled that the D.C. government may apply the best-interests standard to authorize elective surgery for mentally retarded persons for whom the known-wishes standard does not apply.

Facts of the Case

The plaintiffs were three intellectually disabled women who lived in facilities run by the D.C. Mental Retardation and Developmental Disabilities Administration (MRDDA). They filed a class-action lawsuit in the U.S. District Court for the District of Columbia (*Jane Does I through III v. District of Columbia*, 232 F.R.D. 18 (D. D.C. 2005); see also *Does v. District of Columbia*, 374 F. Supp.2d 107 (D. D.C. 2005)). In the lawsuit, the plaintiffs alleged that the MRDDA authorized elective surgical procedures on their behalf without considering their wishes. They argued that the MRDDA policy, which had been amended in 2003, violated the Health Care Decisions Act, D.C. Code § 21-2201 *et seq.* (2007), and the plaintiffs' Fifth Amendment rights. In addition to an injunction against the MRDDA's 2003 policy, the plaintiffs sought monetary awards for damages.

Each plaintiff in the suit had been subjected to surgical procedures authorized by the MRDDA. In 1984, the MRDDA had authorized the abortion of Jane Doe I's pregnancy. Jane Doe II had had exotropia, for which the MRDDA authorized surgical correction in 1994. Jane Doe III had had an abortion of her pregnancy authorized by the MRDDA in 1978.

The reader may be wondering how the MRDDA could be sued for authorizations it provided years before the adoption of its 2003 policy. In its ruling, the district court noted that the 2003 policy largely "duplicates the agency's earlier policies." That is, those portions of the disputed policy remained essentially unchanged between 1978 and 2003.

Jane Does I, II, and III argued that the MRDDA's 2003 policy was incompatible with D.C. law, which states, "Mental incapacity to make a health care decision shall be certified by [two] physicians who are licensed to practice in the District and qualified to make a determination of mental incapacity. One of the [two] certifying physicians shall be a psychiatrist" (D.C. Code. § 21-2204(a)(2007)). The fact that none of the members of the class had ever possessed medical decision-making capacity was accepted by both the plaintiffs and the defense.

D.C. law distinguishes between those patients who were once able to make medical decisions for themselves and those who have always lacked competence. For those patients who were once competent, D.C. law specifies that the "known wishes of the patient" should apply with regard to medical decisions made on their behalf. Such patients may have made known their wishes before their incapacitation, especially if it resulted from age, disease, or injury. For those whose known wishes cannot be ascertained, D.C. law specifies that the medical decision should be made with a "good faith belief as to the best interests of the patient" (D.C. Code § 21-2210(b)(2007)). The plaintiffs asserted that this best-interests standard was improperly applied by the MRDDA in their situation and that the known-wishes standard should have been applied instead.

The U.S. District Court for the District of Columbia, granting summary judgment, found for the plaintiffs. The court permanently enjoined the MRDDA from future authorization of elective surgeries under its 2003 policy and declared the policy unconstitutional and in violation of D.C. law. In the preliminary injunction, the district court wrote, "even a legally incompetent, mentally retarded individual may be capable of expressing or manifesting a choice or preference regarding medical treatment" (*Does*, 374 F. Supp.2d 107, p 115). In the permanent injunction, the district court stated, "Before granting, refusing, or withdrawing consent for any elective surgery on any MRDDA consumer, the District of Columbia must attempt to ascertain 'the known wishes of the patient'. . ." (*Jane Does I through III*,

232 F.R.D., p 34). The D.C. MRDDA appealed the decision to the U.S. Court of Appeals for the District of Columbia.

Ruling and Reasoning

The U.S. Court of Appeals for the District of Columbia Circuit overturned the district court's finding for the class plaintiffs. In its decision, the court wrote that it "reversed the district court's grant of summary judgment, vacated the district court's injunction, and directed the entry of judgment for D.C. and MRDDA with respect to the class plaintiffs' claims for declaratory and injunctive relief" (*Doe*, 489 F.3d, p 384). The court declined to address the class plaintiffs' individual damage claims.

The court noted that it was undisputed that each of the class plaintiffs had always been incompetent to make medical decisions. Addressing this situation, the court wrote:

> Because plaintiffs have never been able to make informed choices regarding their medical treatment, their true wishes with respect to a recommended surgery 'are unknown and cannot be ascertained' for purposes of [D.C. code] § 21-2210(b). Therefore, the District of Columbia is correct that the 'best interests' standard applies . . . [*Doe*, 489 F.3d, p 381].

The court emphasized that considering the wishes of a lifelong incompetent patient may have detrimental consequences for her or his health and would be both legally and ethically tenuous.

The court defended the fairness of the 2003 MRDDA policy, noting that it bestowed medical decision-making powers on its administrators only when a family member, guardian, close friend, or associate was not available to grant or withhold consent. The 2003 MRDDA policy specified that guardians and family members should be given notice of recommended medical treatment and be given an opportunity to grant consent. Further, the policy specified that two physicians must certify that the surgery is clinically indicated before it can be authorized. The court illustrated that, under these administrative requirements, every conceivable effort was made to ensure a fair and ethical medical decision-making process. Accordingly, the policy fulfilled the requirements of D.C. law.

In examining the issue of whether the 2003 MRDDA policy comports with the U.S. Constitution, the court reiterated that the administrative safeguards provide ample protection of individuals' rights under due process of law. Specifically addressing the plaintiffs' assertion that the Constitution requires their wishes be considered, the court wrote, "as we explained above, accepting the wishes of patients who lack (and have always lacked) the mental capacity to make medical decisions does not make logical sense . . ." (*Doe*, 489 F.3d, p 382).

Finally, the court turned its attention to the extraordinary breadth of the plaintiffs' constitutional claims. It was concerned that the plaintiffs' proposed system of allowing lifelong incompetent patients to participate in their own medical decisions ran contrary to the *status quo* of each state. The court wrote, "so far as we are aware, no state applies the rule suggested by plaintiffs." The court noted that the plaintiffs were essentially arguing that "all states' laws and practices with respect to medical treatment for intellectually disabled individuals who have never been competent are inconsistent with the Constitution" (*Doe*, 489 F.3d, p 383). The court concluded, "[the] plaintiffs' constitutional claims are meritless."

Discussion

This case highlights some complex questions surrounding consent for medical procedures in mentally incapacitated adults. The courts have adopted the concept of substituted judgment to address this dilemma, either by deciding the proper course of action directly or bestowing such authority on a separate entity. In this circumstance, the MRDDA was charged with making such decisions.

The concept of substituted judgment is thought to have been originated by Lord Eldon, who presided as Chancellor in the Court of Chancery in the 1816 case of *Ex parte Whitbread, in the matter of Hinde*. Mr. Hinde, a lunatic by English definition, was ordered to pay monies from his surplus to his close relatives (Beyleveld D, Brownsword R: Consent in the Law. Portland, OR: Hart Publishing, 2007, pp 114–17). The case reads, "[T]he court will act with reference to the lunatic, and for his benefit, as it is probable that the lunatic himself would have acted had he been of sound mind" (35 Eng. Rep. 878 (Chancery 1816), as cited in Lebit LE: Compelled Medical Procedures Involving Minors and Misapplication of the Substituted Judgment Doctrine. J Law Health 7:107, 1992). The supposition was that, if Mr. Hinde had had his wits about him, he would have willed that these payments be made.

While Lord Eldon is credited with the concept of substituted judgment, it was not widely recognized

in the United States until many years later (Beyleveld and Brownsword). In 1969, the Kentucky Court of Appeals affirmed a lower court's ruling, ordering the removal of one of Jerry Strunk's kidneys for transplantation into his dying brother (*Strunk v. Strunk*, 445 S.W.2d. 145 (Ky. Ct. App. 1969)). Mr. Strunk, who had an IQ of 35, clearly could not consent to the procedure. The court reasoned that he would suffer more emotional harm from the loss of his brother than he would suffer physical harm from the loss of one kidney. In its opinion, the court gave a detailed history regarding the doctrine of substituted judgment. It traced the origins of the concept of substituted judgment from Lord Eldon's court to its introduction in American courts in 1844 with the New York case *In the Matter of Willoughby*, *a Lunatic*, 11 Paige Ch. 257 (N.Y. Ch. 1844).

In the case of *Jane Does I through III v. District of Columbia*, three women who had never been competent to make medical decisions were faced with health care concerns. Each of these women was afflicted with unfortunate circumstances in life. However, it was clear to the court of appeals that the D.C. MRDDA utilized a variety of measures to ensure the preservation of liberty interests for those entrusted to its care. Lord Eldon, we believe, would have approved of this decision.

Miranda Waiver in a Juvenile

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A Mentally Retarded Juvenile Suspect Did Not Knowingly Waive *Miranda* Rights

In *Smith v. State*, 918 A.2d 1144 (Del. 2007), the Supreme Court of Delaware considered whether a mildly mentally retarded juvenile was competent to stand trial and had knowingly waived his *Miranda* rights before making an inculpatory statement to police.

Facts of the Case

The appellant, James Smith, was a 14-year-old juvenile adjudicated in the New Castle County Family Court of Delaware to be a delinquent on two counts of second-degree rape and one count of second-degree unlawful sexual contact.

On September 20, 2003, James' mother, Rita Smith, took James and his sister to visit their maternal aunt and three-year-old cousin, Georgia. Georgia reported to her mother that she and James were in the bathroom together when James asked her to "lick his wee-wee." Georgia reported further that, later that day, James demanded she perform oral sex on him while they were behind a shed.

Georgia's mother notified authorities. Georgia was examined by a physician, who found no physical evidence of sexual contact. However, Georgia made spontaneous statements in the waiting and examining rooms regarding the incidents. The examining physician opined that Georgia had been abused based on these spontaneous statements. Georgia was later examined in October of 2003 by Terri Kaiser, BA, a forensic interviewer with the Children's Advocacy Center of Delaware, where she disclosed that James had touched her "wee-wee" and her buttocks.

James and his family were living in a motel room on December 19, 2003, when Detective Jason Atallian of the New Castle County Police Department arrived and asked to interview James. Ms. Smith agreed to bring James to the police station, where Atallian reportedly informed both James and Ms. Smith that James was a suspect in a criminal investigation involving sexual misconduct. Further, Atallian reportedly informed them that Ms. Smith and/or an attorney could be present during the interview.

Atallian's videotaped interview of James lasted approximately 45 minutes. He began by asking James if he could read or write. James stated that he had trouble with reading, and Atallian agreed to read James his rights. Atallian then stated:

> Okay number one you have the right to remain silent. And what that means is you can be quiet if you want to. You don't have to answer anything if you don't want to. Anything you say can and will be used against you in a Court of law. It just means whatever we're talking about today you know is legal you know whether it happens from here on out whatever we talk about you know is pertinent to what's going to happen okay. You have the right to talk to a lawyer and have him present with you while you're being questioned. If you can't afford to hire a lawyer one will be appointed to represent you. If you wish one we've already talked to your mom about that and that's fine. At any time during this interview if you wish to discontinue your statement you have the right to do so. All that means is at any time we're talking if you want to talk to me or you don't.

> You understand these things I explained to you? [*Smith*, p 1146].

James replied, "Uh uh." Atallian apparently interpreted this to mean that James understood, and he proceeded with the interview. James then printed his name on the form, as he did not know how to sign it. He frequently gave no response to questions posed during the interview. At one point, Atallian told him, "I'm not going anywhere. The only way we're walking out of here is if you're straight up and honest with me and we deal with this and then I can help you." James later confessed to several of the sexual encounters that Georgia had described.

Before his bench trial, James filed a motion to suppress his statement to Atallian. He argued that his waiver of *Miranda* rights was not knowing and voluntary. This motion was denied and, several months later, James filed a motion to determine his competency to stand trial.

Dr. Abraham Mensch, a psychologist with the Delaware Division of Child Mental Health Services, was the only witness at James' competency hearing. He testified that James had a full scale IQ of 67 and that James had word recognition and arithmetic skills of second-grade equivalency. In his report, Mensch also noted that, despite James' cognitive impairment, he could be taught the roles of the participants in the trial process. James was ultimately found by the trial court to be competent. However, Mensch's findings led the trial court to schedule additional time to allow James to consult regularly with his attorney to review the proceedings.

James did not testify at the trial. The state relied heavily on Georgia's testimony as well as James' videotaped statement. James was found delinquent on two counts of second-degree rape and one count of second-degree unlawful sexual contact. James appealed his conviction and argued that the trial court erred in its finding that he was both competent to stand trial and that he had knowingly waived his *Miranda* rights.

Ruling and Reasoning

The Supreme Court of Delaware upheld the trial court's finding that James was competent to stand trial, noting Mensch's testimony that James appeared to understand the nature of the charges against him and that the trial court had made special accommodations to account for his cognitive limitations.

The Supreme Court of Delaware reversed the trial court's finding that James knowingly waived his *Miranda* rights. The court cited *Fare v. Michael*, 442 U.S. 707 (1979), and Justice Blackmun's opinion that the "totality of the circumstances," including age and intelligence, must be considered when reviewing *Miranda* waivers. In its reversal of the trial court's decision, the Supreme Court of Delaware highlighted the following key issues.

First, the trial court had ruled on the admissibility of James' confession before his competency hearing. Accordingly, the court had not yet heard Mensch's testimony. The trial court recognized this as problematic by noting, after Mensch testified, "probably if I re-heard [the suppression motion] today [I] would have required much more detailed explanation of the *Miranda* rights than I saw today. But that's water over the dam" (*Smith*, 918 A.3d, p 1150).

Second, portions of Atallian's videotaped explanation of James' *Miranda* rights were nonsensical. The confusing manner in which Atallian structured his sentences during this explanation greatly troubled the court. In the court's opinion, Atallian's "explanation" at times was "almost unintelligible."

Third, the court noted that, despite James' right to remain silent, Atallian insisted he was not "going anywhere" until James had given him an explanation with regard to the alleged sexual abuse. This insistence may have led James to believe that he could not in fact remain silent.

Finally, the court noted that James' intellectual deficits, in and of themselves, gave cause for alarm with regard to his knowing waiver of *Miranda* rights. Concluding, the court wrote, "The totality of these circumstances compels the conclusion that James' waiver of his *Miranda* rights was not knowing." His adjudication as a delinquent was therefore vacated, and the matter was remanded for a new trial.

Discussion

The Delaware Supreme Court's upholding of the trial court's competency ruling is in line with the traditionally minimal standards for defendants' ability to stand trial, especially given the accommodations made in this case. Here, the issue of James' competence is most relevant, in that it introduced into the record Mensch's testimony regarding James' intellect that brought into question the validity of his waiver of his *Miranda* rights.

It is clear that the court was concerned that sufficient consideration of James' intellectual deficits was not applied to his waiver of his *Miranda* rights, especially given the requirement in *Fare v. Michael* that juvenile confessions require special consideration. At issue in *Fare* was whether a 16-year-old murder suspect's confession was valid, given that he had requested that his probation officer be present during his interrogation by police. The U.S. Supreme Court found that his request was tantamount to asking for an attorney, and his confession was therefore obtained in violation of *Miranda*. In *Fare*, Justice Blackmun wrote:

> [The] totality of the circumstances [requires] evaluation of the juvenile's age, experience, education, background, and intelligence, and . . . whether he has the capacity to understand the warnings given to him, the nature of his . . . rights, and the consequences of waiving those rights [*Fare*, 442 U.S., p 725].

With this in mind, it is useful to examine James' developmental state in some detail. At the time of the alleged crime, James was chronologically 14 years old. Mensch testified that James' IQ was 67. By mathematical definition, IQ is 100 times mental age divided by chronological age (Tulsky DS, *et al.*: Clinical Interpretation of the WAIS-III and WMS-III. San Diego, CA: Elsevier, 2003). This formula shows James' "mental age" to be approximately 9 years.

According to Piaget's model of cognitive development, James' mental age was in keeping with the concrete-operational stage of cognitive development. This stage typically lasts from ages 7 to 11 years and predates that of the formal-operations stage, when one begins to think abstractly (Kaplan and Sadock: Comprehensive Textbook of Psychiatry (ed 8). Philadelphia: Lippincott, 2005, pp 529–33). Concrete-operational thinkers tend to interpret information on a very literal level. In this case, Atallian's expression "I'm not going anywhere" until "we deal with this" may have meant to James that he simply could not leave until he made a confession. James' concrete thinking, coupled with Atallian's confusing description of James' rights, would have made it extremely difficult for James to appreciate his *Miranda* rights rationally and the potential consequences of waiving them.

This case illustrates the importance that those involved in the juvenile justice system understand the potential impact of a suspect's age, intelligence, education, and background on his or her ability to waive *Miranda* rights knowingly. When there is doubt, a cautious investigator might consult a mental health expert before continuing with such an interrogation.

Mental Retardation and the Death Penalty

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A Defendant May Not Be Sentenced to Death if, at the Penalty Phase, at Least One Juror Finds That the Defendant Has Proven, by a Preponderance of the Evidence, That He Suffers from Mental Retardation

In *State v. Jimenez*, 924 A.2d 513 (N.J. 2007) (*Jimenez III*), the Supreme Court of New Jersey held that the death penalty is precluded when at least one juror finds that the defendant has met his burden of proving that he has mental retardation. The defendant, Porfirio Jimenez, filed a pretrial motion asserting under *Atkins v. Virginia*, 536 U.S. 304 (2002), that his mental retardation precluded the imposition of the death penalty, and he requested that the Supreme Court of New Jersey clarify its opinion in *State v. Jimenez*, 908 A.2d 181 (N.J. 2006) (*Jimenez II*), in which the court provided a framework to adjudicate *Atkins* claims.

Facts of the Case

On May 20, 2001, a 10-year-old boy went to a carnival and did not return home. Two days later, the boy's body was found with evidence that he had been sexually assaulted. On June 7, 2001, Mr. Jimenez was arrested after his DNA matched the DNA of the semen found in the boy's underpants, and he gave the police a detailed confession.

In September 2001, Mr. Jimenez was indicted on multiple charges: murder, felony murder, kidnapping, attempted aggravated sexual assault, and possession of a weapon for an unlawful purpose. In Oc-

tober 2001, the state requested the death penalty for Mr. Jimenez by filing a Notice of Aggravating Factors pursuant to N.J. Stat. Ann. § 2C:11-3c(1) (2000).

Three years later, in September 2004, pursuing an *Atkins* claim on behalf of Mr. Jimenez, the defense submitted a report by Frank J. Dyer, PhD. The state had Mr. Jimenez evaluated by Frank Dattillio, PhD. Both psychologists agreed that Mr. Jimenez fell into the mildly mentally retarded range as defined by DSM-IV; however, their opinions differed regarding the total score of the IQ test (Dyer reported an IQ of 68 and Dattillio an IQ of 69) and the level of Mr. Jimenez's adaptive functioning.

Ruling

To follow the complex road that led to the New Jersey Supreme Court's decision in *Jimenez III*, we must trace the antecedent decisions.

In its August 2005 decision, the Superior Court of New Jersey, Appellate Division, in *State v. Jimenez*, 880 A.2d 468 (N.J. Super. Ct. App. Div. 2005) (*Jimenez I*), described the complex scheme that the trial court devised in light of *Atkins*. If at a pretrial hearing, the defendant proved by clear and convincing evidence that he was mentally retarded, the trial would proceed as a noncapital matter. If at a pretrial hearing, the defendant proved by a preponderance of the evidence that he was mentally retarded, at the penalty phase, the state had the burden of proving beyond a reasonable doubt that the defendant was not mentally retarded. Both the prosecution and the defense appealed the trial court's decision to the New Jersey appellate division.

The appellate court reversed the trial judge's pretrial procedures and affirmed the trial judge's penalty phase procedures. The court noted that the defendant's mental status could also be introduced as a mitigating factor during the penalty phase. The state appealed the decision.

In October 2006, the Supreme Court of New Jersey, in *State v. Jimenez*, 908 A.2d 181 (N.J. 2006) (*Jimenez II*), reversed the decision of the appellate division. In *Jimenez II*, the court established the procedures that the trial court must follow when resolving *Atkins* claims. The court held that the issue can be raised before trial (e.g., if "reasonable minds [do not] differ as to the existence" of mental retardation), during the guilt phase (e.g., to negate an element of the crime), and during the penalty phase, to preclude the death penalty and/or as a mitigating factor. The court declared that asserting an *Atkins* claim, similar to an insanity defense, is an affirmative defense, and the defendant has the burden of proving his or her mental retardation by a preponderance of the evidence. The court was not clear regarding how many jurors were necessary to sustain a finding that the defendant had mental retardation.

In December 2006, in *State v. Jimenez*, 924 A.2d 513 (N.J. 2007) (*Jimenez III*), the Supreme Court of New Jersey, in a four-to-two decision, held that, to preclude a death sentence, only a single juror had to find that the defendant had proven his mental retardation by a preponderance of the evidence and remanded the case to the trial court for proceedings consistent with their opinion.

Reasoning

Fourteen states have addressed the matter of how to resolve *Atkins*. In each state and in the federal courts, the defendant has the burden of proof: six states (Arkansas, Maryland, Missouri, Nebraska, New Mexico, and Tennessee) use the preponderance-of-the-evidence standard; four states (Indiana, Arizona, Colorado, and Florida) use the clear-and-convincing-evidence standard; one state (Georgia) uses the beyond-a-reasonable-doubt standard; and three states and the federal government have not set a standard of proof (*Pruitt v. State*, 834 N.E.2d 90 (Ind. 2005)).

In *Jimenez III*, the Supreme Court of New Jersey, relying on *Mills v. Maryland*, 486 U.S. 367 (1988), clarified how many jurors must find that the defendant has met the burden of proof, holding that "mitigating factors need not be found unanimously because it would preclude deadlocked jurors from giving legal effect to mitigating factors in determining whether a defendant was death eligible" (*Jimenez*, 924 A.2d, p 515). The court found mental retardation to be a "conclusive mitigating factor," and therefore a unanimous jury finding is not required. Each juror must determine its presence or absence on an individual basis.

The court concurred with the appellate division that in cases in which "reasonable minds cannot differ as to the existence of retardation" the judge should resolve the *Atkins* claims before trial, avoiding capital prosecution.

Justice Albin's dissenting opinion, in which Justice Long joined, stated that the burden of proof should require the state to prove beyond a reasonable doubt that the defendant is not mentally retarded, because shifting the burden to the defendant "increases the likelihood of wrongly executing a mentally retarded person" (*Jimenez*, 908 A.2d, p 182).

Discussion

In 1989, in *Penry v. Lynaugh*, 492 U.S. 302 (1989), the U.S. Supreme Court ruled that, due to lack of national consensus, applying the death sentence to the mentally retarded was not categorically prohibited by the Eighth Amendment; however, the defendant could use mental retardation as a mitigating factor. The Court explained that, although the Eighth Amendment categorically prohibits punishments considered cruel and unusual under evolving societal standards of decency, there was insufficient evidence of a national consensus against the execution of mentally retarded people convicted of capital offenses.

In 2002, the question of whether it is constitutional for the state to execute a mentally retarded defendant who had been found guilty of a capital offense was again before the Court. In *Atkins*, the Court reversed *Penry* and ruled that executing a mentally retarded individual is cruel and unusual punishment. The majority, Justices Stevens, O'Connor, Kennedy, Souter, Ginsburg, and Breyer, based their opinion on the "evolving standards of decency" as reflected by the actions of the lower courts and state legislatures.

Justice Rehnquist filed a dissenting opinion in which Justices Scalia and Thomas joined. He stated that: (1) the execution of offenders who were mildly mentally retarded would not have been considered cruel and unusual punishment when the Eighth Amendment was adopted; and (2) the fact that 18 states, which was less than half the number that permitted capital punishment, had enacted legislation barring the execution of criminals who were mentally retarded was not sufficient to establish a national consensus, especially since only 7 of those states had barred all such executions.

The Court left it to state legislatures and the lower courts to describe the procedures to be followed when resolving an *Atkins* claim, which was what the Supreme Court of New Jersey did when it ruled in *Jimenez III*.

In 2006, the New Jersey Legislature created the New Jersey Death Penalty Study Commission, which was in charge of studying all aspects of the death penalty as it is administered in New Jersey. In January 2007, the commission released its report to the legislature and recommended that:

> [T]he death penalty in New Jersey be abolished and replaced with life imprisonment without parole, to be served in a maximum security facility. The Commission also recommends that any cost savings resulting from the abolition of the death penalty be used for benefits and services for survivors of victims of homicide [New Jersey Death Penalty Study Commission Report, January 2007, page 67].

As a result, the Senate and the General Assembly of New Jersey passed Bill 5171 repealing the death penalty, "An Act to allow for life imprisonment without eligibility for parole when certain aggravators exist and to repeal the death penalty, amending N.J. Stat. Ann. 2C: 11-3 and N.J. Stat. Ann. 2B:23-10, repealing P.L. 1983, c.245, and supplementing Title 2C of the New Jersey Statutes" (2007 N.J. ALS 204; 2007 N.J. Ch.204; 2006 N.J. S.N. 171). On December 17, 2007, Governor Corzine signed the bill, making New Jersey the first state to abolish the death penalty by passing a law (Peters JW: Corzine Signs Bill Ending Executions, Then Commutes Sentences of 8. The New York Times. December 18, 2007, B3).

The issues raised in *Jimenez III* are now moot in New Jersey. However, states that are in the process of determining how to resolve *Atkins* claims may profit from reviewing the reasoning in *Jimenez II* and *Jimenez III*.

Right to Refuse Treatment

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Dangerousness Within the Institution Must Be Proven to Treat an Involuntarily Committed Individual Over His Objection

In *Dep't of Health & Mental Hygiene v. Kelly*, 918 A.2d 470 (Md. 2007), the Court of Appeals of Maryland unanimously upheld the Circuit Court for Baltimore City's ruling that Section 10-708 (g), of the

Health-General Article of the Maryland Code (1982, 2005 Repl. Vol.) requires the state to prove that an involuntarily committed individual is dangerous to himself or others within the institution before it may forcibly administer medication.

Facts of the Case

From 2002 to 2003, Anthony Kelly was charged with multiple violent crimes including murder, rape, assault, and theft. On September 16, 2003, the Circuit Court of Montgomery County ordered an evaluation of Mr. Kelly's competency to stand trial after he decided to represent himself. He was subsequently ordered to the Clifton T. Perkins Hospital, a maximum-security psychiatric hospital operated by the state of Maryland, for evaluation for competency to stand trial. Two examining psychiatrists opined that Mr. Kelly had a mental disorder that influenced his understanding of the adversarial nature of the legal proceedings and therefore he was not competent to stand trial. In addition, both doctors opined that he was considered dangerous, due to his history of violent behavior and his serious charges. On June 3, 2004, the circuit court determined that Mr. Kelly was not competent to stand trial and presumed that he was dangerous to himself and others because of the "gravity of the charges pending." Therefore, Mr. Kelly was committed to Perkins Hospital until he was no longer incompetent to stand trial or considered dangerous. No separate hearing was held regarding Mr. Kelly's dangerousness.

While hospitalized, Mr. Kelly took antipsychotic medications for a period of six months. He then refused any kind of medication because he believed he was not mentally ill. On August 23, 2005, pursuant to § 10-708 (b)(2) of the Health-General Article of the Maryland Code, a Clinical Review Panel approved the involuntary administration of medication to treat Mr. Kelly's delusional disorder. Using language found in § 10-708, the panel opined that without the medication, Mr. Kelly was at risk of a longer period of hospitalization due to his remaining serious mental illness that caused him to be a danger to himself or others.

Mr. Kelly appealed the decision to the Office of Administrative Hearings. During the hearing before an administrative law judge (ALJ), Mr. Kelly's psychiatrist at Perkins Hospital, Dr. Wisner-Carlson, opined that Mr. Kelly had a delusional disorder and that he was a danger to himself and others because he was adjudicated as dangerous by the circuit court during his competency hearing. However, Wisner-Carlson was unable to identify any threatening or aggressive behavior by Mr. Kelly during his confinement at Perkins. Nonetheless, the ALJ concluded that the hospital proved by a preponderance of the evidence that Mr. Kelly should be medicated to treat his mental illness and that the circuit court's determination that he was a danger to himself and others was "sufficient to permit forcible medications."

The ALJ decision was reversed by the Circuit Court of Baltimore City based on the Maryland Court of Special Appeals' decision in *Martin v. Dep't of Health & Mental Hygiene*, 691 A.2d 252 (Md. Ct. Spec. App. 1997), (a decision that had been overturned and rendered moot by the Maryland Court of Appeals):

> . . . which held that for purposes of forcible administration of medication, § 10-708 (g) of the Health-General Article requires evidence that an involuntarily committed individual is a danger to himself or others in the context of his confinement within the facility in which he has been committed, rather than to society upon release [*Kelly*, 918 A.2d, p 479].

The Department of Health and Mental Hygiene appealed the Circuit Court of Baltimore City's decision to the court of special appeals. Meanwhile, the Court of Appeals of Maryland issued a writ of *certiorari* before any proceedings in the intermediate appellate court could begin.

Ruling and Reasoning

The Court of Appeals of Maryland unanimously upheld the ruling of the Circuit Court of Baltimore City that Mr. Kelly should not be forcibly medicated. The court held that before individuals involuntarily committed to an institution can be forcibly medicated, the state must prove in accordance with § 10-708 (g) that, because of the individual's mental illness, the individual is dangerous to himself or others while inside the institution.

The court reviewed Maryland's history of involuntary medication legislation to define in which temporal context—past, present, and/or future—the authors of § 10-708 (g) intended dangerousness to be viewed. The court presented a comprehensive review of the evolution of treatment over objection in Maryland, to which we refer all interested scholars. Briefly, in 1984, the Maryland House passed the Mentally Ill

Individuals—Refusal of Medication law (House Bill 1372 (1984)), which permitted involuntary medication if a patient was emergently dangerous, court-ordered to take medication, or simply involuntarily hospitalized. In 1990, the Maryland Court of Appeals applied the Supreme Court decision in *Washington v. Harper*, 494 U.S. 210 (1990) to their decision in *Williams v. Wilzack*, 573 A.2d 809 (Md. 1990), and found that the law provided inadequate procedural and substantive due process protection for the individuals treated with medications over objection. In response to this decision, in 1991, the Maryland General Assembly, with input from the Maryland Psychiatric Society and On Our Own, Inc., changed § 10-708 to provide additional procedural and substantive due process safeguards. Section 10-708, in its current form, permits the forcible administration of medication if, without medication, the individual remains seriously mentally ill and dangerous with no significant relief, remains ill for a significantly longer time, or relapses into essentially being unable to provide for basic human needs and personal safety.

The court further asserted that, because the Maryland Legislature built the new § 10-708 on *Williams* and *Harper* and rejected the possibility that medication could be forced based solely on involuntary commitment, then it must have intended for the circumstances in *Harper* to apply, as well—that is, the patient (like the inmate in *Harper*) had to be dangerous in the context of his confinement before involuntary medication can be undertaken. The court pointed to three federal courts of appeals decisions to bolster its argument: *Morgan v. Rabun*, 128 F.3d 694 (8th Cir. 1997), *Jurasek v. Utah State Hosp.*, 158 F.3d 506 (10th Cir. 1998), and *United States v. Weston*, 255 F.3d 873 (D.C. Cir. 2001). In *Morgan v. Rabun*, the Court of Appeals for the Eighth Circuit found that the administration of psychotropic medication did not violate Mr. Morgan's substantive or procedural due process rights, because the physician had determined that Mr. Morgan was displaying imminently dangerous behavior inside the hospital. In *Jurasek v. Utah State Hospital*, the Court of Appeals for the Tenth Circuit agreed with medication over objection for a patient who was "gravely disabled," but noted that if the hospital was to medicate Mr. Jurasek pursuant to the "immediate danger of physical injury to others or himself" component of the Utah State Hospital policy, it was required to determine whether the individual "poses an immediate danger of physical injury to others or himself" within his current confinement. In *U.S. v. Weston*, the Court of Appeals for the District of Columbia ruled that the record was insufficient to support forcible administration of drugs to Mr. Weston based on dangerousness, because Mr. Weston was in seclusion and under constant observation, which "obviated any significant danger he might pose to himself or others" at the institution.

Based on these federal courts of appeals decisions, *Williams*, and *Harper*, and because there was no finding that Mr. Kelly was dangerous at Perkins Hospital, the Court of Appeals of Maryland affirmed the judgment of the Circuit Court for Baltimore City that Mr. Kelly could not be forcibly medicated.

Discussion

Dep't of Health & Mental Hygiene v. Kelly represents a further tilting of the scales of justice toward a police-powers model of involuntary treatment and away from a treatment-driven philosophy. This case codifies judicial sentiment that has been coalescing for years about the dangerousness criterion for involuntary medication in cases such as *Morgan*, *Jurasek*, and *Weston*.

In essence, understanding the ramifications of *Kelly* rests on understanding *Washington v. Harper*, in which the U.S. Supreme Court held that when a state treats an inmate against his will, the state must balance the inmate's liberty interest to refuse treatment against the state's interest to maintain a safe and secure prison environment. The Court found that "the extent of a prisoner's right under the [Due Process] Clause to avoid the unwanted administration of antipsychotic drugs must be defined in the context of the inmate's confinement" (*Harper*, 494 U.S., p 222).

Kelly extends that reasoning from the prison setting into the hospital. The temporal lens through which dangerousness is viewed has been narrowed, as the court indicated that it is not interested in a person's history of violence before hospitalization or potential for violence once released. The danger, by the Maryland Court of Appeals' standard, must now be imminent and immediate and within the walls of confinement. The court even acknowledged that a probable outcome of this ruling is that individuals will be without effective treatment for longer peri-

ods; require longer, perhaps indefinite, periods of hospitalization; and incur a greater financial cost. What appears lost in the balancing of the liberty interests of avoiding unwanted medication is that remaining involuntarily hospitalized and under the yoke of an untreated mental illness is, in and of itself, a great loss of liberty.

This decision further separates the need for confinement of mentally ill and dangerous individuals to protect society from the need for these ill individuals to receive treatment. The opinion assumes that the lesser restrictive alternative to forced medication is confinement, a holding courts have consistently upheld but one that needs further scrutiny. It is possible to identify a cohort of involuntarily hospitalized patients who are dangerous when outside of an institution; are rendered nondangerous by the security, structure, and services provided inside a hospital; and then become ill and dangerous again after they are discharged.

It deserves comment, although it is perhaps not surprising, that the *Sell* test was not applied to the application for involuntary medication, even though Mr. Kelly was involuntarily hospitalized for the dual purpose of decreasing his dangerousness and restoring his competency to stand trial. In *Sell v. United States*, 539 U.S. 166 (2003), the U.S. Supreme Court opined that for a nondangerous individual to be involuntarily treated for the purpose of competency restoration, the testimony must focus on trial-related side effects and risks of the antipsychotic and how it could affect the defendant's right to a fair trial. In *Kelly*, the issue of competency restoration was not taken into consideration when the request for treatment over objection was brought to the Maryland court. The test was probably not applied because of the state's heeding the Supreme Court's warning in *Sell* that:

> . . . the medical experts may find it easier to provide an informed opinion about whether, given the risk of side effects, particular drugs are medically appropriate and necessary to control a patient's potentially dangerous behavior (or to avoid serious harm to the patient himself) than to try to balance harms and benefits related to the more quintessentially legal questions of trial fairness and competence [*Sell*, 539 U.S., p 182].

If rulings such as *Kelly* proliferate, and dangerousness must be shown to exist inside institutions for ill defendants to be treated properly, *Sell* hearings may become more commonplace.

Competence to Stand Trial

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Feigning Mental Illness Is Punishable by Enhancement of Sentence for Obstruction of Justice

In *United States v. Batista*, 483 F.3d 193 (3rd Cir. 2007), Braulio Antonio Batista knowingly feigned mental illness. His fraud was discovered, and he received a sentence enhancement. He appealed on the grounds that the enhancement was unfair because he was "exploring a potential defense." The enhancement was affirmed.

Facts of the Case

Mr. Batista was arrested September 19, 2002, for being involved in the sale of 450 grams of crack cocaine. He acted as the middleman in a sale between a police informant and the seller. He pleaded guilty to "possessing only 150 grams of crack cocaine." After Mr. Batista had pleaded guilty, his lawyer requested that her client be evaluated to determine whether he was competent to stand trial. He was evaluated at least five times over the next two years. Dr. Barber saw Mr. Batista and opined that he was not competent to stand trial. Later, Dr. Ryan evaluated Mr. Batista and agreed with Barber, but commented that the apparent lack of competence might be the result of malingering. Dr. Ryan suspected malingering, because Mr. Batista did so poorly on an administered memory test that even someone with severe brain damage would have scored better.

The court subsequently asked Dr. Simring to evaluate Mr. Batista. He found that Mr. Batista was "simulating mental illness" and concluded that Mr. Batista was "faking or exaggerating . . . to avoid going to trial." Dr. Ryan re-evaluated Mr. Batista and determined that he was "probably malingering." She stated that, during the evaluation, Mr. Batista had said that he was at home and had opened an imaginary refrigerator and offered her a drink. Dr. Morgan was the final clinician to evaluate Mr. Batista. Morgan (a neuropsychologist) concluded, after examining Mr. Batista, that he was malingering and con-

cluded that there was "significant, incontrovertible and overwhelming evidence regarding the presence of suboptimal effort and malingering in [sic] the part of the examinee" (*Batista*, 483 F.3d, p 194).

Mr. Batista was sentenced on June 2, 2005. He had expected a reduction in his sentence due to his guilty plea. The prosecution asked for an obstruction-of-justice enhancement of his sentence because of his feigning mental illness. The district court denied his request for a reduction due to acceptance of responsibility and granted the prosecution's request for an enhancement due to obstruction of justice. Mr. Batista appealed on four grounds. First, he claimed that the district court should not have given him an enhanced sentence due to obstruction of justice. Second, he complained that he did not receive a reduction for acceptance of responsibility. Third, he opined that there should have been a downward departure for decreased mental capacity. Fourth, he stated that the court failed to apply a "safety valve" in sentencing.

Ruling and Reasoning

The Third Circuit Court of Appeals ruled on all points that the district court had been correct in its decisions.

Mr. Batista argued that by feigning mental illness he was "exploring a potential defense or mitigation." The district court disagreed and concluded that he had knowingly feigned mental illness. The court found that he had even told his co-conspirators that he was planning to fake mental illness. The appellate court found that the district court had "ample evidence" that Mr. Batista was faking. The evidence included the testimony of the doctors and the testimony of Agent Steven Sutley. Sutley had been told by one of Mr. Batista's co-conspirators that Mr. Batista was planning to feign mental illness. His malingering had caused a substantial expenditure of the government's resources and the court's time.

The Due Process Clause protects a defendant from standing trial if he is not competent. Sentencing enhancements are not meant to interfere with constitutional rights. In a Fifth Circuit Court case, *United States v. Dunnigan*, 507 U.S. 87 (5th Cir. 1993), the court held that

> . . . while a criminal defendant possesses a constitutional right to a competency hearing if a bona-fide doubt exists as to his competency, he surely does not have the right to create a doubt as to his competency or to increase the chances that he will be found incompetent by feigning mental illness [*Dunnigan*, 507 U.S., p 96].

The appellate court also found that the district court did not give the enhancement simply because Mr. Batista was found competent, but rather it was imposed because there was sufficient evidence of his having feigned mental illness.

Discussion

The Third Circuit Court of Appeal's strong endorsement of the district court's decision shows that the courts are tiring of defendants who abuse their mental health protections by feigning mental illness. This move could have important ramifications for forensic psychiatrists. First, will clinicians become agents of the court, expected to gather evidence of an enforceable wrong? Second, might there be consequences for those clinicians whom the court deems to have failed to identify malingering in a defendant?

It is important to have the role of the psychiatrist well defined in a legal evaluation. In *U.S. v. Batista*, the competency evaluations themselves were used as evidence that ultimately led to an increased sentence. The reason for an evaluation of competency to stand trial is to protect those who are mentally ill from being forced to participate in a legal proceeding while unable to do so. The psychiatrists involved in such evaluations are gathering information to be used for the purpose of determining whether a defendant has the ability to understand the nature of the proceedings and to assist counsel in a rational manner. If psychiatrists are gathering information that could be used as evidence for an enhanced sentence, this possibility should be made explicit to the defendant before the evaluation. The evaluator may, for example, have to advise the defendant that evidence of feigning a mental illness will be reported to the parties receiving the doctor's conclusions. A further question is whether the evaluator should advise the defendant that such information could be used against the defendant. This could have the effect of deterring defendants from feigning mental illness. However, it could frighten defendants and keep them from participating in the evaluation. The impact of this change may not be positive.

What about those psychiatrists who are thought to have failed to identify someone who is found by the court to be feigning incompetence? If the courts begin punishing those individuals who are determined to be feigning mental illness, then could a psychia-

trist be held responsible for not discovering and reporting the subterfuge? If courts choose to hold psychiatrists responsible in this manner, could the psychiatrist receive consequences such as expulsion from court panels, medical board sanctions, fines, malpractice suits, or criminal penalties because the perceived error in judgment was found to contribute to obstruction of justice?

U.S. v. Batista has made the evaluation of competency to stand trial a source of potential criminal exposure, at least in the Third Circuit. Psychiatrists should be aware of how they must change their informed consent to reflect this, and how the information they gather can be used for purposes other than determining competence. They should also be concerned about the possible consequences of failing to discover that a defendant is feigning mental illness.

Immunity for Professional Review Committees

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Health Care Quality Improvement Act Provides Immunity for Professional Review Activities

In *Wojewski v. Rapid City Reg'l Hosp.*, 730 N.W.2d 626 (S.D. 2005), the Health Care Quality Improvement Act was found to provide immunity to doctors who participated in a meeting that reviewed Dr. Wojewski's actions and the question of whether his bipolar disorder rendered him unable to perform surgery on a particular day.

Facts of the Case

Dr. Paul Wojewski was a cardiothoracic surgeon at Rapid City Regional Hospital (RCRH). He experienced a few manic episodes that required inpatient hospitalization during 1996. The diagnosis was bipolar disorder, and he took a leave of absence from the hospital. He asked RCRH to reinstate him, and he was reinstated with conditions until a review of psychiatric records was completed. Then, the conditions were removed. Dr. Wojewski had another manic episode in June 2003 and took a voluntary leave of absence due to "difficulties." When he returned, RCRH gave him privileges with the condition that he inform them of any changes in his mental health. RCRH appointed Dr. Oury, a surgeon, to monitor him.

Upon Dr. Wojewski's returning to work, some people noticed that he was acting strangely. A meeting was held on the morning of August 19, 2003, to decide whether his surgical privileges should be continued. He had a surgery scheduled that morning and it was decided during this meeting that he could continue with the scheduled procedure. Dr. Oury watched Dr. Wojewski during the procedure that morning. During the surgery, Dr. Wojewski had a manic episode and was escorted from the room by security. His hospital privileges were suspended.

Dr. Wojewski asked for a fair-hearing panel, and a four-day hearing was conducted in which he was represented by counsel. The panel found that his privileges should not be reinstated because of the threat of future relapses of his bipolar disorder. The findings of the panel were reviewed and upheld by an appellate review committee and by RCRH's board of trustees. Dr. Wojewski sued the RCRH and two of the doctors who were at the August 19 meeting on six counts stemming from that meeting. The hospital asked for a dismissal because of immunity given to those in the meeting, or for a summary judgment. The trial court granted RCRH's motion to dismiss because of immunity and also found summary judgment as an alternative ground. Dr. Wojewski appealed and brought six issues forward, most of which had to do with challenging the immunity provided to the meeting on August 19, 2003, by the Health Care Quality Improvement Act. Dr. Wojewski died in a car accident, but his estate replaced him in his case.

Ruling and Reasoning

The Supreme Court of South Dakota affirmed the trial court's judgment. The court held that the review actions that took place during the August 19, 2003, meeting were protected by immunity afforded by the Health Care Quality Improvement Act (HCQIA). They reasoned that the Act was passed "to improve the quality of medical care by encouraging physicians to identify and discipline physicians who are incompetent or who engage in unprofessional behavior" (*Wojewski*, 730 N.W.2d, p 629).

For an activity to be covered by immunity, it must meet the meaning of a "professional review action." Such action is defined in the Act as

> . . . an action or recommendation of a professional review body which is taken or made in the conduct of professional review activity, which is based on the competence or professional conduct of an individual physician (which conduct affects or could affect adversely the health or welfare of a patient or patients), and which affects (or may affect) adversely the clinical privileges, or membership in a professional society, of the physician. Such term includes a formal decision of a professional review body not to take an action or make a recommendation described in the previous sentence and also *includes professional review activities relating to a professional review action* [*Wojewski*, 730 N.W.2d, p 632; emphasis in original].

Dr. Wojewski claimed that the August 19 meeting was not a professional review committee or activity and should not be given immunity. He conceded that the later action taken to suspend his privileges was covered. He said that the group at the meeting was an *ad hoc* group, not a professional review body. The HCQIA grants immunity to the following individuals: "(A) the professional review body, (B) any person acting as a member or staff to the body, (C) any person under a contract or other formal agreement with the body, and (D) *any person who participates with or assists the body with respect to the action* . . ." (*Wojewski*, 730 N.W.2d, p 632; emphasis in original). It is not required by the statute that the group be formal, only that it follow the definition.

The court found that the group that met that morning was "not a powerless group, or an impromptu discussion. This group was meeting to make a decision about Wojewski's surgical privileges" (*Wojewski*, 730 N.W.2d, p 634).

The Supreme Court of South Dakota affirmed the trial court's decision and reasoned as follows:

> Any other interpretation than today's decision would frustrate the congressional intent behind the HCQIA. It was designed to facilitate peer review of potentially incompetent doctors to improve health care and protect patients. Taking Wojewski's argument to its logical consequence, no doctors would ever meet to discuss whether they should stop a surgeon from conducting surgery because they would be liable for their discussion and any subsequent decision [*Wojewski*, 730 N.W.2d, p 635].

Discussion

The decision of the Supreme Court of South Dakota strengthens the immunity provided "professional review committees" or "activities." It allows the monitoring of physicians and their activities without fear of legal action as a result of the monitoring. How could it be wrong to monitor and thereby be able to improve medical care? Would we not all do better if we received some feedback?

Although it is true that monitoring and quality improvement can lead to better health care, there can also be a downside to blanket immunity provided to these proceedings. The Act loosely defines what it takes to be covered by immunity. It defines those who are protected by immunity as, "any person who participates with or assists the body with respect to the action." It requires little to participate or assist in an action against a physician and thereby be covered by immunity, in accordance with the stipulations of the Act, which set a low bar for immunity. There should be more control over what constitutes a professional review body. For example, a physician who is not a mental health professional should not be making decisions about the mental health of another doctor. Further, a nonsurgeon should not decide whether a surgeon's skills are adequate. The committees should have appropriate participants to judge the subject they are reviewing.

Although it may be of concern that these "professional review" bodies are loosely defined and immune to legal remedies, quality improvement and monitoring is at least an attempt at improving health care. It would be difficult to convince anyone to participate on a professional review committee if he or she could be legally responsible for adverse decisions or poor outcomes. There may be no clear answer for whether we should allow "unmonitored" monitoring, but until a better solution for ensuring quality in medical care is found, it may be the best option we have.

Methamphetamine-Induced Psychosis and Diminished Capacity to Form Intent to Kill: Ultimate Issue in Expert Testimony

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Wyoming Does Not Recognize the Diminished-Capacity Defense: Expert Testimony Regarding the Ultimate Issue Is Inadmissible, but in This Case Was Harmless Error

The Supreme Court of Wyoming decided the case of *Martin v. State*, 157 P.3d 923 (Wyo. 2007), on May 10, 2007. At issue was a review of the conviction of Russell James Martin for attempted murder in the second degree. Mr. Martin contended that the trial court erred both in admitting certain hearsay evidence and in improperly instructing the jury on the use of that evidence. Mr. Martin also claimed that the trial court erred in allowing a mental health expert to "invade the province of the jury" by offering testimony regarding the ultimate issue of Mr. Martin's intent to kill his wife.

Facts of the Case

On August 22, 2004, Mr. Martin had "an unpleasant conversation with his wife." Later, he struck her multiple times on the head with a hammer while she was preparing breakfast. When his wife collapsed, Mr. Martin believed that he had killed her. He told his mother he had killed his wife and told a 911 dispatcher the same thing. Mr. Martin then discovered his wife was still alive and waited, as instructed, for medical assistance to arrive. Mrs. Martin was taken to a local hospital, was found to have a severe head injury, and underwent immediate neurosurgery. Law enforcement officers interviewed Mr. Martin. He reported that he had ingested a small amount of methamphetamine, had been up all night, and was hearing voices. He stated that the voices did not instruct him to harm Mrs. Martin, but rather he had "just lost it." Mr. Martin was charged with attempted second-degree murder. He was evaluated by a state psychologist, Dr. Buckwell, and was found competent to stand trial.

At trial, the defense did not deny that Mr. Martin had struck his wife, nor the Martins' previous domestic violence incidents. Instead, Mr. Martin offered a defense

> . . . premised upon two theories: (1) At the time of the incident, he was suffering from a mental disease or defect that made him unable to appreciate what he was doing; and (2) based upon his methamphetamine-induced psychosis, he had not acted with the specific intent to kill his wife [*Martin*, 157 P.3d, p 927].

The defense experts, Drs. Toews and Innes, both opined that "because of [Mr.] Martin's 'methamphetamine psychosis,' it was likely that he had acted impulsively."

The state called Dr. Buckwell as a rebuttal witness. She testified that Mr. Martin did not satisfy the requirements for the defense of not guilty by reason of mental disease or deficiency. She also testified that, based on her interpretation of the audio-taped statements Mr. Martin had made after the incident, he had acted with the specific intent of killing Mrs. Martin. The court instructed the jury that "it could consider expert testimony and the reasons offered therefore, but was not 'bound to accept the expert's opinion as conclusive' " (*Martin*, 157 P.3d, p 928). Mr. Martin was subsequently convicted of attempted second-degree murder and sentenced to 50 years to life imprisonment. He appealed the decision to the Wyoming Supreme Court.

Ruling and Reasoning

Mr. Martin's conviction was affirmed, with Chief Justice Voigt dissenting. To convict Mr. Martin of attempted second-degree murder, the state was required to prove that he had struck his wife purposely and maliciously, with the general intent of killing her. The defense argued that an expert witness is intended to help the jury understand an issue and should not be allowed "to opine on matters well within the grasp of the average individual." The defense asserted that Dr. Buckwell's testimony did not assist the jury as intended. The state countered that her testimony was admissible because it had been offered to explain which facts she relied on in forming her opinion of Mr. Martin's mental status at the time of the offense.

The Wyoming Supreme Court determined that the trial court's evidentiary rulings were entitled "considerable deference" and could not be "disturbed absent a finding of clear abuse of discretion." If the court found abuse of discretion, then it had to determine whether there was a "reasonable possibility" that the verdict might have been more favorable to Mr. Martin had the error not occurred. To demonstrate that the error was not harmless, Mr. Martin had to prove prejudice under "circumstances which

manifest inherent unfairness and injustice, or conduct which offends the public sense of fair play" (*Skinner v. State*, 33 P.3d 758, 767 (Wyo. 2001)).

The court cited *Burton v. State*, 46 P.3d 309 (Wyo. 2002), and *Bennett v. State*, 794 P.2d 879 (Wyo. 1990), in noting, "Testimony by an expert witness concerning a belief that the defendant is guilty of the offense invades the province of the jury and generally mandates reversal of the conviction" (*Martin*, 157 P.3d, p 932). However, the court also cited *McGinn v. State*, 928 P.2d 1157 (Wyo. 1996), acknowledging that they had also previously held that "the trier of fact may give whatever weight and credence it may to the expert testimony as well as all the evidence in reaching a verdict" (*Martin*, 157 P.3d, p 932).

The court examined the context under which Buckwell evaluated Mr. Martin and the circumstances under which she was called to testify. In so doing, the court also reviewed Dr. Buckwell's "semantic" analysis of Mr. Martin's audio-taped interview at the time of his arrest, as well as her conclusions that he seemed coherent and that his statements indicated "deliberate or purposeful action." The court rejected the state's argument justifying Dr. Buckwell's testimony and agreed with the defense that the state had offered Dr. Buckwell's testimony "because it wanted the jury to hear" her opinion that Mr. Martin intended to kill his wife.

However, although the court found that Dr. Buckwell's testimony was improper, it also found that "any error was harmless" for the following two reasons: (1) the jury was able to consider the testimony offered by all experts, including the two defense experts who opined that Mr. Martin could not have had the specific intent to kill his wife, because of his methamphetamine-induced psychosis, and (2) the jury was instructed that it was not required to accept any expert's opinion as conclusive.

Dissent

In his dissent, Voigt stated he would reverse the conviction "because there were just too many errors. . . for us to know that [Mr.] Martin received a fair trial" (*Martin*, 157 P.3d, p 932). He also identified two problems with Mr. Martin's defense strategy that methamphetamine-induced psychosis prevented him from forming the intent to kill his wife, namely that: (1) Wyoming does not recognize diminished-capacity defenses, and (2) expert witnesses should not be allowed to testify as to the state of mind of the defendant outside the parameters of a mental illness defense. While Dr. Buckwell could properly testify that Mr. Martin did not have a mental illness or defect at the time of the offense, her testimony regarding the intent to kill "was simply inadmissible" because she had "invaded the province of the jury" and spoken to the ultimate issue. Voigt added, "We are never going to get adherence to the principles that underlie the admissibility of . . . expert opinion testimony as to guilt if we don't enforce those principles" (*Martin*, 157 P.3d, p 933).

Discussion

This case includes two issues of salience for forensic psychiatrists. The first is whether methamphetamine-induced psychosis is a condition that qualifies as a diminished-capacity defense. This question was not directly raised by the appeal, probably because the defense was unsuccessful in this case, nor was it addressed by the majority opinion. However, in his dissent, Chief Justice Voigt acknowledged that diminished-capacity defenses are not recognized by the state of Wyoming. Thus, both the majority and dissenting opinions avoided consideration of whether the condition of methamphetamine-induced psychosis qualifies as a basis for a diminished-capacity defense.

The second issue concerns the opinions offered as expert testimony. Both the majority and dissenting opinions found that Dr. Buckwell's testimony had been offered so the jury would hear expert opinion that Mr. Martin had acted with the intent to kill. Although the opinions differed in finding whether the error was harmless, both agreed that the testimony overstepped the limits placed on expert opinions. The conclusion that it is improper for an expert to testify about the defendant's intent, particularly in cases where intent is the ultimate issue, affirms that opinions of mental health experts are only admissible as they speak to the mental state of a defendant in relationship to a mental illness. Although it is ultimately the trial court's decision on how to delimit expert testimony, it would be wise for psychiatrists to bear in mind the standard limits for expert testimony in preparing their opinions.

Competency to Stand Trial and to Waive the Sixth Amendment Right to Self-Representation

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The standard of competency to represent oneself at trial is the same standard as competency to stand trial. The federal constitutional right to self-representation requires that a defendant who is competent to be tried for a crime be permitted to proceed *pro se* if that is the defendant's choice.

Edwards v. State, 866 N.E.2d 252 (Ind. 2007), was decided on May 17, 2007, by the Indiana Supreme Court. In this case, Ahmad Edwards had been found competent to stand trial, but the court refused to allow him to represent himself at trial. Following his conviction, he appealed, contending he was denied his Sixth Amendment right to self-representation. The Indiana Supreme Court acknowledged that the trial court's decision seemed reasonable; however, given that the trial court had declared him competent to stand trial, the U.S. Supreme Court precedent required that Mr. Edwards be given the right to represent himself at trial, assuming that his waiver of his right to counsel was knowing and voluntary.

Facts of the Case

On July 12, 1999, Ahmad Edwards stole a pair of shoes. When confronted by a loss-prevention officer, Mr. Edwards fired three gunshots. One shot grazed the officer, and another hit a bystander in the ankle. Mr. Edwards was charged with attempted murder, battery with a deadly weapon, criminal recklessness, and theft.

He was evaluated by two psychiatrists, who diagnosed schizophrenia and declared him incompetent to stand trial. After two years of evaluation and treatment at Logansport State Hospital, Mr. Edwards was found competent by a staff psychiatrist. Later, the trial court ordered another examination by two different psychiatrists, who found him incompetent. Subsequently, a different staff psychiatrist found that Mr. Edwards was competent. Mr. Edwards then moved to represent himself, but the court denied his request, noting his intention to raise an insanity defense. In June 2005, the case went to trial and resulted in convictions for criminal recklessness and theft. The two other counts resulted in a hung jury, and the court declared a mistrial.

At the subsequent trial on the remaining charges, Mr. Edwards made various motions to represent himself that were ultimately denied. The court reasoned that, although Mr. Edwards had been found competent to stand trial, he lacked the additional capability to defend himself adequately. After a three-day trial, Mr. Edwards was convicted of attempted murder and battery with a deadly weapon. He was sentenced to 30 years' imprisonment. He appealed, claiming that he had been denied his Sixth Amendment right to self-representation. The state contended that the trial court properly found Edwards incompetent to represent himself, because he was incapable of presenting a "meaningful defense." The state argued that due process and the fundamental fairness of a criminal trial are overriding considerations limiting a defendant's right to self-representation.

Ruling and Reasoning

The Indiana Supreme Court agreed that Mr. Edwards was denied his Sixth Amendment right to self-representation. The conviction was reversed and remanded. In its reasoning, the court first explored the legal context for standards of competence and waiving Constitutional rights.

In *Faretta v. California*, 422 U.S. 806 (1975), the U.S. Supreme Court concluded that, although the Sixth Amendment makes no explicit reference to the right to self-representation, the right is implicit because "the right to defend is given to the accused and council is to assist, not conduct, the defense." The majority conceded that most criminal defendants would be better defended by counsel, but held that forcing unwanted counsel on a defendant "violates the logic" of the Sixth Amendment. However, the Court also held that, while an accused must "knowingly and intelligently" forego his right to counsel, he need not possess the skill and experience of a lawyer to represent himself.

The dissent in *Faretta* opined that the public confidence in the criminal justice system requires a capable defense and that the right of the accused to

self-representation did not warrant converting that right into an "instrument of self-destruction." The standard for competence to stand trial was established in *Dusky v. United States*, 362 U.S. 402 (1960), which held that a defendant should have "sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding" and have a "rational as well as factual understanding of the proceedings against him" to be competent.

In *Godinez v. Moran*, 509 U.S. 389 (1993), the U.S. Supreme Court reaffirmed the *Dusky* standard, overturning the Ninth Circuit's ruling that competence to waive the right to assistance of counsel requires a higher level of mental function than is needed to stand trial, holding instead that "the competence that is required of a defendant seeking to waive his right to counsel is the competence to waive the right, not the competence to represent himself" (*Godinez*, 509 U.S., p 399). The Court concluded that the standard of competence for waiving the right to counsel is not higher than that required to stand trial. However, it also held that "a trial court must. . . satisfy itself that the waiver of his constitutional rights is knowing and voluntary. In this sense there is a 'heightened' standard for . . . waiving the right to counsel, but it is not a heightened standard of competence" (*Godinez*, 509 U.S., pp 400–1).

The Indiana court cited their own similar reasoning in *Sherwood v. State*, 717 N.E.2d 131 (Ind. 1999), which held that "whereas the competency inquiry focuses on the ability to understand the proceedings, the 'knowing and voluntary' inquiry focuses on whether the defendant actually understands the significance and consequences of his choice and whether the decision is uncoerced" (*Sherwood*, 717 N.E.2d, p 135). That decision recognized the "long-standing distinction between competence to choose self-representation, which is measured by competence to stand trial, and competence to represent oneself effectively, which the defendant is not required to demonstrate."

The state cited the dissenting opinion in *Faretta* and the several opinions in *Martinez v. Court of Appeal of California*, 528 U.S. 152 (2000), to support its position that the denial of Edwards' request for self-representation was required by due process and fundamental fairness. The state argued that *Martinez* cast doubt on the reasoning in *Faretta* when it held that "[t]he historical evidence relied upon by *Faretta* as identifying a right of self-representation is not always useful. . . . [A]n individual's decision to represent himself is no longer compelled by the necessity of choosing self-representation over incompetent or nonexistent representation" (*Martinez*, 528 U.S., p 156). However, the *Martinez* majority view was not shared by all justices in that case. Although several opinions acknowledge that *Martinez* cast doubt on *Faretta*, neither *Martinez*, nor any other Supreme Court decision has overruled *Faretta* or *Godinez*.

The Indiana Supreme Court acknowledged that the trial court's conclusion "was at minimum, reasonable," the right to counsel was intended to ensure that a defendant receives a fair trial, a fundamental requirement of due process. However, it was uncontested that Mr. Edwards was competent to stand trial, and no claim was made that his waiver of counsel was not knowing and voluntary. Thus, in light of *Faretta* and *Godinez*, the court stated, ". . . we hold that because Edwards was found competent to stand trial he had a constitutional right to proceed pro se and it was reversible error to deny him that right on the ground that he was incapable of presenting his defense."

Discussion

The current standard that one who is competent to stand trial is also competent to waive his right to be represented by counsel remains unchanged by this case. However, several compelling questions about the balance of competing fundamental rights are raised.

Mr. Edwards' diagnosis was schizophrenia, and the trial court observed several deficits that led to the conclusion that he was incapable of adequate self-representation. The court denied his requests out of concern that "justice" might not be served if he were to represent himself. That decision indirectly questioned whether the legal system's fundamental interest in substantive due process and fairness could be undermined by adherence to the current legal standard for determining whether he was capable of asserting his implied constitutional right to self-representation, simply because he was competent to stand trial. The *Edwards* case has the potential to shift the issue from one focused on honoring the decisions of the individual to one focused on the constitutional interest in the fair administration of justice, particularly where one party is at a decided disadvantage due to mental illness.

Thus, the issue framed by *Edwards*, ". . . presents an opportunity to revisit the holdings of *Faretta* and *Godinez*, if the Supreme Court decides that it is to be done" (*Edwards*, 866 N.E.2d, p 260). However, although the U.S. Supreme Court granted *certiorari* in this case on December 7, 2007, it plans to address only the more limited question: "May states adopt a higher standard for measuring competency to represent oneself at trial than for measuring competency to stand trial?" Nonetheless, in light of the U.S. Supreme Court's past holdings that heavily weigh substantive due process for disadvantaged defendants (e.g., providing for access to counsel and expert witnesses), the Court's consideration of this case may result in some interesting opinions that will be very important for our field relative to the broader issues.