

# Ethics and the Psychiatric Determination of Competency to Be Executed

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For the last several centuries, most jurisdictions using capital punishment have had formal or informal rules that prohibit the execution of the mentally ill. In this article, the procedures for such exclusions in Florida are examined. The article begins by attempting to answer the question of why legislators and judges, at least nominally, have prohibited the execution of the mentally ill. Next, Florida's criteria for defining and procedures for excluding mentally ill prisoners are examined and found to be vague. We then turn attention to the ethical problems created by the statute and its implementation that face the participating psychiatrists and the profession. These problems are compounded because the physician's findings are not acted upon by politically neutral authorities and the inmate has no opportunity to challenge the findings with his own panel of experts. Finally, since any exclusion of the mentally ill from execution is temporary and the patient will be executed if he recovers, the dilemmas facing the treatment staff if the death sentence is not commuted to life imprisonment before treatment are discussed.

There are strong indications that executions in the United States in the next decade will occur at rates heretofore unseen in this century. As of December 1985, there were more than 1,600 people in this country living under a sentence of death, a figure that is roughly one third of the total number of people executed in the United States since 1930. Florida led the 37 states that have capital punishment statutes with over 225 prisoners condemned to death.<sup>1</sup>

Historically, most jurisdictions using the death penalty have had provisions

that exclude the mentally incompetent from execution.<sup>2</sup> These provisions vary in how incompetency is defined, evaluated, and judged. Specific attention in this article will be directed to the state of Florida, where the execution of Arthur Frederick Goode III and the near execution of Alvin Ford in 1984 raised numerous questions about the state's policy in dealing with its mentally disturbed condemned population. Goode had walked away from a mental institution where he was being treated shortly before his crime, while Ford, sane at the time of his offense, had deteriorated in the time between his death sentence and scheduled execution in 1984 to the point where he could no longer converse in

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coherent sentences. The goals of this article are to examine the Florida provision for delaying the execution of mentally incompetent prisoners and to discuss the ethical questions raised by the statutory requirement that physicians be directly involved in this life or death decision.<sup>3</sup>

Incompetency is a legal concept and, thus, is not synonymous with mental illness or psychosis. Nor is it synonymous with insanity. A person may be competent for one type of action but not for another. Psychiatrists are called on by legislators and the legal profession to evaluate numerous types of competency, such as competency to stand trial, competency to make a will, competency to refuse treatment, and competency to be executed. Indeed, Mezer and Rheingold<sup>4</sup> give 31 examples of legal areas involving determinations of competency. The criteria for competency differ markedly, so a person may be competent for one type of action but not competent for another. Usually the psychiatrist is asked to determine if a mental disease, disorder, or defect exists and, if it does, to give an opinion on whether there is a resultant disability which prevents the individual from functioning up to a specified standard. If the evaluated person cannot function at this standard, then that person is considered to be incompetent in that specific area.

Because the consequences of a determination of competency to be executed are irreversible and human life is at stake, it follows that a relatively precise definition of competency and statement of related evaluative norms are needed.

We will argue that this precision is not present and point out some ethical issues that are involved in the statutory requirement that psychiatrists participate in this process.

## The Law

The exclusion of the mentally incompetent from execution has a history in Anglo-American law dating back to the medieval period.<sup>5-7</sup> English common law recognized that mental illness was a legitimate reason for delaying execution, although the exemption applied only until the prisoner recovered his mental faculties. Although a recovered prisoner could be returned for execution, there are no reported cases in England, at least since the early 1840s, where a person whose execution was postponed because of mental incompetency was later returned and executed.<sup>8</sup> This attitude toward the mentally incompetent death row inmate carried over to nineteenth century America, and legislators and courts to this day continue to voice prohibitions against the execution of the mentally incompetent.

A 1980 survey of 40 American jurisdictions that then had capital punishment statutes found that 31 had laws that explicitly prohibited or implicitly disapproved of the execution of the mentally incompetent.<sup>9</sup> In 1985, of the 37 states authorizing capital punishment, 22 had statutory provisions explicitly prohibiting the execution of the insane, 5 had statutes requiring the transfer of any mentally disordered prisoner to a state mental hospital, 1 state relied on the common law prohibition

against executing the insane, 4 granted authority to the Governor to stay the execution of the presently incompetent, and 4 others have adopted the prohibition by case law.<sup>10</sup> Thus, there is virtually unanimous agreement that the mentally incompetent should not be executed. Yet, there is wide variation in how incompetency is defined and how the claim can be raised and evaluated.<sup>11</sup> With the growing number of executions in the United States, the medical profession will be asked with increasing regularity to participate in the determination of which inmates should be, at least temporarily, considered to be incompetent for execution.

Florida law (Statute 922.07) is used in this article to illustrate the ethical dilemmas faced by a physician participating in competency evaluations of the condemned. The law was passed in its original form in 1939. Before then, incompetency was determined by the trial court.<sup>12</sup> Between 1972, when Florida's present death penalty statute was enacted, and the end of 1985, the statute had been used four times in the attempt to show that death row inmates were incompetent for execution.<sup>13</sup> In three cases the prisoner was found to be competent, while in one the inmate was found to be incompetent.

On its face, the law is quite simple. It states that when the Governor is informed that a person under sentence of death may be "insane," three psychiatrists shall be appointed to examine the condemned inmate. They must determine "whether he understands the nature and effect of the death penalty and

why it is to be imposed upon him." The psychiatrist's reports are a recommendation, at least in theory; the final decision of whether or not to postpone the execution is left to the Governor. If the condemned man is not found to be mentally fit for execution, the Governor is directed by the statute to commit him to a state hospital for the insane. When "the proper hospital official" determines the man has been restored to "sanity," another panel of three psychiatrists is appointed and the above sequence is repeated. If found "sane," the statute directs the Governor to sign his death warrant. The full text of the statute is presented in the Appendix.

An analysis of this law requires some exploration of the rationale for its presence in the statute books.

### **The Rationale of the Law**

There is no single or clear explanation for the presence of this exemption in the statute books. Confusion surrounding the application of this law is in part attributable to a lack of agreement surrounding the purpose of capital punishment.<sup>14-16</sup> That is, the answer to the question of why some prisoners should not be executed is dependent upon society's answer to the question of why others should be executed and what procedures are necessary to ensure the legitimacy of the capital punishment process. As we see it, the exemption can be understood if it is argued that the primary goal of capital punishment is retribution. Because of the immense suffering caused by the prisoner's criminal actions, he is to suffer in anticipation of

his death, and this goal cannot be achieved if the prisoner does not appreciate his impending fate because of mental illness. The mental illness prevents the inmate from suffering in anticipation of death more than he already does in living with the illness.

If retribution was the only justification for excluding some prisoners from execution, the ethical question facing the physician who is asked to participate would be relatively easy to solve. The job of physicians is to preserve life, not to evaluate people to see if they are capable of additional suffering. Therefore, unless the physician was willing to recommend that everyone be found incompetent for execution, the retributive rationale to exclude the mentally incompetent is not a sufficient justification for physician involvement.

What other explanations are there for the presence of this exemption? Some argue that the purpose of capital punishment is incapacitation or deterrence, but these goals are not furthered by the exclusion of the mentally ill. If the only goal of capital punishment is incapacitation, or the elimination of dangerous people, this law makes no sense because the condemned man is not necessarily less dangerous as the result of his inability to appreciate impending death. Similarly, society's refusal to execute the mentally ill makes no sense if the only rationale behind executions is general deterrence. In fact, since the deterrent effect of a punishment is in part dependent upon its certainty, it could be argued that executions that ignore the issue of sanity might be *more* of a deterrent: the

certainty of the punishment is increased with the elimination of each exception.

Weihofen<sup>17</sup> notes two additional possibilities for the existence of this exception: our society does not want to execute mentally incompetent prisoners because such prisoners do not have an opportunity to (1) assist in last minute defense efforts to challenge their guilt, conviction, or sentence and (2) spiritually prepare for death and an anticipated afterlife. Weihofen<sup>17</sup> rejects both of these possibilities. He argues that if such goals were of paramount importance, the statute would ask the evaluating psychiatrists to determine either the condemned man's ability to assist in his defense, in the first example, or, in the second, his realization of moral guilt and ability to ask forgiveness. The statute does not ask for such determinations.

Proponents of the death penalty, however, would disagree with Weihofen's<sup>17</sup> dismissal of the first point above and argue that the exclusion of the mentally incompetent from executions is desirable under the rules of "fair play." Here it would be argued that the state would at least want to go through the ritual of evaluating mentally ill prisoners for competence so that an image that the prisoner had a fair chance to contest the impending execution is presented. Public support for the death penalty might diminish if citizens believed the state's powers were being launched against a prisoner who could not assist in his own defense. Whether the statute actually contains sufficient procedures for the objective appraisal of mental competence will be discussed below; here the

point is that at least the *image* of fair play must be present. Such an image will help reduce any guilt or ambivalence held in the society concerning the morality of capital punishment. No doubt this and the long historical tradition of exclusion of the mentally ill from execution are the major reasons why such laws remain in existence today.

Weihofen<sup>18</sup> further argues that the exemption of the mentally incompetent from execution cannot be understood on humanitarian grounds:

The real issue is whether it is less humane to execute a guilty criminal while he is insane than it is to postpone the execution until we make sure that he understands what we mean to do to him—and then kill him.<sup>18</sup>

Note that Weihofen's<sup>18</sup> rejection of this humanitarian explanation is predicated on the assumption that the postponement of the execution due to mental incompetence is temporary rather than permanent. Because of the historical tradition of making such postponements permanent, however, the humanitarian hypothesis retains utility in explaining some support for the existence of this exception. The postponement might become permanent because of the mental illness itself or because it might give the defendant's lawyers time to mount a successful appeal on other grounds. Those unequivocally opposed to the death penalty would support any reason for the removal of a death sentence, so their support for provisions prohibiting the execution of the incompetent can thus be explained on these humanitarian grounds. They would see the exemption of the incompetent as similar to a re-

quest for clemency and a means to lower the number of people executed.

Specification of the reasons why mentally incompetent prisoners should not be executed is necessary before any discussion of the ethics of physician involvement is possible. That is, physicians must have some awareness of the social functions fulfilled by their work. If the physician believes that none of these reasons are sufficient grounds to postpone execution and can foresee no circumstances that would lead him or her to recommend a finding of incompetence, the inability to conform with the statute would necessitate a decision to decline to participate. Certainly a decision to recommend a finding of competence in all cases does not benefit the prisoner, nor does it benefit the state if its stated goal of identifying incompetent prisoners cannot be achieved. On the other hand, the few physicians who believe that no prisoner should ever be found competent for execution are split between their allegiance to the state and their medical duty to save lives. Usually they would justify such a position on the humanitarian grounds described above. While a routine finding of incompetence would leave them open to charges of lack of patriotism (and no doubt to no further requests to conduct evaluations), some might find such a charge less discomforting than the charge that they did not do everything possible to save a life. Occupying the middle ground are those physicians who see the statute as a means to promote an image of "fair play." While they would vary along a continuum in terms of how conserva-

tively the statute would be applied, they would remain open to the possibility of finding incompetence. The difficult question for this group then becomes whether this fair play is more an image than a reality and whether their participation runs the risk of legitimating an image of fair play that in reality might not actually exist within the procedures outlined by the statute.

### Vague Wording of the Statute

The physician's participation in the process of evaluating condemned prisoners is made difficult by the vagueness of the criteria for incompetency outlined in the statute. Participating physicians must therefore be prepared to make a major commitment of time and energy in order to discharge their duties in an ethical and professional manner. We will argue that this is especially true in cases where a recommendation of competency is made. Several issues are involved.

The first raises the question about the meaning of the word "understand." In the Goode case, a psychiatrist was employed by the defense in an unsuccessful effort to get the Governor to consider findings of a psychiatrist other than the three he had appointed. This psychiatrist raised an important issue. He differentiated cognitive understanding from affective understanding. The psychiatrist found that the prisoner discussed his forthcoming execution as a young child would: he was factually correct but lacked any emotional response. After Goode's death, substantial evidence was found to support this evaluation. For

example, a dozen unmailed letters to such figures as the Governor, Attorney General, lawyers, prison officials, and the media were found among Goode's possessions, all written in the three weeks preceding his death. The letters complained about a lack of toilet paper with which to blow his nose. One would expect that a person with any affective understanding of his execution would have other things on his mind than a lack of toilet paper, and certainly more important things about which to contact the Governor.

Second, what is "the nature of the death penalty" that prisoners are asked to understand before they can be executed? The question is important because there is not and never has been wide consensus in our society on the answer to this question. It could be, as Justice Marshall has suggested, that "people who were fully informed as to the purposes of the penalty and its liabilities would find the penalty shocking, unjust and unacceptable."<sup>19</sup> The point is that the statute asks psychiatrists to treat the nature of the death penalty as a fixed entity unaffected by morality or politics, which it is not. If a range of answers to these questions qualifies for a finding of competency, the range is never specified. Furthermore, does understanding of "why (the death penalty) is to be imposed upon him" require a realization of guilt and remorse? In short, the physician is given no guidelines to use in evaluating the prisoner's understanding of the nature of the death penalty and why it is to be imposed upon him.

Third, what does it mean to under-

stand "the effect" of the death penalty? Does the statute seek a very concrete answer or does it ask for some intuitive understanding? If a concrete answer is sought then a proper response would be that the effect of electrocution is death. If a more abstract answer is called for, then the desired response is more complex. The death penalty has many effects for the inmate, his family, his fellow prisoners, the prison workers, the politicians who authorize it, and the community at large. Some of the effects may be certain, while other effects are not so easy to predict. In essence, this aspect of the statute asks the psychiatrist to evaluate the condemned man's capacity to predict effects which are, to a certain degree, uncertain. In reality, no one can know what effect the death penalty might have, even on such persons as the inmate and his family in the days preceding the execution. This uncertainty and fear of the unknown is one of the primary stresses of death row confinement.<sup>20, 21</sup> In short, if an abstract answer is desired, the inmate is required by the statute to predict and understand something that cannot be predicted and understood: the effect of his impending death on those who continue living. As it stands, what type of answer the state demands is left to the interpretation of the evaluating psychiatrists.

A fourth problem with the statute is its tacit presupposition of immutability in the mental condition of the condemned between the time of examination and the time of execution.<sup>22</sup> The rationale behind the statute appears to be grounded in concern with mental

status at the time of execution, not necessarily at the time of the evaluation. Some prediction of the prisoner's mental prognosis therefore appears to be requested. Insofar as the man's mental status may be influenced by the conditions of imprisonment and the stress of the death penalty, conditions and stresses that get worse as the day of execution approaches, the man's mental condition might deteriorate after the evaluation.<sup>23</sup> This regression is not inevitable, but might be impossible to predict accurately in any given case, particularly with sufficient accuracy to ground a life and death decision.

A fifth problem involves the standard or level of proof. How certain must the psychiatrists be before making their recommendation? Like other physicians, psychiatrists can testify only "within reasonable medical certainty," but such a standard might not be sufficient for this life or death situation. On the surface it may look as though the meaning of this phrase is clear, but on closer examination it is not.

In the law there are three levels of proof: preponderance of the evidence (roughly 51 percent), clear and convincing evidence (75 percent), and beyond a reasonable doubt (95 percent). The "preponderance of evidence" level is used in civil action cases, the "clear and convincing" level is used for involuntary hospitalization, and "beyond a reasonable doubt" is the level necessary for criminal convictions. In *Addington v. Texas* the U.S. Supreme Court ruled that the loss of freedom associated with civil commitment required a clear and

convincing level of proof.<sup>24</sup> It could be argued that since the loss of life is a greater loss than that associated with involuntary hospitalization, then a higher level of certainty is required of the physician deciding this life or death issue. It is not clear which level of proof in the legal arena is approximated by the medical concept of within reasonable medical certainty. Some physicians might base their conclusions on the preponderance of the evidence, whereas others will aspire to arrive at a recommendation using the standard of beyond a reasonable doubt. Does the life or death issue require that the psychiatrist be absolutely certain (a certainty rarely achieved in psychiatry) before coming to his or her conclusion? The state again is vague in spelling out for the physician exactly what it wants. Below we will argue that regardless of the state's requirements, certain ethical principles of medical practice demand that a higher standard of certainty is required for a finding of competence than of incompetence.

There is one final source of confusion in the statute. Although this point does not directly involve the evaluating physicians, it does give other examples of the lack of clarity in the present law. The statute says that the Governor shall stay the execution and appoint the commission of three psychiatrists "when the Governor is informed that a person under sentence of death may be insane." Three points can be made about this wording. First, there is no specification of who can inform the Governor. It seems that everyone from the prison

warden to the defendant's family to someone who has never met the prisoner has the power, at least temporarily, to stop an execution. Second, there is no apparent limit on the frequency with which the Governor may be so informed. Indeed, since the statute specifies that the Governor *shall* stay the execution when he is notified, it appears the execution could still be stopped even if the prisoner was found to be competent only a short time beforehand. This puts the evaluating psychiatrists in a further bind, as there is no stipulation for a judge to grant a stay pending evaluation and the evaluations are typically done under the pressure of an outstanding death warrant. On the other hand, there might be good medical justification for reinvoicing this process shortly before the execution: insofar as the mental incompetency could be caused by the stress of preparing for execution, the prisoner might not become incompetent until his final days or hours. A third problem is that the statute orders gubernatorial action when the Governor is informed the man may be *insane*. Insanity and incompetency are confused. As the term "insanity" is used in the law, it means that the defendant has a mental disease or defect which renders him not legally culpable or responsible for his criminal actions. On the other hand, "incompetency" is used to signify the individual is not legally capable to perform a specific jural act. The statute does not define insanity nor does it specify which level of mental disease or disorder must be present in order to initiate gubernatorial action.



## The Ethics of Physician Participation

Having examined what psychiatrists are asked to do, we now turn our attention to the dilemma of deciding what *should* be done. Some would argue that this arena is no place for a psychiatrist to function, that it downgrades the whole profession, and that all psychiatrists should refuse to participate.<sup>25</sup> The problem with this position is that refusal to participate by psychiatrists who abhor the death penalty or this statute would lead to nonrepresentative participation by other, perhaps less principled psychiatrists, on the commissions. The statute is already in place and a selective boycott will not make it disappear or change. Others would argue that the psychiatrist should only participate to the extent of examining the prisoner and reporting the level of mental disease or impairment but avoid the ultimate question of competency to be executed. Still others would argue that the psychiatrist should do a psychiatric examination, arrive at diagnosis using DSM-III criteria, and then attempt to bridge the (inevitable) gap between medical diagnosis and legal opinion by rendering a recommendation regarding competency to be executed.<sup>26</sup> We will not solve these differences, but instead will raise issues that individual psychiatrists should consider in determining the proper course of action.

***The Need for Professional Standards in the Examination*** The first ethical problem for physicians involved in this process directly relates to the issues of vagueness and lack of clarity discussed

above. As demonstrated by the detailed definitions and diagnostic instructions given in the third edition of the American Psychiatric Association's *Diagnostic and Statistical Manual*, the profession has made great advances in recent years in attempting to specify definitions and increase the reliability of psychiatric diagnoses. Incompetency, however, is a legal rather than a medical concept. It involves assessments and opinions, not diagnoses and facts. The lack of clarity in the statute's definition of "competency to be executed" means that the individual psychiatrists are given wide latitude in defining the status they are asked to assess, creating the possibility for capricious decisions. If the legal definition of incompetency is imprecise, then other factors, such as the psychiatrist's opinion of the death penalty, the heinousness of the offense, and the amiability of the defendant may, at least unconsciously, affect the assessment.

There are numerous uncertainties in the present state of psychiatric knowledge, so that even if there was wide agreement concerning the definition of incompetency, it might be impossible to assess accurately or reliably. Does the evaluation require precision beyond current professional knowledge? This point is often made in criticisms of the ability of psychiatrists to predict dangerousness; one psychiatrist in particular has been widely criticized for his routine predictions of dangerousness in capital cases in Texas.<sup>26-31</sup> Although the accuracy of psychiatric diagnoses and evaluations will always be criticized, it is crucial to note that this evaluation is one of the

few done by psychiatrists in which a life or death question is raised. This life or death issue makes the question of the validity and reliability of psychiatric diagnoses and opinions of more crucial significance than in any other area of psychiatric practice.

By itself, the vagueness of the statute does not necessarily mean that individual psychiatrists must refuse to participate in evaluations until efforts to change or clarify the law are successful. The unnecessary death of an incompetent person is a stake that many will find too high to refuse participation,<sup>32</sup> and, after all, unless a neutral body selects the panel, the state could always find other, less principled psychiatrists to serve. Instead, adopting a pragmatic approach, two courses of action by psychiatrists seem appropriate before an evaluation of competence can be made. The first action is that written reports must be sufficiently detailed so that readers can track the assumptions, facts, and reasoning process used in the evaluation. In order to do this, the data and methodology used to evaluate the prisoner's competence must be presented in the fullest possible detail. The second action, necessitated by both the lack of clarity and the stakes, is that participating psychiatrists must make a strong commitment to make the most thorough and detailed evaluation they can. In the words of the APA Task Force on the "Role of Psychiatry in the Sentencing Process," "On ethical grounds alone, the magnitude of the harm to the subject from incorrect conclusions would seem to justify a "super" level of care in psy-

chiatric assessments . . . when the death sentence may be involved."<sup>33</sup> The limits of the ability to definitively assess competence, even under the best conditions, need to be acknowledged. The three psychiatrists who evaluated Alvin Ford for the Governor were criticized by psychiatrists retained by the defense for failing to do this. These criticisms alleged that the state's examination was not detailed and the evaluating techniques were inadequate and unspecified. The three commission psychiatrists had interviewed Ford for only 30 minutes, not in the best possible environment, and failed to specify in detail the procedures used to arrive at their evaluation of competency.<sup>34</sup> Two of the commission psychiatrists (and all three psychiatrists retained by the defense) found Ford psychotic, but nonetheless the three members of the commission found him competent to be executed. Psychiatrists employed by the defense argued that the physicians did not undertake a reliable forensic evaluation. The point is that evaluations of this sort must be done with the highest level of professional skill possible; no other standard is possible when the purpose is deciding who shall live and who shall die.

Thus, the vagueness of the statute is problematic and steps must be taken if the statute is to be applied in an equitable fashion. Some action by the psychiatric profession as a whole is clearly warranted. A panel of physicians, prosecutors, and defense attorneys (among others) could convene and attempt to reach some definitional consensus on what competency to be executed should

involve and how it should be evaluated, albeit the ultimate necessity of relying on the judgment of the individual psychiatrists must be recognized. If the psychiatric profession decides to accept the legislature's assumption that they have expertise in evaluating competency to be executed, it could work to develop standards of how it should be assessed. The problem with this course of action is that it runs the risk of legitimating the whole process as well as the death penalty itself. Secret evaluation techniques cannot be used; the whole process must be made public. One possibility might be to videotape the defendant's examination to assist the development of consensus and the securing and appraisal of any conflicting interpretations of the data. Baseline evaluation of all new death row prisoners would be useful, as under current practice the inmate is seen only once.

**The Problem of Due Process** A second and more fundamental ethical problem arises for participating physicians because, unlike their testimony in competency to stand trial hearings or in insanity determinations, under present rules their opinions about competency to be executed cannot be challenged in an adversarial judicial process.<sup>35</sup> There are three problems here. First, the final decision regarding competency is not made by a neutral fact finder: it is made by the Governor, who is an elected politician. Community pressures for execution may be great, thus creating the possibility that the physician's involvement will only legitimate what in the end is a political decision. The psychia-

trist's job would be made less difficult if the Governor (and other politicians) were uninvolved in the final decision. Second, the decision is made by the Governor in private, and no judicial review of this decision is permitted. Third, there is no opportunity for the defendant to challenge the commission's findings by presenting the opinions of other psychiatrists.<sup>36</sup> This lack of due process protection presents the largest ethical dilemma facing physicians who are considering involvement in this process.

This third point is particularly salient because of the high probability that the psychiatrists who might agree to sit on the Governor's commission are not a representative sample of the profession. In theory it is possible for the state to find three psychiatrists who will rubber-stamp all condemned prisoners as competent to be executed after a perfunctory evaluation. The objectivity of the panel would be augmented by the exclusion of psychiatrists who stand to lose something if the man is found incompetent, such as those employed by the state hospital where the prisoner will be treated if found incompetent.<sup>37</sup> Political and organizational pressures to find the prisoner competent might be (at least implicitly) present. We believe the potential conflict of interest makes participation by psychiatrists employed by the state mental hospital definitely inappropriate.

In short, the ethical burden on physicians who must decide whether or not to participate would be lessened if procedures existed to ensure that their opinions could be challenged by opinions of

equally credible psychiatrists who are not members of the Governor's commission. Because no such procedures do exist, we conclude that a finding of competence requires more certainty, clarity, and comprehensiveness than a finding of incompetence. This is especially true when any suspicions of incompetency by the defense are supported by evaluations from noncommission psychiatrists. The burden of proof is on those who believe the prisoner is competent to die. Without objective evaluation of the psychiatric reports by neutral parties, judicial review, or challenge by opposing experts, there is an inherent risk of unreliability. An analogy can be made to decisions involving the termination of life-sustaining treatment to a dying patient. The physician might feel his or her decision is correct, but usually will not act on that position until other opinions are solicited and appraised. The statute does not allow the psychiatrist to be part of a forum of divergent opinions in evaluating competency to be executed; the three commission members are the sole and unchallenged evaluators. Such problems threaten the goal of fair play that the statute is meant to serve, creating the possibility that participating psychiatrists are being unknowingly used to legitimate a safeguard that in reality is a farce.

It could be argued in rebuttal that the physician's evaluation of the prisoner's competency to be executed is only a recommendation. This point sidesteps the issue, however, as there is no reason to believe that the recommendations will not be followed routinely.<sup>38</sup> Certainly

having a panel of three psychiatrists reduces the potential for any idiosyncrasies of one physician to completely determine the outcome. The crucial point here is that the single evaluation of one psychiatrist, and certainly the collective recommendation of all three psychiatrists, is more determinative of the outcome than are any other recommendations of psychiatrists in the criminal justice system.<sup>39</sup> It is a powerful role; the psychiatrist is functioning as a judge.

Although this lack of due process has been approved by appellate courts, legal permissibility does not resolve these ethical dilemmas for the psychiatrists.<sup>40</sup> Some would argue that the psychiatrist should never render an opinion on the legal issue since that is the role of the fact finder, be it judge or jury. Others would argue that the psychiatrist should give his or her opinion and let the fact finder take it into consideration. But in this case the fact finder is not an unbiased participant, as one hopes to find in a judge or jury, but a politician. Morris,<sup>41</sup> in discussing the many questions for which the courts look to psychiatrists for answers, states the position of one school of thought:

On many of these issues the psychiatrist has useful insights; on none should psychiatry frame the operative rule, define the dividing line between guilt and innocence, between detention and freedom. Whenever this happens the law is perverted in practice, and psychiatry is brought into disrepute.

Here, of course, the dividing line referred to by Morris<sup>41</sup> is between life and death. The issue can easily become not medical or psychologic, but moral, legal, and especially at this point, political.

*Implications of a Finding of Incompetence* The ethical issues surrounding physician involvement necessitate consideration of all possible outcomes of the evaluation. In this section, we discuss two issues that arise when the inmate is found to be incompetent for execution: the ethics of treating a man so he can be restored to competency and executed and the problems involved in the psychiatric assessment when it is believed that competency has been restored.

If a defendant is found to be incompetent for execution, the mental health staff asked to treat him knows that unless the death sentence is commuted, successful treatment means that the patient will die. This is a use of the state's limited treatment resources that some will find especially outrageous. The issues of informed consent and the inmate's right to refuse treatment will no doubt arise in such cases, as will an individual mental health practitioner's refusal to provide treatment (B. Ward, unpublished manuscript, 1985). Mental health treatment is supposed to be provided for the benefit of the patient, but in such cases the patient will obviously not benefit. Because of this, the Human Rights Advocacy Committee at the state mental hospital where Gary Alvord was sent protested his commitment and recommended that all prisoners found to be incompetent to be executed be given automatic sentence commutations to life imprisonment. The committee also argued that Alvord's presence in the hospital would undermine the morale of both staff and patients, as some patients

would find it difficult to trust staff who someday might recommend another patient's execution. This problem is particularly evident in Florida, where on psychiatrist from the state mental hospital sat on all four 1984 competency commissions and another sat on three.<sup>42</sup> Furthermore, the committee asked that the statute be changed so that it gives standards for determining competency and a right to judicial review. They also endorsed a call by the Florida Mental Health Association for a boycott by members of assessments of competency to be executed, saying that such assessments should be made by judges, not psychiatrists.<sup>43</sup>

The second implication of a positive finding involves what to do when the inmate recovers mental competence. Should the law remain unchanged and the incompetent inmate's sentence remain fixed at death, psychiatric participation is required by the statute before the inmate can be executed. The statute states that the Governor, when notified by the "proper hospital official" of recovery, will initiate another evaluation for competence. Thus, the treatment team is, at least implicitly, involved in returning the man to death row.<sup>44</sup>

In making the initial assessment of competence, the decision facing the physician is whether or not to recommend changing a sentence imposed by the court. If incompetence is found, a later assessment of competence by psychiatrists is tantamount to imposing a new death sentence. In the first evaluation nonintervention leads to death; here intervention by psychiatrists is required

for death. Instead of coming into a situation where the psychiatrist is told the prisoner might be incompetent, the latter intervention rests on a possibility that an established incompetent person may be competent. The criteria used to determine (and measure) incompetence may be different from those used in evaluating recovery from it. Although we would argue that the ethical issues are qualitatively the same at both points, they are even more clear at the latter point because of a quantitative difference. While some physicians might choose not to participate at all, the problems with this approach discussed above lead us to take a more pragmatic position and simply argue that a finding of competence places more responsibility on the physician for certainty, clarity, and comprehensiveness than a finding of incompetence.

Finally, it must be noted that the psychiatrist's participation actually might increase the number of people sentenced to death. Jurors in capital cases, thinking that the sanity of the defendant will be ensured before he is executed, might be less likely to translate their possible misgivings about the defendant's sanity into a recommendation of life imprisonment rather than death. The physician might not be seen by the public as a neutral participant, but rather as an active agent in the legitimization of the death. The ambivalence felt by a juror might diminish with the belief that a psychiatrist will be reviewing the decision to impose death. The medical participation thus might make the act of sentencing the borderline mentally ill to death more

palatable, as well as increase the general legitimacy of capital punishment in the minds of the public.

## Conclusion

The review described above finds that there are many historical and moral reasons why both proponents and opponents of capital punishment have decided to spare mentally ill prisoners from execution. Yet, no precise definition of competence to be executed is present, there are no diagnostic norms that have been prepared by neutral experts, and there is no opportunity for the defendant to challenge the findings. Furthermore, the procedures outlined by the Florida statute demand that the psychiatrist's evaluations be acted upon by the Governor, who is definitely not a neutral party. Many of these ethical issues were not anticipated before well-intentioned psychiatrists became involved in recent cases for the state. Until the definitions and procedures are changed, a psychiatric evaluation which finds a person competent to be executed raises major ethical issues for both the evaluating psychiatrists and the profession as a whole.

### Acknowledgments

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## Appendix

*Text of Statute 922.07 Proceedings when a person under sentence of death appears to be insane.*

1. When the Governor is informed that a person under a sentence of death may be insane, he shall stay execution

of the sentence and appoint a commission of three psychiatrists to examine the convicted person. The Governor shall notify the psychiatrists in writing that they are to examine the convicted person to determine whether he understands the nature and effect of the death penalty and why it is to be imposed upon him. The examination of the convicted person shall take place with all three psychiatrists present at the same time. Counsel for the convicted person and the state attorney may be present at the examination. If the convicted person does not have counsel, the court that imposed the sentence shall appoint counsel to represent him.

2. After receiving the report of the commission, if the Governor decides that the convicted person has the mental capacity to understand the nature of the death penalty and the reasons why it was imposed upon him, he shall issue a warrant to the warden directing him to execute the sentence at a time designated in the warrant.

3. If the Governor decides that the convicted person does not have the mental capacity to understand the nature of the death penalty and why it was imposed on him, he shall have him committed to the state hospital for the insane.

4. When a person under sentence of death has been committed to the state hospital for the insane, he shall be kept there until the proper official of the hospital determines that he has been restored to sanity. The hospital official shall notify the Governor of his determination, and the Governor shall ap-

point another commission to proceed as provided in subsection (1).

5. The Governor shall allow reasonable fees to psychiatrists appointed under the provisions of this section which shall be paid by the state.

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9. Larkin: supra note 6
10. *Ford v. Wainwright*, supra note 7, 530-31
11. Broderick: supra note 5
12. See *Hysler v. State*, 187 So. 261 (1939)
13. In 1979 the Governor ordered a mental competency examination for Gary Alvord, and in 1980 an examination was ordered for Johnny Witt. On the advice of their attorneys, both men refused to participate. Attorneys for Steven Todd Booker requested an examination in 1983, but withdrew their request before the psychiatrists met with Booker. In 1984 competency examinations were ordered and conducted for Goode, Ford, Ronald Jackson, and Gary Alvord. Three days before his scheduled execution, Alvord was found to be incompetent and was transferred to the Florida State Mental Hospital at Chattahoochee. See "Graham moves triple murderer to institution, halting execution," *St. Petersburg Times*, November 27, 1984 at p. 4B
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18. Weihofen: *supra* note 14 at p. 652
19. *Furman v. Georgia*, 408 U.S. 238 (1972) at p. 361
20. Radelet ML, Vandiver M, Berardo FM: Families, prisons, and men with death sentences: The human impact of structured uncertainty. *J Fam Issues* 4: 593-612, 1983
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23. One of the psychiatrists employed by the defense saw Ford twice, once in November 1983 and again on May 23, 1984. The second interview was only one week before Ford's scheduled execution (the execution was later stayed by the 11th Circuit Court of Appeals; the state appealed the stay but the U.S. Supreme Court refused to intervene. See *Ford v. Strickland*, 734 F.2d 538 (11th Cir.) *aff'd* 104 S.Ct. 3498. The psychiatrist found that Ford's condition had "seriously deteriorated" in the time between the two examinations. "Mr. Ford's condition, severe paranoid schizophrenia, has seriously worsened, so that he now has at best only minimal contact with the events of the external world" (Report of Dr. Harold Kaufman, May 24, 1984)
24. *Addington v. Texas*, 441 U.S. 418 (1979)
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26. In the reports to the Governor submitted after the evaluation of Carl Jackson, one physician wrote, "It is my professional opinion that Carl Jackson is feigning mental illness, and that he does understand the nature and affect (sic) of the death penalty and why it is to be imposed on him." This statement misses the point that "professional opinions" require professional standards that in this situation are nonexistent, and that psychiatrists can give professional medical opinions, not professional legal opinions. Another commission psychiatrist wrote: "I therefore declare him competent to be executed."
27. Applebaum PS: Psychiatrists' role in the death penalty. *Hosp Community Psychiatry* 32:761-2, 1981
28. Applebaum PS: Hypotheticals, psychiatric testimony, and the death sentence. *Bull Am Acad Psychiatry Law* 12:169-77, 1984
29. Ewing CP: Dr. death and the case for an ethical ban on psychiatric and psychological predictions of dangerousness in capital sentencing proceedings. *Am J Law Med* 8:407-28, 1983
30. Curran WJ: Uncertainty in prognosis of violent conduct: The Supreme Court lays down the law. *N Engl J Med* 310:1651-2, 1984
31. Showalter CR, Bonnie RJ: Psychiatrists and capital sentencing: Risks and responsibilities in a unique legal setting. *Bull Am Acad Psychiatry Law* 12:159-67, 1984
32. Compare Bolsen B: Strange bedfellows: Death penalty and medicine. *J Am Med Assoc* 248:518-9, 1982; Curran WJ: Psychiatric evaluations and mitigating circumstances in capital-punishment sentencing. *N Engl J Med* 307:1431-2, 1982
33. Halleck SL, Applebaum P, Rappeport J, Dix GE: Report of the Task Force on the role of psychiatry in the sentencing process, in *Issues in Forensic Psychiatry*. Washington, DC, American Psychiatric Press, 1984, pp. 181-215
34. For example, after examining Ford, the three psychiatrists asked the prison correctional officers about Ford's behavior back in his cell. The officers said Ford behaved normally—a response cited in the report of the one commission member who did not find Ford psychotic. Correctional officers are not trained, objective, or neutral observers of a prisoner's mental status. Nonetheless, there was no opportunity for defense attorneys to rebut what the guards had said.
35. Broderick: *supra* note 5
36. Since very few condemned prisoners have the resources to retain psychiatrists and no state funds are provided for this, the psychiatric profession will be faced with requests to provide free evaluations when the issue of competency to be executed is raised.
37. Of the four commissions of psychiatrists appointed by the Governor in 1984, one psychiatrist from the main state mental hospital sat on all four panels, while another from the same institution sat on three.
38. The point that the psychiatrists' evaluation is determinative of the Governor's finding is demonstrated by the Alvord case. The full report, signed by all three participating psychiatrists, reads:
 

Dear Governor Graham:

As per your order no. 84-214, we examined Mr. Gary Alvord (sic) today at the Florida State Prison. It is our unanimous decision that Mr. Alvord does not understand the nature and effect of the death penalty and



he does not understand why it should be imposed upon him. It is therefore our medical opinion that Mr. Alvord is incompetent to be executed as per statute 922.07. If you have any further questions do not hesitate to contact us. A detailed report will follow.

Thank you for giving us an opportunity to be of service to you.

Governor Graham halted the pending execution and ordered Alvord's transfer to the mental hospital immediately upon receiving a phone call in which this letter was read. And, seven months after this letter was written, Alvord's defense attorney stated (to MLR) that the "detailed report" that the psychiatrists had promised had never been written. Note again the confusion between medical and legal opinion.

39. Dix GE: Participation by mental health professionals in capital murder sentencing. *Int J Law Psychiatry* 1:283-308, 1978
40. See *Solesbee v. Balkcom*: supra note 6; *Magwood v. State*, 449 So.2d 1267 (1984); *Ford v. Wainwright*, 752 F.2d 526 (1985)
41. Morris N.: *Madness and the Criminal Law*. Chicago, University of Chicago Press, 1982, pp. 55-6
42. See supra note 37
43. Leonard M: Death row inmate's treatment sparks controversy. *Tallahassee Democrat*, December 12, 1984 at p. 1
44. We were able to identify only one case in which a death row inmate in Florida was found to be incompetent to be executed. Guy H. Eoff killed his wife and attempted suicide on April 24, 1946 in Belle Glade. He was sentenced to death on July 31, 1946. Psychi-

atric testimony placed his mentality as that of a child between 10 years old and early adolescence, but the psychiatrist found him sane and competent to stand trial. A few hours after being condemned, Eoff again attempted suicide. He was then found to be incompetent for execution and confined to a mental hospital until November 1965. The hospital staff then determined that his competency had been restored, and he was returned to the prison for execution. On September 14, 1965—after nearly 20 years of living under a death sentence—the Governor commuted the sentence to life imprisonment (*Palm Beach Post*, September 7, 1966 at p. 4:3 and September 15, 1966 at p. 8:2). In California, between 1942 and 1957 one man was found incompetent for execution, but later he regained his sanity and was executed. See Note: Post-conviction remedies in California death penalty cases. *Stanford Law Review* 11:94-135, 1958, at p. 131. See generally Duffy C: 88 Men and 2 Women. New York, Doubleday, 1962, at pp. 196-204. The prohibition against executing the mentally incompetent has also saved at least one innocent prisoner from execution. In 1900, Richard Phillips was sentenced to death in Virginia, but in 1901 he was declared insane and transferred to a mental hospital. In 1930, after his sister demanded a reinvestigation, it was discovered that another man was the real murderer. Governor Pollard granted Phillips a pardon, and he was released from the hospital. See also Black CL: *Capital Punishment: The Inevitability of Caprice and Mistake*, 2nd Ed. New York, Norton, 1981, at pp. 62-64.