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## Psychiatry and the death penalty: a human rights perspective

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The purpose of this paper is to discuss the death penalty and psychiatry from a human rights point of view. In practice, it will set out some of the basic facts concerning contemporary practice of the death penalty, to present the human rights argument against the death penalty and then argue that psychiatrists have an important potential to ensure that medical skills do not contribute to executions and to the retention of the death penalty.

### The death penalty in practice

According to the latest information published by Amnesty International (AI)<sup>1</sup>, there are 44 countries which have abolished the death penalty for all crimes, 17 countries which are abolitionist for ordinary [i.e. non-military, non-wartime] crimes<sup>2</sup>; 25 which are *de facto* abolitionist [i.e. they have not used the death penalty in the last ten years or more]; and 92 countries and territories which retain and use the death penalty.

In 1990, some 2000 executions were recorded by AI in 26 countries; this figure must be regarded as a significant underestimate. Of these recorded executions, around 75% were carried out in Iran and China<sup>3</sup>. Thus, the death penalty in practice must be viewed as a punishment which is mainly carried out by a small number of countries, some of which have poor human rights records.

### The death penalty: the human rights argument

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<sup>1</sup> Amnesty International. *The death penalty: list of abolitionist and retentionist countries*. AI Index: ACT 50/01/91, 30 January 1991.

<sup>2</sup> All of Western Europe and parts of Eastern Europe are now included in these first two categories.

<sup>3</sup> Amnesty International. *Death sentences and executions in 1990*. AI Index: ACT 51/01/91. The exact figures were 2029 executions recorded in 1990 of which 757 occurred in Iran, 730 occurred in the People's Republic of China, 190 in USSR and 121 in Nigeria.

The human rights critique of the death penalty rests on two kinds of argument. The first draws on a view of the inherent rights of men and women. Simply put, the right to life is the most fundamental of human rights and one which cannot be protected by killing those who fail to respect it. As a major 1989 Amnesty International report on the death penalty<sup>4</sup> suggests, the death penalty is inhuman. If, the report argues, torture in the form of "administering 100 volts to the most sensitive parts of a man's body evokes disgust, what is the appropriate reaction to the administration of 2000 volts to his body in order to kill him?"<sup>5</sup>. The second argument stems from an analysis of the death penalty in practice. The death penalty is applied arbitrarily - some of those convicted are executed; others convicted of similar crimes are not. It is frequently applied after summary or unfair trial. In countries where there is some form of legal process it is still applied disproportionately against minorities and the poor who usually have less access to legal support. It is applied for political reasons. It is applied for crimes which do not involve loss of life, for example, adultery, prostitution, running a brothel and showing pornographic films, taking bribes, embezzlement and economic corruption, kidnapping, rape, robbery or armed robbery, and drug trafficking<sup>6</sup>. And, of course, it is irreversible; a wrongly executed person cannot be restored to life. Recent belatedly successful appeals against wrongful conviction in cases involving multiple killings in the United Kingdom give cause for deep reflection on this point<sup>7</sup>.

### **Role of the medical profession**

Of the current methods of judicial execution - stoning, hanging, decapitation, shooting, electrocution

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<sup>4</sup> Amnesty International. *When the State Kills ....* London: AIP, 1989.

<sup>5</sup> *ibid.* p.2

<sup>6</sup> *ibid.* p.37.

<sup>7</sup> The "Guildford Four", three Irish men and an Irish woman, and the "Birmingham Six", six Irish men, were wrongfully convicted in the mid-1970s on multiple charges of murder in the wake of bombings on public houses in the English town of Guildford and city of Birmingham. In 1989, the four convicted in the Guildford case had their sentences quashed after 14 years in prison and in 1991, the Birmingham Six were released after a successful appeal, after nearly 17 years in prison.

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[USA only], gassing [USA only], lethal injection [USA only]<sup>8</sup> - doctors have played a role in the development or refining of all, with the possible exception of stoning.

- ◆ In 18th century revolutionary France, the decapitation machine named after Dr Guillotin was developed and tested by Dr Antoine Louis, secretary of the Academy of Surgery;
- ◆ In the 1880s, investigative commissions which drew on the evidence of health professionals looked at execution techniques in the USA and in England and medical opinion was significant in the recommendations they made - to introduce electrocution, and to retain hanging respectively;
- ◆ Gassing and lethal injection required medical opinion in their development and implementation in the 1920s and 1970s respectively;
- ◆ Most recently, Taiwanese surgeons were apparently persuasive in their arguments with the government that shooting prisoners through the head rather than the heart could yield usable organs for transplantation<sup>9</sup>.

However, it was the threatened introduction of lethal injection in the United States which galvanised the medical profession and provoked a deep debate within the pages of medical journals<sup>10</sup> and even daily newspapers. Doctors around the world appealed to the US authorities not to proceed with this most medicalised of execution methods. For five years the legislation permitting lethal injection went unused. Then in December 1982, Charlie Brooks, a black Texan, became the first man to die by injection of poison into the veins while two doctors stood by monitoring his rapidly failing system<sup>11</sup>. Under the guise of "certifying" his death, these doctors in fact advised the executioner

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<sup>8</sup> According to the 1991 *Amnesty International Report* (p.122) a further, though unusual, form of execution was used in Iran; a man was executed by being thrown from a precipice.

<sup>9</sup> Amnesty International. *Involvement of medical personnel in abuses against detainees and prisoners*. AI Index: ACT 75/08/91, November 1990.

<sup>10</sup> Curran WJ, Casscells W. The ethics of medical participation in capital punishment by intravenous drug injection. *New England Journal of Medicine*, 1980; **302**:226-30.

<sup>11</sup> Amnesty International. *Health professionals and the death penalty*. AI Index: ACT 51/03/89, 20 January

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of the necessity to keep the poison flowing. It is hard to interpret this activity as other than participation in an execution.

Many other executions in the USA have followed a similar pattern with medical personnel present in the execution chamber telling the executioner when the job was done or when more of the lethal agent was required.

It was in anticipation of this kind of scenario that Amnesty International drafted its declaration on the participation of doctors in the death penalty in 1981. This was revised in 1988 in the light of developments during the 1980s. It set out those activities which the organization believed were incompatible with the health professional's healing role:

- . determining mental and physical fitness for execution
- . preparing, administering, supervising or advising others on any procedure related to execution
- . making medical examinations during executions, so that an execution can continue if the prisoner is not yet dead"<sup>12</sup>

At the time, and indeed since, the major "medical" preoccupation of human rights organizations and those opposed to the death penalty has been the involvement of doctors in executions and their immediate preparation. However, there are ethical dilemmas which occur at different points from arrest to execution and which arise "from the commitment of the healing professions to work for the benefit of their patients and with their consent".<sup>13</sup>

### **Psychiatrists and the death penalty**

#### *The standards*

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1989.

<sup>12</sup> Amnesty International Declaration on the Participation of Health Personnel in the Death Penalty. *When the State Kills...* London: AIP, 1989, p.256.

<sup>13</sup> Amnesty International. *Health professionals and the death penalty*. AI Index ACT 51/03/89, 20 January 1989, p.8.

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In the past decade there have been a variety of declarations on the death penalty and the medical profession made by various organizations. Firstly, the World Medical Association (WMA) adopted a statement in Lisbon in September 1981 which stated that "it is unethical for physicians to participate in capital punishment, although this does not preclude physicians certifying death"<sup>14</sup>. In 1989, the International Council of Nurses (ICN) and the World Psychiatric Association (WPA) both declared their opposition to professional involvement in the death penalty<sup>15</sup>. The ICN went further than opposition solely to professional involvement and urged nurses' associations to work for an end to the use of the death penalty.

At national level, the American Medical Association, the American Public Health Association, the American Nurses' Association, the American Psychiatric Association, and the American College of Physicians, have all made pronouncements on the death penalty. At a minimum all these associations proscribe professional involvement in executions. The APHA opposes executions as such. It should be noted in passing that instances of direct medical involvement in establishing intravenous lines to facilitate execution by lethal injection have recently been reported in Illinois and Missouri in the USA<sup>16</sup>. Despite concerted efforts by physicians opposed to such involvement, it has not been possible to identify those doctors alleged to have participated.

In other countries, medical associations have also considered the death penalty and have made public their opinions. The Nordic countries for example declared in 1986 that it is "indefensible for any physician to participate in any act connected to and necessary for the administration of capital punishment"<sup>17</sup>. In the same year six members of the Central Council of the Turkish Medical Association (TMA) were acquitted on charges relating to the TMA's advocacy of an end to medical presence at executions and medical certification of prisoners as fit for execution. The

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<sup>14</sup> See: Amnesty International. *Ethical Codes and Declarations of Relevance to the Health Professions*. AI Index: ACT 75/01/85, June 1985

<sup>15</sup> See *Ethical Codes and Declarations Relevant to the Health Professions (Addendum)*. AI Index: ACT 75/01/85/Addendum, May 1990. The text of the WPA declaration is appended to this paper.

<sup>16</sup> American Medical Association. *AMA News*, November 1990.

<sup>17</sup> Amnesty International. *The death penalty in the United States of America: an issue for health professionals*. AI Index: AMR 51/40/86.

TMA has repeatedly stated it is in favour of abolition and has instructed members that they should not to be present at executions.

With regard specifically to psychiatrists, the association for which arguably the death penalty is the most vital issue is the American Psychiatric Association. This is because of the existence of the death penalty in the USA and the increasing use made of psychiatric testimony in legal process at all levels in US courts. However, as a human rights issue, psychiatric involvement in capital trials is of importance to a much wider audience including, of course, the international psychiatric community.

### How can psychiatrists become involved in the death penalty?

Psychiatrists can be asked or required to assist in various aspects of death penalty cases, usually in connection with evaluation of the mental state of the accused or the convicted. The issues which are discussed below illustrate some of the ethical dilemmas inherent in such involvement and are drawn from the US - the country from where most published research on the death penalty comes.

#### *Future dangerousness*

In capital trials in Texas, one of the questions which the jury must answer during the sentencing phase is whether the convicted prisoner would be likely to commit further acts of violence which would be a continuing threat to society. In a number of trials, evidence has been introduced at the sentencing stage which purports to be expert psychiatric evidence that the convicted prisoner would have a high probability (or even "100% certainty" according to one psychiatric witness<sup>18</sup>) of "future dangerousness". Sometimes these opinions are given in the absence of an examination of the convicted prisoner but rather in response to hypothetical questions. In an appeal to the US Supreme Court in 1982 by Thomas Barefoot, a prisoner awaiting execution, the American Psychiatric Association submitted an *amicus curiae* brief suggesting that assessment of future dangerousness is not based on *expert*

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<sup>18</sup> Evidence given in the case of *Texas v. Barefoot*, cited in Appelbaum P. Hypotheticals, psychiatric testimony, and the death sentence. *Bulletin of the American Academy of Psychiatry and Law*, 1984; 12:169-77.

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psychiatric knowledge<sup>19</sup>, a point also made by other commentators<sup>20</sup>. The Supreme Court however upheld the constitutionality of accepting evidence which, in this case at least, was regarded by the APA as lacking scientific validity<sup>21</sup>.

It should be emphasised that at the sentencing phase of the trial the defendant has already been convicted. Psychiatric evidence is introduced by the state, not for the determination of the guilt or innocence of the defendant, but solely to persuade the jury that the prisoner should be executed. It is hard to see an ethical argument in favour of such a direct role for a psychiatrist in sending a person to the electric chair or onto the gurney for lethal injection.

#### *Competency for execution*

The psychiatrist (or sometimes psychologist) may also enter the arena when a prisoner appeals against the sentence of death on the ground of incompetence. In comparison to the ethical standards of physicians, the psychiatric response to professional involvement in competency evaluations for punishment is confused. A number of national medical associations specifically rule as unethical medical certification of fitness for corporal punishment. The British Medical Association states the following, for example:

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<sup>19</sup> American Psychiatric Association. *Brief Amicus Curiae. Barefoot v. Estelle*. Case No.82-6080. US Supreme Court, October term 1982.

<sup>20</sup> See, for example: Ewing CP. "Dr Death" and the case for an ethical ban on psychiatric and psychological predictions of future dangerousness in capital sentencing procedures. *American Journal of Law and Medicine*, 1983; **8**:407-28.

<sup>21</sup> The point here is not that predictions cannot be made; rather that, according to the APA, those made by psychiatrists are more often wrong than right, that "hypotheticals" are an inadequate basis for forming such judgments and that the predictors of future dangerousness are parameters accessible to non-psychiatrists - factors such as history of violence. See: Appelbaum PS. Death, the expert witness and the danger of going Barefoot. *Hospital and Community Psychiatry*, 1983;**34**:1003-4; Bennett GT, Sullwold AF. Qualifying the psychiatrist as a lay witness: a reaction to the American Psychiatric Association petition in Barefoot v. Estelle. *Journal of Forensic Sciences*, 1985; **30**:462-6.

Corporal punishment and incarceration in a dark cell are both prohibited punishments under the [United Nations] Standard Minimum Rules [for the Treatment of Prisoners] and a doctor would be acting unethically if he certified a prisoner as fit to undergo either procedure. Attendance at the corporal punishment of a prisoner is unethical.<sup>22</sup>

It is a grim irony that it should be considered unethical to medically certify a prisoner fit to receive a whipping but regarded by some as ethically acceptable to declare them fit to be put to death.

What constitutes "competency" to be executed is an intriguing though surely non-medical concept. The US Supreme Court, in the case of *Ford v. Wainwright* in 1986, affirmed the Florida statute that the condemned prisoner is competent if he or she "understands the nature and effect of the death penalty and why it is to be imposed upon him" though ruled that the state's procedures for determining this were inadequate.

Opinions on the ethical propriety of giving testimony on competency range from those who accept such a role as a valid undertaking, through those who are troubled either by the concept of competency or by psychiatric involvement in assessments, to those who believe that psychiatric evaluation of competency to be executed is ethically unacceptable<sup>23</sup>.

The Amnesty International declaration on participation of health personnel in the death penalty embodies this last position: "fitness" and "competency" have substantially the same meaning. Those arguing that testifying about competency to be executed is merely a forensic exercise devoid of any moral consideration of the consequences appear to implicitly confer a moral validity on the death penalty, since to contribute to a morally unacceptable punishment would in itself be unethical.

In the case of competency evaluations, the legal process appears increasingly, at least in the USA, to thrust important decisions onto mental health professionals; legal issues are turned into medical or psychiatric questions. The effect of this is that psychiatric testimony may be decisive in the

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<sup>22</sup> British Medical Association. *The Handbook of Medical Ethics*. London: BMA, 1981, p.50.

<sup>23</sup> See for example, Mossman D. Assessing and restoring competency to be executed: should psychiatrists participate? *Behavioral Sciences and the Law*, 1987;**5**:387-409; Radelet M, Barnard G. Ethics and the psychiatric determination of competency to be executed. *Bulletin of the American Academy of Psychiatry and Law*, 1986;**14**:37-53; Salguero RG. Medical ethics and competency to be executed. *The Yale Law Journal*, 1986;**96**:167-86; Wallace DH. Incompetency for execution: the Supreme Court challenges the ethical standards of the mental health professions. *Journal of Legal Medicine*, 1987, **8**:265-281.



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outcome of the judicial process. It is arguably incompatible for a psychiatrist to play such a direct role in the life or death of a prisoner and to contribute to the escalation of the medical or psychiatric role in the machinery of capital punishment. Again, the legal point at issue is no longer establishing innocence or guilt but whether or not to electrocute, shoot, gas or lethally inject the prisoner.

#### *Restoring mental health to permit execution*

In at least one case in the US, that of Gary Alvord in Florida in 1984, a court ordered that a prisoner who manifested mental illness after his conviction for murder and imposition of the death sentence, should be sent to a mental institution until restored to a fit state to allow execution<sup>24</sup>.

This brought about a situation of "ethical chaos with only one solution" as US commentators Radelet and Barnard described it<sup>25</sup>. It is surely grotesque to apply humanistic medical skills in a situation where the sign of professional failure is that the person lives and the sign of success is that they die. In a recent case, that of *Perry v. Louisiana*, a prisoner whose competency was only maintained by the use of haloperidol, appealed against a ruling that he should be involuntarily medicated until he could be executed. The US Supreme Court ruled that the case be returned to the Louisiana courts for adjudication in the light of prevailing standards on the rights of prisoners to refuse involuntary medication.

#### **Effect of the death penalty on the forensic psychiatric role**

The possibility of a corrupting effect of the death penalty on the medico-legal role cannot be ruled out. Psychiatrists can be asked to give opinions on matters relating to the prisoner - competency, for example - which are essentially legal, rather than medical, concepts. Presumably, attempts to persuade psychiatrists to give non-medical opinion are made because the psychiatrist's evidence is seen as (or can be portrayed by the prosecution as) scientifically neutral and can be very persuasive.

On the other hand, refusal to give expert evidence in death penalty cases by psychiatrists opposed to the death penalty could lead to a biased population of psychiatrists who will give evidence

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<sup>24</sup> Salguero RG. Medical ethics and competency to be executed. *Yale Law Journal*, 1986; **96**:167-86.

<sup>25</sup> Radelet ML, Barnard GW. Treating those found incompetent for execution: ethical chaos with only one solution. *Bulletin of the American Academy of Psychiatry and Law*, 1988; **16**:297-303.

on, for example, competency, coloured to a greater or lesser extent by their own prejudices<sup>26</sup>. The simplest solution to this ethical morass, as well as to the important issues raised above, is to abolish the death penalty.

### Conclusion

Executions are irreversible. Innocent people can be, and are, executed. There is no evidence that they are a unique deterrent to murder and crimes of similar gravity. It is a matter of record that they are frequently imposed arbitrarily and against minorities and the poor. Arguably they risk encouraging a climate of violence - a belief that violent crimes require violent solutions.

How should psychiatrists respond to such a state of affairs? As a profession dedicated to compassion, to personal well-being and to the advancement of humane values, psychiatrists have an important role not only in ensuring that individual psychiatrists don't contribute to executions through professional activities but also through pressing for a commitment to address the underlying problems in society rather than adopting fraudulent signs of action such as killing off a few convicted prisoners. They should contribute to the effort to instil in society a deep and unshakeable belief in the value of the human person. The psychiatrist's voice should be heard, speaking in defence of human rights and against the death penalty.

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<sup>26</sup> A recent paper by Deitchman *et al* suggests that there was a correlation between willingness to provide assessments of competence and support for the death penalty. The authors acknowledged the methodological limits to their study and presented their evidence very much as preliminary data. Deitchman MA, Kennedy WA, Beckham JC. Self-selection factors in the participation of mental health professionals in competency for execution evaluations. *Law and Human Behavior*, 1991; **15**:287-303.

**Appendix 1:**

**Appendix 2:**