ARTICLE

THE ROLE OF MENTAL HEALTH PROFESSIONALS IN CAPITAL PUNISHMENT: AN EXERCISE IN MORAL DISENGAGEMENT

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I. INTRODUCTION

As was the case almost two decades ago when the U.S. Supreme Court ruled in *Ford v. Wainwright*[1] that the Eighth Amendment prohibits execution of the "insane,"[2] recent developments have again focused attention on the role of mental health professionals in the capital punishment process. One such development is the Court's 2002 ruling in *Atkins v. Virginia*[3] that the Eighth Amendment prohibits execution of the mentally retarded.[4] *Atkins*, like *Ford* before it, creates a class of persons whose constitutional ineligibility for the death penalty will be based heavily on the testimony of psychologists and psychiatrists.[5] *Atkins* thus implicates mental health professionals' forensic assessment function in the capital punishment context.[6]

Another development arises from the conjunction of two recent cases. One is the Eighth Circuit's 2003 en banc ruling in *Singleton v. Norris*[7] upholding the involuntary administration of antipsychotic medication to a capital convict for whom an execution date had been set.[8] *Singleton* must be considered in light of the U.S. Supreme Court's subsequent decision in *Sell v. United States*,[9] which articulated the due process standard for involuntary administration of antipsychotic medications to restore a nondangerous defendant to competence to stand trial

1. 477 U.S. 399 (1986).
2. *Id.* at 401, 409–10.
3. 536 U.S. 304 (2002).
4. *Id.* at 321.
5. *See id.* at 308–10, 338–39 (discussing how the competition between expert psychologists' testimonies regarding the petitioner's mental retardation "was a central issue at sentencing"); *see also Ford*, 477 U.S. at 402–04, 412–15.
6. *See Atkins*, 536 U.S. at 308–10, 338–39.
7. 319 F.3d 1018 (8th Cir.), *cert. denied*, 456 U.S. 938 (2003).
8. *Id.* at 1020.
9. 123 S. Ct. 2174 (2003).

for serious crimes.[10] These developments implicate both the treatment and assessment roles of mental health professionals in the capital punishment context.

As members of professions that claim a core ethical commitment to beneficence and harm-avoidance, psychiatrists and psychologists face increasing ethical challenges as their roles have expanded to include the provision of assessment and treatment services before, during, and after capital sentencing. Professional associations and commentators have offered a variety of positions addressing the tension between those ethical commitments and active involvement in a process aimed at inflicting death.[11]

This Article takes advantage of the opportunity created by recent developments to revisit those positions, but for a purpose different from the usual one. The aim here is not to attempt to resolve the questions of whether and to what extent mental health professionals may ethically lend their services to the capital punishment process. Instead, this Article examines a selection of the leading arguments on those questions as a heuristic device[12] for exploring an important aspect of what I regard as the "underground economy" of capital punishment.

There is good reason to believe that behind the American capital punishment system's official version—its purported instrumental penological purposes of retribution, deterrence, and incapacitation—lies a more covert economy of largely symbolic psychological benefits and costs.[13] I have elsewhere proposed that, in view of evidence of the system's arbitrariness and excessiveness,[14] high rate of serious procedural error,[15] enormous

10. *Id.* at 2184–85. Notably, the U.S. Supreme Court passed up an opportunity to do so when it denied certiorari in *Singleton*.

11. *See, e.g.*, Kirk Heilbrun et al., *The Debate on Treating Individuals Incompetent for Execution*, 149 AM. J. PSYCHIATRY 596, 596 (1992).

12. I have here borrowed the phrase "heuristic device," as applied to this context, from Kirk Heilbrun et al., *supra* note 11, at 596, one of the more thoughtful pieces in the literature on this subject.

13. *See* Donald P. Judges, *Scared to Death: Capital Punishment as Authoritarian Terror Management*, 33 U.C. DAVIS L. REV. 155, 158–59 (1999) [hereinafter Judges, *Scared to Death*] (arguing that capital punishment is ineffective in accomplishing its purported objectives and is based more on attitudes and beliefs than penal efficacy).

14. *See id.* at 161.

15. JAMES S. LEIBMAN ET AL., A BROKEN SYSTEM: ERROR RATES IN CAPITAL CASES, 1973–1995, at i–iii (2000); *see also, e.g.*, DEATH PENALTY INFO. CTR., THE DEATH PENALTY IN 2001: YEAR END REPORT 3 (2001) (quoting Justice Sandra Day O'Connor's observation that "[i]f statistics are any indication, the system may well be allowing some innocent defendants to be executed").

financial burdens,[16] and persistent race effects,[17] the institution is better understood—at least when viewed from a macroscopic perspective rather than in the context of any particular case—as a largely symbolic expression of worldview defense through the ritualistic control over death than as a rational and pragmatic response to crime.[18] This is the "psychological benefits" side to the ledger in the underground economy of capital punishment.[19]

That ledger has a cost side as well: several aspects of the death penalty system, including the disparity between popular support in the abstract (manifested in public opinion, political rhetoric, and legislative enactment) and the relatively low sentencing and even lower execution rates, reflect considerable ambivalence about the enterprise of legislatively and judicially authorized homicide.[20] Ambivalence should not be surprising, because capital punishment instantiates the very things against which it is largely a symbolic defense—including anxiety resulting from awareness of human mortality and violation of powerful cultural norms against killing.[21]

In other words, capital punishment's value is likely more symbolic than tangible; whatever benefits it does offer are purchased at considerable psychological cost.[22] Although it is likely that the infliction of punishment occasions some ambivalence, participation in the capital punishment process threatens to precipitate a psychological crisis because homicide, even if legally authorized, is an especially distressing kind of

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16. Richard C. Dieter, *Millions Misspent: What Politicians Don't Say About the High Costs of the Death Penalty*, in THE DEATH PENALTY IN AMERICA: CURRENT CONTROVERSIES 401 (Hugo Adam Bedau ed., 1997) [hereinafter CURRENT CONTROVERSIES].

17. For a brief overview of the literature of race effects in capital punishment, see Judges, *Scared to Death*, *supra* note 13, at 216–22. For recent work, see generally David C. Baldus et al., *Racial Discrimination and the Death Penalty in the Post-*Furman *Era: An Empirical and Legal Overview, with Recent Findings from Philadelphia*, 83 CORNELL L. REV. 1638 (1998) (contrasting the fact that racial discrimination is not a viable claim in the death penalty context with empirical studies in Philadelphia and New Jersey that strongly suggest that the race of both the victim and the defendant are highly influential in the death penalty determination); William J. Bowers, *Death Sentencing in Black and White: An Empirical Analysis of the Role of Jurors' Race and Jury Racial Composition*, 3 U. PA. J. CONST. L. 1 (2001) (exploring the effect the racial makeup of juries has on capital sentencing and finding that death sentences were most likely to be imposed with a white victim and black defendant).

18. This theory is the premise of Judges, *Scared to Death*, *supra* note 13.

19. *See id.* at 159–61 (explaining how capital punishment may be a psychological defense to the incipient terror caused by awareness of one's mortality).

20. *See id.* at 192–93.

21. These propositions are presented in detail in Judges, *Scared to Death*, *supra* note 13, at 193.

22. *See id.* at 158–59.

norm violation.[23] It transgresses the norm of *humanitas*—that is, humanitarian respect for human life—as well as notions of mercy and faith in the possibility of redemption.

Because of their explicit norms of beneficence and harm-avoidance, that tension should be especially acute for health professionals when they lend their services to the capital punishment process. Those norms are an institutionalized and role-defined version of the more general concept of *humanitas*.[24] The healing professions more explicitly and formally embrace a set of norms that are, at least in the abstract, widely valued, and that are threatened by the death penalty. One reason doctors enjoy the social status that they do is because they are seen as embodying an idealized combination of lofty values: a high degree of skill and learning put in the service of relieving suffering and saving lives. A critical examination of the means by which health professionals address the ethical conflict presented when they involve themselves in the capital punishment process etches in sharp relief capital punishment's psychological costs for society generally. Placing mental health professionals' ethical struggle under analytical scrutiny—watching the psychological currency being spent coin by coin—helps to highlight capital punishment's psychological costs.

Mental health professional associations and commentators have offered a variety of arguments in an effort to reconcile this normative conflict. Their arguments can be roughly grouped into six overlapping categories: (1) that opposition to capital punishment is a matter of personal, not professional, morality;[25] (2) that some involvement by mental health professionals in the

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23. *See* Markus Dirk Dubber, *The Pain of Punishment*, 44 BUFF. L. REV. 545, 580 (1996) (arguing that "virtually everyone who actually participates in the system of capital punishment, from the capital sentencing jurors to the state trial and appellate judges, to their federal counterparts, and on to the governor, the warden, the physician, and the executioner, struggles with the fundamental inhibition against inflicting the always physical violence of execution"). Refer to note 499 *infra* and accompanying text (explaining the psychological effect on soldiers ordered to shoot prisoners during the Holocaust). Further evidence of the force of the proscription against killing, even when state-sanctioned and the actor's personal safety is threatened, is seen in the effort military trainers must exert to render recruits willing to actually kill in battle. *See* GWYNNE DYER, WAR 118, 120–21 (1985). It was found that during World War II, "on average only fifteen percent of trained combat riflemen fired their weapons at all in battle. The rest did not flee, but they would not kill—even when their own position was under attack and their lives were in immediate danger." *Id.* at 118. These findings led to revision in basic training methods to include those specifically designed to socialize recruits to killing, increasing the ratio to at least fifty percent during the Korean War. *Id.* at 120.

24. Refer to Part III.C.2 *infra* (discussing health professionals' role-defined commitment to humanism, healing, care, and life).

25. Refer to Part IV.A *infra*.

capital punishment process is required by the needs of the justice system;[26] (3) that the conflict can be resolved on an "attenuation" basis, that is, by reference to the distance in causal relation between the practice in question and actual executions, at one end, or proximity of the practice to generally noncontroversial forensic work, at the other end;[27] (4) that such professionals are really "forensicists" rather than healers and therefore not bound by the healers' ethic;[28] (5) that some involvement is an unavoidable consequence of providing needed healing services;[29] and (6) that capital punishment itself has therapeutic attributes.[30]

This Article analyzes those arguments in light of Albert Bandura's model of the "mechanisms of moral disengagement."[31] According to Bandura's model, normally socialized people, whose behavior transgresses moral boundaries they otherwise would endorse, find it necessary to resort to predictable cognitive moves to avoid the psychological distress of self-censure (i.e., the anxiety associated with the threat to self-esteem imposed by the possibility that one is not living up to one's moral standards).[32] Those moves—which dissociate the actor from his or her own moral convictions—include cognitive reconstrual, obscuring the causal relationship between one's behavior and the ensuing harm, and devaluing the target of harmful behavior.[33]

This Article shows how the leading arguments in defense of mental health professionals' involvement in the capital punishment process are indeed pervaded by the mechanisms of moral disengagement. Those arguments, although open to question as a practical or logical matter, are quite understandable from the viewpoint of social cognition theory as a means of buffering self-censure. The problem, however, is that moral disengagement in this context results in the forfeiture of values that the professions otherwise would regard as essential. Thus, the extent to which psychiatrists and psychologists find it necessary to resort to such moves indicates the *dissociative*

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26. Refer to Part IV.B *infra*.

27. Refer to Part IV.C *infra*.

28. Refer to Part IV.D *infra*.

29. Refer to Part IV.E *infra*.

30. Refer to Part IV.F *infra*.

31. Albert Bandura, *Mechanisms of Moral Disengagement in the Exercise of Moral Agency*, 71 J. PERSONALITY & SOC. PSYCHOL. 364 (1996) [hereinafter Bandura, *Mechanisms of Moral Disengagement*].

32. Refer to Part II.A *infra* (discussing the Bandura model's social and internalized self sanctions).

33. Refer to Part II.A.3 *infra* (explaining the mechanism of cognitive reconstrual).

costs—the degree to which they must reshape and devalue their conceptions of themselves, their conduct, and their professional values—exacted by the capital punishment process on the functionaries who otherwise personify norms that our society values.

By examining the moral disengagement found in the structure and content of arguments in defense of mental health professionals' participation in the capital process, rather than directly arguing that such participation is or is not "ethical," this Article attempts to account for the price that professionals pay when they provide services in the capital punishment context. By revealing the extent to which such participation compromises norms that are highly valued by our culture, this inquiry illustrates how psychologically costly capital punishment can be. Just as the prisoner is to some extent a symbolic surrogate for the hated and feared attributes that society feels reassured for having the power to exterminate, the participating health professionals' ethical sacrifice embodies the psychological price paid for that reassurance. There is more red ink on the ledger than commonly acknowledged.

It is more important than ever in the moral twilight of the post-September 11 era to appreciate the extent to which capital punishment trades in the currency of moral disengagement. As Bandura observed long before the term "terrorism" entered mainstream American conversation, an analogous currency is itself the coin of the realm in the psychological economy of terroristic behavior.[34] For Americans to make truly informed choices about whether to practice capital punishment—which Justice Marshall implied, as part of the "Marshall Hypothesis" in *Furman v. Georgia*, is essential to the legitimacy of those choices[35] and surely crucial to morally sound policymaking—they must weigh not only the putative tangible benefits and costs described in the official version, but the very real psychological benefits and costs as well.

This Article proceeds in three parts. Part II briefly recounts Bandura's theory of moral disengagement and its general

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34. Refer to notes 52–53 *infra* (describing relationship between terroristic behavior and moral disengagement).

35. Furman v. Georgia, 408 U.S. 238, 362 n.145 (1972) (Marshall, J., concurring) (discussing Marshall's hypothesis that the average American's indifference toward the death penalty and acceptance of the status quo derives from a lack of informed exposure to the issue and examining the results of studies testing his theory). For discussion of the Marshall Hypothesis, see generally Robert M. Bohm, *American Death Penalty Opinion: Past, Present, and Future, in* AMERICA'S EXPERIMENT WITH CAPITAL PUNISHMENT 31–41 (James R. Acker et al. eds., 1998).

relationship to capital punishment. Part III considers the extent to which participation by mental health professionals in the capital punishment process creates ethical conflicts. Part IV explains how such professionals' efforts to resolve those conflicts reflect dissociation through moral disengagement.

II. MORAL DISENGAGEMENT AND CAPITAL PUNISHMENT

A. Moral Disengagement

As Hannah Arendt pointed out in her observations on the "banality of evil," and as Stanley Milgram and other researchers have demonstrated in their obedience experiments, ordinary people can be brought to participate, often directly, in behavior—including the infliction of physical suffering, injury, and even death on others—that otherwise would violate their own moral standards.[36] "Given appropriate social conditions, decent, ordinary people can be led to do extraordinarily cruel things."[37]

According to the social cognitive theory developed by Albert Bandura and others, conduct that violates moral norms "is regulated by two major sources of sanctions—social sanctions and internalized self-sanctions."[38] The internal cognitive self-regulatory mechanism, which is the one relevant to the present inquiry, is especially potent: "There is no greater punishment than self-contempt."[39] In the absence of external behavioral constraints, therefore, "[p]eople regulate their actions by the

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36. *See generally* HANNAH ARENDT, EICHMANN IN JERUSALEM: A REPORT ON THE BANALITY OF EVIL 18–50 (1963); STANLEY MILGRAM, OBEDIENCE TO AUTHORITY, at xi–xiii (1974); Stanley Milgram, *Behavioral Study of Obedience*, 67 J. ABNORMAL & SOC. PSYCHOL. 371 (1963); Stanley Milgram, *Some Conditions of Obedience and Disobedience to Authority*, 18 HUM. REL. 57 (1965). For a study of the processes by which professional torturers are trained, see Mika Haritos-Fatouros, *The Official Torturer: A Learning Model for Obedience to the Authority of Violence*, 18 J. APPLIED SOC. PSYCHOL. 1107, 1107–20 (1988) (describing the selection, training, and socialization to violence and obedience of torturers in the military police during the military junta in Greece). Haritos-Fatouros hypothesized that

> [i]f the proper learning procedures are applied under the right circumstances, any individual is a potential torturer. An explanation that has recourse to the presence of strong sadistic impulses is inadequate; to believe that only sadists can perform such violent acts is a fallacy and a comfortable rationalization to ease our liberal sensibilities.

Id. at 1119.

37. Albert Bandura, *Social Cognitive Theory of Moral Thought and Action*, *in* 1 HANDBOOK OF MORAL BEHAVIOR AND DEVELOPMENT 45, 90 (William M. Kurtines & Jacob L. Gerwitz eds., 1991) [hereinafter Bandura, *Moral Thought and Action*].

38. *Id.* at 68.

39. *Id.* at 69.

consequences they apply to themselves."[40] They monitor their own behavior, evaluate it in light of internal standards and external circumstances, and impose either positive or negative self-reactions.[41]

People are able to engage in conduct that normally would violate their own moral standards because the behavior-regulating forces of "[s]elf-reactive influences do not operate unless they are activated, and there are many psychosocial processes by which self-sanctions can be disengaged from inhumane conduct. *Selective activation and disengagement of internal control permits different types of conduct with the same moral standards*."[42] In other words, people can avoid the negative consequence of self-censure normally associated with behavior that violates internalized moral standards by disengaging or only selectively activating the internal control mechanisms that otherwise would produce self-censure. You have to set your alarm clock if you want it to keep you from oversleeping. Thus, transgressive behavior leads either to self-censure or to the dissociative processes of moral disengagement. Further, people can sometimes find themselves in situations that offer external incentives and modeling for transgressive behavior.[43]

Bandura and his colleagues have catalogued the mechanisms of moral disengagement.[44] Those mechanisms can be grouped into three categories: cognitive reconstrual, obscuring the causal relationship between one's behavior and outcomes, and degradation of both self and the targeted other.[45]

1. Cognitive Reconstrual. One way to disengage self-sanctions is to reconstrue the conduct as morally justified by some socially or morally valued purpose: "[w]hat is culpable can be made honorable through cognitive reconstrual."[46] For example, moral reconstrual of killing, so that it "can be done free from self-censuring restraints," is an important aspect of military training and is also seen, for example, in terrorist and counter-terrorist

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40. Bandura, *Mechanisms of Moral Disengagement*, *supra* note 31, at 364.

41. *Id.*

42. *Id.* (emphasis added) (citations omitted).

43. *See* Haritos-Fatouros, *supra* note 36, at 113–18 (discussing the situational factors contributing to participation in torture).

44. Albert Bandura, *Mechanisms of Moral Disengagement*, *in* ORIGINS OF TERRORISM: PSYCHOLOGIES, IDEOLOGIES, THEOLOGIES, STATES OF MIND 161, 161–62 (Walter Reich ed., 1990) [hereinafter Bandura, ORIGINS OF TERRORISM]; Bandura, *Mechanisms of Moral Disengagement*, *supra* note 31, at 364.

45. Bandura, ORIGINS OF TERRORISM, *supra* note 44, at 161; Bandura, *Mechanisms of Moral Disengagement*, *supra* note 31, at 364.

46. Bandura, ORIGINS OF TERRORISM, *supra* note 44, at 163.

measures.[47] Another "convenient tool for masking reprehensible activities or even conferring a respectable status upon them" is simply to refer to them by another, more acceptable label.[48] Through euphemistic labeling, "destructive conduct is made benign and those who engage in it are relieved of a sense of personal agency."[49] The process ranges from trivial self-deceptions to the legitimation of wholesale killing. Thus, "dyeing the hair is a deception that one hesitates to admit, even to oneself. So the deceiver is willingly deceived by products advertised as *rinses*."[50] Topless bars are billed, without a trace of irony, as "gentlemen's clubs." By the same mechanism, "[t]errorists label themselves 'freedom fighters.' Bombing attacks become 'clean, surgical strikes,' invoking imagery of the restorative handicrafts of the operating room, and the civilians they kill are linguistically converted to 'collateral damage.'"[51]

A related kind of cognitive reconstrual relies on the contrast principle: "By exploiting advantageous comparison with more reprehensible activities, injurious conduct can be rendered benign or made to appear to be of little consequence."[52] This process is evident, for example, in socio-political conflicts: "terrorists minimize their slayings as the only defensive weapon they have to curb the widespread cruelties inflicted on their people . . . . People who are objects of terrorist attacks, in turn, characterize their retaliatory violence as trifling, or even laudable, by comparing them with carnage and terror perpetrated by terrorists."[53]

These "self-exoneration" mechanisms of moral reconstrual, euphemistic labeling, and advantageous comparison are especially potent because they not only deactivate the deterrent force of self-censure but also activate the rewarding force of positive self-evaluation.[54] Behavior that otherwise would produce the sting of self-criticism instead yields the glow of enhanced self-

47. *Id.* at 164–65.

48. Bandura, *Mechanisms of Moral Disengagement*, *supra* note 31, at 365.

49. *Id.*

50. DWIGHT BOLINGER, LANGUAGE—THE LOADED WEAPON: THE USE AND ABUSE OF LANGUAGE TODAY 116 (1980).

51. Bandura, ORIGINS OF TERRORISM, *supra* note 44, at 170 (citation omitted).

52. Bandura, *Mechanisms of Moral Disengagement*, *supra* note 39, at 365.

53. Bandura, ORIGINS OF TERRORISM, *supra* note 44, at 171.

54. Albert Bandura et al., *Disinhibition of Aggression Through Diffusion of Responsibility and Dehumanization of Victims*, 9 J. RES. IN PERSONALITY 253, 254 (1975). Bandura has observed that "[o]ver the years, much reprehensible and destructive conduct has been perpetrated by ordinary, decent people in the name of religious principles, righteous ideologies, and nationalistic imperatives." Bandura, ORIGINS OF TERRORISM, *supra* note 44, at 164.

worth. From a moral perspective, this is akin to both turning off the alarm and taking a sleeping pill before retiring.

2. Obscuring the Causal Relationship. A second category of dissociative mechanisms involves obscuring the causal relationship between one's behavior and outcomes. In the first mechanism, the individual displaces responsibility onto some other external source such as social pressure or the dictates of authority.[55] This device was dramatically demonstrated in the Milgram studies, in which research participants obeyed authoritative commands to administer electric shocks (up to 450 volts) to another individual, despite that individual's protests, pleas, cries of pain, screams, and even apparently fatal silence.[56] Personal moral agency can also be obscured through diffusion of responsibility for destructive behavior. Moral accountability is thus diluted through the following: division of labor, so that the particular task performed by each group member seems itself relatively innocuous; group decisionmaking, so that the responsibility of all displaces the responsibility of each; and group action, so that the harm inflicted by the group can be attributed to the other members.[57] Both displacement and diffusion of responsibility have been shown to facilitate inhumane behavior: people behave more cruelly when they can assign responsibility for their conduct to legitimate authority or to a group.[58]

Another device for obscuring personal agency is to disregard or distort the consequences of one's actions. Thus, the potential conflict between one's moral standards and harm-infliction is reduced by minimizing the suffering one is causing or by denying that suffering results from one's conduct: "choosing to carry out

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55. *See* Bandura, ORIGINS OF TERRORISM, *supra* note 44, at 173; Bandura, *Mechanisms of Moral Disengagement*, *supra* note 31, at 365.

56. *See* MILGRAM, *supra* note 36, at 13–26, 35 tbl.2.; *see also* Timothy C. Brock & Arnold H. Buss, *Effects of Justification for Aggression and Communication with the Victim on Postaggression Dissonance*, 68 J. ABNORMAL & SOC. PSYCHOL. 403, 403 (1964) (stating that dissonance between opposition to punishment and infliction of punishment is reduced "by expressing obligation to give shocks").

57. Bandura, *Mechanisms of Moral Disengagement*, *supra* note 31, at 365. *See generally* Steven Prentice-Dunn & Ronald W. Rogers, *Deindividuation and the Self-Regulation of Behavior*, *in* PSYCHOLOGY OF GROUP INFLUENCE 87, 87–90, 93–99, 105 (Paul B. Paulus ed., 2d ed. 1989) (discussing the competing human needs of group membership versus individuation and describing the process of "deindividuation," by which a person's presence in a group leads to decreased self-awareness and more disinhibited behavior).

58. Bandura, *Mechanisms of Moral Disengagement*, *supra* note 31, at 365. *See generally* Phillip G. Zimbardo, *The Psychology of Evil: A Situationist Perspective on Recruiting Good People to Engage in Anti-Social Acts*, 11 RES. SOC. PSYCHO. 125, 125–33 (1995) (drawing on the studies of the author, Milgram, and Bandura to theorize that deindividualization is one of the social factors that leads to aggression and violence).

aggression of which one disapproves leads to minimization of its painfulness."[59] And this device is facilitated by social distance: "It is relatively easy to hurt others when their suffering is not visible and when causal actions are physically and temporally remote from their effects."[60]

3. Degradation. The third category of moral dissociation operates by degrading the target of harmful behavior. Empathy increases moral self-sanction for infliction of harm on another; blaming, devaluing, or otherwise degrading the other disengages or dilutes self-censure.[61] Thus, "[t]he joys and suffering of those with whom one identifies are more vicariously arousing than are those of strangers, out-group members, or those who have been divested of human qualities."[62] The degradation process "is an essential ingredient in the perpetuation of inhumanities."[63] For example, Nazi camp commanders found it necessary to degrade their victims "so that those who operated the gas chambers would be less burdened by distress."[64] But this process need not entail explicit degradation; anonymous and impersonal treatment through ordinary bureaucratization can foster disengagement of self-sanction.[65]

4. Operation of the Mechanisms of Moral Disengagement. The combination of these mechanisms is a recipe for harm. They tend to potentiate each other: "Thus, combining diffused responsibility with dehumanization greatly escalates the level of punitiveness, whereas personalization of responsibility, along with humanization, have a powerful self-deterring effect."[66] An especially stark example of this potentiation is evident in the atrocities committed by lynch mobs.[67] The combination of moral justification, responsibility diffusion, and degradation yields a

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59. Timothy C. Brock & Arnold H. Buss, *Dissonance, Aggression, and Evaluation of Pain*, 65 J. ABNORMAL & SOC. PSYCHOL. 197, 197, 200 (1962).

60. Bandura, *Moral Thought and Action*, *supra* note 37, at 86.

61. Bandura, *Mechanisms of Moral Disengagement*, *supra* note 31, at 366.

62. *Id.*

63. Bandura, *Moral Thought and Action*, *supra* note 37, at 88.

64. *Id.* The specific example of the relationship between disengagement of self-sanction and the facilitation of the Holocaust is discussed at note 498 *infra* and accompanying text.

65. *See* Bandura, *Moral Thought and Action*, *supra* note 37, at 88 (observing that "[b]ureacratization, automation, and high geographical mobility" lead to anonymity and depersonalization).

66. *Id.*

67. *See* Prentice-Dunn & Rogers, *supra* note 57, at 99–100.

profound disengagement of moral agency and a corresponding "increase in . . . transgressive behaviors."[68]

Moral disengagement does not occur wholesale. "Rather, the change is usually achieved through gradual diminution of self-sanctions in which people may not fully recognize the changes they are undergoing."[69] The process begins with morally questionable but psychologically tolerable acts that produce little self-censure.[70] As the individual becomes habituated to a new internal self-regulatory baseline, another morally dubious step can be taken with little or no self-reproach.[71] Eventually, quite abhorrent conduct can be engaged in without much psychological distress.[72] This "[e]scalative self-disinhibition is accelerated if inhumane behavior is construed as serving moral purposes and the people being subjected to maltreatment are divested of human qualities."[73]

The dissociative processes that facilitate the ability to inflict harm on others ultimately involve a bilateral dehumanization—of the actor as well as the target. As one of Milgram's subjects put it, "you really begin to forget that there's a guy out there, even though you can hear him."[74] According to one review of the conformity and obedience literature,

> [t]his dehumanization of the victim is a counterpart to the obedient person's self-picture as an agent of another's will, someone 'who has a job to do' and who does it whether he likes it or not. The obedient person sees himself as an instrument; by the same token, he sees the victim as an object. In his eyes, both have become dehumanized.[75]

These processes are amply evident in American capital punishment generally, as briefly discussed in the ensuing section, and in the adjustment of health professionals to their participation in the process, as addressed in detail in Part III.

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68. *Id.* at 100 (quoting B. Mullen, *Atrocity as a Function of Lynch-Mob Composition: A Self-Attention Perspective*, 12 PERSONALITY & SOC. PSYCHOL. BULL. 187, 187 (1986)). *See generally* BILL BUFORD, AMONG THE THUGS (1991) (providing an intriguing lay anecdotal account of the phenomenon of disinhibition through both deindividuation and responsibility diffusion).

69. Bandura, *Moral Thought and Action*, *supra* note 37, at 93.

70. *Id.*

71. *Id.*

72. *Id.*; *see also* Bandura, *Mechanisms of Moral Disengagement*, *supra* note 31, at 364–66 (discussing the role of self-censure in controlling inhumane conduct, and the process by which people disengage self-censure).

73. Bandura, *Moral Thought and Action*, *supra* note 37, at 93–94.

74. MILGRAM, *supra* note 36, at 38.

75. HENRY GLEITMAN, PSYCHOLOGY 467 (4th ed. 1995).

B. Living with Killing

As the ultimate act of state-sanctioned individual aggression, capital punishment threatens its functionaries with a psychological crisis. It both reminds them of their own mortality and involves them in an enterprise that may create a conflict among strongly held values.[76] The resultant incipient negative affective consequences should generate powerful incentives to disengage internal control systems to avoid self-censure, to protect worldview, and to restore a sense of self-worth. And that is exactly what we find: American capital punishment's processes have been aptly described as "a complex system of denying and dispersing responsibility" for "the infliction of physical violence that is capital punishment."[77]

Moral disengagement in capital punishment has long been manifested in a variety of ways. One is rationalization of the behavior as necessary, for example, to serve deterrent, retributive, or incapacitative purposes as described in the official version of capital punishment's benefits. The need to sustain this moral justification of instrumental utility (while capital punishment covertly serves its symbolic goals) may help to explain the resistance of some death penalty supporters to evidence of its chronic inefficacy in accomplishing those purposes.[78]

More specifically, modern execution methods combine responsibility diffusion and displacement into a medicalized, Milgramesque chain of command with specified tasks but calculatedly vague responsibility.[79] Beginning with the movement

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76. *See* Judges, *Scared to Death*, *supra* note 13, *passim* (providing a description of the psychological processes at work when people are reminded of their own mortality and when their worldviews are threatened, and an application to the capital punishment context).

77. Dubber, *supra* note 23, at 545. The relationship between mortality awareness, defense of worldview, and capital punishment is described in Judges, *Scared to Death*, *supra* note 13.

78. *See* Judges, *Scared to Death*, *supra* note 13, at 184 n.105 (discussing the research evidence of this resistance).

79. Dubber, *supra* note 23, at 547.

> [T]he capital punishment system has evolved into a complex sequence of tasks, each of which is assigned to a different participant and all of which are necessary, but none of which is sufficient, to inflict the death penalty on a given person. Along with the fragmentation of tasks comes the fragmentation of responsibility. As a result of the fragmentation of tasks, 'no actor in the legal system can say he had no choice;' as a result of the independent insufficiency of their tasks, every actor in the legal system can say he had no choice.

Id. (quoting Robert Weisberg, *Deregulating Death*, 1983 SUP. CT. REV. 305, 395) (footnote omitted). Dubber discounts the claims of those proponents of capital punishment who assert that they would be happy to "have pulled the switch" as at best empty posturing

away from public executions, for example, the process has depersonalized not only the condemned, but also the executioner, and thereby helped to minimize its affective impact. The modern trend toward bureaucratization of executions "not only fractures the execution procedure and distributes the resulting tasks among an army of officials but also ensures that those officials can think of themselves both as united in the pursuit of a common perilous task and as duty bound unquestioningly to obey the orders of their superiors."[80] The hangman has been replaced by a committee—that wonderful engine of responsibility-diffusion. Craig Haney has described how the mechanisms of moral disengagement constitute the nuts and bolts of modern capital trials, making it possible for jurors to distance themselves from the realities of their decisions.[81] I have described the various methods by which judges seek to diminish personal responsibility for their involvement in the process—such as by invoking the moral justification of values such as federalism and judicial restraint; by shifting responsibility onto others such as prosecutors, jurors, legislators, and other judges; and by minimizing the scope of substantive judicial review.[82] Not

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and at worst moral bankruptcy. *Id.* at 580 & n.110. Significantly, Dubber observed that "[t]he only people [apart from "fanatical Nazis like . . . Adolph Eichmann"] who express a desire to inflict capital punishment personally are those who not only have nothing to do with the imposition or infliction of this penalty, but also never will be in a position to inflict it." *Id.*

80. *Id.* at 570, 580 ("Not unlike the Milgram experiment, the capital punishment system creates a hierarchical and formal environment that permits even those who possess a well-developed empathic capacity to suspend that capacity in a clearly defined and limited context.").

81. *See* Craig Haney, *Commonsense Justice and Capital Punishment: Problematizing the "Will of the People,"* 3 PSYCHOL. PUB. POL'Y & L. 303, 324–27 (1997) (postulating that the structure of capital trials creates emotional distance between jurors and defendants by focusing, during the guilt phase, on the defendant's negative attributes while minimizing humanizing factors, and thus prevents jurors from fully appreciating the implications of a death sentence during the sentencing phase); *see also* Craig Haney, *Violence and the Capital Jury: Mechanisms of Moral Disengagement and the Impulse to Condemn to Death*, 49 STAN. L. REV. 801 (1997) (explaining how capital jurors use five psychological mechanisms to distance themselves from defendants and impose death sentences, including dehumanization, violent responsiveness to deviance and difference, vicarious self-defense, minimizing personal consequences, and the need to follow authorized instructions).

82. *See* Judges, *Scared to Death*, *supra* note 13, at 232–38 (describing how courts avoid taking personal responsibility for capital punishment). It is remarkable to witness such responsibility-shifting and -diffusion firsthand. I once observed a panel discussion at a psychology and law conference that concerned forensic practice in capital cases. The panel represented most of the players, including a forensic psychiatric expert, a state supreme court judge, and a prosecutor. All admitted harboring personal qualms when confronted with the prospect of accepting moral responsibility for participating in killing, and each—quite unself-consciously—immediately pointed out that the ultimate responsibility lay elsewhere. The expert pointed to the prosecutor, judge, and jury; the prosecutor pointed to the judge, legislature, and jury; and the judge pointed to the trial

surprisingly, such mechanisms are also explicitly deployed with respect to mental health professionals' participation in the capital punishment process.[83]

Thus, the American movement away from public executions, the evolution of a complex multilayered sentencing and review process that distributes functions among prosecutors, judges, jurors, and legislators, and the search for more purportedly "humane" methods all may do more to address a psychological need to buffer the harsh facts of legal homicide than to promote humanitarian concern for justice or the condemned's welfare.[84] As Bandura has noted in another context, "[o]ur death technologies have become highly lethal and depersonalized."[85] Use of lethal injection, for example, like the introduction of lethal gas before it, conjures up nonthreatening images of a benign medical procedure.[86] In this way, the consequences of the conduct are distorted. In other words, such procedures tend to deactivate the self-sanctioning potential of participation in killing. Indeed, the need to create interpersonal distance between the killers and the killed and the symbolic value of "medicalization" contributed to the Nazis' use of gas chambers as an alternative to shooting their victims.[87] The advent of lethal injection represents a significant

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judge, jury, and legislature. Presumably a legislator, had one been present, would have pointed to everyone else. In this way, the buck stops nowhere.

83. *See, e.g.*, Robert T.M. Phillips, *The Psychiatrist as Evaluator: Conflicts and Conscience*, 41 N.Y.L. SCH. L. REV. 189, 194 (1996) (observing that "the psychiatrist does not make the formal determination of competence that results in the ability to stand trial or to be sentenced to execution" and that "[t]he judge or jury plays that critical role in the adjudicatory process; the psychiatrist offers an opinion").

84. *E.g.*, V.A.C. GATRELL, THE HANGING TREE: EXECUTION AND THE ENGLISH PEOPLES 1770–1868, at 20–24 (1996) (explaining how political aims and public reaction against excessive executions, and not humanitarian concerns, brought about changes in English capital law); Peter S. Adolf, Note, *Killing Me Softly: Is the Gas Chamber, or Any Other Method of Execution, "Cruel and Unusual Punishment?,"* 22 HASTINGS CONST. L.Q. 815, 819 n.19 (1995) (noting abolitionists' objection to challenges to execution methods, including "that even if the litigation is successful, and all states switch to a less painful and more degrading method like lethal injection, the result will only make the death penalty more palatable to the public, and perhaps prolong its use").

> "'It is precisely because [lethal injection] falsely appeals to the sense of medical technology and efficiency and humaneness and painlessness that it is intended to make the process of sentencing people to death and executing them easier on everybody,' said Henry Schwarzchild, director of the New York office of the National Coalition to Abolish the Death Penalty. 'That is the true horror of it.'"

Id. (alteration in original) (quoting Ian Fisher, *Merits of Lethal Injection Are Questioned by Its Foes*, N.Y. TIMES, Feb. 17, 1995, at B5).

85. Bandura, *Moral Thought and Action*, *supra* note 37, at 86.

86. *See* Dubber, *supra* note 23, at 563–64 (noting that "[t]he advantage of such a medicalized execution procedure . . . is obvious: if the condemned experiences no physical pain, the inhibition against inflicting pain remains unaffected").

87. Refer to text accompanying notes 497–501 *infra* (explaining how physician involvement in Nazi gas chambers gave executions a "perverse medical aura" and was

achievement in our effort to blur the distinction between physical and symbolic aggression and to disengage moral qualms about killing.

American capital punishment is thus rife with dehumanization. Others have described the dehumanization of the condemned.[88] The focus here is primarily on the self-inflicted dehumanization of capital punishment's functionaries. This is because I believe that one of the "true curses" of institutionalized authoritarian excesses is their dehumanizing effect on those who participate in them.[89]

I refer to these moral-disengagement moves as "dehumanizing" because they involve forfeiture of important attributes of personal moral integrity that the individual otherwise would likely claim for himself or herself. In particular, I mean shrinkage of *humanitas*, or an ethic of humaneness, such that a humanistically oriented individual thereby becomes less than the person he or she would otherwise probably claim to be. This is the dissociative aspect of moral disengagement.

Integrity of the self is diminished, and hence dehumanization is produced, by these moves. Moral justification, through rationalization and denial, injects false premises into one's undertakings while stubbornly insisting they are true and refuses to entertain evidence of their contradiction.[90] Other moves, which deny the actor's moral agency and affective response, arguably entail even greater self-abnegation because they negate important aspects of the actor's very existence. And discounting the moral worth of the target has a similar consequence for that individual. The end result is dehumanization of the self by dissociation and dehumanization of the other by debasement.

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less traumatic for the persecutors than the use of firing squads).

88. *See generally* ROBERT JOHNSON, CONDEMNED TO DIE, LIFE UNDER SENTENCE OF DEATH (1981) (exposing the isolation and dehumanization of condemned men on Alabama's Death Row through a series of interviews with thirty-five prisoners); HELEN PREJEAN, DEAD MAN WALKING: AN EYEWITNESS ACCOUNT OF THE DEATH PENALTY IN AMERICA (1993) (sharing the personal reflections of a Catholic nun who befriended a Louisiana death row inmate); WILLIAM A. SCHABAS, THE DEATH PENALTY AS CRUEL TREATMENT AND TORTURE (1996) (discussing the dehumanizing and torturous effects of enduring harsh living conditions on death row, waiting prolonged and uncertain periods before execution, and facing the horror of even relatively humane modern execution methods); John Rutledge, *The Definitive Inhumanity of Capital Punishment*, 20 WHITTIER L. REV. 283 (1998) (discussing modern U.S. execution methods and concluding that execution is inherently inhumane because it disregards human life).

89. *See* Jones v. Alfred H. Mayer Co., 392 U.S. 409, 445 (1968) (Douglas, J., concurring) (commenting that "[t]he true curse of slavery is not [only] what it did to the black man, but [also] what it has done to the white man").

90. *See* Judges, *Scared to Death*, *supra* note 13, at 184 n.105 (discussing people's reluctance to change their conceptions about capital punishment, even when facing contrary information).

Let me clarify one point before describing how these moves manifest in mental health professionals' efforts to reconcile their own especially acute ambivalence about their various roles in the capital punishment process. My use of the term "dehumanization" is intended to describe the dissociative processes of psychological adaptation (via moral disengagement) to the demands of an extraordinarily stressful and conflict-ridden situation, not to pass moral judgment on that adaptation. The assertion that the ethical conflict is more potent than prevailing professional practice would indicate is not intended to impugn the personal virtue of those professionals who provide evaluation and treatment services. Instead, the purpose here is to describe the extent to which normal individuals—who presumably are adequately socialized within their professions and larger culture—must reshape their conceptions of themselves, their conduct, and their professional values to defend against capital punishment's awful affective and cognitive impositions. This work, then, is an account of the price these individuals pay for rendering their services in the capital punishment context. No coherent ethical system is likely to remain unaffected within the murky moral environment of American capital punishment, and this point ought to be especially true of the avowedly humanistic ethics of health professionals.

III. CAPITAL PUNISHMENT AND PROFESSIONAL ETHICS

A. Mental Health Professionals' Functions

Psychiatrists, psychologists, and other mental health professionals participate in the capital punishment process in several capacities, and the death penalty is only one of a variety of areas of forensic practice. As in other forensic contexts, mental health professionals' role in the capital punishment process continues to expand, and this expansion has pushed the edges of the ethical envelope.

Mental health professionals, of course, perform assessment functions in both civil and criminal cases.[91] In the general criminal arena, the services they provide include assessment, consultation, and testimony related to competency to waive *Miranda* and other rights and to stand trial, criminal

91. In addition, mental health professionals sometimes serve as "educating" rather than "evaluating" witnesses, who provide the trier of fact with background information about issues relevant to the case, such as variables affecting the reliability of eyewitness evidence.

responsibility (such as the insanity defense and *mens rea*), sentencing, parole, and other dispositional matters. These functions can be referred to as "non-capital evaluations."

Mental health professionals also increasingly perform a variety of "capital evaluation" functions.[92] One is the increased legal demand for psychiatric and psychological evaluations in capital trials beyond the general question of competence to stand trial (and to waive appeal rights). The movement toward guided jury discretion under *Gregg v. Georgia*[93] expanded the need for expert testimony at sentencing on aggravating factors such as future dangerousness.[94] The Supreme Court in 1983 ruled that due process is not violated when psychiatric testimony—even if lacking a solid empirical foundation—is admitted on that issue.[95] The Court's ruling in *Lockett v. Ohio*[96] that jurors must "not be precluded from considering, *as a mitigating factor*, any aspect of a defendant's character"[97] invited an array of defense-side psychological evidence. Criminal responsibility has also long been an area of forensic expert involvement. Many states had provided for pretrial psychiatric evaluations even before the U.S. Supreme Court announced in *Ake v. Oklahoma*[98] that due process requires states to provide "access to a psychiatrist's assistance" when an indigent criminal defendant indicates that his sanity at the time of the offense is likely to be a significant issue at trial[99] or when a state presents psychiatric evidence at capital sentencing of the defendant's future dangerousness.[100]

Although the Court ruled in 1989 that execution of mentally retarded persons is not per se cruel and unusual punishment,[101] the Court required the sentencing body to be allowed to consider

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92. For an overview, see Mark D. Cunningham & Alan M. Goldstein, *Sentencing Determinations in Death Penalty Cases*, 11 HANDBOOK OF PSYCHOLOGY: FORENSIC PSYCHOLOGY ch. 21 (Alan M. Goldstein ed., 2003).

93. 428 U.S. 153 (1976).

94. *Id.* at 206–07.

95. *See* Barefoot v. Estelle, 463 U.S. 880, 896–905 (1983) (reaffirming the admissibility of psychiatric testimony in evaluating the likelihood of defendants' future dangerousness and permitting the use of hypotheticals, even when based on disputed facts, in providing such testimony). For a discussion of *Barefoot* and the prediction of future dangerousness, refer to note 426 *infra*.

96. 438 U.S. 586 (1978).

97. *Id.* at 604.

98. 470 U.S. 68 (1985).

99. *Id.* at 74.

100. *See generally* RALPH REISNER ET AL., LAW AND THE MENTAL HEALTH SYSTEMS: CIVIL AND CRIMINAL ASPECTS 485–87 (1999).

101. *See* Penry v. Lynaugh, 492 U.S. 302, 340 (1989) ("[W]e cannot conclude today that the Eighth Amendment precludes the execution of any mentally retarded person . . . simply by virtue of his or her mental retardation alone.").

the defendant's retardation as a mitigating factor—a point the Court reaffirmed in 2001.[102] The Court revisited the Eighth Amendment question in *Atkins v. Virginia*[103] and ruled that, because a mentally retarded person's cognitive impairments diminish his or her moral culpability and compromise the reliability of verdicts, and because Congress and an increasing number of states now specifically exempt the mentally retarded from the death penalty, execution of the mentally retarded constitutes cruel and unusual punishment prohibited by the Eighth Amendment.[104] *Atkins* ensures that psychological evaluations and expert testimony regarding the results of evaluations (which may have been conducted years before the trial) will become an even more commonplace feature of capital trials.

The Supreme Court's recognition in *Ford v. Wainwright*[105] of an Eighth Amendment prohibition on execution of the "insane"[106] has extended the capital punishment system's demand for mental health evaluations beyond the sentencing process.[107] Justice Marshall's opinion in *Ford* invoked both long-standing historical repugnance at execution of the "insane"—on the grounds that it "simply offends humanity"; that it serves no deterrence purposes because such individuals provide no example to others; that insanity itself is its own punishment; and that it violates religious scruples against sending "into another world" a convict who is unable to prepare himself for death—and contemporary moral and instrumental objections.[108] Justice Powell, whose concurrence provided the necessary fifth vote in *Ford*, articulated a low constitutional threshold for competence to be executed: "the Eighth Amendment forbids the execution only of those who are unaware of the punishment they are about to

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102. *Id.* at 327–28; *see also* Penry v. Johnson 532 U.S. 782, 796–97 (2001) (reaffirming the requirement that the jury be allowed to adequately consider the defendant's mental retardation).

103. 536 U.S. 304 (2002).

104. *Id.* at 314–21. For a pre-*Atkins* discussion of the issues surrounding capital punishment for the mentally retarded, see generally Lyn Entzeroth, *Putting the Mentally Retarded Criminal Defendant to Death: Charting the Development of a National Consensus to Exempt the Mentally Retarded from the Death Penalty*, 52 ALA. L. REV. 911 (2001).

105. 477 U.S. 399 (1986).

106. *Id.* at 409–10.

107. *See* John L. Farringer, IV, *The Competency Conundrum: Problems Courts Have Faced in Applying Different Standards for Competency to Be Executed*, 54 VAND. L. REV. 2441, 2485–88 (2001) (providing an analysis of the problems arising in the judicial application of *Ford*).

108. *Ford*, 477 U.S. at 407–08 (citations omitted).

suffer and why they are to suffer it."[109] Capital convicts found competent to stand trial often deteriorate under the highly stressful conditions on death row.[110] Mental health professionals now perform postsentencing evaluations and testify concerning *Ford* competence, the standards and procedures for which vary considerably among the death penalty jurisdictions.[111] For example, some states require that the prisoner be "able to assist in his or her own defense."[112]

Mental health professionals also have provided treatment services, including the involuntary administration of antipsychotic medication, in the criminal justice system in general and the capital punishment system in particular.[113] Capital-related treatment raises some of the most difficult ethical challenges for the professions. Several developments underscore the difficulty of these challenges.

In a series of opinions, the U.S. Supreme Court has addressed the substantive and procedural due process implications of involuntary administration of antipsychotic medication both before and after conviction.[114] In *Washington v. Harper*, the Court recognized a convicted prisoner's liberty interest in refusing antipsychotic medication, but upheld the state's authority to administer medications involuntarily when it determined, through administrative procedural mechanisms, that the prisoner's condition presented a danger to himself or others and that the treatment was in the prisoner's medical

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109. *Id.* at 422 (Powell, J., concurring in part and concurring in the judgment).

110. *See generally* Keith Alan Byers, *Incompetency, Execution, and the Use of Antipsychotic Drugs*, 47 ARK. L. REV. 361, 367–71 (1994) (discussing the problem of condemned prisoners becoming incompetent). For an early study suggesting that the stresses of a death sentence can provoke a psychotic reaction, see Harvey Blumstone & Carl L. McGahee, *Reaction to Extreme Stress: Impending Death by Execution*, 119 AM. J. PSYCHIATRY 393 (1962).

111. *See generally* Farringer, *supra* note 107, at 840–46; Lindsay A. Horstman, *Commuting Death Sentences of the Insane: A Solution for a Better, More Compassionate Society*, 36 U.S.F. L. REV. 823, 839–48 (2002) (discussing the issues of ripeness, insanity hearings, proving insanity, and governor discretion in making sanity determinations).

112. *See* Van Tran v. State, 6 S.W.3d 257, 265 (Tenn. 1999) (noting that some states adopted the "assistance prong" test, requiring that the condemned be capable of assisting the defense in order to be determined competent for execution). *Van Tran* also provides an overview of the procedural issues involved in implementing *Ford*. *See id.* at 265–74 (discussing the judicial adoption of substantive and procedural standards for implementing *Ford* in the absence of a governing statute).

113. *See generally* Thomas L. Hafemeister & John Petrila, *Treating the Mentally Disordered Offender: Society's Uncertain, Conflicted, and Changing Views*, 21 FLA. ST. U. L. REV. 729 (1994); Douglas Mossman, *The Psychiatrist and Execution Competency: Fordi*ng *Murky Ethical Waters*, 43 CASE W. RES. L. REV. 1 (1992) [hereinafter Mossman, *Execution Competency*].

114. *See* Sell v. United States, 123 S. Ct. 2174 (2003); Riggins v. Nevada, 504 U.S. 127 (1992); Washington v. Harper, 494 U.S. 210 (1990).

interest.[115] The Court concluded that the state's procedures (which provided for internal administrative review but not predeprivation judicial review) reflected an acceptable "accommodation between an inmate's liberty interest in avoiding the forced administration of antipsychotic drugs and the State's interests in providing appropriate medical treatment to reduce the danger that an inmate suffering from a serious mental disorder represents to himself or others."[116]

Riggins v. Nevada addressed the substantive scope of an individual's liberty interest in avoiding involuntary administration of antipsychotic medication to render him competent to stand trial.[117] The Court first stated that only an "essential" or "overriding" government interest could outweigh that liberty interest.[118] In the context of a capital murder case, while disclaiming adoption of a "strict scrutiny" standard, the Court elaborated on the *Harper* standard by reversing because the State had failed to demonstrate that involuntary administration of antipsychotic medication "was medically appropriate and, considering less intrusive alternatives, essential for the sake of Riggins' own safety or the safety of others" or that the State "could not obtain an adjudication of Riggins' guilt or innocence" through "less intrusive means."[119] Treading the borderland between procedural and substantive due process, the Court further suggested that the trial court's failure to adequately consider Riggins' substantive liberty interest "may well have impaired the constitutionally protected trial rights Riggins invokes," including creation of an overly sedated demeanor and impairment of his cognitive functioning.[120]

Most recently, in *Sell v. United States*, the Court revisited the standard for the involuntary administration of antipsychotics to render a nonviolent defendant accused of a serious nonviolent crime competent to stand trial.[121] The Court synthesized *Harper* and *Riggins* into a three-part test, permitting the state to involuntarily administer antipsychotic drugs to a mentally ill defendant facing serious criminal charges, to render that defendant competent to stand trial so long as the treatment is (1) "medically appropriate," (2) "substantially unlikely to have side effects that may undermine the fairness of the trial," and

115. 494 U.S. at 221–22, 228–36.
116. *Id.* at 236.
117. 504 U.S. at 132–33, 137.
118. *Id.* at 135.
119. *Id.* at 135–36, 138.
120. *Id.* at 137.
121. Sell v. United States, 123 S. Ct. 2174, 2178–79 (2003).

(3) "taking account of less intrusive alternatives, is necessary significantly to further important government trial-related interests."[122] The Court cautioned that the instances in which involuntary administration of antipsychotic medication will be appropriate "may be rare,"[123] and elaborated this standard in four respects. First, the State must show "that *important* governmental interests are at stake," which include bringing an individual accused of a serious crime (whether to person or property) to trial.[124] That interest, however, may be diminished by the possibility that a defendant who refuses medication might be confined for a lengthy period of time and thereby require less incapacitation through imprisonment upon conviction.[125] Second, the trial court must find that administration of medication is both "substantially likely to render the defendant competent to stand trial" and "substantially unlikely to have side effects" that would interfere with a fair trial.[126] Third, involuntary medication must be "*necessary*" to accomplish the State's objective of rendering the defendant competent and thus the trial court must find that other, less intrusive means (such as nondrug therapies) are unlikely to be substantially effective.[127] And fourth, the administration of medication must be in the defendant's "best medical interest."[128]

The Court emphasized that the foregoing considerations apply to forced medication for the purpose of "rendering the defendant competent to stand trial."[129] The Court asserted that forced medication related to an individual's dangerousness, as in *Harper*, involves more "'objective and manageable'" standards than the medicate-to-render-competent decision and is typically

122. *Id.* at 2184.

123. *Id.*

124. *Id.* (explaining that "[i]n both instances the Government seeks to protect through application of the criminal law the basic human need for security").

125. *Id.* Curiously, when discussing the possibility of lengthy pretrial confinement of an incompetent defendant, the Court did not mention *Jackson v. Indiana*, which limits pretrial commitment of a defendant found incompetent to stand trial to a reasonable period of time in order to determine whether there is a substantial probability that the defendant will become competent in the foreseeable future. *Id.*; *see* Jackson v. Indiana, 406 U.S. 715, 738 (1972). If that is found not to be the case, the State must either institute civil commitment procedures or release the defendant. *Id. Jackson* has been honored more in the breach than the observance. *See generally* Grant H. Morris & J. Reid Meloy, *Out of Mind? Out of Sight: The Uncivil Commitment of Permanently Incompetent Criminal Defendants*, 27 U.C. DAVIS L. REV. 1 (1993).

126. *Sell*, 123 S. Ct. at 2184–85.

127. *Id.* at 2185.

128. *Id.*

129. *Id.*

decided in a civil proceeding.[130] The Court indicated that it usually would be appropriate for the trial court to consider *Harper* grounds for involuntary medication before addressing the more complicated competence question.[131]

Sell, which articulates relatively rigorous substantive standards for the forcible medication of defendants found incompetent to stand trial, will expand both the forensic evaluation and treatment roles of mental health professionals in criminal cases in several respects. First, the trial court perforce will be largely dependent, in treatment-to-render-competent cases, on the testimony of mental health professionals in making the requisite findings on the probable efficacy of the proposed course of medication, its anticipated side effects, and the relative merits of nondrug alternatives. Second, *Sell*'s various expressions of a strong preference that a trial court consider *Harper*-type treatment (i.e., to address dangerousness) before ordering *Riggins*-type treatment (i.e., to render defendant competent to stand trial),[132] emphasize mental health professionals' role in evaluating an individual's potential dangerousness. Third, *Sell*'s mandated consideration of less intrusive treatments, including nondrug therapies[133]—which reflects recognition of the position taken by the American Psychological Association's amicus brief—may conceivably offer nonmedical professionals more opportunities to provide forensic treatment.

Notwithstanding the Court's admonition that the instances when forced medication for trial competence purposes would be appropriate "may be rare,"[134] *Sell*'s practical impact may be to shift the asserted grounds for forcible medication of criminal defendants rather than to reduce its frequency. The Court went out of its way to criticize the trial court's finding—affirmed by the Court of Appeals and not challenged by the government in the Supreme Court—that Sell was not dangerous to himself or others.[135] That dicta strongly hints that the Court regards the dangerousness threshold as relatively low for *Harper* treatment purposes and that asserted *Harper* grounds may often become an acceptable surrogate for *Riggins* treatment.[136] Government

130. *Id.* (quoting Riggins v. Nevada, 504 U.S. 127, 140 (1992)).

131. *Id.*

132. *Id.* at 2185–86.

133. *Id.* at 2185.

134. *Id.* at 2184.

135. *Id.* at 2186–87.

136. The Court appeared to place considerable weight in its own dangerousness assessment of an incident at the United States Medical Center for Federal Prisoners in which Sell approached a nurse, suggested that he loved her, complained that she had

officials can hardly fail to notice the Court's signal to consider pursuing *Harper* treatment of incompetent defendants. The net effect of *Sell* may ultimately be to expand both the evaluation and possibly even the treatment roles of mental health professionals in criminal cases, while driving underground the state's actual purpose in enlisting such professionals' services.

Finally, given that at least part of *Sell*'s rationale is based on medication's adverse side effects and the uncertainty of treatment responsiveness, the recent advent of so-called "atypical" antipsychotic medications may eventually result in even *Riggins*-type medication on a less rare basis than that suggested by *Sell*. Although not without their own risks and uncertainties, atypicals both decrease the risk of those adverse side effects associated with older-generation antipsychotics (such as extrapyramidal symptoms) and increase the likelihood of a positive treatment response.[137] Atypicals, especially the newer forms such as respiridone and its cousins, thus in many cases may be the least intrusive, effective alternative (especially as they become approved for administration in injectable form in the United States).[138]

Ford's recognition of an Eighth Amendment prohibition on execution of the mentally incompetent,[139] on the one hand, and *Sell*'s due process standards for involuntary administration of antipsychotic medication to restore competence for trial,[140] on the other, bracket the issue presenting one of the most acute sets of

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nothing to do with him, and responded to an admonition that his behavior was inappropriate by claiming he could not help it. *Id.* at 2180. The proceedings below were mixed and combined determinates related to competence with those related to dangerousness. *Id.* at 2179–81. The Medical Center's reviewing psychiatrist found that, because of Sell's persecutory delusions and threats, the psychiatrist regarded Sell as dangerous if released from prison but likely to function appropriately in prison. *Id.* at 2180. The psychiatrist authorized involuntary medication on both dangerousness and competence grounds. *Id.* The Medical Center administrative review upheld that conclusion. *Id.* Sell challenged the Medical Center's authority to medicate him in federal court. *Id.* Medical Center staff testified before the magistrate that Sell was a risk even within the institution, citing the nurse incident. *See id.* The magistrate found that Sell was a danger to himself and others within the institution. *Id.* at 2180–81. The District Court, after reviewing the record, ruled that the magistrate's finding regarding Sell's dangerousness in the institution was clearly erroneous. *Id.* at 2181. The Court of Appeals affirmed the District Court's ruling. *Id.*

137. *See* David M. Siegel, *Psychoactive Medication and Your Client: Better Living and (Maybe) Better Law Through Chemistry*, CHAMPION, Dec. 2003, at 23.

138. *See* Douglas Mossman, *Unbuckling the "Chemical Straitjacket": The Legal Significance of Recent Advances in the Pharmacological Treatment of Psychosis*, 39 SAN DIEGO L. REV. 1033, 1038–44 (2002) (presenting a comprehensive description of advances in psychopharmacology and their legal implications).

139. Ford v. Wainwright, 477 U.S. 399, 401 (1986).

140. *Sell*, 123 S. Ct. 2174 at 2184–85.

ethical dilemmas for forensic mental health professionals: the involuntary administration of antipsychotic medication to a *Ford*-incompetent death row inmate. Until recently, available judicial opinion and the overwhelming weight of commentary had vigorously rejected the forcible medication of *Ford*-incompetent condemned inmates.[141] The conflict between so-called "treatment" and execution, the profound ethical conflicts generated for medical professionals, and the invasion of the inmate's personhood—including the side effects of antipsychotic medications—figured prominently in the few judicial pronouncements on the issue that emerged in *Ford*'s wake.

The question of whether a state may forcibly medicate a prisoner to restore *Ford* competency came before the Supreme Court in *Perry v. Louisiana*,[142] but the Court vacated its grant of certiorari and remanded for reconsideration in light of its then-recent decision in *Harper*.[143] On remand, the Louisiana Supreme Court issued a strongly worded ruling on state constitutional grounds that the state may not forcibly medicate a *Ford*-incompetent prisoner to restore him to competence to carry out his death sentence.[144] The court first concluded that involuntary medication to render Perry competent to be executed was not authorized treatment under *Harper*.[145] For one thing, administration of such medication is not "treatment" but instead "is antithetical to the basic principles of the healing arts" (the principles of beneficence and harm-avoidance), preempts the patient's ability to make treatment choices, precludes establishment of a trustful doctor-patient relationship, compromises the doctor's independent medical judgment, and may unethically involve the physician as a participant in an execution.[146] Furthermore, the State's explicit goal in *Perry* was solely to restore the prisoner to *Ford* competence—not to provide appropriate medical treatment in his best medical interest or ensure his safety and the safety of others as in *Harper*.[147]

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141. Refer to notes 162–72 *infra*.

142. 498 U.S. 38 (1990).

143. *Id.* Refer to notes 115–16 *supra* and accompanying text (discussing *Washington v. Harper*, 494 U.S. 210 (1990)).

144. State v. Perry, 610 So. 2d 746, 771 (La. 1992) (asserting, in its holding, that "[f]or a state at this stage of the history of the usage of the death penalty to subject insane prisoners to execution under the pretense that they can be made 'sane' by forcibly invading their minds, bodies and personhood with antipsychotic drugs, clearly would constitute cruel, excessive and unusual punishment").

145. *Id.* at 751–52.

146. *Id.*

147. *See id.*

The court then considered whether involuntary medication as an integral part of Perry's punishment, rather than as a legitimate medical treatment, violated Perry's rights under Louisiana constitutional principles protecting liberty interests in privacy or personhood[148] and prohibiting "cruel, excessive, or unusual punishment."[149] Forcible administration of antipsychotics to carry out a capital sentence, the court concluded, effected "an *extremely severe* interference with [the prisoner's] liberty" because the drugs can cause substantial adverse neurological side effects, merely mask symptoms rather than cure the disorder, and invade the individual's very thought processes.[150] This interference did not survive the strict scrutiny imposed by the court because the state's asserted *Harper* grounds were patently pretextual, and because, as explained below, forcible medication of a *Ford*-incompetent prisoner would not effectively advance the retributive or deterrent goals of capital punishment.[151]

Forcible medication also constitutes cruel, excessive, and unusual—i.e., "inhumane"—punishment according to the four elements of that concept identified by the *Perry* court.[152] The court first concluded that such action "is severely degrading to human dignity" in view of the potential side effects and interference with the individual's thought processes.[153] Second, because of the widespread prohibition of execution for incompetents, the general absence of laws authorizing involuntary medication of prisoners for such purposes, and the ethical dilemma for physicians, the court found an increased risk of arbitrariness and capriciousness in making medication and competence decisions.[154] Third, the court found that no legitimate retributive or deterrent purpose for the punishment would be served.[155] The court surmised that the likelihood of marginal gains in deterrence from executing a few otherwise incompetent convicts was remote.[156] Retributive purposes were not properly served, the court reasoned, because the forcible medication of Perry imposed additional burdens beyond the extinguishment of the convict's life—"a course of maltreatment that is inherently loathsome and degrading to his

148. *See* LA. CONST. art. I, § 5.
149. *Id.* art. I, § 20.
150. *Perry*, 610 So. 2d at 758–60.
151. *Id.* at 761.
152. *Id.* at 747, 765.
153. *Id.* at 766.
154. *Id.*
155. *Id.* at 761.
156. *Id.* at 766–67.

dignity as a human being" and amounts to "something inhuman, barbarous and analogous to torture."[157] Fourth, the court concluded that forcible medication to effect *Ford* competence offended contemporary standards of decency.[158] That conclusion was supported in part by the historical and contemporary prohibition on executing the incompetent and also by the medical profession's ethical standards prohibiting participation in executions: "Like the use of lethal injections, forcible medication in an attempt to restore competency constitutes a part of capital punishment that inherently conflicts with medical ethics."[159] The court stayed Perry's execution until he regained competence for execution independent of the influence of psychoactive drugs.[160]

Soon after the Louisiana Supreme Court's ruling in *Perry*, South Carolina also explicitly addressed the constitutionality of the forcible medication of a *Ford*-incompetent prisoner.[161] Borrowing heavily from *Perry*, particularly regarding the incompatibility of forcible medication to restore *Ford* competence with medical ethics, the South Carolina court ruled that its state constitution's privacy provision disallowed such action and then stayed the execution.[162]

In the several years following *Ford*, the few courts to consider the matter thus roundly rejected the forcible medication of *Ford*-incompetent prisoners.[163] The overwhelming weight of scholarly opinion, both before and after *Perry*, has taken a similar position.[164] According to one review, "[t]he principal ethical objection to the compelled use of psychotropic medication to achieve competency for execution is that the ultimate goal of such intervention is to take life, by allowing a lawfully imposed sentence of death to be executed, rather than to alleviate suffering as an end in itself."[165]

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157. *Id.* at 768.

158. *Id.*

159. *Id.* at 768–69.

160. *Id.* at 771.

161. *See* Singleton v. State, 437 S.E.2d 53, 55 (S.C. 1993).

162. *Id.* at 61. It is purely coincidental that the prisoner's surname in the South Carolina case is the same as that of the prisoner in the Arkansas case, discussed below.

163. *See, e.g.*, *Perry*, 610 So.2d at 758; *Singleton*, 437 S.E.2d at 89.

164. Refer to notes 165 & 172 *infra* (citing recent commentary on forced medication and competency for execution).

165. James R. Acker & Charles S. Lanier, *Unfit to Live, Unfit to Die: Incompetency for Execution Under Modern Death Penalty Legislation*, 33 CRIM. L. BULL. 107, 145 (1997). To avoid the wrenching ethical problem posed by the administration of medication to induce competency for execution, an amicus brief filed jointly by the American Psychiatric Association and the American Medical Association in *Perry* suggested that the sentences of these prisoners be automatically commuted to life. Brief for the American Psychiatric Association and American Medical Association as Amici Curiae in support of

Perry, however, did not put an end to the matter. In the past several years, rulings from at least two courts have revived the possibility that mental health professionals will be called upon to face the ethical dilemma created by the involuntary medication of *Ford*-incompetent convicts who may thereby be rendered competent for execution.[166] And to the extent that atypical antipsychotic medications achieve therapeutic effect (i.e., reduce psychotic processes) with markedly less neurological side effects,[167] the "side effects" and "personhood" objections discussed in *Perry* diminish in force, leaving the ethical conflict objection even more prominent in the foreground.

Charles Laverne Singleton had been under a death sentence in Arkansas since 1979 for capital felony murder in the stabbing death of a grocery store owner.[168] He had argued since 1992 that, if unmedicated, he would be *Ford*-incompetent.[169] He was placed under a *Harper* involuntary medication plan in 1997.[170] The Arkansas Supreme Court, in a later *Singleton* proceeding,[171] found that "the involuntary administration of medication was appropriate under *Washington v. Harper* for appellant's own good . . . and for the security of the institution in which he is incarcerated."[172] Singleton sought a stay of execution so long as

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Petitioner, Perry v. Louisiana, 498 U.S. 38 (1990) (No. 89-5120). *See generally* David B. Wexler & Bruce J. Winick, *Therapeutic Jurisprudence and Criminal Justice Mental Health Issues*, 16 MENTAL & PHYSICAL DISABILITY L. REP. 225 (1992). Refer to notes 319–26 *infra* and accompanying text (discussing proscription against direct participation in executions).

166. *See, e.g.*, Singleton v. Norris, 964 S.W.2d 366, 369 (Ark. 1998) (granting stay of execution), *affirming denial of relief*, 992 S.W.2d 768, 769–70 (Ark. 1999); State v. Maturana, 882 P.2d 933 (Ariz. 1994).

167. Refer to note 138 *supra* and accompanying text (discussing atypical antipsychotics).

168. Singleton v. State, 623 S.W.2d 180, 181 (Ark. 1981).

169. Singleton v. Norris, 267 F.3d 859, 861 (8th Cir. 2001).

170. *Id.* at 863–64.

171. *Singleton*, 964 S.W.2d at 369.

172. Singleton v. Norris, 992 S.W.2d 768, 769 (Ark. 1999) (citations omitted). For a critique of the Arkansas Supreme Court's ruling, see generally Rebecca A. Miller-Rice, *The "Insane" Contradiction of* Singleton v. Norris*: Forced Medication in a Death Row Inmate's Medical Interest Which Happens to Facilitate His Execution*, 22 U. ARK. LITTLE ROCK L. REV. 659 (2000). For additional recent commentary on the medicate-to-execute dilemma, see Kacie McCoy Daugherty, *"Synthetic Sanity": The Ethics and Legality of Using Psychotropic Medications to Render Death Row Inmates Competent for Execution*, 17 J. CONTEMP. HEALTH L. & POL'Y 715 (2001); *see also* Brent W. Strickler, Comment, *Seeking an Answer: Questioning the Validity of Forcible Medication to Ensure Mental Competency of Those Condemned to Die*, 32 MCGEORGE L. REV. 317 (2000) (discussing the constitutional implications of medicate-to-execute policies and suggesting ways for reviewing courts to apply precedent).

his competency to be executed was being maintained by involuntary medication.[173]

In 1999, the Arkansas Supreme Court addressed the question whether Singleton could be involuntarily medicated on *Harper* grounds even though "a collateral effect of that medication is to render him competent to understand the nature and reason for his execution."[174] In view of the state's unchallenged assertion of *Harper* grounds for involuntary medication and Singleton's failure to obtain a ruling on the *Ford* issue, the court concluded that *Harper* controlled and that "the collateral effect of the involuntary medication rendering him competent to understand the nature and reason for his execution is therefore no violation of any due process [of] law."[175] The court thus accepted at face value the assertion that "[t]he intent of the State was not to medicate him in order to make him competent to be executed."[176] Justice Thornton's dissent directly addressed the aspect of the state's reliance on *Harper* that the majority virtually ignored and that both the Louisiana and South Carolina courts found to be essential to resolving the problem: "I disagree that forcible medication that enables a mentally ill prisoner to become competent to be executed can be in the inmate's medical interest . . . ."[177]

Singleton's case eventually reached the Eighth Circuit Court of Appeals (the same Circuit that decided *Sell*),[178] which held, sitting en banc, that neither the due process clause of the Fourteenth Amendment nor the Eighth Amendment is violated by the involuntary medication of a prisoner for whom an execution date has been set or by the execution of a prisoner who has been involuntarily medicated under *Harper*.[179] The Eighth Circuit's consideration of Singleton's claim was more detailed than the Arkansas Supreme Court's, and was based on a different view of the record, which brought the *Ford* and *Perry* problems squarely before the court.[180] According to the Eighth Circuit, "[t]he district court found that Singleton was *Ford*-incompetent at the time the mandatory medication was started in 1997."[181]

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173. *Singleton*, 964 S.W.2d at 366.

174. *Singleton*, 992 S.W.2d at 769.

175. *Id.* at 770.

176. *Id.*

177. *Id.* at 771 (Thornton, J., dissenting).

178. *See* United States v. Sell, 282 F.3d 560 (8th Cir. 2002), *vacated by* 123 S. Ct. 2174 (2003).

179. Singleton v. Norris, 319 F.3d 1018, 1026–27 (8th Cir. 2003) (en banc).

180. *Id.* at 1022–23, 1026–27.

181. *Id.* at 1026.

Singleton's core claim before the Eighth Circuit was that, once his execution date has been set, involuntary medication could not be in his best medical interests as required by *Harper* if it would render him competent for execution.[182] Despite language explicitly to the contrary in its *Sell* opinion,[183] the Eighth Circuit determined that its *Sell* standards also applied in the death row context. The state must show (1) an "'essential interest'" that is not outweighed by Singleton's interest in refusing medication; (2) that there is no available "'less intrusive'" means to achieve that interest; and (3) by clear and convincing evidence, that medication is "'medically appropriate.'"[184] Medical appropriateness, under *Riggins*, means that the medication is likely to render the inmate competent, that its side effects do not overwhelm its benefits, and that it is in the inmate's best medical interests.[185]

The court first concluded that carrying out a death sentence is an "essential" state interest.[186] Singleton offered no evidence of the usual harmful side effects of antipsychotic medication (such as the extrapyramidal symptoms of traditional antipsychotics or the risk of agranulocytosis under some atypicals) and did not suggest any less intrusive means to render him competent.[187] Administration of antipsychotics was medically appropriate, the court concluded, because it effectively controlled Singleton's symptoms and rendered him competent while medicated and because the record was "devoid of any significant negative side effects from the antipsychotic medication."[188]

The foregoing conclusions brought the Eighth Circuit to the crux of the matter: Singleton's argument that "medication 'obviously is not in the prisoner's ultimate best medical interest' where one effect of the medication is rendering the patient competent for execution."[189] Singleton urged the court to avoid the dilemma of either involuntarily medicating a prisoner and then executing him or not medicating him and allowing him to revert to psychosis by staying his execution until involuntary

182. *Id.* at 1020.

183. The Eighth Circuit in *Sell* said that "an entirely different case is presented when the government wishes to medicate a prisoner in order to render him competent for execution" and that its ruling was to be "read narrowly." *Sell*, 282 F.3d at 571.

184. *Singleton*, 319 F.3d at 1024 (quoting *Sell*, 282 F.3d at 567–68).

185. *Id.*; *see* Riggins v. Nevada, 504 U.S. 127, 135 (1992).

186. *Singleton*, 319 F.3d at 1025 (stating that "[s]ociety's interest in punishing offenders is at its greatest in the narrow class of capital murder cases in which aggravating factors justify imposition of the death penalty").

187. *Id.*

188. *Id.* at 1026.

189. *Id.*

medication would no longer be necessary to maintain his competence.[190] The court would have none of it:

> Eligibility for execution is the only unwanted consequence of the medication. The due process interests in life and liberty that Singleton asserts have been foreclosed by the lawfully imposed sentence of execution and the *Harper* procedure. In the circumstances presented in this case, the best medical interests of the prisoner must be determined without regard to whether there is a pending date of execution.[191]

The Eighth Circuit next summarily rejected Singleton's *Perry* argument, that the Eighth Amendment precludes execution of one who has been rendered "'artificially competent'"[192] or "synthetically sane."[193] The Eighth Circuit made short work of *Perry*, simply distinguishing it as resting on more expansive protections under state constitutional law.[194] With respect to the substance of the Louisiana court's reasoning, the Eighth Circuit offered two responses.[195] One was merely, albeit straightforwardly, to note "that the *Perry* court accepted the view of 'best medical interests' that we have rejected"—in the Eighth Circuit's distinction between "short-term" (relief from psychosis) and "ultimate" (execution) medical interests.[196]

The court's other response to *Perry* is less clear in its logic but more predictable in its effect. As noted above, *Perry* rested in part on the Louisiana court's conclusion that the state's goal in medicating Perry was to restore him to competence for execution and not to provide for his or others' safety.[197] The Eighth Circuit, by contrast, declined "to undertake a difficult and unnecessary inquiry into the state's motives in circumstance[s] where it has a duty to provide medical care."[198] Because the record supported the finding that Arkansas was "under an obligation" to administer antipsychotic medication to Singleton, the court reasoned, "any additional motive or effect is irrelevant."[199] This rationale is

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190. *Id.*

191. *Id.*

192. *Id.*

193. *See* Riggins v. State, 808 P.2d 535, 540–41 (Nev. 1991) (Springer, J., dissenting).

194. *Singleton*, 319 F.3d at 1026.

195. *Id.* at 1026–27.

196. *Id.* at 1026.

197. Refer to text accompanying note 147 *supra*.

198. *Singleton*, 319 F.3d at 1027.

199. *Id.* Compare the approach of the Eighth Circuit panel opinion vacated by the court en banc. On appeal from the U.S. District Court's denial of Singleton's petition for a writ of habeas corpus, the Eighth Circuit panel reversed and directed the district court to grant the writ, to permanently enjoin Singleton's execution, and to reduce his sentence to

difficult to follow. One problem is the leap from the State's *authorization* (under due process standards) to administer antipsychotics involuntarily under *Harper* to an *obligation* (presumably under Eighth Amendment standards) to do so. Next, in addressing Singleton's due process challenge to forcible medication under its *Sell* standards, the Eighth Circuit's point of departure was in recognizing the state's "essential interest in carrying out a lawfully imposed sentence."[200] At that juncture, the court explicitly relied on the relationship between medicating Singleton, restoring *Ford* competence, and the State's avowed goal in executing him.[201] How an inquiry into such a clearly stated government purpose for forcible administration of antipsychotic medication suddenly became "difficult" for Eighth Amendment purposes is baffling.[202]

Judge Heaney's dissent (joined by Judges Bright, McMillian, and Bye) addresses in detail the considerations that the majority either ignored or deemed irrelevant.[203] After noting the difficulties related to "synthetic sanity" and the uncertainty of psychopharmacological interventions, the dissent argued that, because of the glaring problem of pretextuality and mixed motives reflected in, but unresolved by, the majority opinion, the setting of an execution date creates an irreconcilable conflict with purported *Harper* grounds for involuntary medication.[204] And unlike the majority, the dissent explicitly recognized that "the majority holding will inevitably result in forcing the medical

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life imprisonment without possibility of parole. Singleton v. Norris, 267 F.3d 859, 871 (8th Cir. 2001). The court rejected the state's assertion that its stated intention in involuntarily medicating Singleton (to protect him from harming himself or others) controlled the constitutional question of whether a state could involuntarily medicate and then execute a prisoner if the medication restored *Ford* competency. *Id.* at 869. The court pointed out the problems of pretextuality in an approach that relied on the State's claimed intentions and on the potentially interminable nature of cycles of competence and incompetence that might ensue if involuntary medication was interrupted to permit judicial oversight of the state's decision. *Id.* at 869–70. In short, "there is no way . . . to know whether Singleton will be competent on the day he is executed." *Id.* at 870. To bring an end to the lengthy litigation (Singleton was convicted and sentenced to death in 1979), the court allowed the state to continue medicating Singleton but prohibited the state from executing him. *Id.* at 860, 871. The Eighth Circuit granted the State's petition for rehearing en banc and vacated its opinion and judgment, however, and eventually issued its en banc decision in *Singleton*. *Id.* at 871.

200. *Singleton*, 319 F.3d at 1025.

201. *Id.*

202. Note that, although the en banc court seemed to regard the state's motive as inscrutable, it showed little reluctance to question Singleton's motivations. *See id.* at 1025 n.3 (describing "Singleton's attempts to avoid the penalty Arkansas has imposed on him").

203. *Id.* at 1030–37 (Heaney, J., dissenting).

204. *Id.* at 1035–36 (Heaney, J., dissenting).

community to practice in a manner contrary to its ethical standards."[205]

Absent intervention and further clarification by the U.S. Supreme Court, an opportunity for which the Court's denial of certiorari in *Singleton* bypassed,[206] the combined effect of the *Sell* and *Singleton* proceedings may be to increase the ethical stakes for mental health professionals in the capital punishment context. Under *Singleton*'s application of the Eighth Circuit's *Sell* standards (which the U.S. Supreme Court did not find facially unacceptable), a *Ford*-incompetent inmate may be forcibly medicated even if the foreseeable and actually intended result is to render him competent for execution.[207] And under *Singleton*'s response to *Perry*, viewed in light of the U.S. Supreme Court's dicta in *Sell*,[208] one step in the process will likely be to obtain a *Harper* order.[209]

These developments not only increase the likelihood of mental health professionals' most ethically problematic involvement in the capital punishment process and further blur the line between participation in treatment and in killing, they also model the deployment of mechanisms of moral disengagement, which, as discussed below, characterize the professions' response to the ethical challenges presented in the capital context. The *Singleton* proceedings use the mechanism of obscuring the causal connection: the Arkansas Supreme Court, for example, invoked reasoning resembling the principle of double effect when the court asserted that restoration of competence to be executed was merely "a collateral effect of that medication."[210] The Eighth Circuit's distinctions between Singleton's "long-term" and "short-term" medical interest and

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205. *Id.* at 1036 (Heaney, J., dissenting). As the dissent observes, the U.S. Supreme Court has given constitutional weight to such ethical concerns. *See* Washington v. Glucksburg, 521 U.S. 702, 731 (1997) (noting the opposition of the American Medical Association and other medical groups to physician-assisted suicide); Washington v. Harper, 494 U.S. 210, 222 n.8 (1990) (referring to the American Psychiatric Association's code of ethics). For a thoughtful discussion of this aspect of the case, see Jennifer Lloyd, Primum Non Nocere: Singleton v. Norris *and the Ethical Dilemma of Medicating the Condemned* (undated) (unpublished manuscript, on file with Author).

206. Charles Laverne Singleton was executed on January 6, 2004. *Nation in Brief*, WASH. POST, Jan. 7., 2004, at A2.

207. *See Singleton*, 319 F.3d at 1024–25, 1027.

208. Refer to note 136 *supra* and accompanying text.

209. *See Singleton*, 319 F.3d at 1022 (stating that Singleton's case should not be regarded as moot due to the likelihood of a *Harper* order and scheduled date of execution arising in tandem).

210. Singleton v. Norris, 964 S.W.2d 366, 368 (Ark. 1998). For a discussion of the principle of double effect, refer to notes 468–70 *infra* and accompanying text.

between the State's "obligation to administer antipsychotic medication" and "any additional motive"[211] are to similar effect.

Indeed, the opinions of the Arkansas Supreme Court and the Eighth Circuit in *Singleton* take that process a step further. In the normal course of events—that is, in any context other than the death penalty—the state would assert the authority to enforce the very ethical norms that the *Singleton* result may call upon health professionals to violate. Both courts' silence on that conflict suggests that it may be too acute to resolve directly or by any means short of the usual moral disengagement moves. Such avoidance is often the result, in the capital punishment context, when explicit recognition of an ethical or moral conflict threatens to raise the stakes beyond a level that decisionmakers are willing to tolerate.[212]

A recent development in Arizona—the Maturana proceeding—indicates just how painful the conflict can become for the ethical professional caught in its middle and also illustrates the extent to which, in the death penalty context, the state can become a healing professional's ethical adversary.[213] Despite questions about his competence to stand trial, Claude Maturana was convicted of a grisly 1990 murder and sentenced to death in 1992.[214] His appellate counsel successfully challenged his competence to be executed.[215] Maturana, suffering from bizarre delusions (including the belief that he was already dead), was diagnosed with paranoid schizophrenia.[216] Maturana's confinement to the Arizona State Hospital brought him under the care of psychiatrist Jerry Dennis, a doctor at the hospital.[217] Following prevailing medical ethical guidelines, Dr. Dennis provided minimal psychopharmacological treatment to alleviate Maturana's suffering (by reducing his level of agitation), but refused to provide sufficient treatment to restore him to competence.[218]

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211. *Singleton*, 319 F.3d at 1026–27.

212. Refer to Part III.B *infra*.

213. *See, e.g.*, Emily Heller, *Docs Refuse to Open Death's Door: Ariz. Doctors, Prosecutors Fight Over Treating Man Too Mentally Ill to Execute*, NAT'L L.J., Nov. 1, 1999, at 5A [hereinafter Heller, *Docs Refuse*]; Emily Heller, *New Doc Deems Man Fit to Be Killed: Judge Weights Fate of Ariz. Killer Previously Found Incompetent*, NAT'L L.J., Jan. 24, 2000, at 4A [hereinafter Heller, *New Doc Deems Man Fit*]; Carol Morello, *"Healthy" Would be a Fatal Diagnosis for Prisoner*, USA TODAY, Nov. 9, 1999, at 4A.

214. Morello, *supra* note 213; Heller, *Docs Refuse*, *supra* note 213.

215. Heller, *New Doc Deems Man Fit*, *supra* note 213.

216. Heller, *Docs Refuse*, *supra* note 213.

217. *See* Lindsay A. Horstman, Comment, *Commuting Death Sentences of the Insane: A Solution for a Better, More Compassionate Society*, 36 U.S.F. L. REV. 823, 826 (2002) (describing Maturana's psychosis); Morello, *supra* note 213.

218. Morello, *supra* note 213. Refer to Part III.C *infra* (discussing applicable ethical guidelines).

Arizona's response demonstrates how intense the official pressure can be to enlist—or even conscript—mental health professionals (especially those employed by the state) in the service of capital punishment. At first, counsel for the Arizona Attorney General's office threatened to bring contempt charges against Dr. Dennis.[219] In other words, the state's highest legal office actually considered employing the legal process to force a physician to violate his own professional ethical code—a code that the state would otherwise enforce—and to become an involuntary formal participant in executing a human being. When Dr. Dennis and his colleagues remained steadfast in their refusal, the state solicited the services of every psychiatrist and nurse practitioner (almost 2,000 combined) in the state and even advertised in a local newspaper.[220] None accepted the state's invitation to violate their professional code.[221] Disappointed by the ethical commitment of Arizona psychiatrists, the state expanded its search nationwide and ultimately found a psychiatrist, the medical director of a company that provides mental health services to inmates in Georgia's prisons, who resolved the impasse by finding Maturana competent to be executed.[222] Maturana's counsel characterized the evaluation as "drive-by psychiatry." Dr. Dennis, puzzled by Dr. Bennett's conclusion, asked, "how can a person who says he's dead already have an adequate understanding of being killed?"[223]

Finally, another disturbing example of the extent to which ethical limitations on health care professionals' role in the capital punishment process are subject to subversion by the state can be found in *Thorburn v. Department of Corrections*.[224] The *Thorburn* plaintiffs were a group of California physicians who sought an injunction against the physician participation in the execution of California inmates.[225] According to the plaintiffs' allegations,

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219. Morello, *supra* note 213.

220. *Id.*

221. *See id.*

222. Alfred M. Freedman, *The Doctor's Dilemma: A Conflict of Loyalties*, 18 PSYCHIATRIC TIMES, (2001), *available at* http://www.psychiatrictimes.com/p01010b.html; Heller, *New Doc Deems Man Fit*, *supra* note 213; Morello, *supra* note 213.

223. Maturana's fate, and the ethical dilemma presented by his case, was placed on hold by the Court's decision in *Ring v. Arizona*, 536 U.S. 584, 609 (2002), which invalidated Arizona's capital sentencing scheme as violating *Apprendi v. New Jersey*, 530 U.S. 466, 491–92 (2000) (holding that a defendant may not be exposed to a penalty exceeding that which he would have received if he was punished based on facts reflected in the jury verdict).

224. 78 Cal. Rptr. 2d 584 (1998).

225. *Id.* at 585. *Thorburn* is not the only challenge to physician participation in the execution process. New Mexico recently executed Terry Clark by lethal injection, the state's first execution since January of 1960. *National Briefing Southwest: New Mexico:*

California physicians perform a number of specific tasks in assisting the administration of lethal injections:

> examining the condemned inmate to determine whether any medical condition might interfere with the process; examining the inmate's medical records to determine and prescribe an appropriate sedative; identifying primary and secondary injection sites; making a list and supervising the arrangement of medical supplies needed for execution; preparing syringes with the lethal solution; supervising the attachment of a heart monitor to the inmate and verifying that the inmate's heartbeat can be detected on the instrument; locating appropriate veins for insertion of catheters that will carry the lethal solution; inserting the catheters; monitoring the flow of the lethal substances to ensure that there will be no interruption and death will occur; monitoring the inmate to notify the warden when death has occurred; and pronouncing death.[226]

The court relegated to a footnote the plaintiffs' citation to the "views of the American Medical Association, the California Medical Association, the World Medical Association, the American College of Physicians, and the American Public Health Association, as well as medical ethicists, all agreeing that physician participation in lethal injection executions violates the ethical principles to which the profession adheres."[227] The court rejected the plaintiffs' petition, pointing out that "'unprofessional conduct'" was defined by statute to mean "'unfitness to practice medicine,'" and concluding that "there is nothing about physician participation in executions which automatically constitutes 'unprofessional conduct' or renders a participating physician 'unfit' to practice medicine in California."[228] The court attached even "greater significance" to the archaically worded statutory provisions for an evaluation of the condemned prisoner's sanity by "three alienists."[229]

Girl's Killer is Executed, N.Y. Times, Nov. 7, 2001, at A18. The participation of Dr. Fred Pintz, the state's Chief Medical Officer, in providing authorization for the acquisition of the drugs used in Clark's execution, provoked an ethics complaint against Dr. Pintz to the State Board of Medical Examiners by Dr. Sidney M. Wolfe, Director, Public Citizen's Health Research Group. Dr. Wolfe's complaint invoked Opinion 2.06 of the American Medical Association's Council on Ethical and Judicial Affairs, discussed *infra* notes 322–41 and accompanying text. For an account of Clark's case, see Leslie Linthicum & Tania Soussan, *Executed*, ALBUQUERQUE J., Nov. 7, 2001, at A1. For Wolfe's complaint, see Letter from Sidney M. Wolfe, M.D., to John Romine, M.D., President, New Mexico State Board of Medical Examiners (Nov. 2, 2001) (on file with Author).

226. *Thorburn*, 78 Cal. Rptr. 2d at 586.

227. *Id.* at 589 n.6.

228. *Id.* at 590.

229. *Id.*

In summary, mental health professionals, particularly psychiatrists and psychologists, routinely perform a substantial and growing role in the capital punishment process.[230] Legal developments such as *Ford* and now *Singleton* have moved that involvement beyond the sentencing phase to include assessment and even treatment, the aim (or at least the direct consequence) of which is to restore competence to be executed.[231] Additionally, in some states, health care professionals, including physicians, allegedly participate in a concrete, hands-on capacity during the execution.[232] And the legal system's pull for more psychiatric and psychological evaluation and treatment services has recently coincided with a push from within those professions to find new markets for their services in response to managed care's impact on the profitability of private clinical practice.[233] The net result of these developments is that an increasing number of mental health professionals must face the ethical conflicts raised by their participation in the capital punishment process.[234] The nature and extent of those conflicts are explored in the ensuing section.

B. Essence of the Ethical Problem

Phillipa Foot, referring to psychiatrists, bluntly captured the essence of the ethical objection to mental health professionals' facilitative participation in capital punishment: "that because theirs is a healing and life-preserving role, they should not take part in a procedure that has a conflicting aim."[235] Given the apparent conflict between their obligation to preserve the life of those persons whom they encounter in their professional role and their facilitation of a process designed to bring about the death of

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230. Refer to notes 239–41 *infra* and accompanying text.

231. *See* Singleton v. Norris, 319 F.3d 1018, 1025–27 (8th Cir. 2003) (en banc) (weighing the defendant's and the state's respective interests and concluding that *Ford* is not violated when a prisoner who has been medicated to competency is executed).

232. Refer to notes 238–41 *infra* and accompanying text (discussing health care professionals' intimate involvement in the death penalty process generally). Refer also to text accompanying note 226 *supra* (pointing out California physicians' role specifically).

233. *Cf.* Stuart A. Greenberg & Daniel W. Shuman, *Irreconcilable Conflict Between Therapeutic and Forensic Roles*, 28 PROF. PSYCHOL.: RES. & PRAC. 50, 50 (1997) (noting the "tightened insurance reimbursement rules" have contributed to the "increasing frequency" with which mental health professionals are participating as forensic experts in litigation on behalf of their patients).

234. Refer to notes 238–41 *infra* and accompanying text.

235. Phillipa Foot, *Ethics and the Death Penalty: Participation by Forensic Psychiatrists in Capital Trials*, *in* ETHICAL PRACTICE IN PSYCHIATRY AND THE LAW 207, 209 (Richard Rosner & Robert Weinstock eds., 1990). Although her comments are directed towards psychiatrists, they could also apply to psychologists. Refer to notes 300–06 *infra* and accompanying text (noting the similarities between both groups and discussing the ethical standards of psychologists).

some of those persons, she asks the critical question: "How, then, can the participation of psychiatrists in capital cases be defended, even on the assumption that execution is a morally unobjectionable penalty for certain murders?"[236]

Foot's complete abstentionist position is a distinct minority.[237] Few writers on the subject today advance the categorical position 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."[238] Most commentators and the American Medical Association have instead, under a variety of theories, tried to draw a line short of a hands-on role at the execution.

In actual practice, psychiatrists and psychologists routinely provide professional services before, during, and after capital sentencing. Indeed, physicians have long "been intimately involved with the death penalty process—by issuing death certificates following executions, examining an inmate's neck to determine the optimal rope length for hanging, examining and counseling death row inmates, and resuscitating condemned inmates who attempt suicide."[239] The advent of lethal injection has invited even more intimate physician involvement with executions.[240] The allegations of the *Thorburn* appellants paint a

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236. Foot, *supra* note 235, at 209 (emphasis added).

237. *See* Mossman, *Execution Competency*, *supra* note 113, 9–10 n.34 (noting that in a survey of psychiatrists, "[a] clear majority of the psychiatrists polled saw no ethical problem in evaluating competency to be executed").

238. Michael L. Radelet & George W. Barnard, *Ethics and Psychiatric Determination of Competency to Be Executed*, 14 BULL. AM. ACAD. PSYCHIATRY & L. 37, 45 (1986). Radelet and Barnard describe, but do not endorse, this position. *Id.* For an example of a writer who does advocate abstention, see Louis Jolyon West, *Psychiatric Reflections on the Death Penalty*, 45 AM. J. ORTHOPSYCHIATRY 689 (1975). One especially influential writer originally opposed psychiatric participation in the process but eventually changed his position. *See* Paul S. Appelbaum, *The Parable of the Forensic Psychiatrist: Ethics and the Problem of Doing Harm*, 13 INT'L J.L. & PSYCHIATRY 249, 256 & n.4 (1990) [hereinafter Appelbaum, *The Parable*] (describing that, in his "early stages of thinking through this problem, [opposition to psychiatric participation in implementing the death penalty] was precisely the position" that he advocated). For a relatively recent example of the abstentionist position, see Jack C. Schoenholtz et al., *The "Legal" Abuse of Physicians in Deaths in the United States: The Erosion of Ethics and Morality in Medicine*, 42 WAYNE L. REV. 1505 (1996) (opposing physician participation in such death-centered practices as euthanasia and execution as undermining the physician's oath to refrain from doing harm); *see also* Alfred M. Freedman & Abraham L. Halpern, *The Erosion of Ethics and Morality in Medicine: Physician Participation in Legal Executions in the United States*, 41 N.Y.L. SCH. L. REV. 169, 187–88 (1996) (likening doctors' justification of their participation in executions to German doctors' rationalization of their roles in Nazi concentration camps during World War II).

239. Barbara Ward, *Competency for Execution: Problems in Law and Psychiatry*, 14 FLA. ST. U. L. REV. 35, 84 (1986).

240. *See id.* Refer to text accompanying note 226 *supra* (describing tasks related to lethal injection that may be performed by physicians).

chillingly detailed picture of the extent of direct physician involvement in killing the condemned.[241]

Mental health professionals' efforts to reconcile their participation in capital punishment with a core ethical commitment to healing, care, and life reflect the markers of moral disengagement described above.[242] The first task in the analysis, therefore, is to describe that core ethical commitment.

C. Core Ethical Commitment

1. "Thick" Versus "Thin" Ethics. Accounts of professional ethics can be grouped into two broad categories, which for convenience I will label "thin" and "thick."[243] Thin ethics are minimalist, code-based, and mandatory; they are externally imposed.[244] These are the provisions that professionals get in trouble for violating. As one article put it, such ethics "establish minimum requirements for professional performance via prescriptive guidelines and behavioral rules."[245] They may or may not have much moral content and are sometimes criticized as overly concerned with the "guild" aspects of professional behavior.[246]

Thick ethics, by contrast, aspire to maximize the moral content of the professional role, emphasize professional virtues,

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241. Refer to notes 225–26 and accompanying text.

242. Refer to Part II.A *supra*.

243. *See* James T. Laney, *"Thick" and "Thin" Approaches to Ethics Education*, *at* http://www.chowan.edu/acadp/ethics/eac/james_laney.htm (last visited Mar. 10, 2004).

244. *See id.*

245. Jody L. Newman et al., *Beyond Ethical Decision Making*, 48 CONSULTING PSYCHOL. J.: PRAC. & RES. 230, 230 (1996).

246. *See* Lewis S. Pilcher, *Codes of Medical Ethics*, *in* ETHICS IN MEDICINE: HISTORICAL PERSPECTIVES AND CONTEMPORARY CONCERNS 34, 35 (Stanley Joel Reiser et al. eds., 1977) [hereinafter ETHICS IN MEDICINE] (providing an early expression of objection to the codification of medical ethics). Pilcher claimed that

> [a] physician is not a member of a guild or corporation, the rules of which he must comply with in order to retain his membership therein, and to enjoy its benefits, but a member of a liberal profession, the rules of which are the unwritten law of humanity, and the special requirements of which must vary much according to the peculiarities of his environment.

Id. For a more modern caveat about the limits of code-based ethics, see TOM L. BEAUCHAMP & JAMES F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS 7 (4th ed. 1994).

> Unfortunately, some professional codes oversimplify moral requirements or claim more completeness and authority than they are entitled to claim. As a consequence, professionals may mistakenly suppose that they satisfy all moral requirements if they obediently follow the rules of the code, just as many people believe that they discharge their moral obligations when they meet all relevant legal requirements.

Id.

and speak in terms of principles rather than rules.[247] Thick ethics locate the primary source of responsibility within the professional himself or herself.[248] They go beyond the often binary, behavioral question of "may (or must) I do this?" to also address the more layered, existential question of "who shall I become if I do this?"[249] Partly as an accommodation between the ideal and the pragmatic, professional organizations' ethics documents often explicitly distinguish between unenforceable aspirational principles (wherein thick ethics tend more explicitly to be recognized) and enforceable, conduct-regulating rules and standards (wherein thin ethical requirements tend to be more evident).[250]

Recognizing the problem of prescriptive indeterminacy, some ethicists have asserted that "the moral value of formal principles largely is a function of the effectiveness with which they are defined and interpreted. Thus, it is the steward of the principles that determines their impact more so than the content of the principles themselves.[251] Others have proposed that "virtues need principles and rules to regulate and supplement them."[252] Under this view, who you are sometimes matters as much as what you are required or permitted to do.[253] It is in this connection that the potential existential impact of participation in capital punishment assumes critical dimensions. The professions have reconciled at least some forms of participation in the capital punishment process with thin ethical requirements; the thick ethics are what present the problem.

Foot's challenge implicitly draws on a thick conception of professional ethics, ascribing to mental health professionals a constitutive humanistic commitment toward healing that recognizes the intrinsic worth of human life.[254] Such a perspective would regard as presumptively unethical behavior that appeared

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247. *See* Laney, *supra* note 243.

248. *See* Newman et al., *supra* note 245, at 231–32 (discussing the distinction between "virtue" (thick) and "principle" (thin) ethics in these terms).

249. *Id.*

250. *See, e.g.*, AM. PSYCHOL. ASS'N, ETHICAL PRINCIPLES OF PSYCHOLOGISTS AND CODE OF CONDUCT (2002), *reprinted in* 57 AM. PSYCHOLOGIST 1060, 1061 (2002) (describing the difference between aspirational General Principles and enforceable rules contained in the Code of Conduct).

251. *See* Newman et al., *supra* note 245, at 231.

252. BEAUCHAMP & CHILDRESS, *supra* note 246, at 67; *see also id.* at 62–69 (discussing character and virtue ethics and their relationship to principles and rules).

253. *Id.* at 65 (stating that "one who is disposed by character to have the right motives and desires is the basic model of the moral person . . . because right motives and character tell us more about moral worth than do right actions").

254. Refer to notes 235–36 *supra* and accompanying text.

to be inconsistent with that fundamental moral commitment and would accordingly demand either a convincing explanation that no such conflict in fact exists or an exceedingly compelling justification (perhaps based on other potent, related commitments such as patient autonomy). Defenses of at least some forms of participation by mental health professionals in the capital punishment process, by contrast, frame the issue in thin binary form as *whether* such professionals may "ethically" render a particular service—i.e., whether applicable conduct-regulating guidelines specifically prohibit such participation—and relegate all other objections to a realm denominated as individual "morality."[255] Thus, as discussed below, a common move in the justificatory process is simply to place thick ethics out of bounds.[256] Other approaches to the problem purport to reconcile participation with a thick ethical commitment, but at considerable cost to the content of that commitment.[257]

My inquiry, like Foot's challenge, assumes that professional ethics have moral content and asks what mental health professionals give up when they participate in the capital punishment process. As indicated, the thick ethical question is not limited to "may I do this without incurring sanction?" but also asks "*who do I become by doing this*?"[258] Thus, even if mental health professionals can, without risking professional discipline, perform some functions (of increasing scope) that facilitate the state's capital punishment agenda—as is plainly the case—the question remains whether they thereby sacrifice a core component of their professional ethical identity. Foot made the key observation that it is not so much a matter of "*whether*" mental health professionals can participate in capital punishment but "*how*" they can do it.[259] As shown below, it appears that the dissociative processes of moral disengagement play a substantial role.[260]

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255. The verb "participate" in connection with capital punishment has acquired (through the process of cognitive reconstrual) a specialized meaning in the medical ethics literature as connoting the performance of proscribed tasks in aid of an execution. Refer to notes 319–331 *infra* and accompanying text. Unless otherwise indicated, I use the word in its usual sense of taking part in an enterprise.

256. Refer to Part IV.A *infra*.

257. Refer to notes 378–80 *infra* and accompanying text (discussing the prohibition on direct involvement with executions and the endorsement of activities that are sufficiently removed).

258. Refer to text accompanying note 249 *supra*.

259. Foot, *supra* note 235, at 209.

260. Refer to Part III *infra*.

2. Humanism, Healing, Care, and Life. Foot's approach is a robust version of what ethicist and theologian Paul Ramsey has described as ethical reasoning from an ultimate norm, which requires as its "first move . . . to agree on a term to express the ultimate requirement or standard or warrant binding in all cases upon the helping and healing professions."[261] Such a norm, while certainly finding expression in professional codes, is never adequately captured by them.[262] Ramsey suggests that the operative construct is "care," in the humanitarian sense of respect for human life—which, as a suitably universal norm, avoids the problems of ethical relativism and intradisciplinary technocracy presented by codal ethics.[263] It is thick rather than thin and has deep historical roots as well as modern expression.[264] A more nuanced and contextual approach—which will be familiar to lawyers and philosophers but has only recently been reintroduced into ethical theory—is the case-based reasoning offered by Beauchamp and Childress.[265] They would begin with "clusters" of *principles*, or standards to serve as general guides to action, and a set of more specific *rules* (substantive, procedural, and decisional) that limit or require particular behaviors, all of which must be applied in a reasoned and coherent fashion to make judgments about particular cases.[266]

Whether accorded dominant or guiding force, fundamentally humanitarian norms—beneficence and nonmaleficence (especially avoiding killing), along with respect for patient autonomy and concern with distributive justice—have repeatedly emerged as primary principles identified by the literature on biomedical ethics over the past twenty-five years.[267] Mainstream

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261. Paul Ramsey, *The Nature of Medical Ethics*, *in* ETHICS IN MEDICINE, *supra* note 246, at 123, 125.

262. *See, e.g.*, William F. May, *Code and Covenant or Philanthropy and Contract?*, *in* ETHICS IN MEDICINE, *supra* note 246, at 65, 65 (contrasting codal ethics, which tend to emphasize technical proficiency, professional decorum, and personal detachment, with covenant ethics, which has its roots in personal relation and is responsive in character).

263. Ramsey, *supra* note 261, at 125. Ramsey's use of the term "care" thus has a somewhat different focus than the relational perspective offered by writers such as Carol Gilligan. For an analysis of the relational perspective on care in the context of abortion rights, see generally Donald P. Judges, *Taking Care Seriously: Relational Feminism, Sexual Difference, and Abortion*, 73 N.C. L. REV. 1323, 1336 (1995) [hereinafter Judges, *Taking Care Seriously*] (describing Gilligan's use of "care" as an "other-centered concern with 'goodness' and acceptance").

264. *See* Ramsey, *supra* note 261, at 125.

265. *See* BEAUCHAMP & CHILDRESS, *supra* note 246, at 92–100.

266. *See generally id.* Beauchamp and Childress's approach calls to mind HENRY HART & ALBERT SACKS, THE LEGAL PROCESS: BASIC PROBLEMS IN THE MAKING AND APPLICATION OF LAW (1958).

267. ROBERT M. VEATCH, MEDICAL ETHICS 32 (1989); BEAUCHAMP & CHILDRESS, *supra* note 246, at 38.

representatives of health care professionals, such as the American Medical Association (AMA) and the American Psychiatric Association (APA), today recognize beneficence and harm-avoidance as core ethical commitments. For example, their Ramseyian "first move" in addressing the ethical dilemmas presented by the issue of physician-assisted suicide was to assert that their "central mission" is to promote "healing."[268] As modern medical technology has dramatically increased the potential for preservation of life, the commitment to healing has come to include an ethic of death-avoidance and a resultant need to address the ethical implications of care for the dying, for the critically and irreversibly ill, and for those in a persistent vegetative state.[269] I will return shortly to end-of-life issues and the ethical commitment to autonomy, as addressed by Beauchamp and Childress.[270]

Indeed, even most writers who argue that it is ethical for health professionals to perform some facilitative role in the capital punishment process readily acknowledge the traditions of beneficence and *primum non nocere*.[271] Paul Appelbaum, one of the leading writers in this area, has stated that the principles set forth in the contemporary medical ethical code "can only be understood, in the framework of two millennia of medical ethics, as incorporating the principles of beneficence and nonmaleficence"—principles that would be endorsed by a majority of physicians and patients alike.[272]

The implications of a robust humanistic ethic of care for health professionals are profound. As Ludwig Edelstein has pointed out, one of the strongest early expressions of *humanitas* in medical ethics can be found, not in the Hippocratic Corpus or Galen, but in the late Stoicist writings of Scribonius Largus—

268. In their amici brief in the so-called "assisted suicide" cases, the AMA, American Nurses Association, and the APA begin with the premise that "[t]he power to assist in intentionally taking the life of a patient is antithetical to the central mission of healing that guides both medicine and nursing." Brief of the American Medical Association, the American Nurses Association, and the American Psychiatric Association et al. as Amici Curiae in Support of Petitioners at 2, Vacco v. Quill, 521 U.S. 793 (1997) (No. 95-1858).

269. *See, e.g.*, Robert M. Veatch, *The Ethics of Death and Dying: Changing Attitudes Toward Death and Medicine*, *in* SOURCE BOOK IN BIOETHICS: 113, 114 (Albert R. Jonsen et al. eds., 1998).

270. Refer to Part III.C.3 *infra*.

271. Refer to notes 332–35 *infra* and accompanying text.

272. Appelbaum, *The Parable*, *supra* note 238, at 251.

which are singularly relevant to the present inquiry.[273] According to Edelstein, Scribonius asserted that

> The true physician . . . "is not allowed to harm anybody, not even enemies of the state (hostibus). He may fight against them with every means as a soldier (miles) or as a good citizen (vir bonus), should this be demanded of him. [As a physician, he cannot and must not fight or harm them], since medicine does not judge men by their circumstances in life (fortuna), nor by their character (personis). Rather does medicine promise (policetur) her succor in equal measure to all who implore her help, and she professes (profitetur) never to be injurious to anyone." For . . . "medicine is the knowledge of healing, not of hurting. If she does not try in every way to help the sick with all means at her disposal, she fails to offer to men the sympathy she promises."[274]

In this view, the physician's role-defined obligations of sympathy and humaneness, of "'proficiency and benevolence toward all men without distinction,'"[275] take precedence over even those of citizenship.[276] Indeed, the physician's obligations are as binding in their own way as are the soldier's in theirs, so that, as Edelstein put it, "he who acts in a way unbecoming to a physician is a deserter, as it were" and has "'transgressed the proper boundaries of the profession.'"[277]

Edelstein traced the professional humanistic ethic reflected in Scribonius's writing to the Stoic concept of role-based virtue described by Panaetius and Cicero, in which one's calling imposes certain moral obligations.[278] Hence, just as the judge must adhere

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273. Ludwig Edelstein, *The Professional Ethics of the Greek Physician*, 30 BULL. HIST. MED. 392 (1956), *reprinted in* ETHICS IN MEDICINE, *supra* note 246, at 40, 44–45.

274. *Id.* (second alteration in original) (citation omitted).

275. *Id.* at 45.

276. *Id.* A strong modern expression of this ethical stance can be seen in organizations such as Médecins Sans Frontières. According to its charter,

> Médecins Sans Frontiéres offers assistance to populations in distress, to victims of natural or man-made disasters and to victims of armed conflict, without discrimination and irrespective of race, religion, creed or political affiliation.
>
> Médecins Sans Frontiéres observes neutrality and impartiality in the name of universal medical ethics and the right to humanitarian assistance and demands full and unhindered freedom in the exercise of its functions.
>
> Médecins Sans Frontières' volunteers undertake to respect their professional code of ethics and to maintain complete independence from all political, economic and religious powers.

The Charter of Médecins Sans Frontières, *available at* http://www.msf.org (last updated Aug. 3, 2002).

277. Edelstein, *supra* note 273, at 45.

278. *Id.* at 45–46.

to the pursuit of truth and fairness, the physician's professional virtues demand "love of humanity and all the duties it entails."[279] In this way, the physician who does assume the role of citizen or soldier to fight and kill the state's enemies ceases to be a physician "in the same manner in which the judge who indulges in favoritism ceases to be the representative of justice."[280] Even if the Stoicists' potent medical humanism reflected a minority position in its day, overshadowed as it was by the Hippocratic and Galenic emphasis on professional discretion, decorum, and scientific medicine, it did "indeed foreshadow the categories of Christian [i.e., subsequent] medical ethics."[281] As we shall see, it is this role-based commitment to *humanitas* that is the most thoroughly deactivated by today's prevailing views on physician participation in the capital punishment process.

Antecedents to modern medical ethical codes, including that portion of the Hippocratic Corpus known as the Oath—to which modern physicians "trace the foundations of their ethics," or at least their codal ethics[282]—are less explicitly dedicated to the primacy of *humanitas*; they nevertheless do acknowledge the principles of beneficence and harm-avoidance. For example, the Oath not only concerns itself with the medical profession as a fraternal order—by defining the physician's relationship to his teacher—as a son to his father—and pledging him to secrecy, but also promises to "use treatment to help the sick according to my ability and judgment, but never with a view to injury and wrong-doing" and to refrain from administering or suggesting the administration of "a poison to anybody when asked to do so."[283] It

279. *Id.* at 46.

280. *Id.*

281. *Id.*

282. VEATCH, *supra* note 267, at 7.

283. *Selections from the Hippocratic Corpus: "Oath," "Precepts," "The Art," "Epidemics I," "The Physician," "Decorum," and "Law," in* ETHICS IN MEDICINE, *supra* note 246, at 5, 5. The Oath goes on to provide that "[i]nto whatsoever houses I enter, I will enter to help the sick, and I will abstain from all intentional wrong-doing and harm." *Id.* It also proscribes the use of poison (a "pessary") to induce abortion and prohibits the sexual exploitation of patients. *Id.* Other portions of the Corpus also include beneficence and harm-avoidance among the many other issues that they address. *Id.* at 6–7. The Precepts' discussion of fee arrangements is, to modern eyes, a curious mix of the altruistic and instrumental, suggesting that too precipitous a discussion of fees may harm both the patient and the physician's reputation. *Id.* at 5. The Precepts assert that "[t]herefore it is better to reproach a patient you have saved than to extort money from those who are at death's door." *Id.* (footnote omitted). The Precepts go on to state that "if there be an opportunity of serving one who is a stranger in financial straits, give full assistance to all such. For where there is love of man, there is also love of the art." *Id.* In *The Art*, medicine is defended against its critics as finite in power against overwhelming afflictions, and its purpose is defined not only "to do away with the sufferings of the sick, to lessen the violence of their diseases," but also "to refuse to treat those who are overmastered by their

defines medicine as "to do away with the sufferings of the sick, to lessen the violence of their diseases" as well as to recognize medicine's limits.[284] The Oath's most famous statement explicitly enjoins physicians, "[a]s to diseases, [to] make a habit of two things—to help, or at least to do no harm."[285] The Corpus's general admonitions in favor of science and against quackery, along with its specific instructions on preparations and procedures, are competence-oriented directives that are also implicitly grounded on a dedication to the patient's welfare.[286]

Likewise, medieval legal codes prescribed training and licensing requirements, and regulated practice, with the stated purpose of protecting patients' health and welfare.[287] The Christianized version of the Oath, "The Oath According to Hippocrates in so far as a Christian May Swear It"—in addition to dropping references to Greek deities, the pledge of secrecy, and the ritual adoption of the physician's teacher as father[288]—strengthened its beneficent and harm-avoidant commitments.[289] Eighteenth century commentary on professional decorum generally urged physicians to "let Integrity, Candour, and Delicacy be your Guides" as the "best Counterpoise to Self-

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diseases, realizing that in such cases medicine is powerless." *Id.* at 6. Medicine is thus a healing art, not a miracle. The portion of the Corpus known as Epidemics, in addition to offering instruction on recognizing the course of disease, contains the well-known injunction that physicians, "[a]s to diseases, make a habit of two things—to help, or at least to do no harm." *Id.* at 7. The portion entitled "The Physician" describes appropriate appearance and deportment, and "Decorum" offers instruction in etiquette and bedside manner and pragmatic advice about the preparation of proper equipment, supplies, and medicines. *Id.* at 7–8. Here the ethics of beneficence and harm-avoidance are implicit. To be sure, the goal of these instructions is partly the protection of the profession's image, but they also plainly aim to enhance the patients' welfare. *Id.* The portion of the Corpus in which a clear humanitarian statement might have been made, but was not, is "Law," which lists as prerequisites to an understanding of medicine "natural ability, teaching, a suitable place, instruction from childhood, diligence, and time." *Id.* at 8.

284. *Id.* at 6.

285. *Id.* at 7.

286. *Id.* at 5–8.

287. Frederick II, *Medieval Law for the Regulation of the Practice of Medicine*, *reprinted in* ETHICS IN MEDICINE, *supra* note 246, at 10, 10–12.

288. VEATCH, *supra* note 267, at 9.

289. For an English translation of the new Oath, see W.H.S. JONES, THE DOCTOR'S OATH: AN ESSAY IN THE HISTORY OF MEDICINE 23–25 (1924). The new Oath strengthened the prohibition on abortion and provided, "Into whatsoever houses I enter, I will do so to help the sick, keeping myself free from all wrong-doing, intentional or unintentional, tending to death or to injury . . . ." *Id.* Compare the new Oath with the language quoted *supra* note 177.

Interest"[290] and defined the practice of medicine as "the art of preserving health, of prolonging life, and of curing diseases."[291]

The most prominent post-Hippocratic precursor to contemporary ethical codes for the medical profession, Thomas Percival's *On Professional Conduct*, tended to focus "more on the institutional ethics of health care," expressing its underlying commitment to beneficence as "the ethic of the British gentleman more than anything else."[292] Percival's work formed the basis for the nascent AMA's first code of medical ethics in 1847, the introduction to which proclaimed the "abundant evidences," since the days of Hippocrates, "of the devotedness of medical men to the relief of their fellow-creatures from pain and disease, regardless of the privation and danger, and not seldom obloquy, encountered in return."[293]

Modern ethical codes all reflect patient care as medicine's central concern, although they vary in the clarity and forcefulness with which they express that commitment and its content. The primarily deontological and virtue-based ethical approach has come to include a more explicit utilitarian component. For example, the introduction to the AMA's 1847 code characterized medical ethics as "Medical Deontology."[294] The 1957 Principles of Medical Ethics states that "[t]he principal objective of the medical profession is to render service to humanity with full respect for the dignity of man."[295] The current version of the Principles of Medical Ethics recognizes in its Preamble that the profession has "long subscribed to a body of ethical statements developed primarily for the benefit of the patient," while acknowledging that physicians also owe duties to each other, to society, to other health professionals, and to themselves.[296] The AMA's Council on Ethics and Judicial Affairs described the Principles as "a potent contract of caring between physicians and patients."[297] Respect for patient autonomy has

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290. SAMUEL BARD, A DISCOURSE UPON THE DUTIES OF A PHYSICIAN 9–12 (1769), *reprinted in* ETHICS IN MEDICINE, *supra* note 246, at 17.

291. JOHN GREGORY, LECTURES ON THE DUTIES AND QUALIFICATIONS OF A PHYSICIAN 6 (1817) (lectures submitted for publication in 1772).

292. VEATCH, *supra* note 267, at 10.

293. AM. MED. ASS'N, FIRST CODE OF MEDICAL ETHICS (1846), *reprinted in* ETHICS IN MEDICINE, *supra* note 246, at 26, 26.

294. *Id.*

295. AM. MED. ASS'N, PRINCIPLES OF MEDICAL ETHICS § 1 (1958).

296. AM. MED. ASS'N, COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, PRINCIPLES OF MED. ETHICS, pmbl. (1980).

297. American Medical Association's Home Page, *at* http://www.ama-aan.org/ethic/pome.htm (last visited Sept. 29, 1999) (citing AM. MED. ASS'N, CODE OF MEDICAL ETHICS: CURRENT OPINIONS WITH ANNOTATIONS (1996)).

also emerged as an important component of the physician's obligations. Concern for patient welfare, including patient autonomy, is thus addressed through such requirements as competency, honesty, respect, consent, and confidentiality.

A more explicit commitment to *humanitas* appears in the World Medical Association's Declaration of Geneva, under which members "solemnly pledge . . . to consecrate [their lives] to the service of humanity," and promise to "maintain the utmost respect for human life," and to refrain from using their "medical knowledge contrary to the laws of humanity."[298] Doctors are not permitted "to do anything that would weaken the physical or mental resistance of a human being except from strictly professional reasons in the interest of his patient" and "must always bear in mind the importance of preserving human life from conception."[299]

Of particular concern to the present inquiry are psychologists and psychiatrists. Both groups endorse patient welfare, beneficence, and harm-avoidance, as well as autonomy, as primary principles. The APA's newly revised Ethical Principles of Psychologists and Code of Conduct is explicit on this point. Whereas its predecessor identified Competence as the first of its Principles, the revised version lists Beneficence and Nonmaleficence as Principle A:

> Psychologists strive to benefit those with whom they work and take care to do no harm. In their professional actions, psychologists seek to safeguard the welfare and rights of those with whom they interact professionally and other affected persons . . . . When conflicts occur among psychologists' obligations or concerns, they attempt to resolve these conflicts in a responsible fashion that avoids or minimizes harm.[300]

Psychologists' conduct-regulating Ethical Standards list a number of care-based obligations. Ethical Standard 3.04 specifically provides that "[p]sychologists take reasonable steps to avoid harming their clients/patients . . . and others with whom they work, and to minimize harm where it is foreseeable and unavoidable."[301] Other care-based obligations (which include respect for client/patient autonomy) inhere in duties related to

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298. WORLD MED. ASS'N, DECLARATION OF GENEVA (1949), *reprinted in* ETHICS IN MEDICINE, *supra* note 246, at 37, 37.

299. *Id.* at 38.

300. AM. PSYCHOL. ASS'N, ETHICAL PRINCIPLES OF PSYCHOLOGISTS AND CODE OF CONDUCT, Principle A (2002).

301. *Id.* Ethical Standard 3.04.

professional competence,[302] nonexploitation,[303] informed consent,[304] and privacy and confidentiality.[305] In general, the first two of the seven principles identified by Redlich and Pope (under prior versions of the APA's Ethical Standards) for "meaningfully coordinating ethical guidelines with other standards of professional practice in a way that can be most useful to psychologists and psychiatrists attempting to carry out their professional tasks responsibly" are "(1) above all, do no harm; [and] (2) practice only with competence."[306]

Psychiatrists, as physicians, are bound by the beneficent and nonmaleficent precepts of the medical profession discussed above. With respect to their own specialty, those duties mean that "[t]he patient may place his [or] her trust in his [or] her psychiatrist knowing that the psychiatrist's ethics and professional responsibilities preclude him [or] her gratifying his [or] her own needs by exploiting the patient."[307] The psychiatrist is explicitly precluded from using his or her position "in any way not directly relevant to the treatment goals."[308]

In summary, although expressed in different ways and in different historical contexts, beneficence and harm-avoidance, as well as commitments to patient autonomy and to distributive justice, are the defining self-declared ethical attributes of the health professions, including psychiatry and psychology. At this level of generality, few would disagree. The problem arises with application of meta-principles to specific contexts, especially in the morally perilous terrain of capital punishment. If the facilitative participation by health professionals in the capital punishment process is indeed involvement in killing, then they risk transgressing the very essence of their professional identity by entering that domain.

3. Distinguishing Other End-of-Life Issues. Before turning to the capital punishment context, it is necessary to briefly

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302. *Id.* Ethical Standard 2.

303. *Id.* Ethical Standard 3.08 ("Psychologists do not exploit persons over whom they have supervisory, evaluative, or other authority, such as clients/patients, students, supervisees, research participants, and employees.").

304. *Id.* Ethical Standard 3.10.

305. *Id.* Ethical Standards 4.01–.07.

306. Kenneth S. Pope et al., *Ethics of Practice: The Beliefs and Behaviors of Psychologists as Therapists*, 42 AM. PSYCHOLOGIST 993, 999 (1987).

307. Am. Psychiatric Ass'n, *The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry*, *in* KEEPING UP THE GOOD WORK: A PRACTITIONER'S GUIDE TO MENTAL HEALTH ETHICS 204, 207, app. B (Leonard J. Haas & John L. Malouf eds., 2d ed. 1995) [hereinafter APA, *Principles of Medical Ethics*].

308. *Id.* at 208 (Section 3).

distinguish the ethical challenges, increasingly confronted by health professionals, that arise in other life-or-death contexts. For example, in addressing the moral and ethical challenges posed by withdrawal of treatment, withholding treatment, and assisted suicide, leading bioethicists Beauchamp and Childress go beyond the AMA's formal position (but perhaps not beyond that of many practicing physicians and ethicists) to conclude that, in the interest of patient autonomy, "merciful physician interventions in the form of voluntary active euthanasia are not inherently wrong or incompatible with the role of a health professional."[309] Their position that it is sometimes ethical and moral for physicians to have a hand in causing death is subject to a number of crucial constraints.[310] First, they would regard it as ethical only in extraordinary circumstances—for a "small percentage of patients" when "a condition has become overwhelmingly burdensome[,] . . . [so that] pain management is inadequate, and only a physician can and is willing to bring relief"[311]—for a physician to help "certain patients achieve what for them is a comfortable and timely death."[312] Second, they would insist that such practices should be subject to "extraordinarily careful regulation and monitoring"[313]—to ensure, for example, that the patient's decision is truly informed, voluntary, is based on a considered rejection of available alternatives, reached in a "supportive yet critical and probing environment of decisionmaking" and involves "a[n] ongoing patient-physician relationship."[314] Third, they are well aware of the slippery-slope risks, observing that proscriptions "in our moral code against actively causing the death of another person are not isolated fragments" but are instead "threads in a fabric of rules that support respect for human life."[315] They point out that removal of such threads, and hence the loss of both their instrumental and symbolic function, "could weaken a set of practices, restraints, and attitudes that we cannot replace."[316]

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309. BEAUCHAMP & CHILDRESS, *supra* note 246, at 227.

310. *Id.*

311. *Id.* at 226 (explaining that there is only a small percentage of such patients "because pain management and improvements in patient's environments have made circumstances at least bearable for most patients, and hospice environments have improved the care of the dying").

312. *Id.* at 227 (noting that easing certain prohibitions in biomedical ethics against such physician-assisted suicide would make most physicians more comfortable with the procedure).

313. *See id.*

314. *Id.* at 240.

315. *Id.* at 230.

316. *Id.*

None of the positions defending health professionals' participation in capital punishment canvassed in the ensuing section meet the carefully circumscribed and narrow class of cases that even Beauchamp and Childress would recognize as appropriate for a health professional's participation in causing death. For example, it would take dedication to a much more radical conception of patient autonomy than Beauchamp and Childress are prepared to accept to regard avoidance of the aversiveness of long-term incarceration as an adequate grounds for assisted suicide. In any event, it seems exceedingly unlikely that circumstances surrounding such a question would meet their rigorous procedural requirements.[317]

In addition, contrary to the implication by some commentators described below, trying to defend health professionals' participation in capital punishment by pointing to end-of-life issues involves a morally suspect circularity that is incompatible with Beauchamp and Childress's careful effort to balance patient autonomy and dignity against the risks of abuse and moral erosion.[318] In the capital punishment context, a group of people in the name of the state are working together with the express purpose of killing the capital convict. All of the conditions giving rise to the health professionals' ethical dilemmas result from that deliberate, state-sponsored, human agency—in which the health professional is being asked to become an active participant. To be sure, colorable arguments have been advanced that it is, in extraordinary cases, ethical for a health professional to help end the life of, for example, a terminally ill patient, but those arguments offer no justification for the professional's assistance in giving the patient the fatal disease in the first place.

We are left, then, where we started. Principles of beneficence and harm-avoidance have traditionally defined the humanitarian ethical commitment of the health professions (including the mental health professions); these principles have, in recent years, been augmented by concern for patient autonomy and distributive justice. To the extent that leading arguments in defense of mental health professionals' participation in capital punishment reconcile conflicts with principles of *humanitas* by deploying mechanisms of moral disengagement, those professionals will have forfeited a constituent element of their professional identity. Their participation will have come at the price of professional dissociation.

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317. Refer to notes 309–16 *supra* and accompanying text.

318. Refer to notes 341–44 *infra* and accompanying text.

IV. DISENGAGEMENT OF MORAL AND ETHICAL OBJECTIONS

This Part analyzes a sample of the post-*Ford* literature addressing the ethics of mental health professionals' participation in the capital punishment process. Again, the goal here is not primarily to resolve the ethical question of the permissible scope, if any, of the mental health professional's role in the capital punishment process. The point instead is to examine the nature and structure of the moves made by those who have attempted to address that question and to identify the extent of moral disengagement.

Toward that end, I have organized the literature into six categories of arguments or moves made by writers in this area. These are categories of convenience. They overlap somewhat, some have multiple layers, and the positions of several sources invoke more than one category. They are nevertheless conceptually distinct enough to provide a useful framework for the present analysis.

The first move is to distinguish "Personal Moral" objections to capital punishment from "Professional Ethical" concerns. The second pragmatically invokes the "Needs of the Justice System" in rejecting abstentionist arguments. The third, which I label the "Attenuation" position, focuses on the causal proximity of the professional's role to the actual killing of the prisoner. The fourth position, the "Forensicist" argument, seeks to redefine the professional role. The fifth category attempts to define a narrow range of ethical capital-related treatment for the "Relief of Suffering." The sixth position, which is the most marginal, reaches for a moral justification of the professional's contribution, not only to the adjudicatory processes of capital punishment, but to the substantive outcome. This "Capital Punishment as Therapy" position has two branches. One contends that assisting the prisoner in paying his debt to society is consistent with beneficence and respect for patient autonomy; the other regards society as the "patient."

A. Personal Morality Versus Professional Ethics

A common move in the literature is to distinguish personal moral convictions from professional ethical constraints.[319] The

319. A leading treatise on forensic psychological evaluations urges mental health professionals to determine in advance of participation in capital cases "whether their personal beliefs will make an objective assessment difficult." GARY B. MELTON ET AL., PSYCHOLOGICAL EVALUATIONS FOR THE COURTS: A HANDBOOK FOR MENTAL HEALTH PROFESSIONALS AND LAWYERS 183 (2d ed. 1997). Because the guiding ethical precept of this approach is objectivity, it is essentially an implicit adoption of the Forensicist

first comment that the AMA's Council on Ethical and Judicial Affairs (CEJA) makes concerning a physician's role in capital punishment is that "[a]n individual's opinion on capital punishment is the personal moral decision of the individual."[320] The CEJA holds that "[a] physician, as a member of a profession dedicated to preserving life when there is hope of doing so, should not be a *participant* in a legally authorized execution."[321] The operative concept is "physician participation," which the CEJA defines to include physical preparation for and attendance at the actual killing, but not capital evaluations (including *Ford* evaluations).[322] The difficulties involved in attempting to distinguish among these roles are discussed below in connection with the Attenuation and Forensicist arguments.[323] The point here is that the AMA, as well as other leading commentators,[324] regards a wide range of behaviors that facilitate capital punishment (at least most capital evaluation functions) as consistent with the normative standards of "a profession dedicated to preserving life when there is hope of doing so"[325] and relegates more categorical refusals to participate in the enterprise of state-sponsored killing to some less officially binding level of norms. Indeed, the CEJA proposes that for physicians whose "personal" morality is more demanding than professional ethical standards, the appropriate resolution is referral "to another physician."[326]

The CEJA's position on torture, which it describes as "deliberate, systematic, or wanton administration of cruel, inhumane, and degrading treatments or punishments during imprisonment or detainment," by contrast, is categorical and uncompromising: "Physicians must oppose and must not participate in torture for any reason."[327] "Participation" in this

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position. Refer to Part IV.D *infra* and accompanying text.

320. AM. MED. ASS'N, COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, CURRENT OPINION 2.06, CAPITAL PUNISHMENT [hereinafter CEJA/AMA, CAPITAL PUNISHMENT], *available at* http://www.ama-assn.org/apps/pf_new/pf_online (last visited Mar. 10, 2004).

321. *Id.* (emphasis added).

322. *Id.*

323. Refer to Parts IV.C–D *infra*.

324. *See, e.g.*, Richard J. Bonnie, *Dilemmas in Administering the Death Penalty: Conscientious Abstention, Professional Ethics, and the Needs of the Legal System*, 14 L. & HUM. BEHAV. 67, 76–77 (1990).

325. CEJA/AMA, CAPITAL PUNISHMENT, *supra* note 320.

326. *Id.* The CEJA further notes that those physicians who have personal moral qualms about capital evaluation or treatment—at least of potentially incompetent prisoners—should not be compelled to participate in such cases, but instead should be allowed to refer them to physicians for whom such activity is not "contrary to [their] personal beliefs." *Id.*

327. COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, AM. MED. ASS'N, CURRENT

context is defined broadly. It "includes, but is not limited to, providing or withholding any services, substances or knowledge to facilitate the practice of torture."[328] While physicians may, consistently with their ethic of care, "provide support for victims of torture," they should "strive to change situations in which torture is practiced or the potential for torture is great."[329]

The contrast between these two approaches demonstrates the power of euphemistic (or dysphemistic) labeling. Physicians may, consistently with professional ethics, perform an array of facilitative functions in state-sponsored killing, but they are absolutely prohibited from performing analogous functions if the state's activity is labeled "torture."[330] The humanitarian sentiments that rebel against physician participation in the "torture" context remain active in the norms recognized as conduct-regulating "professional ethics," but similar sentiments in the capital punishment context are deemed mere nonbinding "personal opinion."[331]

This move also constitutes minimization of both the consequences of facilitative participation in capital punishment and the causal relationship between that participation and those consequences.[332] For one thing, as discussed below in connection with the Attenuation position, the "Personal Morality" approach, combined with a narrow definition of "physician participation," effectively denies that the consequences of the physician's conduct in capital cases are themselves harmful (i.e., in violation of *primo non nocere*).[333] For another, the CEJA's categorical proscription against sex with patients—not only on the ultimate consummation but also on the incremental steps contributing thereto—more closely resembles the prohibition on participation in torture in its recognition of the causal relationship between the professional's conduct and resultant harm.[334] The contrast

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OPINION 2.067, TORTURE [hereinafter CEJA/AMA, TORTURE], *available at* http://www.ama-assn.org/apps/pf_new/pf_online (last visited Mar. 10, 2004).

328. *Id.*

329. *Id.*

330. *Compare* CEJA/AMA, CAPITAL PUNISHMENT, *supra* note 320, *with* CEJA/AMA, TORTURE, *supra* note 327.

331. *Compare* CEJA/AMA, CAPITAL PUNISHMENT, *supra* note 320, *with* CEJA/AMA, TORTURE, *supra* note 327.

332. There are also legal consequences. As Professor Bonnie has pointed out, publicly employed physicians or psychologists would probably have a more solid foundation for abstention if "refusal to participate is grounded in a recognized ethical proscription [rather than] rooted . . . in personal scruples against the death penalty." Bonnie, *supra* note 324, at 68 (opining that presently "an employee who declines to carry out assigned responsibilities on grounds of personal conscience probably may be lawfully discharged").

333. *Id.* at 69. Refer to Part IV.C *infra*.

334. Another example is the American Psychological Association's absolute

between those prohibitions and the CEJA's position on physicians' role in capital punishment produces a curious result: a physician is on much safer ethical grounds engaging in conduct that foreseeably, albeit incrementally, contributes to the deliberate killing of the patient than conduct that "may lead to sexual contact."[335]

More fundamentally, this move discounts the *moral* consequences of the health professional's role in the capital punishment process. It deactivates, simply by deeming irrelevant, most of the moral force behind objections to such conduct.[336] This traversal of thick ethics comes at a substantial moral cost to the profession. As a general matter, objections to capital punishment ultimately rest on a global humanitarian worldview that values human life.[337] As we have seen, *humanitas* is a value on which physicians' *professional* ethics are simply not neutral. Quite to the contrary, it is one of the defining values of the healing professions. The medical profession itself does not generally concede that its ethics are thin: the CEJA defines ethics as "matters involving (1) moral principles or practices and (2) matters of social policy involving issues of morality in the practice of medicine."[338] Nor are ethical values defined exclusively by legal principles: "In general, when physicians believe a law is unjust, they should work to change the law. In exceptional circumstances of unjust laws, ethical responsibilities should supersede legal obligations."[339]

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prohibition on sex with current clients or patients: "Psychologists do not engage in sexual intimacies with current therapy clients/patients." AM. PSYCHOL. ASS'N, ETHICAL PRINCIPLES OF PSYCHOLOGISTS AND CODE OF CONDUCT, Ethical Standard 10.05 (2002). The APA Code goes on to prohibit sex with relatives of current therapy clients or patients or their significant others. *Id.* Ethical Standard 10.06. Sexual Intimacy is also prohibited with former clients or patients within two years of termination and strongly discouraged with former clients or patients thereafter. *Id.* Ethical Standard 10.08.

335. COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, AM. MED. ASS'N, CURRENT OPINION 8.14, SEXUAL MISCONDUCT IN THE PRACTICE OF MEDICINE, *available at* http://www.ama-assn.org/apps/pf_new/pf_online (last visited Mar. 10, 2004).

336. Discussion of the complicated ethical and moral issues arising out of physician participation in abortion is beyond the scope of this Article. For discussion of an ethic of care in the context of abortion, see generally Judges, *Taking Care Seriously*, *supra* note 263. *See also* DONALD P. JUDGES, HARD CHOICES, LOST VOICES: HOW THE ABORTION CONFLICT HAS DIVIDED AMERICA, DISTORTED CONSTITUTIONAL RIGHTS, AND DAMAGED THE COURTS 66–73 (1993) (setting forth the actual procedure for an abortion and the required skills of the attending physicians).

337. *See* Judges, *Scared to Death*, *supra* note 13, at 158 (citations omitted) (observing that the ABA's opposition to capital punishment is based on evidence of its current lack of fairness, impartiality, and accuracy).

338. COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, AM. MED. ASS'N, CURRENT OPINION 1.01, TERMINOLOGY, *available at* http://www.ama-assn.org/apps/pf_new/pf_online (last visited Mar. 10, 2004).

339. COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, AM. MED. ASS'N, CURRENT

This point can be clearly demonstrated by comparing the medical profession's "Personal Morality" approach to capital punishment with its responses to the array of difficult and painful ethical dilemmas surrounding end-of-life issues outside the capital punishment context. Those dilemmas are so acute in large part because they involve a conflict between various aspects of an ethic of care—for example between the preservation of life or the relief of suffering—and respect for patient autonomy and self-hood. To be sure, the medical profession is neither united in its resolution of those dilemmas (witness, for example, the "assisted-suicide" controversy)[340] nor a stranger to cognitive reconstruals in struggling with them (witness, for example, its invocation of the principle of "double effect"). What we do *not* see in the profession's response to these end-of-life issues is the kind of wholesale demurrer to the very ethic of care itself that we find in the capital punishment context.

The CEJA does not start from the premise that physician-assisted suicide, euthanasia, or withdrawal or withholding of life-sustaining treatment is a "personal moral decision" (neither, for that matter, do Beauchamp and Childress). Instead, the CEJA's first pronouncement with respect to withdrawing or withholding life-sustaining treatment is to reaffirm that "[t]he social commitment of the physician is to sustain life and relieve suffering."[341] The Current Opinion goes on to recognize that those care-based duties may conflict, and it provides guidance (based on the principle of patient autonomy) for resolving that conflict. It does not place the central moral issue largely beyond the ken of professional ethical consideration. With respect to both euthanasia and physician-assisted suicide, the CEJA notes the tragic collision of care-based duties, but concludes that both practices are "fundamentally incompatible with the physician's role as healer."[342] As we have seen, leading bioethicists such as

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OPINION 1.02, RELATION OF LAW AND ETHICS, *available at* http://www.ama-assn.org/apps/pf_new/pf_online (last visited Mar. 10, 2004).

340. Refer to notes 309–16 *supra* and accompanying text (discussing Beauchamp's and Childress's approach to that issue). *See also* BEAUCHAMP & CHILDRESS, *supra* note 246, at 206–11 (discussing and critiquing the principle of double effect, which is "invoked to justify claims that a single act having two foreseen effects, one good and one harmful . . . , is not always morally prohibited if the harmful effect is not intended").

341. COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, AM. MED. ASS'N, CURRENT OPINION 2.20, WITHHOLDING OR WITHDRAWING LIFE-SUSTAINING MEDICAL TREATMENT (clarifying that the patient's autonomy should prevail when "the performance of one duty conflicts with the other"), *available at* http://www.ama-assn.org/pf_new/pf_online (last visited Apr. 20, 2004).

342. COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, AM. MED. ASS'N, CURRENT OPINION 2.21, EUTHANASIA, *available at* http://www.ama-assn.org/pf_new/pf_online (last visited Apr. 20, 2004); COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, AM. MED. ASS'N,

Beauchamp and Childress part company with the CEJA at this point, but even they are exceedingly careful to articulate stringent constraints to ensure that health professionals' participation in killing is reserved only for the most compelling cases from the perspective of the *patient's* interests.[343]

The professional ethical disengagement evident in the "Personal Morality" approach to capital punishment is quite understandable, however, when viewed in light of social cognition theory. This move temporarily exiles the core humanitarian values—which, given full force, would generate considerable dissonance with facilitative participation in capital proceedings—to the ethical limbo of individual subjectivity. This strategy buffers the self-censure that otherwise might result from transgressive behavior. Such relief, however, requires dissociation from values that the profession would otherwise deem essential. It is therefore purchased at considerable cost to identity: "A profession's ends are constitutive of the profession; the ends, and their interpretation, define the profession's mission and distinguish it from other activities."[344] If one takes away care, what remains is mostly self-serving guild regulation and professional courtesy, which is perhaps of considerable practical value to guild members, but has little or no intrinsic moral weight.

B. Needs of the Justice System

A second argument offered in defense of mental health professionals' participation in the capital punishment system invokes the needs of the justice system. In an influential article rejecting a complete abstentionist position, Professor Bonnie argued that "[w]idespread abstention by forensic specialists would create serious difficulties for the administration of justice in capital cases."[345] This is because "the legal system would be deprived of clinical evidence that is often essential to fair and reliable administration of the law in capital cases."[346] Paul

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CURRENT OPINION 2.211 PHYSICIAN-ASSISTED SUICIDE (stating also that physician-assisted suicide is "impossible to control, and would pose serious societal risks"), *available at* http://www.ama-assn.org/pf_new/pf_online (last visited Apr. 20, 2004).

343. Refer to notes 309–16 *supra* and accompanying text.

344. EZEKIEL J. EMANUEL, THE ENDS OF HUMAN LIFE: MEDICAL ETHICS IN A LIBERAL POLITY 14 (1991).

345. Bonnie, *supra* note 324, at 78. Others have also made the point that the justice system, particularly from the defense's perspective, would suffer from total abstention. *See, e.g.*, Rochelle Graff Salguero, Note, *Medical Ethics and Competency to Be Executed*, 96 YALE L.J. 167, 176 (1986).

346. Bonnie, *supra* note 324, at 68 (noting that such a deprivation would be

Appelbaum similarly argued that abstention might be "a serious loss to the pursuit of justice."[347] Bonnie noted that a "defense-only" posture by forensic experts in capital cases is no guarantee that their hands would not be sullied by involvement in the state's "quest for a death sentence" because the introduction of any mental health testimony (either in exculpation or mitigation) might inadvertently open the door to adverse inferences (for example, of depravity or dangerousness) or further evidence damaging to the defense.[348] Abstention, in his view, offers no solution because the result largely would be to harm the interests of the defense in obtaining individualized sentencing.[349] He pointed out that large-scale abstention by forensic specialists would seriously deplete the ranks of available experts, and the remaining pool would presumably "be skewed in the direction of those least likely to provide mitigating testimony."[350]

Other commentators, relying on a similar set of predictions, and recognizing that "[c]apital punishment is currently a political and social reality in the United States," have gone so far as to assert that qualified forensic experts thus have an "affirmative duty" to "*actively seek* an opportunity to participate" in the capital process—including the assessment of competency to be executed, a controversial role.[351] Those commentators propose a more naked version of the "Needs of the Justice System" position by explicitly invoking the interests of the *state* in carrying out capital punishment as well as those of defendants: In addition to identifying the foregoing pragmatic concerns, they assert that "[c]ontextual fairness" requires forensic experts to recognize that "the state has an interest in carrying out a lawfully imposed sentence."[352]

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especially problematic for a capital defendant or condemned prisoner attempting to use the evidence to establish a case for leniency).

347. Appelbaum, *The Parable*, *supra* note 238, at 255.

348. Bonnie, *supra* note 324, at 77.

349. *Id.* at 78. The prosecution, Bonnie argued, could conceivably be forced to get along without mental health evidence. *Id.*; *see also* Salguero, *supra* note 345, at 176 (stating that "total physician abstention from these proceedings may adversely affect the exercise of individual rights associated with the criminal justice process").

350. Bonnie, *supra* note 324, at 78.

351. Kirk S. Heilbrun & Harry A. McClaren, *Assessment of Competency for Execution? A Guide for Mental Health Professionals*, 16 BULL. AM. ACAD. PSYCHIATRY & L. 205, 206 (1988). Bonnie has noted that "[e]valuations of a condemned prisoner's competency to be executed are more problematic." Bonnie, *supra* note 324, at 78.

352. Heilbrun & McClaren, *supra* note 351, at 206. The amici brief to the U.S. Supreme Court of the AMA and the American Academy of Psychiatry and the Law in *Sell v. United States*, which goes far beyond simply advising the Court of the state of the art regarding treatment of psychosis and actually argues the weightiness of the state's interest in bringing defendants to trial, is a striking example of the extent to which

The "Needs of the Justice System" position, like the "Relief of Suffering" position,[353] highlights the forensic psychologists' and psychiatrists' ethical dilemma. As Bonnie and others point out, the likely short-term practical impact of widespread abstention would simply be to deprive the death penalty process of information, some of which might be relevant to culpability, and may even drive out the more ethically sensitive practitioners—hardly a resounding humanitarian victory. Yet to participate at all is, to some degree, to promote the overall enterprise and its concomitant conflict with beneficence and harm-avoidance[354] (the issue of to what degree is taken up in the next section). To recognize the dilemma, however, is not to resolve it. A marginally better-informed death penalty system is still about killing at least some defendants.

The "Needs of the Justice System" position, while ultimately failing to resolve the dilemma, does offer a measure of moral disengagement. It urges forensic experts to see themselves, not as ethically compromised participants in a homicidal enterprise, but as morally justified defenders of procedural or retributive justice. The system's need for their services becomes the basis for legitimation of their conduct. Like conscientious objectors in other contexts, would-be abstainers are depicted not as heroes of *humanitas* but as saboteurs of justice. As Bandura put it, "detrimental conduct is [thereby] made personally and socially acceptable by portraying it in the service of moral purposes. People then act on a moral imperative."[355] Moral justification is generally facilitated by assertions, such as those made in the literature described above, that abstention from transgressive conduct is ineffective and that the utilitarian balance favors participation.[356] The "Needs of the Justice System" argument reaches its logical conclusion in the invocation of the state's interest in executing capital sentences.

This position also reflects responsibility-shifting and diffusion. Under the "Needs of the Justice System" argument,

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mainstream representatives of the medical professions can adopt the state's agenda. Motion for Leave to File Brief and Brief for the American Psychiatric Association and American Academy of Psychiatry and the Law as Amici Curiae Supporting Respondent at 24, Sell v. United States, 282 F.3d 1018 (8th Cir. 2003) (No. 02-5664) [hereinafter APA/AAPL Brief] ("Leaving untreated a defendant who is incompetent to stand trial harms other public interests too. If enough time passes, the government may lose its ability to try the charges at all.").

353. Refer to Part IV.E *infra* and accompanying test.

354. Refer to note 268–70 *supra* and accompanying text.

355. Bandura, *Moral Thought and Action*, *supra* note 37, at 72–73.

356. *See id.* (noting also that "[p]eople do not ordinarily engage in reprehensible conduct until they have justified to themselves the morality of their actions").

mental health professionals' participation in the capital punishment process is not only justified but compelled by the existence of the process itself. Moral accountability for participation thus becomes displaced onto the faceless anonymity that is the capital punishment system and dispersed among its numerous functionaries. In this way, they are not healers who have forsaken *humanitas* by choosing to participate in killing, but reasonable people realistically and appropriately responding to the practical needs of a complex social situation of which they are only a small part and for the existence of which they are not seen as personally responsible.

The moral disengagement moves of the "Needs of the Justice System" position combine with the dissociative processes inherent in the "Personal Morality" approach to rest on an underlying "justification of what is by the fact that it is."[357] In other words, the "Needs of the Justice System" position regards mental health professionals' participation in the capital punishment process as simultaneously caused and justified by the existence of the process itself—the ultimate morality of which the "Personal Morality" position has placed beyond the reach of professional ethical concern.[358] Countervailing ethical objections are thus both subordinated to the dictates of authority and rendered irrelevant. In this way, forensic experts in the capital context bear an eerie resemblance to the participants in Milgram's obedience experiments, whose objections to inflicting electrical shock on another were met with such commands as "the experiment requires that you continue."[359] In a sense, the intersection of these two approaches surpasses the Milgram protocol by explicitly discouraging participants from questioning the validity of the overall enterprise in the first place.

Once the central issue of the morality of the enterprise—and hence one's association with it—is assumed, ignored, or placed off limits, and that enterprise takes on a reified agenic life of its own, the logic of the ensuing justificatory moves seems unassailable. By its threshold acceptance of the "political and social reality" of capital punishment,[360] the "Needs of the Justice

357. BOLINGER, *supra* note 50, at 115 (commenting on the role of language in the pursuit of self-defense and self-promotion).

358. In some respects, this state of affairs reminds me of A.J.P. Taylor's description of World War I: "The statesmen were overwhelmed by the magnitude of events. The generals were overwhelmed also. . . . All fumbled more or less helplessly. . . . No one asked what the war was about." A.J.P. TAYLOR, A HISTORY OF THE FIRST WORLD WAR 7, 38 (1963).

359. MILGRAM, *supra* note 36, at 21.

360. Refer to note 351 *supra* and accompanying text (citing Heilbrun and McClaren's

System" position transforms the moral choice from one that is about healing professionals' participation in killing to one that is about forensic experts' support of justice—and the "Personal Morality" approach forestalls inquiry into the underlying premises.

Again it is useful to compare capital punishment to "torture"—a hypothetical case which, in the wake of September 11, 2001, and the abuse of Iraqi prisoners by American military personnel at Abu Ghraib prison, has become much less farfetched.[361] The efficient and even "humane" administration of torture as an instrument of state policy presumably requires that the nature and severity of suffering must be carefully titrated to achieve optimum results, which would probably require the assistance of qualified health professionals (including, conceivably, mental health professionals). One might offer the utilitarian argument that abstention would leave only the least qualified and morally insensitive practitioners to participate and hence would result in an unnecessary and unjust increase in suffering. One might also point out that the existence of the policy itself—for which the practitioner would not be deemed responsible—would create the need that makes such participation not only acceptable, but commendable. Because the system itself would actually be responsible for harm, the practitioners would be seen not as censurable harm-inflictors, but as admirable mitigators injustice and suffering.

This is the attitude expressed by Albert Pierrepoint, one of Great Britain's last—and most "productive"—hangmen:

> I have gone on record and been many times quoted with apparent irony as saying that my job was sacred to me. That sanctity must be most apparent at the hour of death. A condemned prisoner is entrusted to me, after decisions have been made which I cannot alter. He is a man, she is a woman, who, the Church says, still merits some mercy. The supreme mercy I can extend to them is to give them and sustain in them their dignity in dying and in death. The gentleness must remain.[362]

Try a thought experiment. Suppose the United States were to abolish the Thirteenth and Fourteenth Amendments and to allow reintroduction of slavery, only this time based not on race

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characterization of capital punishment as social and political reality).

361. For example, a *Christian Science Monitor* poll published two months after September 11 indicated that one in three individuals polled would support use of state-sponsored torture in the war on terrorism. Abraham McLaughlin & Seth Stern, *How Far Americans Would Go to Fight Terror*, CHRISTIAN SCI. MONITOR, Nov. 14, 2001, at 1.

362. ALBERT PIERREPOINT, EXECUTIONER: PIERREPOINT 99 (1974).

but on intelligence. Such a system, to be fair and efficient, would require some reliable and valid method for determining intelligence. Arguments as forceful as, and quite similar to, those deployed in defense of psychologists' conducting capital evaluations could be invoked in favor of their performing evaluations for purposes of determining eligibility for and immunity from involuntary servitude.

As noted above, the medical profession has explicitly deemed any facilitative role in torture, regardless of its legality, categorically unethical because torture itself is so irreconcilable with the profession's core values.[363] It is easy to imagine a similar stance with respect to slavery. One might object, of course, that capital punishment is neither a form of torture nor morally analogous to slavery. But that response—which puts the morality of the overall enterprise in which one participates, and hence one's own ethical accountability for such participation, back into play—runs afoul of the "Personal Morality" position. In any event, history demonstrates that health professionals and others have indeed employed these same kinds of moral disengagement mechanisms to justify their participation in an array of organized social activities that by contemporary standards appear to be extreme norm violations, including eugenics, torture, slavery, and genocide.[364]

C. Attenuation

As used here, the term "Attenuation" refers to any argument based on causal proximity to either (1) the core final fatal act in the capital punishment process (reasoning from the core to the periphery), or (2) other forensic work that has generated little or no controversy (reasoning from the periphery to the core). Periphery-to-core reasoning has been deployed to defend participation in the capital punishment process generally. Core-to-periphery reasoning has been invoked as a line-drawing means both to support and to oppose facilitative participation by psychologists and psychiatrists at various stages of the process. Proximity reasoning has ultimately proved to be a slippery foundation for resolving ethical issues in this context. It is sometimes alternately invoked and rejected to support the line sought to be drawn. While proximity-based arguments ultimately may be on a collision course with themselves as a matter of logic, they do accomplish something as a matter of moral

363. Refer to note 327 *supra* and accompanying text.

364. This point is developed more fully below in connection with the "Society as Patient" argument. Refer to notes 491–94 *infra* and accompanying text.

disengagement, particularly through euphemistic labeling, minimization of consequences, diffusion and denial of responsibility, and advantageous comparison.

Both Bonnie and Mossman have applied periphery-to-core reasoning to reject a total abstentionist position.[365] Their argument has two aspects, the first of which is the proves-too-much part. They assert that abstention arguments based on the principle of nonmaleficence prove too much because *any* forensic evaluation entails the risk of harmful consequences for the defendant.[366] As Mossman puts it, "[t]o argue that assessment or treatment is an *indirect* cause of a convict's death—the 'but for' argument—would impugn a host of other commonly accepted forensic activities."[367] Thus, because health professionals engage in a wide array of forensic activities that might contribute to potentially harmful consequences for criminal defendants without experiencing ethical agony, their participation in the capital process is not, without more, ethically objectionable.

This reasoning is a form of palliative comparison. In effect, it reasons that because psychiatrists and psychologists routinely have a hand in the infliction of harm in nondeath contexts, it must be acceptable to do so in the capital punishment context as well. It also recapitulates the moral justification moves of the "Needs of the Justice System" approach by implying that pulling the nonmaleficence thread unravels the entire fabric of the justice system by requiring universal abstention from all forensic work.

The proves-too-much aspect of the argument, while purporting to deal with the nonmaleficence objection to forensic participation in the capital process, ultimately discounts the principle's relevance (thus resembling the "Personal Morality" approach) and thus minimizes the consequences of participation. This move simply begs rather than directly addresses what Paul Appelbaum has described as one of "the central ethical enigmas of forensic psychiatry. If psychiatrists are committed to doing good and avoiding harm, how can they participate in legal proceedings from which harm may result?"[368] Efforts to confront

365. Bonnie, *supra* note 324, at 75–90 (concluding that the value of professional evaluations of condemned criminals, such as enabling criminals to develop and present their pleas for leniency, makes total professional abstention from the capital punishment process undesirable); Mossman, *Execution Competency*, *supra* note 113, at 11 (arguing in part that there are no coherent ethical objections to psychiatric participation if the death penalty itself is just).

366. Bonnie, *supra* note 324, at 75–76.

367. Mossman, *Execution Competency*, *supra* note 113, at 38 (footnote omitted).

368. Appelbaum, *The Parable*, *supra* note 238, at 250.

squarely that question have yielded the "Forensicist" position, discussed below. The point here is that the "proves-too-much" move is a form of consequence minimization.

The second aspect of the periphery-to-core argument rejects the proposition that "the distinction between death and other harms has a categorical force in ethical terms" by noting that "the preservation of life is not always the paramount ethical value, even in the context of the physician-patient relationship."[369] The combination of these two parts of the periphery-to-core argument led Bonnie back to the "Personal Morality" position. He concluded that objection to participation in capital cases is rooted in "personal conscience, not in the ethical injunction to avoid harm."[370]

Both euphemistic labeling and obscuring of personal causal agency appear in this second part's equation of the *activity* of killing that is capital punishment with the *result* of death. This move reframes the role of the psychologist or psychiatrist from that of an active participant in a complex state-sponsored enterprise (originating in and consisting entirely of human agency), the goal of which is the deliberate killing of the prisoner, into a functionary who is insulated from the consequence of death, which originates from some other independent yet unspecified cause (whether resisted, yielded to, or hastened). The argument's logic seems to be that because physicians must, and at some point do, make ethical peace with death's inevitability and the limits of their ability to forestall it, objections to becoming active participants in deliberate killing lie outside the realm of professional ethics.[371] The argument serves to obscure the causal agency of everyone involved in the capital punishment process by equating it with a consequence that does not originate in human intention.

This palliative characterization elides the struggles of the medical profession to draw the line that the argument would erase. As discussed above, the CEJA's positions on end-of-life

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369. Bonnie, *supra* note 324, at 76; *see also* Mossman, *Execution Competency*, *supra* note 113, at 86–88 (concluding that "[a] psychiatrist thus fulfills his physicianly duty to avoid harm by conducting honest and objective forensic evaluations, even when the information obtained supports criminal conviction or punishment"). Other commentators have recognized that the "death-is-different" axiom recognized in capital punishment jurisprudence is also implicated in mental health professionals' involvement in the process. *E.g.*, *id.* at 76–77; Heilbrun et al., *supra* note 11, at 597 (explaining that capital-related treatment "is a powerful ethical dilemma because it occurs in the context of capital cases").

370. Bonnie, *supra* note 324, at 76–77.

371. Refer to Part III.C.3 *supra* (rejecting the equation of participation in the capital process and end-of-life issues).

issues attempt to distinguish between mitigating suffering, yielding to the inevitability of *death*, and becoming an active agent in deliberate *killing*.[372] That effort to define the limits of life-preservation is itself rooted in the principle of nonmaleficence, and the compromises forced by those limits result from an attempt to balance several care-based concerns (including autonomy, dignity, and relief of suffering). Beauchamp and Childress strike a different balance, but they too seek to serve the interest of patient autonomy while avoiding the problems of abuse and moral degeneration.[373] Once again we see that moral disengagement mechanisms are deployed in the capital context at the cost of the profession's essential values. The effect of equating participation in capital punishment with a distorted view of the profession's struggles with end-of-life issues is to deactivate, in the capital punishment context, those values that matter so much in the end-of-life context.

Finally, and most obviously, the periphery-to-core argument offers the responsibility-diffusing comfort of numbers. It implies that evaluations must be ethically acceptable because many professionals perform, without objection, the wide array of forensic tasks of which capital evaluations are only an indistinguishable subset. In a sense, this reasoning is reminiscent of the familiar but rather primitive "but everybody does it" form of responsibility diffusion. It exemplifies the incremental process by which norm violations come to be psychologically tolerable. Acceptance of a small or indirect role in harm infliction can serve as a baseline against which to measure the acceptability of a somewhat larger or more direct role. The trajectory from the periphery to the core is not a slippery slope, but instead is a series of shallow stairs. In this way, the debate over *Ford* assessments has been eclipsed by the reality of *Singleton* treatment.

The periphery-to-core argument also reflects a kind of denial. It is as if the potential enormity of the moral implications of healing professionals' participation in the harm-inflicting enterprise of the criminal justice system—which appears most starkly in the capital context—precludes deliberate acknowledgment and consideration. Like death itself, this position suggests that if we really thought about it, we would find it overwhelming.

This kind of denial pervades institutional consideration of the normative consequences of capital punishment. It is arguably

372. Refer to Part IV.A *supra*.

373. Refer to notes 310–14 *supra* and accompanying text.

reflected in the *Singleton* proceedings, as discussed above.[374] More generally, it is characteristic of the U.S. Supreme Court's response to substantive challenges to the American capital punishment system. It can be seen in Justice White's refusal to interfere with Georgia's criminal laws against murder, despite evidence of racial discrimination in sentencing, because to rule otherwise would lead to "an indictment of our entire system of justice."[375] Justice Powell echoed this theme a decade later when he rejected Warren McCleskey's equal protection challenge to the demonstrable race effects in Georgia's capital sentencing practices. "McCleskey's claim, taken to its logical conclusion, throws into serious question the principles that underlie our entire criminal justice system."[376] The point here is that, like the challenges in *Gregg* and *McCleskey*, periphery-to-core reasoning threatens to raise the moral stakes to a level beyond what most individuals will tolerate. Powerful psychological incentives for denial and disengagement arise when taking a norm seriously calls into question a broad spectrum of widely practiced behaviors.[377]

While periphery-to-core arguments seek to defeat a complete abstentionist position, core-to-periphery arguments try to draw distinctions between various stages of the process. The CEJA's definition and elaboration of "physician participation" is an exercise in core-to-periphery line drawing. The definition prohibits actions that would (1) "directly cause the death of the condemned"; (2) "assist, supervise, or contribute to the ability of another individual" to do so; or (3) "automatically cause an execution to be carried out on a condemned prisoner."[378] The CEJA's elaboration of this definition begins with a core set of proscribed activities revolving around the actual execution itself, such as administering tranquilizers or medications, monitoring vital signs, providing technical assistance, and various tasks associated with preparing and administering lethal injections.[379] Other activities, apparently regarded by the CEJA as sufficiently remote from the actual killing, are permitted, including capital evaluations (both pre- and postsentencing) and certifications of death (at least so long as someone else has declared death).[380]

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374. Refer to Part III.A *supra* (detailing the *Singleton* proceedings).

375. Gregg v. Georgia, 428 U.S. 153, 226 (1976) (White, J., concurring).

376. McCleskey v. Kemp, 481 U.S. 279, 314–15 (1987).

377. *See* Judges, *Scared to Death*, *supra* note 13, at 234–38 (providing further discussion of denial and disengagement).

378. CEJA/AMA, CAPITAL PUNISHMENT, *supra* note 320.

379. *Id.*

380. *Id.*

Other commentators have relied on core-to-periphery reasoning to defend psychiatrists' and psychologists' participation in capital evaluations. Salguero, for example, has invoked an explicit attenuation argument in defending competency-to-stand-trial evaluations in capital proceedings by stating, "physician responsibility at this stage of the criminal process for an inmate's execution is quite attenuated."[381]

Much of the literature has focused on whether *Ford* assessments are ethical and, if so, whether treatment of *Ford*-incompetents is ethical. Some authors have argued that *Ford* evaluations are qualitatively distinct from other capital evaluations, such as competency to stand trial, criminal responsibility, and sentencing, reasoning that they are too close to the facilitation of execution because the possibility of acquittal or some lesser sentence has passed.[382]

Bonnie's influential thinking in this area invokes attenuation reasoning to support the distinctions he endorses (between participation in actual executions and performance of capital evaluations) and dismisses the ethical significance of such reasoning to dispute distinctions he rejects (between presentencing capital evaluations and *Ford* evaluations).[383] Bonnie relies on core-to-periphery attenuation reasoning to conclude, for example, that unlike "injecting the lethal dose of barbiturates, or, in an earlier era, by measuring the prisoner's head and neck for the noose, . . . [a]n execution competency evaluation does not implicate the clinician *directly* in the infliction of suffering."[384] On the other hand, he struggles with attenuation reasoning when he disputes the proposition that competency-to-be-executed evaluations are ethically distinct from other capital evaluations. He first applies a version of the periphery-to-core argument by likening *Ford* evaluations to "other modes of clinical participation in the correctional process,"

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381. Salguero, *supra* note 345, at 176.

382. *See, e.g.*, Ward, *supra* note 239, at 85–86 (describing the distinction between *Ford* and other capital evaluations). Ward stated that

> [t]he execution competency posture, however, may be different because an inmate who has been sentenced to death is in a less favorable position than one who has not yet been sentenced or one who has not exhausted his remedies. Thus, notwithstanding his beneficent intentions, the psychiatrist may be facilitating the inmate's execution.

Id. A board of the American Psychological Association has also expressed reservations about routine participation by psychologists in *Ford* certifications. *See* MELTON ET AL., *supra* note 319, at 183.

383. Bonnie, *supra* note 324, 75–90.

384. *Id.* at 79 (emphasis added); *accord* Salguero, *supra* note 345, at 175–77; Mossman, *Execution Competency*, *supra* note 113, at 38–39.

including placement and parole evaluations.[385] Ultimately, his defense of competency-to-be-executed evaluations collapses into a Forensicist argument.[386]

In addition to invoking role-based distinctions discussed below in connection with the "Forensicist" argument,[387] or "Relief of Suffering" arguments,[388] some commentators also rely on core-to-periphery attenuation reasoning to recognize an ethical distinction between capital evaluations and treatment to restore *Ford* competency. Drawing on the criminal law's concept of "but for" causation, Salguero asserts that "in the treatment phase, the moral culpability of the physician is so clear and direct that it is justifiable to draw a line and recognize the physician's ethical objections."[389] Even Bonnie, who ultimately relies both on Forensicist and "Relief of Suffering" arguments, makes a point of stating that in capital evaluations—presumably unlike treatment to restore *Ford* competency—the decision that condemns the prisoner is "to be made by someone else."[390]

Core-to-periphery reasoning to support line-drawing in the capital context evidences moral disengagement by obscuring personal causal agency. As the professional comes closer to the execution's core functions, it becomes more difficult to maintain that his or her role is not causally related to the prisoner's death. The mechanism of responsibility diffusion is manifest in the frequent distinction between "direct" and "indirect" causation. Thus, the more removed from the moment of killing that the professional remains—whether simply as a matter simply of temporal sequence, physical proximity, or of impact on the proceeding's outcome—the easier it is for the professional to regard himself or herself as only one of a host of actors and not as a causal agent in the prisoner's death. Conversely, the closer the connection the greater the difficulty in denying causal agency and hence the greater the anxiety produced by dissonance between the professional's ethical opposition to killing and his or her participation in a process with that very aim. As noted above, diffusion of responsibility is a hallmark of the capital process and attenuation is an important means to deploy that mechanism.[391] It is doubtful that capital

385. Bonnie, *supra* note 324, at 79–80.

386. Refer to note 405 *infra* and accompanying text.

387. Refer to Part IV.D *infra*.

388. Refer to Part IV.E *infra*.

389. Salguero, *supra* note 345, at 177.

390. Bonnie, *supra* note 324, at 80.

391. Refer to Part II.A.2 *supra* (explaining how diffusion of responsibility obscures causal relationships).

punishment could exist in contemporary America without a means to spread its moral weight.

The allure of responsibility diffusion and other mechanisms of moral disengagement in the capital context can also be seen in their re-emergence in both Bonnie and Appelbaum's rejection of the ultimate ethical significance of core-to-periphery distinctions between pre- and postsentence capital evaluations. Bonnie points out that "[w]hat seems to differentiate the two contexts is the *immediacy* of the link between the evaluator's opinion and the decision whether the person being evaluated will live or die. . . . The emotional impact of this contextual difference cannot be doubted, but I do not see its ethical significance."[392] In addition to rejecting the ethical significance of this timing difference, Bonnie further argues that "outcome-effect" has no ethical force.[393] Appelbaum points out that "heighten[ed] ethical concerns" in this area "may simply be a case of being closer to the consequences of one's actions."[394]

Finally, the internal logical weakness of attenuation arguments suggests that their popularity derives more from their psychological function of obscuring causal agency than from their intrinsic persuasiveness.[395] For one thing, it seems contradictory to argue in one breath, as some commentators do in the "Needs of the Justice System" position, that mental health professionals play such an important role in the proper functioning of the capital punishment system that their absence would frustrate

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392. Bonnie, *supra* note 324, at 80.

393. *Id.* This point assumes, for the sake of argument, that in some cases a *Ford* evaluation has more impact than a presentence evaluation. In fact, Bonnie argues that the reverse is probably true. *See id.* at 80–81. The postsentence evaluation alters the outcome only by delaying, through a finding of incompetence, a sentence that has already been rendered, while the presentence evaluation can increase the chances of receiving a death sentence not yet determined. *Id.* Bonnie extends this position to restoration-of-competency evaluations, which he first intuited might be ethically distinguishable because of its outcome-determinative basis. His subsequent reconsideration of that attenuation-based position relies in part on the "Needs of the Justice System" argument. *See id.* at 81–82 n.43.

394. Appelbaum, *The Parable*, *supra* note 238, at 257.

395. To be sure, "proximate cause" and "remoteness" are venerable legal concepts. William Prosser's eloquent argument in their favor as preferable to the conclusory notion of "duty" is a classic. *See* William L. Prosser, *Palsgraf Revisited*, 52 MICH. L. REV. 1 (1953). But the best that negligence law has been able to do in that connection is attempt to sort out the reasonable from "the freakish and the fantastic." *Id.* at 27. Although executions are rare and occur, if at all, years after capital sentencing, they are not, again to quote Prosser, "too cockeyed and far-fetched" an outcome of a capital proceeding. *Id.* They are the state's asserted goal in the enterprise. It therefore hardly seems apt to borrow the analogy of proximate causation from accident law to address the moral implications of deliberate participation in an enterprise, the asserted purpose of which is to produce the problematic outcome.

the enterprise, while asserting in the next breath that much of what those professionals do is, at best, so peripheral to the final event that no ethical responsibility attaches.

For another thing, taken to their logical extreme, core-to-periphery arguments and periphery-to-core arguments (which seem at first glance to be two ways of talking about the same thing) are on a collision course with each other. Start with core-to-periphery reasoning: The ethical problem at the core derives from the norm of nonmaleficence. It is unethical for a physician to directly participate in an execution because it is unethical for physicians to inflict harm. But as Appelbaum and others have aptly noted, that ethical conflict arises in all phases of criminal forensic work. Thus, walking the application of nonmaleficence from the core to the periphery would potentially foreclose most, if not all, forensic work. If we turn around from this point—the proves-too-much point—and walk the argument back in, there is really not much as a logical matter to prevent one from taking it all the way to the core. If nonmaleficence and care are ethics of convenience rather than of professional identity, as is implied by the "proves-too-much" point, it is difficult to see why they may not be compromised for the inconvenience they cause at the core no less readily than at the periphery—especially if such reasoning is combined with the "Needs of the Justice System" rationale. *Singleton* and the Maturana episode demonstrate how close to the core the pressure for compromise can be felt.[396] Yet if the nonmaleficence norm means what it says at the core, it is hard to see why it does not also mean something at the periphery. There seems to be no self-evident stopping point in either direction. Thus, both core-to-periphery and periphery-to-core reasoning prove too much and consequently prove too little.

D. Forensicist

It took Paul Appelbaum's insight in *The Parable of the Forensic Psychiatrist* to point the way out of this hall of mirrors.[397] His resolution to the conundrum of when and how much to apply harm-avoidance and beneficence norms in forensic contexts, including capital punishment, was to propose that they are simply the wrong norms.[398] Facilitative participation by psychiatrists in the capital punishment process in particular and the criminal justice process in general, he reasoned, does not

396. Refer to Part III.A *supra* (discussing *Singleton* and the Maturana proceeding).

397. *See* Appelbaum, *The Parable*, *supra* note 238.

398. *Id.* at 250–51 (suggesting that ethical principles guiding forensic psychiatrists are necessarily different from those followed by their clinical colleagues).

violate those norms because they do not apply in that context.[399] The "Forensicist" argument is like winning one's case on jurisdictional grounds rather than having to defend on the merits.

Appelbaum argued that beneficence and harm-avoidance become "obligatory, primary goals for physicians" only in the context of a doctor-patient relationship directed toward healing.[400] "[T]hey do not attain primacy for the forensic psychiatrist" because the function of that role "is not healing, but evaluation for the purpose of testimony in court to advance the general interests of justice."[401] He responded to the objection that abandonment by physicians of their core values would be unacceptable by pointing out that "the forensic psychiatrist in truth does not act as a physician . . . [i]f the essence of the physician's role is to promote healing and/or to relieve suffering, it is apparent that the forensic psychiatrist operates outside the scope of that role."[402] He further suggested that

> [p]erhaps it would be better if we even used a different term to denote the role played by the evaluator who applies knowledge of psychiatric diagnosis and psychological functioning to assist the legal system in reaching legally useful conclusions. Were we to call such a person a "forensicist," or some similar appellation, it might more easily be apparent that a different—nonmedical—role with its own ethical values is involved.[403]

Appelbaum's Forensicist position is the dominant model today in the literature on the ethics of mental health professionals' participation in the capital punishment process. It underlies the CEJA's definition of "participant." When the CEJA states that guilt- and penalty-phase evaluation and testimony "do not constitute physician participation in execution," it is tacitly embracing the Forensicist concept.[404] As mentioned above, Bonnie ultimately fell back on the concept in discounting attenuation-based distinctions between capital and noncapital evaluations and between capital sentencing and execution competency evaluations: "[A] clinician's role as an *evaluator* (for the legal system or any third party) is independent of, and not

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399. *Id.* at 255, 258 (concluding that "psychiatrists operate outside the medical framework when they enter the forensic realm, and the ethical principles by which their behavior is justified are simply not the same").

400. *Id.* at 251.

401. *Id.* at 252.

402. *Id.*

403. *Id.*

404. CEJA/AMA, CAPITAL PUNISHMENT, *supra* note 320.

inherently incompatible with, the clinician's healing or therapeutic role as long as the roles are kept distinct."[405] Other commentators, while perhaps drawing the line at different points, similarly rely on the basic Forensicist premise.[406]

It is easy to see why this model has caught on. It seems to slice through the tangle created by other models, such as attenuation reasoning. While those models struggle to assert that the norms of beneficence and harm-avoidance have not been violated, the Forensicist position clearly states that those norms do not even apply. One feels relieved to finally have the roles candidly clarified. Appelbaum's breakthrough appears to transform the sense of compromise latent in efforts to reconcile forensic work with an ethic of care into a triumph of candor: "'To pretend that the usual doctor-patient relationship is in effect during a forensic examination is patently dishonest and unethical.'"[407] Instead of laboring under ethical commitments they cannot possibly meet, Forensicists are directed to a more appropriate, albeit incompletely developed, set of ethical standards. For the Forensicist, beneficence and nonmaleficence are replaced by objectivity, veracity, and competence as the core ethical commitments.[408]

The Forensicist model sounds right. The contemporary conception of professional duties locates their source primarily in the professional-client relationship.[409] Under this view, if that

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405. Bonnie, *supra* note 324, at 79 (emphasis added).

406. *E.g.*, Salguero, *supra* note 345, at 177 (stating that "in performing an evaluation, the role of the physician as a healer is not necessarily implicated"); *see also* Radelet & Barnard, *supra* note 238, at 47–48 (leaning toward the forensicist position by relying on procedural protections to reduce the ethical burden on psychiatrists in *Ford* evaluations); Ward, *supra* note 239, at 86–87 (same).

407. Salguero, *supra* note 345, at 177 (quoting Jonas R. Rappeport, *Ethics and Forensic Psychiatry*, *in* PSYCHIATRIC ETHICS (S. Block & P. Chodoff eds. 1981).

408. Appelbaum, *The Parable*, *supra* note 238, at 251–53. In 1991, Division 41 of the American Psychological Association and the American Psychology-Law Society published *Ethical Guidelines for Forensic Psychologists*. Those guidelines "do not represent an official statement of the American Psychological Association." Committee on Ethical Guidelines for Forensic Psychologists, *Specialty Guidelines for Forensic Psychologists*, 15 L. & HUM. BEHAV. 656 (1991). The guidelines are currently undergoing revision. The 1992 American Psychological Association's Code of Conduct contains a brief section on Forensic Activities (section 7). *See* Gary I. Perrin & Bruce D. Sales, *Forensic Standards in the American Psychological Association's New Ethics Code*, 25 PROF. PSYCHOL: RES. & PRAC. 376 (1994) (critiquing the Code's treatment of forensic practices). The 2002 Code of Conduct does not contain a discrete section applicable to forensic psychology, but does briefly address some forensic issues at various places throughout the Code. *See, e.g.*, AM. PSYCHOL. ASS'N, ETHICAL PRINCIPLES OF PSYCHOLOGISTS AND CODE OF CONDUCT, Ethical Standards 3.07, 3.10, 3.11, 9.01, 9.02, 9.03, 9.04 (2002).

409. This conception is what made the extension of legal obligations to persons outside that relationship, as in *Tarasoff v. Regents of the University of California*, 551 P.2d 334, 343–46 (Cal. 1976), so controversial. *Tarasoff* is the exception that illustrates

relationship never arises, its corresponding ethical burdens never accrue. Recognition of a distinct forensic role for physicians can be found as early as 1846 in the AMA's First Code of Medical Ethics.[410] Leading contemporary works on forensic evaluations are careful to explain the distinctions between therapeutic and forensic evaluations, including a focus and scope determined by legal requirements rather than by concern for the individual's psychological well-being, diminished respect for the individual's autonomy, or the absence of a therapeutic "helping" role.[411]

The Forensicist model, at first glance, seems to offer a supportable basis for line drawing in the capital context. Evaluations, including *Ford* evaluations, are done by forensicists and therefore do not conflict with the values of beneficence and nonmaleficence.[412] Treatment, on the other hand, is provided by "healers" and accordingly does implicate those concerns.[413] With respect to capital-related treatment of prisoners declared incompetent to be executed, the literature largely seeks to reconcile the clinician's participation with the obligations of a duty of care by focusing either on the clinician's intent (under the CEJA Current Opinion) or on patient autonomy (as discussed in the ensuing section).[414]

But all of this may be too good to be true. First, it is doubtful whether the Forensicist model can actually live up to its several promises. As we have seen with the previously discussed

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the main point.

410. *See* AM. MED. ASS'N, FIRST CODE OF MEDICAL ETHICS (1846), *reprinted in* ETHICS IN MEDICINE, *supra* note 246, at 26, 27 ("With them rests, also, the solemn duty of furnishing accurate medical testimony in all cases of criminal accusation of violence, by which health is endangered and life destroyed, and in those other numerous ones involving the question of mental sanity and of moral and legal responsibility.").

411. *See, e.g.*, Greenberg & Shuman, *supra* note 233, at 53 (explaining that while "[t]he therapist is a care provider and usually supportive, accepting, and empathic; the forensic evaluator is an assessor and usually neutral, objective, and detached as to the forensic issues"); Alan M. Goldstein, *Overview of Forensic Psychology*, *in* 11 HANDBOOK OF PSYCHOLOGY: FORENSIC PSYCHOLOGY 3, 5 (Alan M. Goldstein ed., 2003) (observing that "in forensic assessments, the motivation [of the client] to consciously distort, deceive, or respond defensively is readily apparent" compared to nonforensic clinical evaluations).

412. *See* Appelbaum, *The Parable*, *supra* note 238, at 251–53.

413. *Id.* at 251.

414. CEJA/AMA, CAPITAL PUNISHMENT, *supra* note 320. The CEJA draws the line at the physician's intentions. If the purpose of treatment is to restore competence, the CEJA states that a physician should not proceed unless a commutation order is in place. *Id.* If, on the other hand, the purpose is to mitigate "extreme suffering as a result of psychosis or any other illness," the physician may proceed. *Id.* Physicians may also, to the extent necessary to relieve acute suffering of a prisoner awaiting execution, administer a sedative at the prisoner's express request. *Id.* Refer to notes 341–42 *supra* and accompanying text (discussing treatment issues).

approaches, those practical shortcomings highlight the psychological function that the model serves.

Whether the Forensicist position really works on its own terms is open to question. For one thing, it is not clear that the Forensicist position completely avoids the pitfalls of attenuation reasoning. Even if one assumes that it offers a workable basis for distinguishing treatment from evaluation in the capital context (a point to which I shall return), it does not provide a compelling distinction between capital evaluations, which most of its adherents condone, and direct participation in actual executions, which almost no one regards as ethical.[415] Both tasks draw on the professional's clinical skills, and neither unavoidably implies a doctor-patient relationship. To carry the point to its logical conclusion, if application of the label "Forensicist" and the disavowal of a doctor-patient relationship—the ethics-by-disclaimer approach—are sufficient to liberate the physician from obligations of *humanitas*, then there would appear to be little limit to the tasks the physician could perform for the state.[416]

This observation brings us back to the conceptual problems described above in connection with the "Personal Morality" and "Needs of the Justice System" approaches. To Foot, the conjunction of these arguments proves too much. It would "remove all objection to even the most direct participation by doctors in the process of execution. The courts could ask them to kill the condemned because in such a role they would be 'forensicists.'"[417] Efforts by supporters of the Forensicist model to draw the line at direct participation in executions have largely resorted to core-to-periphery arguments, the problems of which are discussed above and which the Forensicist position itself sought to avoid.[418]

If a simple disclaimer of role is sufficient to detach the healer's ethic from the deployment of clinical skills, it is not clear that even the purported distinction between evaluation and

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415. For example, refer to text accompanying notes 321–22 *supra*.

416. Refer to notes 362–64 *supra* and accompanying text (providing torture and slavery examples).

417. Foot, *supra* note 235, at 211. Foot distinguishes the example of Army doctors who examine and treat soldiers so that they can return to battle: "Army doctors do not aim at the death of the recruits and soldiers whom they examine and treat, *nor are they working for people who do have this as even as a conditional end*." *Id.* Freedman and Halpern concur in this slippery-slope critique. *See* Freedman & Halpern, *supra* note 238, at 181–85. As Foot points out, role-based distinctions also include the conflicts imposed by the *Tarasoff* duty to warn, but she dismisses such duties as ancillary to the professionals' *primary* responsibility as "healer." Foot, *supra* note 235, at 209–10.

418. Refer to notes 378–91 *supra* and accompanying text.

treatment survives. So long as the Forensicist makes it clear to the prisoner that the purpose is not to heal, administration of antipsychotic medications for the express purpose of restoring competence to be executed would seem to be an equally legitimate forensic task.

The context of treatment to restore competence is exactly where the distinction between "healer" and "forensicist" ultimately breaks down. The health care professional in that context is clearly employing *clinical* skills in the service of the state's ultimate harm-infliction agenda. The amicus brief of the American Psychiatric Association and the American Academy of Psychiatry and the Law ("APA/AAPL Brief") in *Sell v. United States* strongly supported involuntary administration of antipsychotic medication to restore competence to stand trial.[419] Part of the APA/AAPL Brief was devoted to educating the Court about the medical benefits of antipsychotic medication, especially the atypicals, as the treatment of choice for psychosis,[420] but a portion also advocated the state's interest in promptly bringing the defendant to trial.[421]

The APA/AAPL Brief's point of departure in *Sell* for arguing the "weighty" interests "supporting medication" to restore competence to stand trial was identical to that of the Eighth Circuit in *Singleton* in upholding involuntary medication to restore competence to be executed—"the 'compelling interest in finding, convicting, and punishing those who violate the law.'"[422] The loop between the "healer" and "forensicist" roles was closed in *Singleton* when the court, neglecting to even mention the potential ethical conflict for the health professional, ultimately resorted to *Harper* grounds—and its arguable justification in the "patient's" need for "treatment"—to rebut Singleton's *Perry* argument.[423] Once the distinction between short-term and ultimate effect is accepted for purposes of analyzing the issue of medical appropriateness, thus insulating the health professional from responsibility for the foreseeable and intended outcome, then the arguments set forth in the APA/AAPL Brief would seem to apply with equal force in the context of competence to be executed as in *Singleton*. The notion of "treatment," invoked in

419. APA/AAPL Brief, *supra* note 352, at 11–13.

420. *Id.* at 13–22.

421. *Id.* at 22–26.

422. *Id.* at 22 (quoting Moran v. Burbine, 475 U.S. 412, 426 (1986)); *see also* Singleton v. Norris, 319 F.3d 1018, 1025 (8th Cir.) (stating that "the government has an essential interest in carrying out a lawfully imposed sentence"), *cert. denied*, 124 S. Ct. 74 (2003).

423. *Singleton*, 319 F.3d at 1025–27.

Singleton to legitimize involuntary medication that has the effect of restoring *Ford* competence, thereby becomes not only a forensic function in fact, but also a conceptual cover in law.

A further, practical problem with the Forensicist position is that its own ethical standards of objectivity, veracity, and competence are under constant threat from the adversarial environment in which Forensicists must operate, and that strain is especially evident in the capital punishment context. The difficulties of resisting the pull of advocacy and maintaining objectivity are well documented.[424] "The group activity of a death penalty case creates a particularly fertile ground for this overidentification."[425] Some of the most notorious examples of failures in this regard can be found in capital cases.[426] Although some concern about the problem of creeping advocacy has been that Forensicists will abuse their position on behalf of defendants in order to thwart the state's efforts to impose the death penalty, it is clear that the pressure toward bias accrues on behalf of the state as well.

These threats to the Forensicist's own norms are especially evident in a common presentencing forensic task: assessment of the risk of future dangerousness. Such assessment is always an uncertain enterprise and it is only recently that the literature has begun to reflect confidence in mental health professionals' ability to do so with even marginal gains in accuracy.[427] But that ability remains modest at best, and increases in accuracy have been achieved partly through the expansion of the construct of

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424. *See generally* Richard Rogers, *Ethical Dilemmas in Forensic Practice*, 5 BEHAV. SCI. & L. 149 (1987) (describing the problems of agency, forensic identification, and attitudes towards criminal defendants that emerge in forensic practice).

425. Cunningham & Goldstein, *supra* note 92, at 417.

426. One of the best-known is Dr. James Grigson, dubbed "Dr. Death" for his extreme forensic advocacy in capital cases. Grigson was one of the forensic experts who testified in *Barefoot v. Estelle*, 463 U.S. 880 (1983). He testified that, whether Barefoot was in society at large or kept in prison, there was a "'*one hundred percent and absolute*'" chance that he would commit future violent acts and present a continuing threat to society. *Id.* at 919 (Blackmun, J., dissenting).

427. *See generally* James Bonta et al., *The Prediction of Criminal and Violent Recidivism Among Mentally Disordered Offenders: A Meta-Analysis*, 123 PSYCHOL. BULL. 123 (1998); Randy Borum, *Improving the Clinical Practice of Violence Risk Assessment*, 51 AM. PSYCHOLOGIST 945 (1996); Thomas Grisso & Alan J. Tomkins, *Communicating Violence Risk Assessments*, 51 AM. PSYCHOLOGIST 928 (1996); Thomas R. Litwack, *Actuarial Versus Clinical Assessment of Dangerousness*, 7 PSYCHOL. PUB. POL'Y & L. 409 (2001); John Monahan, *Mental Disorder and Violent Behavior: Perceptions and Evidence*, 47 AM. PSYCHOLOGIST 511 (1992); Randy K. Otto, *On the Ability of Mental Health Professionals to "Predict Dangerousness": A Commentary on Interpretations of the "Dangerousness" Literature*, 18 L. & PSYCHOLOGY REV. 43 (1994).

"dangerousness"—which has had the accuracy-boosting effect of increasing the base rate of the predicted behavior.[428]

Commentators have long been uneasy about mental health professionals' forensic role in this context. Some have argued that "there is good reason to conclude that psychologists and psychiatrists act unethically when they render predictions of dangerousness that provide a legal basis for restricting another person's interest in life or liberty."[429] Others, such as Appelbaum and Grisso, have proposed that risk assessment is ethical if stated in sufficiently qualified, probabilistic terms.[430]

Even Appelbaum and Grisso agree, however, that the ethics of predicting future dangerousness in the capital sentencing context "indeed are questionable."[431] Considering research suggesting the dominant role of future dangerousness as a consideration in capital jury deliberations, such caution is well-founded.[432] Jury deliberations may be heavily influenced by testimony from Forensicists, which may lack an adequate empirical basis and may be prone to numerous error-producing methodologies, including inadequate reliance on base rates, failure to consider the influence of situational factors, clinician susceptibility to illusory correlation, failure to specify the

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428. *See* Otto, *supra* note 427, at 52–53 (stating that "adoption of broader definitions of violence results in higher accuracy rates").

429. Charles Patrick Ewing, *Preventive Detention and Execution: The Constitutionality of Punishing Future Crimes*, 15 L. & HUM. BEHAV. 139, 162 (1991).

430. *See* Thomas Grisso & Paul S. Appelbaum, *Is It Unethical to Offer Predictions of Future Violence?*, 16 L. & HUM. BEHAV. 621, 624, 628 (1992); *see also* John Monahan & Henry J. Steadman, *Violent Storms and Violent People: How Meteorology Can Inform Risk Communication in Mental Health Law*, 51 AM. PSYCHOLOGIST 931 (1996) (suggesting alternative models of communicating risk assessment); Robert F. Schopp, *Communicating Risk Assessments: Accuracy, Efficacy, and Responsibility*, 51 AM. PSYCHOLOGIST 939 (1996).

431. Grisso & Appelbaum, *supra* note 430, at 629. Grisso and Appelbaum summarize the problems as follows:

> [M]ental health professionals have testified routinely about the likelihood of future violence when there were no data about comparable groups of subjects, or when such data began to be available, often in disgard of them. Moreover, such testimony often has been based on evaluation procedures or methods that manifest little regard for a reliable description of the defendant's characteristics. Such is the case when predictions are offered on the basis of information provided in a hypothetical question posed by the prosecutor, typically without the expert having had an opportunity to examine the defendant or to become acquainted with documentary evidence relevant to the defendant's history.

Id. at 628–29 (citations omitted).

432. *See* Joseph L. Hoffman, *How American Juries Decide Death Penalty Cases: The Capital Jury Project*, *in* CURRENT CONTROVERSIES, *supra* note 16, at 336 ("[O]ne of the most important issues for jurors—more important than the defendant's criminal history, background and upbringing, and remorse—is whether the defendant, if he is allowed to live, is likely to pose a danger to society in the future.").

severity of violence being estimated, overreliance on clinical interviews, misuse of personality testing, drawing faulty implications from diagnoses of antisocial personality disorder and psychopathy, ignoring the effects of aging, reliance on insufficient data, and failure to express the risk estimate in probabilistic terms.[433]

Reliance on hypothetical questions in capital sentencing proceedings is another problem. For example, the mental health professional in such cases often has insufficient unbiased information on which to base an opinion. No differential diagnosis can be pursued because follow-up inquiry is precluded.[434] Appelbaum thus concludes that hypothetical opinions ought not to be admissible as the sole basis for psychiatric opinion in capital cases, but may be admissible, for example, to clarify the basis for the expert's opinion.[435] The mental health professions agree that opinions ought to be based on examination of the subject.[436]

Beyond the particular issue of hypothetical questions is the fundamental question of predictive validity. The evidence indicates that subsequent violence by capital convicts tends to be overpredicted. Longitudinal studies of capital convicts whose sentences were commuted to life in the wake of *Furman* show low rates of recidivism and gross overprediction of violence, even by capital convicts for whom the jury had specifically found future

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433. *See* Mark D. Cunningham & Thomas J. Reidy, *Don't Confuse Me with the Facts: Common Errors in Violence Risk Assessment at Capital Sentencing*, 26 CRIM. JUST. & BEHAV. 20, 23–35 (1999); *see also* Mark D. Cunningham & Thomas J. Reidy, *Integrating Base Rate Data in Violence Risk Assessment at Capital Sentencing*, 16 BEHAV. SCI. & L. 71 (1998).

434. Further, available information

> is likely to be biased by the advocacy needs of the side offering the question, and the intangible, but very real, value of "experiencing" the subject as a person is lost. Even if the courts would like to accept such testimony in some cases as "the best available," the level of certainty morally, as well as constitutionally, required in capital sentencing cases demands a rejection of such testimony in those circumstances.

Paul S. Appelbaum, *Hypotheticals, Psychiatric Testimony, and the Death Sentence*, 12 BULL. AM. ACAD. PSYCHIATRY & L. 169, 175 (1984).

435. *Id.* at 175–76.

436. APA, *Principles of Medical Ethics*, *supra* note 307, at 214 ("[I]t is unethical for a psychiatrist to offer a professional opinion unless [he or she] has conducted an examination."); AM. PSYCHOL. ASS'N, ETHICAL PRINCIPLES OF PSYCHOLOGIST AND CODE OF CONDUCT, Ethical Standard 9.01(b) (2002) ("[P]sychologists provide opinions of the psychological characteristics of individuals only after they have conducted an examination of the individuals adequate to support their statements or conclusions.").

dangerousness.[437] A number of studies show that jurors greatly overestimate the risk of future violence by capital murderers.[438]

Whatever the conceptual and practical strains on fidelity to its own normative precepts, the moral disengagement implications of the Forensicist position are profound. Through the simple expedient of euphemistic relabeling, the Forensicist position repudiates the very essence of the physician's constitutive humanistic ethic and thereby forfeits the physician's professional identity. Appelbaum regarded this forfeiture as unremarkable and equated it to a physician's acting in the same economically self-interested manner as would anyone else in, for example, "[n]egotiating the sale of a house."[439]

This equation of mundane circumstances, in which no one would reasonably expect obligations of *humanitas* to arise—that is, circumstances in which one's status as a physician is purely coincidental and utterly irrelevant—with the explicit employment of one's professional skill and training in a process, the express purpose of which is the deliberate extinction of human life, illustrates the extent to which moral disengagement attends the Forensicist position. Its casual assumption that one can "apply that expertise" and yet not "practice psychiatry"[440] effectively severs the identity between the professional, the mantle of *humanitas*, and moral responsibility for which the professional's expertise is used.

This dissociation perfectly instantiates moral disengagement. The professional norms of beneficence and harm-avoidance can be deactivated as necessary when professional behavior—the use of the expertise usually associated with the professional role otherwise identified with those norms—conflicts with the limitations those norms impose.

The logic of this position is hermetic. As Appelbaum put it, "[i]f the essence of the physician's role is to promote healing and/or to relieve suffering, it is apparent that the forensic psychiatrist operates outside the scope of that role."[441] In other words, because it would transgress moral standards for a

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437. James W. Marquart & Jonathan R. Sorensen, *A National Study of the* Furman-*Commuted Inmates: Assessing the Threat to Society from Capital Offenders*, 23 LOY. L.A. L. Rev. 5 (1989); James W. Marquart et al., *Gazing into the Crystal Ball: Can Juries Accurately Predict Dangerousness in Capital Cases?*, 23 L. & SOC'Y REV. 449 (1989).

438. *See, e.g.*, Jonathan R. Sorensen & Rocky L. Pilgrim, *An Actuarial Risk Assessment of Violence Posed by Capital Murder Defendants*, 90 J. CRIM. L. & CRIMINOLOGY 1251 (2000).

439. Appelbaum, *The Parable*, *supra* note 238, at 252.

440. *Id.*

441. *Id.*

physician to use his or her expertise for forensic purposes, the fact that a physician actually used his or her expertise for a forensic purpose demonstrates that he or she was not then acting as a physician. Taking this reasoning to its logical extreme, as Foot pointed out,[442] the Forensicist position would allow the physician to administer lethal injections on Tuesdays and Thursdays and to deliver babies on Mondays, Wednesdays, and Fridays. Moral obligations are activated by cognitive construal (the formal definition of role and relationship) rather than by actual behavior (the application of professional expertise to a real person). Indeed, under the labeling logic of the Forensicist position, those experts who apply their expertise in violation of the norm of objectivity, as at least some surely do, arguably commit no ethical violation but merely assume yet another identity, which we perhaps should label "Forensic-Advocate" to avoid confusion.

This occasion-dependent, transactional perspective on professional ethics is at odds with the constitutive view advanced by Scribonius two millennia ago.[443] Appelbaum's *Parable* identifies the shift in professional identity from a physician to something else, but elides the central point that consequences attach to that shift. In Scribonius's view, a physician who helps to kill enemies of the state and a soldier who provides them aid and comfort do not merely swap uniforms.[444] They both compromise fundamental aspects of their previously held identities.[445] Those norms are thus not transactionally dependent but constitutive. By defining the uses to which one's expertise may be put, they describe the person one has become by entering the profession. As described above, this view finds modern expression in the World Medical Association's Declaration of Geneva, under which members "solemnly pledge [themselves] to consecrate [their lives] to the service of humanity," and promise to "maintain the utmost respect for human life," and to refrain from using their "medical knowledge contrary to the laws of humanity."[446]

To be sure, as mentioned above, Forensicists do not cast off all responsibility and accountability, nor do they become mindless automatons. To the contrary, the obligations of

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442. *See* Foot, *supra* note 235, at 210–12 (arguing that Appelbaum's theory of conceptually distinguishing physician roles as healers and forensicists fails to resolve their inherent conflicts).

443. Edelstein, *supra* note 273, at 44–45.

444. *Id.*

445. *Id.*

446. Refer to note 298 *supra*.

objectivity, veracity, and competence require that they be "conscientious and self-directed in the performance of their duties."[447] What moral disengagement means in this kind of context, Bandura has explained, is a resolution of the conflict between two levels of responsibility: "duty to one's superiors and accountability for the effects of one's actions."[448] The Forensicist position in effect substitutes obedience to the demands of the system (objectivity, veracity, and competence) for ultimate humanitarian accountability for the beneficial or harmful consequences of one's actions (*humanitas*). The result is not irresponsibility, but instead displacement of the origin and content of obligation. Care is replaced with obedience. As Bandura pointed out, "[i]t requires a strong sense of responsibility to be a good functionary."[449] This realignment of commitments—from care to obedience—means that the ordinary processes of moral control are now at the command of authority: "Self-sanctions operate most efficiently in the service of authority when followers assume personal responsibility for being dutiful executors while relinquishing personal responsibility for the harm caused by their behavior."[450]

When the Forensicist applies his or her skill to facilitate capital punishment, and thereby necessarily deactivates the obligation of *humanitas*, the result is a bilateral dehumanization. Just as the forensic professional is no longer a "physician" whose professional identity is defined by the "solemn pledge" of beneficence and harm-avoidance, the *other* person in the equation is no longer a "patient" to whom such obligations are owed.[451] A "physician" is a healer, a "patient" literally is "one who suffers." The Forensicist metamorphosis produces both a functionary serving the needs of the state and an object of forensic attention who is to be evaluated and perhaps even manipulated, but whose suffering is of no special moral relevance to the forensic task at hand.

Perhaps the most striking aspect of the Forensicist position, which again is the dominant model today, is the blitheness with which its proponents allow all of this to happen.[452] Doctors are

447. Bandura, *Moral Thought and Action*, *supra* note 37, at 83.

448. *Id.* at 83–84.

449. *Id.* at 83.

450. Bandura, *Mechanisms of Moral Disengagement*, *supra* note 31, at 175.

451. As Melton trenchantly put it: "*Not all clients should be perceived as 'patients.'*" MELTON ET AL., *supra* note 319, at 43.

452. *But see* Jack C. Schoenholtz, *The "Legal" Abuse of Physicians in Deaths in the United States: The Erosion of Ethics and Morality in Medicine*, 42 WAYNE L. REV. 1505, 1564–70 (1996) (criticizing the Forensicist position).

regarded as special people, at least in the abstract, precisely because of the unique combination of expertise and lofty ideals that constitute their professional identity. One assumes that they do not casually take on the obligations inherent in the healer's role, but instead shoulder those responsibilities with an appropriate mixture of pride and gravity. One might therefore reasonably expect those values to be jealously guarded and their compromise to be an occasion for pause, if not remorse. That those aspirations can be shelved so readily, and on so transparently inapposite a basis as Appelbaum's analogy to a physician selling a house, evidences the potency of the psychological pressure for moral deactivation when doctors venture into the ethically perilous realm of capital punishment. It is probably no accident that it was in the context of addressing the question of psychiatric participation in capital punishment itself that Appelbaum originally articulated the Forensicist position. That position, as I have said, is moral disengagement *par excellence*: Doctors' participation in the extreme harm-inflicting enterprise of capital punishment occasions so little remorse because the Forensicist position provides the ready means to avoid a collision between behavior and countervailing a priori ethical commitments.

E. Relief of Suffering

Proponents of the Forensicist position, and some attenuation advocates as well, assert a distinction between "evaluation," which is said to be an appropriate Forensicist task carrying no obligations of *humanitas*, and "treatment," which is what healers do.[453] This distinction is of enormous ethical significance in the post-*Ford* capital context because of the potentially fatal consequences of successful treatment of the condition that produces incompetence to be executed.[454] For some commentators, this risk is so serious, and the link between the doctors' actions and the killing of the prisoner so proximate, that such treatment is presumptively unethical—at least absent a commutation order.[455] Developments like those seen in *Singleton* suggest that this conceptual boundary is breaking down.

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453. *See generally* Appelbaum, *The Parable*, *supra* note 238. *But cf.* Mossman, *Execution Competency*, *supra* note 113, at 10, 32–33, 84–85 (criticizing this distinction and suggesting that evaluation is a subsidiary of treatment).

454. *See* Mossman, *Execution Competency*, *supra* note 113, at 32–33 (identifying the essential dilemma for the state-employed psychiatrist: "[W]here refusing to treat incompetent condemnees could increase their suffering, treating them could lead to their death.").

455. *E.g.*, Charles Patrick Ewing, *Diagnosing and Treating "Insanity" on Death Row:*

Others have struggled with the awful dilemma created by a system that, in the absence of commutation, forces doctors to choose between refusing to provide otherwise available treatment (thereby relinquishing the norm of beneficence) and agreeing to help remove one of the last obstacles to killing (thereby threatening the norm of nonmaleficence). This dilemma is real and of substantial proportions. While *Ford* obviously creates a powerful incentive for malingering, there is good reason to believe that the incidence of genuine serious mental illness on death row is high, and it is likely that conditions on death row are themselves pathogenic.[456]

There are two main perspectives on capital-related treatment. One is the CEJA approach, which focuses on the physician's intent. It prohibits physicians from providing treatment "for the purpose of restoring competence unless a commutation order is issued before treatment begins."[457] The CEJA would allow treatment in the absence of a commutation order "[i]f the incompetent prisoner is undergoing extreme suffering as a result of psychosis or any other illness," provided that the purpose of the medical intervention is "to mitigate the level of suffering."[458] This is essentially the narrow course that Dr. Jerry Dennis attempted to steer in the case of Claude Maturana.[459] His solution to the dilemma was to attempt to titrate treatment: provide enough to mitigate suffering (by reducing agitation), but not enough to restore competence.[460] Other commentators take a similar position in urging mental health professionals to provide types of treatments that might offer some relief but have a low likelihood of restoring competence to be executed (such as psychotherapy or counseling), but avoid rendering treatments (such as administration of antipsychotics) that have a higher, more direct likelihood of restoring competence to be executed.[461]

The other approach, described by Bonnie, regards the matter as one of patient autonomy.[462] He rejected the "never treat"

Legal and Ethical Perspectives, 5 BEHAV. SCI. & L. 175, 180–85 (1987); Salguero, *supra* note 345, at 177–78.

456. *See* Byers, *supra* note 110, at 366–71 (describing the potential pathogenic impact of death row); *see also* Knight v. Florida, 528 U.S. 990, 993 (1999) (Breyer, J., dissenting from denial of certiorari) (providing a judicial recognition of this problem); People v. Simms, 736 N.E.2d 1092, 1143–45 (Ill. 2000) (Harrison, C.J., dissenting) (same).

457. CEJA/AMA, CAPITAL PUNISHMENT, *supra* note 320.

458. *Id.*

459. Refer to notes 213–23 (describing Dr. Dennis's treatment of Maturana's case).

460. Refer to text accompanying note 218 *supra*.

461. Heilbrun et al., *supra* note 11, at 601–02.

462. A third possibility—treatment for the express purpose of restoring competence

position as ethically flawed: "The question [of] whether treatment is beneficial to the prisoner, or whether it is harmful instead, should actually turn on the prisoner's own preferences, if known, not on the clinician's values."[463] Bonnie proposed the device of a "'living will' in which a condemned prisoner—contemporaneously determined to be competent—states that if he becomes incompetent while awaiting execution, he wished to be treated."[464] Bonnie reasoned that the prisoner might prefer risking "the unknown consequences of death to the known pains of psychosis, or because he prefers death to lifelong imprisonment which might follow commutation."[465] Bonnie's emphasis on the prisoner's autonomy to define what is beneficial also, in terms that call *Singleton* to mind, led him to reject the proposition that it is ever ethical for a physician to treat a prisoner over the prisoner's previously expressed objection: "Because the clinician's actions no longer have any link to the prisoner's own interests—he would be an object of treatment, not a patient—the clinician would be serving a role that is ethically indistinguishable from the physician who administers the lethal injection of barbiturates."[466]

The issue of capital-related treatment gives rise to a direct ethical dilemma. While proposed resolutions may ultimately have little practical force, they do offer some psychological cover. As Salguero has pointed out, the dilemma appears to be entirely state-created when viewed from the nonforensicist clinician's perspective.[467] The existence of capital punishment itself, together with its often pathogenic implementation, the legal rules deriving from *Ford*, and the absence of effective mechanisms for commutation of *Ford* incompetents, are all aspects of a legal system that the nonforensicist clinician can legitimately claim to have had no hand in creating. It is the concatenation of those forces that confronts the clinician with the ethically impossible choice between forsaking either beneficence or nonmaleficence. When circumstances render the option of conforming one's behavior to a priori norms unavailable, the clinician must either

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because execution itself may be in the prisoner's best interest—has been proposed by Mossman. Refer to text accompanying notes 479–81 *infra*. His view, which apparently has engendered little overt support, is discussed below. Refer to text accompanying notes 482–84 *infra*.

463. Bonnie, *supra* note 324, at 83.

464. *Id.*

465. *Id.*

466. *Id.* at 85.

467. Salguero, *supra* note 345, at 167 (attributing the dilemma's existence to state reliance on physician treatment of inmates, to which physicians are ethically bound, in pursuit of state goals that conflict with physicians' ethics).

seek the best psychological adjustment that he or she can make or suffer the pain of self-censure.

Neither the CEJA's physician's-intent/titrated-treatment approach nor Bonnie's express-consent approach is likely to prove workable as a practical matter, but either may well provide some psychological comfort. The CEJA approach gives clinicians two choices. One is to treat the *Ford*-incompetent prisoner as the clinician would any other patient under the premise that the physician's intent is solely to relieve suffering. The other alternative is to seek the narrow theoretical range between a minimally therapeutic dosage sufficient to relieve suffering but not to restore competence (or treatment types with relatively low risk of restoring competence).

The first CEJA alternative, of course, requires the physician to simply disregard the likely practical consequences of his or her actions. This familiar move, referred to as the principle of double effect, posits that moral responsibility attaches only to the intended consequence and not the unintended, but foreseeable, outcome.[468] It is usually asserted in end-of-life cases in which palliative treatment has the probable consequence of hastening death.[469] From a social cognition perspective, it reflects the self-censure buffering mechanisms of disregard or minimization of consequences as well as denial of causal agency. As explained above, moral disengagement is not so much an example of self-deception as it is "[s]elective self-exposure and distorted interpretations of events, which confirm and strengthen preexisting beliefs, reflecting biased self-persuasion, not . . . self-deception."[470] This selective self-attention does nothing to alter the underlying fact that the clinician's treatment will, absent last-minute intervention from some other quarter, have the tangible effect of removing the final remaining obstacle to the killing of the prisoner. But it does offer the possibility of cognitive reconstrual of the clinician's role to minimize the sense of responsibility for the undesired consequence. And its superficial resemblance to the usual end-of-life scenarios once again helps to further obscure the brutal fact that capital punishment involves deliberate killing of one human by others rather than the physiological inevitability of death. As discussed above, there is no easy resolution of the capital-related treatment dilemma. The

468. *See* BEAUCHAMP & CHILDRESS, *supra* note 246, at 206–07 (providing a description and criticism of this principle).

469. *Id.* (illustrating double effect with the example of a physician prescribing medication that relieves pain at the risk of hastening death).

470. Bandura, *Moral Thought and Action*, *supra* note 37, at 94–95.

CEJA's intent approach, while not really altering the underlying harsh realities of the situation, at least provides a familiar means for the clinician to mitigate his or her potential psychological distress.

The titrated-treatment alternative is likewise probably of little tangible utility but has some psychological value. There are several practical problems. First, its practical usefulness depends on the existence of a window of therapeutic effect that alleviates suffering but does not restore competence. Even if such a window actually exists in most cases, which seems unlikely, it is far from clear that available treatments permit such a finely calibrated intervention. In any event, because nonclinical factors so rigidly bracket the physician's judgment, no outcome is ethically satisfactory: The clinician who undershoots the mark fails to relieve suffering despite the availability of effective treatments; the clinician who hits the bull's eye has still fallen short of providing the usual measure of relief; and the clinician who provides that level of treatment clinically indicated in a normal treatment context has effectively handed the patient over to the executioner. Second, as Dr. Dennis discovered, once a clinician enters the arena of capital-related treatment, he or she becomes subject to the enormous pressures of the system to serve the state's purposes. Those pressures will be most acutely felt by those clinicians who are public employees. Because they are the ones most likely to confront the dilemma in the first place, such pressure will pervade capital-related treatment cases. Third, as the Maturana case also illustrates, because *Ford* competence is a legal rather than clinical threshold, there is simply no way for the clinician to exercise control over the ultimate outcome even if titration is clinically feasible.[471] The state may well have an easier time persuading a court that a treated prisoner, whose symptoms probably will have abated somewhat, has regained competence to be executed.

Despite these practical limitations, the titration alternative does offer some solace. Like the intent alternative, it provides a cognitive structure for selectively focusing attention on the immediate aspects of one's behavior—in this connection the effort to find the right therapeutic range—while discounting or disregarding other, less acceptable consequences. *Singleton*'s rationale exploits this kind of posture.[472] Under either approach, clinicians can reassure themselves that they at least tried to do

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471. Refer to notes 213–23 *supra* and accompanying text (discussing Maturana's case).

472. Refer to notes 178–202 *supra* and accompanying text (discussing *Singleton*).

the right thing in a difficult situation not of their own creation. Indeed, one might go even further: Unlike the "Personal Morality," "Needs of the Justice System," and "Forensicist" approaches, which respectively suspend, subvert, or forfeit core ethical commitments, or the "Attenuation" approach, which chases its own tail to evade them, the CEJA alternatives at least seek—however ineffectually—to preserve them.

Bonnie's "patient autonomy" version,[473] which also attempts to draw an analogy to end-of-life issues, similarly suffers from practical limitations. Unlike the CEJA approach, however, it expands the range of permissible intended outcomes to include treatment to restore *Ford* competency—so long as the prisoner has expressly and competently consented.[474] One major practical shortcoming of Bonnie's approach is that it is likely to apply in only a small fraction of cases, if any. His approach contemplates a prisoner living in the psychologically crushing environment of death row and who suffers from intermittent psychosis, carefully weighing during a lucid interval the risks and benefits of future competence-to-be-executed-restoring treatment.[475] It seems likely that Bonnie's hypothetical prisoner is more hypothetical than real. Bonnie himself concedes that "conditions on death row could be regarded as so coercive as to vitiate the possibility of a 'voluntary' preference for death."[476] A related conceptual problem with Bonnie's approach is that it strongly resembles assisted suicide (in that it explicitly seeks to effectuate the prisoner's preference for death) and thus simply trades one set of ethical dilemmas for another. All of the concerns about the limits on autonomy, the potential for abuse, and the slipperiness of the slope that arises in that context would seem to apply, perhaps with much more force, for capital convicts—yet one does not find the exquisite care given by writers like Beauchamp and Childress to strike an appropriate balance.[477] It seems exceedingly unlikely that capital-related treatment could ever satisfy their requirements.

While Bonnie's approach may do little as a practical matter to resolve the capital-related treatment dilemma, it too serves some moral disengagement purposes. First, by invoking the value of patient autonomy—which as mentioned above has come to be

473. Refer to notes 462–66 *supra* and accompanying text.

474. Refer to notes 462–66 *supra* and accompanying text.

475. Refer to notes 462–66 *supra* and accompanying text.

476. Bonnie, *supra* note 324, at 84

477. Refer to Part III.C.3 *supra* (discussing Beauchamp's and Childress's approach on assisted suicide and capital punishment).

included as an attribute of an ethic of care—Bonnie's approach offers some moral justification and shifts attention away from the clinician's role in facilitating the prisoner's execution. Second, the autonomy perspective more particularly displaces responsibility for those choices onto the prisoner himself. And third, the analogy to end-of-life issues (explicit in the reference to "living wills"), as is the case in the CEJA approach, contributes to minimization of the consequences of the clinician's role. The situation is portrayed as one of the difficult and unfortunately inevitable clinical challenges presented by human mortality rather than as the employment of clinical interventions that help put the patient in a legal position so that other people can kill him.

As previously mentioned, the key difference between Bonnie's consent approach and the CEJA titration/intent approach is that Bonnie would allow the state's goal of executing the prisoner to become part of the clinician's aims—albeit through the vehicle of the prisoner's consent.[478] To the extent that Bonnie's approach describes a convergence between the clinician's and the state's aims, it treads dangerously close to the sixth and final model—which regards capital punishment itself as a form of therapy. As discussed in the ensuing section, the moral disengagement inherent in that model accomplishes a complete perversion of the healer's ethic.

F. Capital Punishment as Therapy

This category consists of two arguments. Unlike any of the foregoing models, both of these arguments directly seek to reconcile participation in the capital punishment process with the healers' ethic. To do so, however, requires a brute-force cognitive reconstrual that stands that ethic on its head. It is little wonder, then, that the professions have largely chosen instead to rely on more subtle strategies.

The first is the deontological syllogism offered by Douglas Mossman, whose first move is to emphasize respect for patient autonomy as the operative ethical norm. He then invokes Kantian contractarianism to argue that "[f]ailure to punish a criminal is failure to give him what his humanity entitles him to."[479] Because retributive punishment "ultimately preserves the opportunity for rational action," and because "[t]his opportunity is essential to any conception of the good that includes dignity,

478. Refer to notes 462–66 *supra* and accompanying text.

479. Mossman, *Execution Competency*, *supra* note 113, at 71 (footnote omitted).

self-respect, and autonomy," punishment "affirms . . . an individual's humanity in the same way that ethical medicine does."[480] Mossman concludes that

> assuming that the criminal justice system and capital punishment are morally justified and fair, hypothetical rational consent provides the grounds for evaluation and treatment of the incompetent prisoner. The prisoner's consent is implied because he accepts the benefits of civil society and because he rationally would have consented in an antecedent position of choice. The condemnee has waived the right to avoid suffering in exchange for the benefits of civil society.[481]

In this way, Mossman finds that both capital evaluations and capital-related treatment, presumably even treatment that has the express purpose of restoring competency so that the capital convict may be executed, are consistent with applicable ethical obligations of autonomy-preservation.

There is much to question about Mossman's position. One might suggest, for example, that his foundational assumption about the essential fairness of American capital punishment is so completely out of line with the realities of the system as to moot the remainder of his argument.[482] One might also point out that Mossman's conflation of the constructs of distributive and retributive justice seems more at home in a *critique* of liberal contractarian theory than in an application of Rawlsian *ex ante* hypothetical consent.[483] Or one might, as does Bonnie, summarily observe that "[t]he ethical norms of the mental health professions do not derive from the Kantian philosophy of punishment."[484]

For present purposes, though, the main point is the extent to which Mossman's analysis demonstrates the power of moral reconstrual. Mossman rejects the Forensicist position as

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480. *Id.* at 70.

481. *Id.* at 84 (footnote omitted).

482. As recounted in *Scared to Death*, there is ample basis to question whether the American system of capital punishment can ever be administered in a fair and rational manner. *See* Judges, *Scared to Death*, *supra* note 13, at 246–47 (summarizing the inherent unfairness of the American capital punishment). More recent scholarship examining the incidence of serious error in a quarter-century of capital cases concludes that the system is broken beyond repair. *See generally* LEIBMAN ET AL. *supra* note 15, at i (finding that "courts found serious, reversible error in nearly 7 of every 10" of capital cases reviewed).

483. *Compare* JOHN RAWLS, A THEORY OF JUSTICE 314–15 (1971) (distinguishing distributive and retributive justice), *with* MICHAEL J. SANDEL, LIBERALISM AND THE LIMITS OF JUSTICE 90–95 (1982) (criticizing the distinction).

484. Bonnie, *supra* note 324, at 85 n.50.

"counter-intuitive."[485] For him, the ethics of psychiatric evaluation and treatment in the capital context do not depend on a mere relabeling of role, but on a redefinition of the very concept of care. In this way, Mossman eclipses the Forensicist resolution of the "problem of doing harm":

> The problem is solved if we recognize that, for an accused or convicted individual, exposing the truth is a hypothetically, rationally desired benefit. In the context of being tried, sentenced, or punished, this benefit outweighs many others, including the "benefit" of avoiding the "harm" of being punished. Truthful psychiatric input into the determination of the various competencies associated with trials, sentencing, and administration of punishment helps assure that the rationality and humanity of the accused or convicted individual is respected.[486]

What is striking about Mossman's position is that, stripped to its essentials, it inverts that most defining of professional norms to derive a moral justification for violating it: Under Mossman's view, doctors can help kill the condemned prisoner because it is for his own moral good. And, like the Forensicist position he rejects, Mossman's argument would impose the responsibilities of veracity and objectivity—except that for him discharge of those responsibilities expresses respect for the prisoner's humanity: "Insofar as the individual's humanity is of paramount interest to him, a psychiatrist is bound to respect that interest above all others. A psychiatrist thus fulfills his physicianly duty to avoid harm by conducting honest and objective forensic evaluations, even when the information obtained supports criminal conviction or punishment."[487]

Having ridden the moral justification tiger this far, however, Mossman stops short of the next logical step. Even he would balk at applying his theory to authorize a physician to actually administer the lethal agent.[488] The lack of a logical distinction between hands-on killing and steps preparatory thereto under Mossman's theory reflects a last-minute resort to the responsibility-diffusion and displacement devices of the Attenuation model, which are addressed above.[489] If a physician is morally justified in helping get the prisoner ready for someone else to kill, because killing him is ultimately for his own good,

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485. Mossman, *Execution Competency*, *supra* note 113, at 86.

486. *Id.* at 87.

487. *Id.* at 87–88 (footnote omitted).

488. *Id.* at 38–41 (distinguishing between treating psychosis as an *indirect* cause of a convict's death and administering the lethal injection, which is the *direct* cause of death).

489. Refer to Part IV.C *supra* (discussing attenuation theory).

then there is no obvious logical reason why the physician cannot eliminate the middle man and do the job directly. It is just this kind of ultimately phony distinction that Beauchamp and Childress reject in their analysis of physician-assisted suicide and euthanasia.[490] There is, of course, an enormous psychological difference—especially for a physician whose professional identity normally would recoil at the thought—and this is probably why even Mossman's bold effort crumbles at the crucial juncture.

Mossman's theory does, however, arguably provide a logical bridge to the second "Capital Punishment as Therapy" argument. Although Mossman expressly asserts a deontological moral justification, one might argue that the prisoner has also implicitly consented to subject himself to utilitarian grounds for punishment and for a physician's role in the process. His position and the "Society as Patient" argument are thus not entirely distinct.

The "Society as Patient" position is described (and ultimately rebutted) by Charles Patrick Ewing as a logical extension of the utilitarian notion "that the healer's responsibility extends beyond the individual patient to society as a whole."[491] Thus, if the healer's "true commitment" is to the health of both the individual and society, then "it might be argued that psychiatric and psychological participation in capital sentencing is consistent with the traditional healing mission of these professions."[492] Just as a public health physician uses his or her expertise to protect the public health, the argument runs, a forensic mental health professional who testifies, for example, that the capital defendant presents a danger to society, "is simply exercising his or her healing commitment on behalf of society in general and prospective victims of the defendant in particular."[493]

Ewing disputes the "Society as Patient" position by distinguishing psychiatric participation (for example, in the form of predictions of future dangerousness) in civil commitment and other noncapital criminal processes, which at least theoretically offer both treatment to the individual and protection of society,

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490. BEAUCHAMP & CHILDRESS, *supra* note 246, at 239 (distinguishing between permitting physician assistance in preparing a suicide patient for death and the state "requir[ing such] assistance").

491. Charles P. Ewing, *"Dr. Death" and the Case for an Ethical Ban on Psychiatric and Psychological Predictions of Dangerousness in Capital Sentencing Proceedings*, 8 AM. J. L. & MED. 407, 419 (1983).

492. *Id.*

493. *Id.*

from the capital process, which could provide protection to society even without psychiatric involvement. He concludes that

> stripped of any genuine "public health" justification, clinical predictions of dangerousness in the capital sentencing context may amount to little more than professional sanction of the defendant's execution. In effect, the psychiatrist or psychologist who renders such a prediction in this setting is telling the sentencing authority that the state has good reason to execute the defendant.[494]

His objections could be asserted with even more force against *Singleton*'s conflation of patient "treatment," protection of public health, and the state's goal of restoring competence to execute the prisoner.

For present purposes, what is striking about the "Capital Punishment as Therapy" position is that, while it is the only position in the literature to directly address the "problem of harm," its obliteration of the distinction between healing and killing reflects the most disturbing manifestation of moral disengagement. This is capital punishment's ultimate psychological cost, and it bears a frightening resemblance to the "'biomedical vision' of the Nazis that recommended the 'excision' of 'diseased' individuals in the interest of the whole societal 'organism.'"[495]

Robert Jay Lifton's thorough exploration of the "medicalization" of the Holocaust offers relevant insights for the "Capital Punishment as Therapy" argument. Nazism's transcendental conception of the "Volk" formed the basis for its version of "revolutionary immortality"—a kind of symbolic immortality.[496] According to Lifton, "the medicalization of killing—the imagery of killing in the name of healing—was crucial to that terrible step [toward systematic genocide]. *At the heart of the Nazi enterprise, then, is the destruction of the boundary between healing and killing*."[497]

Medicalization of the killing accomplished two important purposes. First, it increased both technological efficiency and the psychological distance between the killers and their victims. As the Milgram studies later confirmed, such distance significantly facilitates infliction of harm.[498] We have also seen the extent to

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494. *Id.* at 420.

495. Foot, *supra* note 235, at 211.

496. ROBERT JAY LIFTON, THE NAZI DOCTORS 14 (1986).

497. *Id.* (emphasis added).

498. Refer to text accompanying notes 55–56 *supra* (demonstrating how displacing responsibility onto authority figures enables individuals to inflict greater harm than they otherwise would).

which themes of denial of causal agency for actual killing pervade the literature defending healers' participation in capital punishment. The Nazis had found that the troops who carried out the face-to-face shootings (the *Einsatzgruppen*) experienced such severe psychological trauma that "'[t]hese men are finished [*fertig*] for the rest of their lives.'"[499]

A second, more insidious function was the justification of killing as a therapeutic exercise. One Nazi doctor reconciled his actions with his Hippocratic Oath in this way: "Of course I am a doctor and I want to preserve life. And out of respect for human life, I would remove a gangrenous appendix from a diseased body. The Jew is the gangrenous appendix in the body of mankind."[500] It was under this racist version of the "Society as Patient" view that physicians participated in virtually all aspects of the Holocaust.[501]

For example, Lifton reports that physicians "presided over the murder of most of the one million victims" of Auschwitz.[502] They selected prisoners for the gas chambers.[503] They supervised the gassing.[504] They pronounced the victims dead and signed the (falsified) death certificates.[505] They superintended the care of the slave laborers.[506] As Lifton put it,

> In sum, we may say that doctors were given much of the responsibility for the murderous ecology of Auschwitz—the choosing of victims, the carrying through of the physical and psychological mechanics of killing, and the balancing of killing and work functions in the camp. While doctors by no means ran Auschwitz, they did lend it a perverse medical aura. As one survivor who closely observed the process put the matter, "Auschwitz was like a medical operation," and "the killing program was led by doctors from beginning to end."[507]

To be sure, the example of the Holocaust must not be casually invoked. The point is neither to equate genocide of the innocent with execution of convicted criminals nor to argue that any society that practices capital punishment is inevitably on a

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499. LIFTON, *supra* note 496, at 159 (second alteration in original) (quoting Erich von dem Bach-Zelewski's complaint to Heinrich Himmler).

500. *Id.* at 15–16.

501. *Id.* at 16.

502. *Id.* at 18.

503. *Id.*

504. *Id.*

505. *Id.*

506. *Id.*

507. *Id.*

slippery slope to such excesses. But "[t]he holocaust continues to serve as a powerful vision of the bottom of the slippery slope for a society that carelessly initiates killing"[508]—especially killing in the name of "healing." The point is thus to expose the moral implications for health professionals of the destruction of the boundary between healing and killing that the "Capital Punishment as Therapy" rationalization threatens to accomplish and the responsibility diffusion that it permits, and to thereby reveal the moral disengagement processes at work in this aspect of the capital punishment process.[509]

V. CONCLUSION

American capital punishment is long overdue for an accounting. The detailed attention devoted over the past decade or so to the problems of serious procedural and factual error, race effects, and arbitrariness has produced a rich literature that calls into substantial question the system's capacity to yield the tangible benefits typically invoked as its justification. While its tangible benefits are in doubt, the system's tangible costs—the direct financial expense and diversion of prosecutorial, law enforcement, and judicial resources—are undeniably enormous.

Despite this apparent imbalance in the official-version economy of capital punishment, and growing criticism, the institution continues to flourish.[510] It remains to be seen whether current executive, legislative, and judicial efforts at reform will put that account in the black. In the meantime, a full accounting would also include in its reckoning the "underground economy" of capital punishment's psychological benefits and costs. The literature in that domain is, not surprisingly, less well developed. I have elsewhere offered some observations regarding the benefits side of that ledger.[511] This Article considers the institution's cost in terms of deactivation of the norm of *humanitas* by examining the reactions of representatives of those

508. BEAUCHAMP & CHILDRESS, *supra* note 246, at 231; *see also* Lloyd, *supra* note 205 (critiquing *Singleton* in light of physician's role in the Holocaust).

509. *See* Dubber, *supra* note 23, at 564 (describing how the medicalization of executions negate the necessity for moral responsibility for executions).

510. By the close of 2003, there had been 885 executions in the United States since 1976. *See, e.g.*, Death Penalty Information Center, *Facts About the Death Penalty*, *at* http://www.deathpeanltyinfo.org (last visited Jan. 9, 2004). The death row population had climbed from 420 in 1976 to 3,504 by October 2003 (down slightly from 2002 in part because of the Illinois commutations). *Id.*

511. *See* Judges, *Scared to Death*, *supra* note 13, at 157–61 (commenting that capital punishment is not about deterrence, incapacitation, or retribution, but about terror management, in which people increase the level of punishment when they have a heightened awareness of death).

participants in the process for whom that norm otherwise would be self-defining.

Involvement in a process aimed at killing does appear to be at odds with mental health professionals' constitutive ethical commitment to beneficence and harm-avoidance, and not warranted by reference to autonomy or distributive justice. Capital punishment confronts professionals, who otherwise claim a strong humanistic norm, with a situation calling for participation in the infliction of extreme harm. According to Bandura's theory of moral disengagement, most people who proceed in the face of such a conflict would find it psychologically necessary to resort to predictable cognitive moves to avoid the distress of self-censure. Those moves include cognitive reconstrual (through moral justification, euphemistic labeling, and advantageous comparison), obscuring the causal relationship between one's actions and ensuing harm (through displacement and diffusion of responsibility and distortion of the consequences of one's actions), and blaming, degrading, or disregarding the humanity of the target of one's behavior.

Commentators and professional associations have offered a variety of arguments in an effort to reconcile the apparent conflict between involvement in capital punishment and the norms of beneficence and harm-avoidance. Critical examination of those arguments finds them pervaded, perhaps dominated, by the familiar mechanisms of moral disengagement. In other words, facilitative participation by health professionals in the capital punishment process raises at least a facial conflict between powerful professional norms against harm-infliction. When we look at a selection of the leading efforts to address that apparent conflict, we see the kinds of moves most people make when they are doing something they otherwise would regard as wrong. For health professionals who become involved in the capital punishment process, those moves involve forfeiture of what, in any other context, they would regard as among their most cherished values.

This cost seems steep, and it is surely not confined to health professionals. Health professionals offer a useful subset of participants to study, not because they are so different from the process's other functionaries or the citizenry-at-large, but because their relationship to the norm of *humanitas* is relatively explicit and formalized, because recent developments have highlighted and intensified the conflict between norm and behavior, and because they have left behind a well-articulated paper trail in their struggles to reconcile the conflict.

What does an ordinary person come to understand about the death penalty process and his or her role in it when personally involved? Consider the concluding thoughts of the individual who has very likely had more first-hand experience, literally, with legal capital punishment than anyone else in the twentieth century. Albert Pierrepoint, who otherwise would strike one as the quintessential ordinary man, has hanged hundreds of persons (he has long refused to disclose the exact number) in his lengthy career as Great Britain's number one executioner.[512] Having "written as an executioner of experience, who has worked in nine countries, looking back on [his] life with all the honesty [he could]," Pierrepoint came to the following conclusion:

> During my twenty-five years as an executioner, I believed with all my heart that I was carrying out a public duty. I conducted each execution with great care and a clear conscience. I never allowed myself to get involved with the death penalty controversy.
>
> I now sincerely hope that no man is ever called upon to carry out another execution in my country. I have come to the conclusion that executions solve nothing, and are only an antiquated relic of a primitive desire for revenge which takes the easy way and hands over the responsibility for revenge to other people.[513]

512. Refer to note 362 *supra* and accompanying text.

513. PIERREPOINT, *supra* note 362, at 405–06.