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Health Law

Medicating Death Row Inmates so They Qualify for Execution

Ethical questions arise when physicians are asked to medicate death row inmates so that they qualify for execution.

Leah Eisenberg

Charles Singleton was convicted of murder and sentenced to death in 1979 [1]. Once on death row, he began taking psychotropic medications to alleviate anxiety and depression. His mental health began to deteriorate further around 1987, at which time he came to believe that his cell was inhabited by demons and that his thoughts were being stolen from him. Singleton was subsequently diagnosed with schizophrenia and given antipsychotic medication. Over the next several years, he sometimes agreed to take the medication; at other times, it had to be administered forcibly. When he went off the medication, the paranoid and delusional behaviors—including the belief that he was on a mission to kill the president and that he had already been executed—returned. At this point, antipsychotic medication was deemed medically necessary, so, starting in 1997, the prison placed Singleton on an involuntary medication regime, subject to an annual review. The precedent for doing so was the 1990 US Supreme Court decision in *Washington v Harper* [2]. Harper was a psychotic inmate with a history of violent outbursts, who became unwilling to take antipsychotic medication while in prison. The Court decided that the State could medicate such an individual against his will only if "the inmate is dangerous to himself or others and the treatment is in the inmate's medical interest" [3].

Under the involuntary medication regime, Singleton's symptoms abated, and the State of Arkansas scheduled his execution for March 2000. Singleton subsequently filed a petition for habeas corpus, a judicial mandate ordering that a prisoner be brought before the court to determine whether or not he is being held unlawfully. Singleton contended that he was only competent because of the antipsychotic medication he was taking and that it was unconstitutional for the court to render him competent for execution by forcibly medicating him. The 8th Circuit Court of Appeals was faced with deciding whether the state can execute someone who is involuntarily medicated to meet competency requirements for execution.

The 8th Circuit Court was guided in its deliberation by several landmark cases concerning mentally ill prisoners. The US Supreme Court first addressed the question of whether the Constitution allows the mentally ill to be executed in 1986, in the case of *Ford v Wainwright* [4]. The court found it unconstitutional, although it could not agree on a single rationale for that decision, citing variously concerns about inhumane treatment and the lack of either deterrent effect or retributive value of such action. In his concurring opinion, Justice Lewis F. Powell, Jr, suggested that, under the Eighth Amendment, prisoners are not competent to be executed if they are "unaware of the punishment they are about to suffer and why they are to suffer it" [5]. This language has become the standard used to evaluate the mental capability of prisoners, and inmates are now judged on their "Ford competence." It is important to note that this refers to the prisoner's level of competence at the time of execution, not at the time that the crime was committed. Neither party in the Ford case disputed the fact that the defendant was mentally competent when he committed the crime and during the trial and sentencing.

Charles Singleton's situation was more complicated than the one described in *Ford v Wainwright*, since the psychosis that caused Singleton's mental incompetence could be diminished, if not eliminated entirely, with psychotropic

medication. And Singleton's case was more complicated than that of Harper because Harper was not on death row. Medicating Harper involuntarily did not mean that he would die as a result.

While the due process clause of the Fourteenth Amendment grants every person the right to liberty, including the liberty to be free from unwanted medication, limits may be imposed upon that liberty in order to meet a legitimate state interest. Although prisoners maintain some constitutional rights, the state has both a right and an obligation to preserve order in prisons, and, in these cases, the state's interests in maintaining a safe prison environment were found to supersede the inmates' right to refuse medication. The *Washington v Harper* court had also decided that it was not necessary to hold a judicial hearing to determine competence prior to imposing an involuntary medication regime on an inmate. The court went on to explain that the ruling did not imply that every prison had the right to medicate a prisoner against his will; rather, it meant that competence did not have to be determined by a judicial decision maker. The hearing by committee that had decided Harper's incompetence—and had included both a psychiatrist and a psychologist—was found to be sufficient to meet Harper's due process rights. In 1992, the Supreme Court again confronted the issue of forcing antipsychotic medication on inmates, and it again ruled that there are times when such action may be appropriate, so long as the treatment is shown to be essential for the defendant's safety or the safety of others [6].

How do these decisions impact the Singleton case? The 8th Circuit Court reviewed these cases when deciding Charles Singleton's fate, and, while the precedents were instructive, none of them addressed the specific issue of whether it was constitutional to force a psychotic prisoner who has been condemned to death to take medication that makes him competent and, hence, eligible for execution. Singleton argued that once an execution date was set, it was no longer in his best medical interest to be medicated, since by rendering him competent, the medication also made him eligible for execution. On the other hand, whenever Singleton went off his medication, he quickly reverted to psychosis, and being in a psychotic and delusional state was not in his best medical interest either. The court found that since the medication controlled Singleton's mental illness, and since Singleton himself admitted to feeling better while on it, the only unwanted side effect of forcing him to take antipsychotic medication was the fact that it would make him eligible for execution, a sentence that was lawfully imposed upon him for a crime he was found to have committed. The state always has an essential interest in making sure that lawfully imposed sentences are carried out. Therefore, the 8th Circuit Court decided that Singleton was to continue to receive the medication regardless of the fact that an execution date had been set, because it was still in his best medical interest. On January 6, 2004, after spending a record length of time on Arkansas' death row, Charles Singleton was put to death.

Implications for Physicians

The case of Charles Singleton forces physicians to make a number of difficult ethical decisions, inasmuch as there is no treatment plan that is clearly in the patient's *overall* best interest. Under normal conditions, principles of patient autonomy require that a patient be allowed to make his or her own treatment decisions; however, an incarcerated prisoner—and one who is declared incompetent to make medical decision—does not have the same autonomy as a competent individual living independently.

The AMA *Code of Medical Ethics* has 2 opinions that offer guidance on physician participation in cases like Singleton's—the opinion on court-ordered medical treatment and the opinion on capital punishment. As it turns out, the latter is more to the point. The former, Opinion 2.065 concerning court-ordered medication, states that it is ethical for a physician to provide such treatment as long as the treatment is "therapeutically efficacious and…not a form of punishment or solely a mechanism of social control" [7]. A physician, and not the court, must make the diagnosis, and if the physician who is to treat the inmate makes the diagnosis, it must be confirmed by an independent physician or panel of physicians not responsible to the state.

There is no dispute that the antipsychotic medication effectively controlled Singleton's schizophrenia. However, this opinion concerns itself chiefly with court-ordered treatments to which the prisoner is likely to consent. Thus, it states that "the physician must be able to conclude, in good conscience…that the informed consent was given voluntarily to the extent possible, recognizing the element of coercion that is inevitably present," and that in the case of pharmacological treatments, "an independent physician or panel of physicians not responsible to the state should confirm that the informed consent was given" [7]. Though physician permission to participate in court-ordered

medication applies to the Singleton case, "with patient consent only" clearly does not. Should a physician then refuse to provide court-ordered treatment to which the patient does not consent? There is no clear answer. The report drafted by the AMA's Council on Ethical and Judicial Affairs (CEJA) from which Opinion 2.065 was derived remarked that each state has the authority to determine whether or not it will allow the courts to mandate medical procedures, but that a physician who treats a patient against his will, in violation of the principles of informed consent, may be liable for medical malpractice or battery [8]. Even if the physician were not held liable, the council expressed concern that such action would damage the integrity of the medical profession by making physicians agents of the state rather than providers of care.

The question of whether Charles Singleton's physicians ought to comply with a forced medication regime is further complicated by his death sentence, and, therefore, the *Code's* opinion on physician participation in capital punishment (Opinion 2.06) offers more guidance in the dilemma. By giving medication that would restore Singleton to competence and render him eligible for execution, the physician would be incidentally participating in his execution, and the *Code of Medical Ethics* states unequivocally 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" [9]. The *Code* goes on to say that a physician should not treat a condemned prisoner for the purpose of restoring competence, unless a commutation order is in place before treatment begins, but that "if the incompetent prisoner is undergoing extreme suffering as a result of psychosis or any other illness, medical intervention intended to mitigate the level of suffering is ethically permissible" [9]. Without medication, Charles Singleton suffered from psychosis and delusions, and, since the medication alleviated those symptoms, a physician could be justified in giving it to him if the commutation issue was first addressed.

The *Code of Medical Ethics* declares that a physician should never be "compelled to participate in the process of establishing a prisoner's competence or be involved with treatment of an incompetent, condemned prisoner if such activity is contrary to the physician's personal beliefs" [9]. However, regardless of whether a physician decides to participate, or to transfer the patient's care to another physician, issues like those presented by the Singleton case leave all doctors between a rock and a hard place. Is it better to provide care for such patients, because everyone deserves competent care and protection from needless suffering, or does it devalue the healing profession to use one's clinical skills to prepare a person for execution? Suppose all physicians agreed that the profession's ethical code forbade medicating a death row inmate if doing so would result in his being executed. Must the prisoner then live out the remainder of his days tortured by psychosis?

References

1. *Singleton v State,* 274 Ark 126.
2. *Washington v Harper,* 494 US 210.
3. *Ibid.* at 227.
4. *Ford v Wainwright,* 477 US 399.
5. *Ibid.* at 422. (Justice Powell, concurring).
6. *Riggins v Nevada,* 504 US 127.
7. American Medical Association. Opinion 2.065, Court-initiated medical treatments in criminal cases. *Code of Medical Ethics*. Accessed August 16, 2004.
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8. Council on Ethical and Judicial Affairs, *Court-Initiated Medical Treatments in Criminal Cases.* Unpublished report. Chicago: American Medical Association; June 1998.
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9. American Medical Association. Opinion 2.06, Capital punishment. *Code of Medical Ethics*.
