

INCOMPETENCY TO BE EXECUTED: CONTINUING ETHICAL CHALLENGES & TIME FOR A CHANGE IN TEXAS

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I. INTRODUCTION

Steven Staley is a Texas death row inmate “who was convicted of a 1989 robbery and murder at a Fort Worth Steak and Ale restaurant.”¹ He also has a serious mental illness—schizophrenia.² The primary form of treatment for schizophrenia is appropriate antipsychotic medication.³ On May 14, 2012, the Texas Court of Criminal Appeals granted Staley’s application for a post-conviction writ of habeas corpus and a stay of execution.⁴ The court of criminal appeals issued the stay “after defense lawyers argued that the state was violating Staley’s constitutional rights by forcing him to take powerful anti-psychotic drugs so that he could be

1. Brandi Grissom, *Court Stays Execution of Mentally Ill Inmate*, TEX. TRIBUNE (May 14, 2012), <http://www.texastribune.org/texas-dept-criminal-justice/death-penalty/court-stays-execution-mentally-ill-inmate/>.

2. *Id.* NAMI, the National Alliance on Mental Illness, defines “schizophrenia” as follows:

Schizophrenia is a serious and challenging medical illness, an illness that affects well over 2 million American adults, which is about 1 percent of the population age 18 and older. Although it is often feared and misunderstood, schizophrenia is a treatable medical condition.

Schizophrenia often interferes with a person’s ability to think clearly, to distinguish reality from fantasy, to manage emotions, make decisions, and relate to others. The first signs of schizophrenia typically emerge in the teenage years or early twenties, often later for females. Most people with schizophrenia contend with the illness chronically or episodically throughout their lives, and are often stigmatized by lack of public understanding about the disease. Schizophrenia is not caused by bad parenting or personal weakness. A person with schizophrenia does not have a “split personality,” and almost all people with schizophrenia are not dangerous or violent towards others while they are receiving treatment. The World Health Organization has identified schizophrenia as one of the ten most debilitating diseases affecting human beings.

Mental Illness: Schizophrenia, NAT’L ALLIANCE ON MENTAL ILLNESS (Feb. 2007), http://www.nami.org/Template.cfm?Section=By_Illness&Template=/TaggedPage/TaggedPageDisplay.cfm&TPLID=54&ContentID=23036. For further instructive definitions and discussion of schizophrenia, see *Schizophrenia: Definition*, MAYO CLINIC (Jan. 27, 2012), <http://www.mayoclinic.com/health/schizophrenia/DS00196>, and *Schizophrenia*, TEX. DEP’T ST. HEALTH SERVS. 1-2, available at <http://www.dshs.state.tx.us/mhprograms/pdf/SCZFact.pdf> (last visited Nov. 19, 2012).

3. See *Mental Health Medications*, NAT’L INST. MENTAL HEALTH 1-2, available at <http://www.nimh.nih.gov/health/publications/mental-health-medications/nimh-mental-health-medications.pdf> (last visited Nov. 19, 2012) (stating that antipsychotic medications are used to treat the symptoms of schizophrenia and other mental disorders). Indeed, ordinarily the provision of medically appropriate medication to treat the symptoms of serious psychiatric illnesses, such as schizophrenia, also has value within the criminal justice system. As one commentary observed,

Antipsychotic medications are not mind-altering drugs . . . [but] are beneficial treatments that uncontroversially improve cognition among patients with psychotic disorders, including schizophrenia. Whether the task involves making competent and informed treatment decisions, assisting defense counsel during trial, or enduring the hardships of prolonged incarceration, these medicines enhance a person’s ability to make rational decisions. There is [also] evidence that antipsychotic medications may prevent further clinical deterioration . . .

Steven K. Erickson et al., *Legal Fallacies of Antipsychotic Drugs*, 35 J. AM. ACAD. PSYCHIATRY & L. 235, 242 (2007).

4. *Ex parte Staley*, No. WR-37,034-05, 2012 Tex. Crim. App. Unpub. LEXIS 482, at *3 (Tex. Crim. App. May 14, 2012) (per curiam).

considered mentally competent for execution.”⁵ In its order, the court observed that Staley’s pleadings asserted, “among other issues, that the trial court erred in finding him [Staley] competent and that his forced medication violates the constitutional prohibition against cruel and unusual punishment.”⁶

Though, fortunately, the legal issue of an incarcerated individual’s competency to be executed is a relatively uncommon problem in medical ethics and legal jurisprudence, it is incredibly important because it pits the ethical duties of the medical and legal professions in opposition and casts a shadow over the legitimate and appropriate intentions and professional responsibilities of physicians and lawyers.

This Article focuses on a small, but unique, group of death row inmates who have largely exhausted their post-conviction procedural rights and have a date set for execution but, while awaiting execution, have become incompetent to be executed because of serious mental illness. The United States Supreme Court has determined that it is unconstitutional to execute an individual who is mentally incompetent.⁷ The Court has not, however, ruled as to whether it is constitutionally permissible for a state to order a death row inmate to be medicated forcibly for the purpose of restoring that inmate’s competency to allow an execution to proceed. This Article will first review the constitutional requirement for execution competence,⁸ then identify the scope of the ethical concerns related to this very challenging scenario,⁹ and address state and lower federal court decisions that have considered the issue, as well as United States Supreme Court opinions that have considered other, related medication issues concerning offenders with mental disorders.¹⁰ In particular, however, this Article will offer and discuss a possible legislative solution that the Texas Legislature could enact that would avoid the thorny ethical and legal issues that are at stake in such cases.¹¹

5. Grissom, *supra* note 1 (observing that his attorneys had urged “that it is unethical and unconstitutional for the state to forcibly medicate Staley so that he can be executed”).

6. *Staley*, 2012 Tex. Crim. App. Unpub. LEXIS 482, at *3. In August 2012 the Texas Court of Criminal Appeals ordered further briefing in *Staley* on several issues including whether the issue of forcible medication was properly before the court, and, if reviewable, by what standard should the forcible medication claims be reviewed. *Staley v. State*, Nos. AP-76,798 & AP-76-868, 2012 Tex. Crim. App. Unpub. LEXIS 801, at *4 (Tex. Crim. App. Aug. 22, 2012) (per curiam).

7. *Panetti v. Quarterman*, 551 U.S. 930, 934-35 (2007); *Ford v. Wainright*, 477 U.S. 399, 409-10 (1986).

8. See discussion *infra* Part II.

9. See discussion *infra* Part III.

10. See discussion *infra* Part IV.

11. See discussion *infra* Part VI.

II. EXECUTION COMPETENCE IS CONSTITUTIONALLY REQUIRED

Over twenty-five years ago, in *Ford v. Wainright*, the Supreme Court held that “the Eighth Amendment prohibits a State from carrying out a sentence of death upon a prisoner who is insane.”¹² In turn, after finding the Florida procedures to be inadequate, a plurality of the Court determined that Ford was “entitled to an evidentiary hearing in the District Court, *de novo*, on the question of his competence to be executed.”¹³ The plurality opinion, however, did not address the scope of what it means to be competent for execution.¹⁴ By way of contrast, Justice Powell in his separate opinion fleshed out the concept of execution competency somewhat by indicating that he “would hold that the Eighth Amendment forbids the execution only of those who are unaware of the punishment they are about to suffer and why they are to suffer it.”¹⁵

The Court provided clarification of the scope of execution competence some two decades later in a case arising in Texas, *Panetti v. Quarterman*.¹⁶

12. *Ford*, 477 U.S. at 409-10. The State of Florida had convicted Ford of murder in 1974 and sentenced him to death. *Id.* at 401. There had been no indication “that he was incompetent at the time of his offense, at trial, or at sentencing.” *Id.* at 401-02. Starting in 1982, however, Ford began to manifest behavioral changes, including “increasingly pervasive” delusions, indicating the presence of a mental illness. *Id.* at 402. Psychiatrists diagnosed him with a severe mental disease or disorder, and one of his psychiatrists determined that it was not possible that Ford was merely malingering. *Id.* at 402-03. Pursuant to Florida’s then-existing procedures, “the Governor of Florida appointed a panel of three psychiatrists to evaluate” Ford to determine his competency to be executed. *Id.* at 403. They interviewed him collectively in a single session for a half-hour. *Id.* at 404. The doctors then submitted individual reports that set forth “three different diagnoses, but accord on the question of sanity as defined by state law.” *Id.* The Governor thereafter signed Ford’s death warrant, and Ford’s subsequent habeas challenge eventually arrived at the Supreme Court. *Id.* at 404-05. In reaching its decision, the Court considered the common law “bar against executing a prisoner who has lost his sanity” and observed that the bar was based upon “impressive historical credentials” as to a “practice consistently . . . branded ‘savage and inhuman.’” *Id.* at 406 (citing 4 WILLIAM BLACKSTONE, COMMENTARIES *21, *24-25, available at http://avalon.law.yale.edu/18th_century/blackstone_bk4_ch2.asp (last visited Dec. 16, 2012)). After reviewing both common law and modern rationales, as well as state statutory approaches, the Court concluded the following:

Faced with such widespread evidence of a restriction upon sovereign power, this Court is compelled to conclude that the Eighth Amendment prohibits a State from carrying out a sentence of death upon a prisoner who is insane. Whether its aim be to protect the condemned from fear and pain without comfort of understanding, or to protect the dignity of society itself from the barbarity of exacting mindless vengeance, the restriction finds enforcement in the Eighth Amendment.

Id. at 409-10.

13. *Id.* at 418. Although Justice Powell was a part of the majority in determining that the Constitution requires a person to be competent to be executed, he wrote separately with regard to the process due and observed that in his view, “a constitutionally acceptable procedure may be far less formal than a trial.” *Id.* at 427 (Powell, J., concurring in part and concurring in the judgment).

14. *See id.* at 401-08.

15. *Id.* at 422 (Powell, J., concurring in part and concurring in the judgment). Justice Powell observed that states with relevant statutes at the time did not dispute “the need to require that those who are executed know the fact of their impending execution and the reason for it.” *Id.*

16. *Panetti v. Quarterman*, 551 U.S. 930, 949-52 (2007). A Texas jury convicted Scott Panetti of murdering his estranged wife’s parents and sentenced him to death. *Id.* at 935, 937. Despite a lengthy

In *Panetti*, a Texas death row inmate sought habeas relief in the federal courts relating to the issue of whether he was competent to be executed given his symptoms of serious mental illness.¹⁷ The federal district court found that the state courts had not followed Texas's statutory requirements and that the state proceedings did not meet the requirements of *Ford*.¹⁸ Nonetheless, the federal district court denied relief based on its application of Fifth Circuit precedent for execution competency, which required the inmate to "know no more than the fact of his impending execution and the factual predicate for the execution."¹⁹ After an affirmance by the Fifth Circuit, the Supreme Court reversed, holding both that this test was "improperly restrictive" and that the state district court had provided inadequate procedures to Panetti to review the question of execution competence.²⁰ In finding the lower courts' test for execution competency to be flawed under *Ford*, the Court reasoned that a "prisoner's awareness of the State's rationale for an execution is not the same as a *rational understanding* of it. *Ford* does not foreclose inquiry into the latter."²¹ The Court further determined that the district court should have considered Panetti's contention "that he suffers from a severe, documented mental illness that is the source of gross delusions preventing him from comprehending the meaning and purpose of the punishment to which he has been sentenced."²²

history of psychiatric illness and bizarre behavior, the trial court found Panetti competent both to stand trial and to waive counsel and represent himself at trial. *Id.* at 936-37. Eventually, as part of post-conviction proceedings, Panetti urged that he was incompetent to be executed due to mental illness. *Id.* at 938. In 2004, the trial court appointed two mental health experts to evaluate Panetti; they concluded that Panetti was competent and that his "uncooperative and bizarre behavior was due to calculated design." *Id.* at 939-40. Despite objections to the experts' methodology and reports, the state court determined that Panetti was not incompetent to be executed. *Id.* at 941. Panetti's counsel then pursued habeas relief in the federal courts. *Id.*

17. *Id.* at 941-42.

18. *Id.* at 942.

19. *Id.* (quoting *Panetti v. Dretke*, 401 F. Supp. 2d 702, 711 (W.D. Tex. 2004), *aff'd*, 448 F.3d 815 (5th Cir. 2006), *rev'd sub nom.* *Panetti v. Quarterman*, 551 U.S. 930 (2007)).

20. *Id.* at 935.

21. *Id.* at 959 (emphasis added).

22. *Id.* at 960. The Court pointed out that with the symptoms of serious mental illness, there can be a difference between mere awareness and actual understanding: "Gross delusions stemming from a severe mental disorder may put an awareness of a link between a crime and its punishment in a context so far removed from reality that the punishment can serve no proper purpose." *Id.* In addition, separate from the Court's holding regarding the proper scope of the *Ford* test for execution competency, the Court also held that the state district court had provided inadequate process to Panetti to consider the issue. *See id.* at 950-51 (identifying that the trial court had "refused to transcribe its proceedings," repeatedly provided inaccurate information to Panetti's counsel, failed to provide a competency hearing, and "failed to provide petitioner with an adequate opportunity to submit expert evidence"). The Texas Court of Criminal Appeals has recently opined that the Supreme Court in *Panetti* did not invalidate the Texas statutory scheme for execution competency hearings but that the trial court "in that specific case had provided inadequate protection to the defendant" and that the trial judge had likely violated the Texas statutory process. *Green v. State*, 374 S.W.3d 434, 440 (Tex. Crim. App. 2012). For a thoughtful discussion of *Panetti*, see Richard J. Bonnie, Commentary, *Panetti v. Quarterman: Mental Illness, the*

III. THE ETHICAL QUANDARY

Both *Ford* and *Panetti* preclude a state from executing an inmate who is not mentally competent. The issue of whether the state can forcibly medicate an incompetent death row inmate with serious mental illness for the purpose of making that defendant competent to be executed, however, did not arise in either case, and the United States Supreme Court has never directly decided the issue.²³ Nonetheless, there are serious ethical concerns surrounding the issue, including tensions between a doctor's ethical obligations and those of the inmate's legal counsel.

Most mental health professionals believe it is unethical to provide treatment for the purpose of restoring a person's competence to enable a state to carry out an execution.²⁴ As Professor Richard Bonnie has observed, "According to nearly universal ethical opinion within the mental health professions, treatment with the purpose *or inevitable effect* of enabling the state to carry out an otherwise prohibited execution is unethical"²⁵ Although the state has a very important interest in carrying out a lawful death sentence in a capital case, there is a countervailing ethical concern within the medical community with regard to a court ordering a physician to provide medication that will restore an incompetent inmate's competence to be executed.²⁶

A physician's first duty is to his or her patient. As required by the American Medical Association's (AMA) Principles of Medical Ethics, a "physician shall, while caring for a patient, regard responsibility to the patient as paramount" and must provide medical care "with compassion and

Death Penalty, and Human Dignity, 5 OHIO ST. J. CRIM. L. 257, 257 (2007) (asserting that *Panetti* exposed "the utter failure of the criminal justice system to take adequate account of the effects of severe mental illness in capital cases, specifically by failing to assure a fair defense for defendants with mental disabilities, by failing to give morally appropriate mitigating effect to claims of diminished responsibility" and in not correcting "these deficiencies in post-conviction proceedings").

23. For an analysis of the relevant Supreme Court cases, see discussion *infra* Part IV.

24. See ABA Task Force on Mental Disability and the Death Penalty, *Recommendation and Report on the Death Penalty and Persons with Mental Disabilities*, 30 MENTAL & PHYSICAL DISABILITY L. REP. 668, 676 (2006) [hereinafter ABA Task Force] (stating that "[m]ental health professionals are nearly unanimous in the view that treatment with the purpose or likely effect of enabling the state to carry out an execution" of an inmate who is mentally incompetent is unethical). *But see* Douglas Mossman, *The Psychiatrist and Execution Competency: Forging Murky Ethical Waters*, 43 CASE W. RES. L. REV. 1, 90 (1992) (concluding that if "capital punishment is just and is administered fairly, psychiatrists ethically may . . . treat incompetent condemnees in an effort to restore their rationality").

25. Richard J. Bonnie, *Mentally Ill Prisoners on Death Row: Unsolved Puzzles for Courts and Legislatures*, 54 CATH. U. L. REV. 1169, 1175 (2005) (emphasis added). Professor Bonnie, who served on the ABA's Task Force on Mental Disability and the Death Penalty, indicated that there are two narrow exceptions: when the prisoner, while competent, asked for medication in an advanced directive or when there is "a compelling need to alleviate extreme suffering." *Id.*

26. See *id.* at 1174-75 (recognizing the state's "powerful interest in carrying out the sentence of death" but identifying how forced medication for such a purpose violates a physician's "fundamental ethical norms").

respect for human dignity and rights.”²⁷ Traditionally, a physician, upon taking the Hippocratic Oath, has sworn, among other things, to employ “regimens which will benefit my patients according to my greatest ability and judgment, and I will do no harm or injustice to them.”²⁸ With regard to psychiatric treatment for a death row inmate who is incompetent to be executed because of the symptoms of serious mental illness, the AMA has opined: “When a condemned prisoner has been declared incompetent to be executed, physicians should not treat the prisoner for the purpose of restoring competence unless a commutation order is issued before treatment begins.”²⁹

On the other hand, a treating physician will undoubtedly recognize that the most important and, typically, the only effective means of treatment for the inmate’s symptoms of a serious mental illness is to provide appropriate medications. As the American Psychiatric Association (APA) and American Academy of Psychiatry and the Law (AAPL) have explained in a recent amicus brief, “Antipsychotic medications are an accepted and often irreplaceable treatment for acute psychotic illnesses, as most firmly established for schizophrenia, because the benefits of antipsychotic medications, compared to any other available means of treatment, outweigh their acknowledged side effects.”³⁰ Moreover, the physician will be aware that allowing a patient to languish “without treatment leaves in place the suffering and impairment of functioning that psychoses cause—the core reasons that medication is medically appropriate.”³¹ Accordingly, in a

27. AM. MED. ASS’N, *Principles of Medical Ethics*, in CODE OF MEDICAL ETHICS I, VIII (1957 & rev. 2001), available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/principles-medical-ethics.page?>. Another AMA principle directs that an ethical physician “shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.” *Id.* at III.

28. HIPPOCRATES, HIPPOCRATIC OATH (Michael North trans., Nat’l Library of Med. 2002) (400 B.C.), available at http://www.nlm.nih.gov/hmd/greek/greek_oath.html.

29. AM. MED. ASS’N, *Opinions on Social Policy Issues*, in CODE OF MEDICAL ETHICS, Op. 2.06 – Capital Punishment (1998), available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion206.page?>. The ethics statement includes an exception, however, for providing treatment in a situation in which an incompetent prisoner is “undergoing extreme suffering as a result of psychosis or any other illness.” *Id.* This position statement also includes the broad proscription 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.” *Id.* Additionally, the APA adopted the AMA’s policy on capital punishment in July 2008. See Am. Psychiatric Ass’n, Position Statement on Capital Punishment: Adoption of AMA Statements on Capital Punishment (July 2008), available at <http://www.psych.org/advocacy--newsroom/position-statements>.

30. Brief of American Psychiatric Association et al. as Amici Curiae Supporting Neither Party, *United States v. Loughner*, 672 F.3d 731 (9th Cir. 2012) (No. 11-10339), 2011 WL 3672689, at *12 [hereinafter Brief of APA & AAPL], available at <http://www.psychiatry.org/learn/library--archives/amicus-briefs>; see also E. FULLER TORREY, *SURVIVING SCHIZOPHRENIA: A MANUAL FOR FAMILIES, PATIENTS, AND PROVIDERS* 196 (5th ed. 2006) (stating that “[d]rugs are the most important treatment for schizophrenia, just as they are the most important treatment for many physical diseases of the human body”).

31. Brief of APA & AAPL, *supra* note 30, at *18.

capital case involving a mentally incompetent inmate who has a mental illness, the treating physician faces a moral dilemma between desiring to provide the best and most efficacious treatment to alleviate the symptoms of the inmate's illness while at the same time recognizing that the very treatment could, in all likelihood, restore the person's competence to then be executed.³²

The APA adopted a relevant position statement in 2005 regarding prisoners on death row with mental illnesses.³³ Subpart (d) of the policy position provides that if, after an execution date is established, the inmate has a mental disorder or disability that results in his or her incompetence to be executed, "the sentence of death should be reduced to a lesser punishment."³⁴ The APA formulated its position statement following the 2005 issuance of a Report of the Task Force on Mental Disability and the Law.³⁵ As to the overarching ethical concern, the drafters of the report explained that "[w]hether a person found incompetent to be executed should be treated to restore competence implicates not only the prisoner's constitutional right to refuse treatment but also the *ethical integrity of the mental health professions*."³⁶ The report also took the position that "treating a condemned prisoner, especially over his or her objection, for the purpose of enabling the state to execute the prisoner strikes many observers as barbaric and also violates the fundamental ethical norms of the mental health professions."³⁷ In addition to the physician-psychiatrists comprising

32. See *id.* at *5 ("For a physician, there may be special anguish in treating a capital defendant if such treatment could, eventually, prove to be a step on the long road towards execution of the defendant."). In this brief, the two organizations of psychiatrists argued that even in a capital case, Supreme Court precedent allows court-ordered medication treatment in earlier stages of the case to avoid risk of harm to others or to the inmate or for competence to stand trial. *Id.* at *4-6; see also discussion *infra* Part IV (discussing relevant Supreme Court medication decisions).

33. Am. Psychiatric Ass'n, Position Statement on Mentally Ill Prisoners on Death Row (Dec. 2005), available at <http://www.psych.org/advocacy--newsroom/position-statements>.

34. *Id.* ¶ (d).

35. See AM. PSYCHIATRIC ASS'N, REPORT OF THE TASK FORCE ON MENTAL DISABILITY AND THE DEATH PENALTY (2005) [hereinafter APA Task Force Report], available at <http://www.apa.org/pubs/info/reports/mental-disability-and-death-penalty.pdf>.

36. *Id.* at 12 (emphasis added). The Task Force included psychiatrists, psychologists, and law professors among its membership. See *id.* at 1 n.1 (listing the Task Force's members).

37. *Id.* at 12; see also Lyn Suzanne Entzeroth, *The Illusion of Sanity: The Constitutional and Moral Danger of Medicating Condemned Prisoners in Order to Execute Them*, 76 TENN. L. REV. 641, 657 (2009) (describing the decision of whether to take medication to treat the symptoms of a psychiatric illness, but which could lead to execution as being a "grisly choice" that "is as barbaric and inhumane as executing someone who is insane" and observing that "this dilemma forces the prisoner to either suffer the agonies of the 'delusions and hallucinations' that plague him or her when unmedicated or treat the symptoms of his or her illness and be executed"). But see Mossman, *supra* note 24, at 40 (contending that a psychiatrist's treatment of a death row inmate's mental illness is not the same as participation in an execution, and that the medical benefits of treatment "to the condemned inmate are not negated by one of the non-medical consequences of sanity—eligibility for execution—though they may be less welcome"); Melissa McDonnell & Robert T.M. Phillips, *Physicians Should Treat Mentally Ill Death Row Inmates, Even If Treatment Is Refused*, 38 J.L. MED. & ETHICS 774, 784 (2010) (arguing that even if a psychiatrist is treating an inmate under a *Harper* order and that execution is imminent, treatment

the APA, three other important groups have embraced the Task Force Report and endorsed largely identical policy statements relating to mental disabilities and the death penalty: the American Psychological Association, the American Bar Association (ABA), and the National Alliance on Mental Illness (NAMI).³⁸

A lawyer's ethical obligations to a client on death row can diverge from a psychiatrist's ethical responsibilities. The Preamble to the Texas Disciplinary Rules of Professional Conduct provides insight into the dilemma faced by an attorney who represents a death row inmate with mental illness who has been found incompetent to be executed.³⁹ The Preamble provides a delineation of a lawyer's responsibilities and includes the following in paragraph 3: "In all professional functions, a lawyer should zealously pursue [a] client's interests within the bounds of the law."⁴⁰ In zealously representing a client on death row, it is incumbent on the defense attorney to pursue lawful efforts to keep the prisoner from being executed. If it is possible or even likely that the inmate can attain competence for execution through treatment for his or her serious mental illness, the attorney should readily recognize that the administration of medication will not be in the client's long-term interests. Accordingly, the attorney should no doubt be concerned that as a legal matter, treatment could inexorably lead to the client's execution. Thus, from the perspective of that attorney's legal-ethical obligations of being a zealous advocate for the client, the attorney will endeavor to fight attempts by the state to seek any court-

should continue and observing that "[e]ven if the patient's execution is a consequence of the medical treatment, it is certainly a legally permissible consequence and may also be a morally permissible consequence if the primary purpose of the care was not to bring about the execution"). It should be noted, however, that these authors concluded their article by conceding that they had argued their "position as an academic function of task assignment, not necessarily as a representation of personal or professional conviction." McDonnell & Phillips, *supra*, at 786.

38. See E. Packard, *Associations Concur on Mental Disability and Death Penalty Policy*, 38 MONITOR ON PSYCHOL. 14 (2007), available at <http://www.apa.org/monitor/jan07/associations.aspx> (observing that these three organizations had actually followed the lead of the American Psychological Association in adopting policies that supporters hoped would "influence both case law and state legislation"). The American Psychological Association adopted the Task Force's recommendations in February 2005, followed by the APA later in 2005, and the ABA in 2006. See *id.* (quoting a Task Force member who indicated that to his knowledge, this was "the very first time in history that those four organizations have adopted the same position on anything"); see also Howard Zonana, *Physicians Must Honor Refusal of Treatment to Restore Competency by Non-Dangerous Inmates on Death Row*, 38 J.L. MED. & ETHICS 764, 765-67 (2010) (summarizing the evolution of the medical ethics guidelines relating to executions).

39. TEX. DISCIPLINARY RULES PROF'L CONDUCT Preamble, reprinted in TEX. GOV'T CODE ANN., tit. 2, subtit. G, app. A (West 2005 & Supp. 2012), available at [http://www.legalethics.texas.com/Ethics-Resources/Rules/Texas-Disciplinary-Rules-of-Professional-Conduct/Preamble-\(1\)/Preamble.aspx](http://www.legalethics.texas.com/Ethics-Resources/Rules/Texas-Disciplinary-Rules-of-Professional-Conduct/Preamble-(1)/Preamble.aspx).

40. *Id.* Preamble ¶ 3. In addition, paragraph 1 instructs that a "lawyer is a representative of clients, an officer of the legal system and a public citizen having special responsibility for the quality of justice." *Id.* ¶ 1. In turn, paragraph 5 provides that "[a]s a public citizen, a lawyer should seek improvement of the law, the administration of justice and the quality of service rendered by the legal profession." *Id.* ¶ 5.

ordered administration of medication for purposes of restoring the inmate's competence for execution.⁴¹

The tension between the attorney's zealous advocacy efforts—even if ethically required—and the corresponding medical concerns becomes apparent when the attorney is successful in persuading a court not to order involuntary treatment for the client's psychiatric illness. If the lawyer is able to obtain legal relief to prevent the state from an involuntary administration of psychotropic medications, the client will likely remain in an untreated state.⁴² Thus, for all practical purposes, because of the ethical obligation of zealous advocacy to avoid or delay the imposition of the client's execution, the lawyer is placed in the situation of having to turn a blind eye to the ongoing medical and psychiatric needs of a client who is suffering from the symptoms of an untreated mental illness. In contrast, from a medical perspective, medication treatment that can ameliorate the symptoms of a serious mental illness is available.⁴³ Thus, it is likely in the inmate's best interests medically to receive treatment for the individual's mental disease. Yet, if a physician provides such treatment—whether because of a court order or following the inmate's consent—the physician is forced to turn a blind eye to the likelihood that the inmate will regain competence to then be executed. Furthermore, treatment that will have the “likely effect of enabling the state to carry out an execution” of an inmate who is otherwise incompetent to be executed is unethical from a medical perspective.⁴⁴

The Texas statutes and relevant policies relating to competency for execution exacerbate these ethical challenges and the tensions between a treating physician's obligations and those of the inmate's legal counsel. Some thirteen years following the United States Supreme Court's decision in *Ford*, in which the Court held that the Constitution forbids executing a prisoner who is mentally incompetent,⁴⁵ the Texas Legislature in 1999 finally enacted statutory procedures to guide courts in determining whether a defendant sentenced to death is incompetent to be executed.⁴⁶ The

41. Correspondingly, the attorney would not be acting in the client's long-term legal interests in attempting to persuade the death row inmate client to take antipsychotic medication voluntarily given that it could result in the client's becoming competent to be executed.

42. A similar result arises if the attorney is successful in persuading the state not to seek a court order for forced medication.

43. See *supra* notes 30-31 and accompanying text.

44. See APA Task Force Report, *supra* note 35, at 12.

45. See *Ford v. Wainwright*, 477 U.S. 399, 409-10 (1986).

46. Act of May 21, 1999, 76th Leg., R.S., ch. 654, § 1, 1999 Tex. Gen. Laws 3225, amended by Act of May 22, 2005, 77th Leg., R.S., ch. 1420, § 21.001(13), 2001 Tex. Gen. Laws 4210, 4560 (renumbered from TEX. CODE CRIM. PROC. ANN. art. 46.04), amended by Act of May 23, 2007, 80th Leg., R.S., ch. 677, § 1, 2007 Gen. Laws 1258 (current version at TEX. CODE CRIM. PROC. ANN. art. 46.05 (West Supp. 2012)); see also Tex. House Office of Bill Analysis, Bill Analysis, Tex. H.B. 245, 76th Leg., R.S. (1999), available at <http://www.legis.state.tx.us/tlodocs/76R/analysis/html/HB00245F.htm> (reflecting that the bill sponsors recognized that the “United States Supreme Court held that the

legislation, which is codified at Article 46.05 of the Texas Code of Criminal Procedure, makes explicit the Constitutional mandate that an inmate “who is incompetent to be executed may not be executed.”⁴⁷ If the defendant’s motion and supporting documents are sufficient for the trial court to determine “that the defendant has made a substantial showing of incompetency, the court” is required to appoint “at least two mental health experts to examine the defendant.”⁴⁸ Thereafter, the trial court is to decide whether the inmate is incompetent to be executed.⁴⁹ If the trial court determines that the prisoner lacks execution competence, the court must transfer relevant portions of the file to the court of criminal appeals for its review of whether to adopt the trial court’s determination⁵⁰ and to decide whether to issue any stay of execution.⁵¹ The statute does not, however, address the provision of medical or psychiatric treatment to the death row

United States Constitution requires that a person sentenced to death be mentally competent to be executed”). The 2007 amendments equalized the opportunity for either the defense or the prosecution to appeal trial court findings as to whether the death row inmate is incompetent to be executed. See Tex. S. Research Ctr., Bill Analysis, Tex. H.B. 1545, 80th Leg., R.S. (2007), available at <http://www.legis.state.tx.us/tlodocs/80R/analysis/pdf/HB01545E.pdf#navpanes=0> (indicating that the Act equalized “the appellate rights for the prosecution and the defense and shift[ed] the method of district court determinations to a process similar to that adopted in habeas corpus proceedings”). The Texas Legislature’s 1999 codification of *Ford*-required procedures occurred some *eleven* years following a plea in 1988 by the Texas Court of Criminal Appeals. See *Ex parte Jordan*, 758 S.W.2d 250, 253 (Tex. Crim. App. 1988) (en banc) (discussing a “grave need” for legislation, “especially in light of *Ford*,” and seeking “immediate legislative resolve”). Indeed, the court in *Jordan* referenced the trial court’s concerns regarding “the alarming lack of any Texas statute specifying the procedures to be followed in raising and determining a defendant’s execution competency and in the treatment and periodic reassessment of competency following an incompetency finding.” *Id.* at 252 (emphasis added). The court of criminal appeals also noted that, despite the lack of statutory coverage post-*Ford*, “[a]t common law, Texas forbade execution of the insane and the 1879 through 1965 Codes of Criminal Procedure all contained statutes explicitly barring execution of the insane and setting out the general procedures to be followed once the issue was raised.” *Id.* at 253. The court stayed *Jordan*’s execution “until the trial court finds him competent for execution.” *Id.* at 255. Almost a quarter-century following the court’s decision in *Jordan*, Clarence Jordan remains on death row. See *Offender Information Details*, TEX. DEP’T CRIM. JUSTICE, <http://offender.tdcj.state.tx.us/POSdb2/offenderDetail.action?sid=01830291> (last visited Aug. 13, 2012).

47. TEX. CODE CRIM. PROC. ANN. art. 46.05(a) (West Supp. 2012).

48. CRIM. PROC. art. 46.05(f). These experts are to examine the defendant as to whether the defendant understands or does not understand “(1) that he or she is to be executed and that execution is imminent; and (2) the reason he or she is being executed.” CRIM. PROC. art. 46.05(h); see also *Wood v. Quarterman*, 572 F. Supp. 2d 814, 818 (W.D. Tex. 2008) (construing *Panetti v. Quarterman*, 551 U.S. 930 (2007), to require an additional showing of the defendant’s “rational understanding of the connection between his role in his offense and the punishment imposed upon him” and requiring that the state appoint counsel and a mental health expert to assist defendant with the threshold requirement of Article 46.05(f) of making a “substantial showing of incompetency”), vacated on other grounds, *Wood v. Thaler*, 787 F. Supp. 2d 458 (W.D. Tex. 2011).

49. CRIM. PROC. art. 46.05(k). The trial court’s decision is to be based on the experts’ reports, the inmate’s motion, the pleadings, and the evidence introduced at a competency hearing and to be decided by a preponderance of the evidence. *Id.*

50. CRIM. PROC. art. 46.05(l); see also TEX. CODE CRIM. PROC. ANN. art. 11.071, § 8(d) (West Supp. 2012) (listing those documents to be transferred to the court of criminal appeals).

51. CRIM. PROC. art. 46.05(l).

inmate, thereby leaving any treatment decisions under the purview of established procedures that might or might not be relevant to a death row inmate who is incompetent to be executed.⁵²

In particular, the statute does not speak to the medication issue that is the subject of this Article. Instead, the medical- and legal-ethical challenges arise primarily because of subsection (m) of Article 46.05, which provides the following:

(m) If a stay of execution is issued by the court of criminal appeals, the trial court periodically shall order that the defendant be reexamined by mental health experts to determine whether the defendant is no longer incompetent to be executed.⁵³

For all practical purposes, this subsection allows a death row inmate who has been adjudicated as being incompetent to be executed because of a severe psychiatric illness to remain in a state of fulminant and severe mental illness until such time that mental health experts ultimately find the inmate no longer to be incompetent—if ever.⁵⁴ As described above, this statutory requirement for medical experts to reexamine the inmate periodically can result in opposing and conflicting ethical dilemmas for the legal and medical professionals obligated either to represent their clients or to treat their patients.⁵⁵ Treatment with medication is likely appropriate and medically necessary to address the symptoms of the prisoner's mental illness, but that very treatment can result in restored competency for execution. Nonetheless, because treatment may well restore the inmate's competency, the inmate's attorney—in zealously representing the legal interests of the inmate within the limits of the law to avoid or postpone execution—is placed in the position of having to advise the client regarding the risks of consenting to the medication treatment or opposing the state's efforts to obtain court-ordered medication.

52. The policies relating to medical care within the Texas Department of Criminal Justice are under the auspices of the Correctional Managed Health Care Committee (CMHCC), which the state legislature has charged with developing and implementing a managed health care plan for all state prisoners. TEX. GOV'T CODE ANN. § 501.146 (West 2012). In addition, the CMHCC contracts on behalf of the state prison system “for complete health care services for offenders confined in the state’s incarceration facilities.” *Correctional Managed Health Care Committee*, CMHCC, http://www.cmhcc.state.tx.us/the_cmhcc.htm (last visited Aug. 13, 2012). Significantly, the CMHCC also develops and maintains the Correctional Managed Health Care Policy Manual, which is a compilation of policies and procedures for the provision of medical services within the state prison system. See *Correctional Managed Health Care Policy Manual*, CMHCC [hereinafter *Policy Manual*], available at http://www.cmhcc.state.tx.us/CMHC_Policy_Manual/TOC%20May%202010.htm (last visited Aug. 13, 2012).

53. CRIM. PROC. art. 46.05(m).

54. See discussion *supra* notes 27-32 and accompanying text.

55. See discussion *supra* notes 33-44 and accompanying text.

IV. THE BACKGROUND CASE LAW

In this Part of the Article, we will discuss case law relevant to the issue of whether a state can order forced medication for the purpose of restoring an inmate's competency to be executed. First, we will address pertinent United States Supreme Court precedent and, then, address state and lower federal court decisions that have directly considered the issue.

A. *United States Supreme Court*

Although the United States Supreme Court has not decided the issue of whether a state may forcibly medicate a defendant on death row for the purpose of restoring that defendant's competency to be executed, the Court has issued opinions in several relevant cases involving the administration of antipsychotic medications to persons in the criminal justice system. The seminal case is the Court's 1990 decision in *Washington v. Harper*, in which a state prisoner with mental illness (who was not on death row) attempted to refuse antipsychotic medication and challenged a state prison policy that permitted the forcible administration of the medication.⁵⁶

Walter Harper was a convicted felon who had a diagnosis of serious mental illness.⁵⁷ The state assigned him to its "Special Offender Center . . . , a 144-bed correctional institute established by the Washington Department of Corrections to diagnose and treat convicted felons with serious mental disorders."⁵⁸ Although Harper initially provided consent to prison psychiatrists for the administration of antipsychotic medications to treat his illness, he later refused to keep taking the prescribed drugs.⁵⁹ Following Harper's objections, the treating physician pursued a process set forth in a prison policy to obtain permission to treat Harper involuntarily.⁶⁰ That process authorized involuntary drug treatment provided that (1) the inmate suffered from a "mental disorder"; (2) he was "gravely disabled" according to state definitions or posed a "likelihood of serious harm" to self, others, or property; (3) a psychiatrist ordered the medication; and (4) the prison afforded an opportunity for "a hearing before a special committee consisting of a psychiatrist, a psychologist, and the Associate Superintendent of the Center, none of whom" could be involved in Harper's treatment or diagnosis.⁶¹ The policy also provided the inmate with certain

56. *Washington v. Harper*, 494 U.S. 210, 214, 217 (1990).

57. *See id.* at 214 & n.2 (observing that Harper initially had a diagnosis of manic depressive illness—now known as bipolar disorder—but that his diagnosis later changed to schizophrenia).

58. *Id.* at 214.

59. *Id.*

60. *Id.* The state had developed the policy "in partial response to" the Court's holding in an earlier case, *Vitek v. Jones*, 445 U.S. 480 (1980). *Harper*, 494 U.S. at 215.

61. *Id.* The committee could approve forced medication only by a majority vote, and the psychiatrist had to be in the majority. *Id.* at 215-16.

procedural rights including twenty-four hours notice of the hearing, notice of the diagnosis, the factual basis for the diagnosis, the reasons why the treating physician believed that medication was necessary, and rights to attend the hearing, to present evidence, to cross-examine witnesses, to have the assistance of a lay advisor, to appeal to the Center's Superintendent, and to seek subsequent judicial review.⁶²

State prison officials, following the process authorized by state law, imposed several medication treatment orders following Harper's refusal to take prescribed medications voluntarily.⁶³ Rather than seeking judicial review of the orders, Harper sought money damages and other relief when he later "filed suit in state court under 42 U.S.C. § 1983 (1982 ed.) against various individual defendants and the State, claiming that the failure to provide a judicial hearing before the involuntary administration of antipsychotic medication violated . . . both the Federal and State Constitutions, as well as state tort law."⁶⁴ Although the trial court recognized that Harper had a "liberty interest in not being subjected to the involuntary administration of antipsychotic medication," the court held that the procedures met due process requirements.⁶⁵ The Washington Supreme Court reversed, holding that due process required a judicial hearing prior to the administration of antipsychotic medication.⁶⁶ The United States Supreme Court then reversed the Washington Supreme Court, holding that the state prison's involuntary medication procedures met due process requirements and provided a permissible "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."⁶⁷

In reaching its decision, the majority in *Harper* recognized the government's interest in maintaining prison safety and emphasized that the drugs could "be administered for no purpose other than treatment, and only under the direction of a licensed psychiatrist" for inmates with mental illness who were either gravely disabled or posed a significant danger to themselves or others.⁶⁸ In turn, the Court rejected Harper's contention that due process required "a judicial decisionmaker," as opposed to the policy's specification of a three-person hearing panel "composed of a psychiatrist, a psychologist, and the Center's Associate Superintendent," none of whom

62. *Id.* at 216. The policy also called for periodic follow-up reviews in the event the medication order was issued. *Id.* These reviews were to take place seven days following the initial treatment and every fourteen days thereafter. *Id.*

63. *Id.* at 217.

64. *Id.*

65. *Id.* at 217-18.

66. *See id.* at 218 (citing *Harper v. State*, 759 P.2d 358, 364-65 (Wash. 1988) (en banc)).

67. *Id.* at 236.

68. *Id.* at 226.

could then be involved in the inmate's treatment or diagnosis.⁶⁹ The Court concluded "that an inmate's interests are adequately protected, and perhaps better served, by allowing the decision to medicate to be made by medical professionals rather than a judge."⁷⁰ In sum, the Court deemed the State's procedures to meet procedural due process requirements and held that the forcible administration of medication was substantively permissible given concerns both about prison and prisoner safety and that the drugs were to "be administered for *no purpose other than treatment*."⁷¹

As in *Harper*, a common thread in the Court's later decisions involving antipsychotic medications in the criminal justice process relates to the medical appropriateness of the medications. For example, subsequent to *Harper*, the Court again addressed an issue pertaining to antipsychotic medication in *Riggins v. Nevada*.⁷² In *Riggins*, the defendant faced murder charges and was voluntarily taking antipsychotic medications in the jail.⁷³ After the trial court found him competent to stand trial, his defense moved for a suspension of the medications that he had been taking.⁷⁴ The defendant urged that—as part of offering an insanity defense at trial—he should have the right to demonstrate to jurors a more accurate view of his mental state at the time of the underlying offense.⁷⁵ The trial court denied the motion, and *Riggins* was convicted of murder and sentenced to death.⁷⁶ The Court in *Riggins* relied on *Harper* to declare that "Nevada certainly would have satisfied due process if the prosecution had demonstrated, and the District Court had found, that treatment with

69. *Id.* at 228-29.

70. *Id.* at 231. "The risks associated with antipsychotic drugs are for the most part medical ones, best assessed by medical professionals." *Id.* at 233.

71. *Id.* at 226 (emphasis added). Texas has adopted prison procedures somewhat consistent with those at issue in *Harper* to authorize involuntary medication treatment following a limited, non-judicial administrative process. *Policy Manual*, *supra* note 52, § 1.67.1. As was the case in *Harper*, there is no adversarial hearing before a judge. Instead, in the case of a non-emergency situation, the process involves an administrative hearing before a "non-treating, psychiatrist/psychiatric mid-level practitioner." *Id.* § V.D, at 3. Other participants include the inmate and the "treating psychiatrist/psychiatric mid-level practitioner." *Id.* § V.D, at 3. The policy defines a non-emergency as one in which a prisoner with mental illness refuses to take medication voluntarily, and without the medication, the person is likely to continue to suffer "from severe and abnormal mental, emotional and physical distress or deterioration of the patient's ability to function independently." *Id.* § I.B, at 1. There are fewer procedures in an emergency situation, which is defined as one in which the inmate who has refused medication is "imminently likely to cause serious harm to the patient and/or others due to mental illness." *Id.* § I.A. In such a situation, there is no hearing, but a "non-treating psychiatrist/psychiatric mid-level practitioner" must "examine the patient and agree or disagree with the decision to compel medications," and there must be documentation in the inmate's health record. *Id.* § IV.C, at 2. This process would appear to be woefully inadequate procedurally to protect the constitutional rights of a death row inmate who has been found incompetent to be executed due to mental illness, as treatment would lead to execution rather than a return to the routine of prison life.

72. *Riggins v. Nevada*, 504 U.S. 127 (1992).

73. *Id.* at 129-30.

74. *Id.* at 130.

75. *Id.*

76. *Id.* at 131.

antipsychotic medication was medically appropriate, and considering less intrusive alternatives, essential for the sake of Riggins' own safety or the safety of others."⁷⁷ The Court also reasoned that the state could have "[justif[ied] medically appropriate, involuntary treatment with the drug by establishing that it could not obtain an adjudication of Riggins' guilt or innocence by using less intrusive means."⁷⁸ The Court appeared troubled, however, by the record in *Riggins* given that the trial court had "denied Riggins' motion to terminate medication with a one-page order that gave no indication of the court's rationale."⁷⁹ The Court described the order as "laconic" and expressed concern that the order made no determination about the need for continuing the medication and included no "findings about reasonable alternatives."⁸⁰ The Court remanded the case after concluding the following: "Because the record contains no finding that might support a conclusion that administration of antipsychotic medication was necessary to accomplish an essential state policy . . . , we have no basis for saying that the substantial probability of trial prejudice in this case was justified."⁸¹

Of course, although it was a death penalty case involving an offender with mental illness, the Court in *Riggins* did not have before it the issue of whether the government can order the administration of antipsychotic medication to a defendant with mental illness for the purpose of assuring that the defendant is competent to be executed. In a later case, the Court in 2003 decided *Sell v. United States*, which involved the somewhat related question of "whether the Constitution permits the Government to administer antipsychotic drugs involuntarily to a mentally ill criminal defendant—in order to render that defendant competent to stand trial for serious, but nonviolent, crimes."⁸² The Court concluded that the Constitution, indeed, permits doing so "in limited circumstances . . . upon satisfaction of conditions," which the Court delineated.⁸³

77. *Id.* at 135.

78. *Id.*

79. *Id.* at 131.

80. *Id.* at 136. Given the sketchy record, the Court commented, "Efforts to prove or disprove actual prejudice from the record before us would be futile, and guesses whether the outcome of the trial might have been different if Riggins' motion had been granted would be purely speculative." *Id.* at 137.

81. *Id.* at 138.

82. *Sell v. United States*, 539 U.S. 166, 169 (2003). Accordingly, the case involved competency to stand trial and not execution competency. *See id.* To be competent to stand trial, a criminal defendant must be able to consult with an attorney "with a reasonable degree of rational understanding" and have "a rational as well as factual understanding of the proceedings." *Dusky v. United States*, 362 U.S. 402, 402 (1960).

83. *Sell*, 539 U.S. at 169. The ensuing discussion of *Sell* is drawn largely from a prior article by one of the authors. *See* Brian D. Shannon, *Prescribing a Balance: The Texas Legislative Responses to Sell v. United States*, 41 ST. MARY'S L.J. 309, 311-15 (2009) (discussing *Sell* and the Court's factors for decision making in such cases).

Charles Sell was a former dentist with a long history of mental illness.⁸⁴ The federal government charged him with mail fraud, Medicaid fraud, and money laundering in connection with the submission of “fictitious insurance claims for payment.”⁸⁵ In 1998, “the grand jury issued a new indictment charging Sell with attempting to murder the FBI agent who had arrested him and a former employee who planned to testify against him in the fraud case.”⁸⁶ In 1999, a federal magistrate found Sell to be incompetent to stand trial and ordered him to be hospitalized for competency restoration treatment.⁸⁷ Thereafter, the treatment facility sought permission to administer antipsychotic medication to Sell after he refused to do so voluntarily.⁸⁸ After a hearing, a federal magistrate found that Sell was a danger to himself and others, that the drugs would render him less dangerous, and that there was a substantial probability that the medication would restore Sell’s competency to stand trial.⁸⁹ Thereafter, the district court found the magistrate’s factual determination that Sell was dangerous to be clearly erroneous but nonetheless upheld the medication order on the grounds that the antipsychotic medications were “medically appropriate” and were “necessary to serve the government’s compelling interest in obtaining an adjudication of [the] defendant’s guilt or innocence of numerous and serious charges.”⁹⁰ A divided panel of the court of appeals affirmed the judgment upholding the order but agreed with the district court’s determination that the evidence did not support a finding that Sell was a danger to himself or others while at the treatment facility.⁹¹ The Supreme Court granted certiorari to consider whether the lower courts had erred in “allowing the government to administer antipsychotic medication [to Sell] against his will solely to render him competent to stand trial for non-violent offenses.”⁹² In framing its analysis, the Court in *Sell* observed that *Harper* and *Riggins* had determined

that the Constitution permits the Government involuntarily to administer antipsychotic drugs to a mentally ill defendant facing serious criminal charges in order to render that defendant competent to stand trial, but only if the treatment is medically appropriate, is substantially unlikely to have side effects that may undermine the fairness of the trial, and, taking

84. *Sell*, 539 U.S. at 169.

85. *Id.* at 170.

86. *Id.*

87. *Id.* at 171.

88. *Id.*

89. *Id.* at 173. The magistrate stayed the order to administer the medication to allow Sell a chance to appeal to the district court. *Id.*

90. *Id.* at 174.

91. *Id.*

92. *Id.* at 175 (quoting Sell’s brief).

account of less intrusive alternatives, is necessary significantly to further important governmental trial-related interests.⁹³

Accordingly, the Court in *Sell* concluded that the foregoing “standard will permit involuntary administration of drugs solely for trial competence purposes in certain instances.”⁹⁴ The Court then provided a framework for trial courts to apply in analyzing and balancing the competing interests as part of considering whether to issue an order for the administration of antipsychotic medication for the sole purpose of rendering a defendant competent to stand trial.⁹⁵ In particular, the Court identified four areas for trial courts to consider:

(1) Significance of governmental interests. Is the government’s interest in bringing the individual to trial important?⁹⁶ Is the offense a serious crime against a person or property?⁹⁷ Would the “defendant’s failure to take drugs voluntarily . . . mean lengthy confinement in an institution for the mentally ill” and thereby “diminish the risks that ordinarily attach to freeing without punishment one who has committed a serious crime”?⁹⁸ Would it “be difficult or impossible to try a defendant who regains competence after years of commitment during which memories may fade and evidence may be lost”?⁹⁹

(2) Furtherance of governmental interests. Will the involuntary medication serve to further the governmental interests?¹⁰⁰ That is, will the administration of the drugs be “substantially likely to render the defendant competent to stand trial” but be “substantially unlikely to have side effects that will interfere significantly with the defendant’s ability to assist counsel in conducting a trial defense”?¹⁰¹

(3) Consideration of alternatives. Is the involuntary medication necessary to further the governmental interests?¹⁰² In this regard, has the trial court considered “any alternative, less intrusive treatments” and whether these “are unlikely to achieve substantially the same results”?¹⁰³

93. *Id.* at 179 (referencing *Washington v. Harper*, 494 U.S. 210, 226 (1990), and *Riggins v. Nevada*, 504 U.S. 127, 137-38 (1992)).

94. *Id.* at 180. The Court, however, indicated that “those instances may be rare.” *Id.*

95. *Id.* at 180-81.

96. *Id.* at 180.

97. *Id.*

98. *Id.*

99. *Id.*

100. *Id.* at 181.

101. *Id.*

102. *Id.*

103. *Id.*

(4) Medical appropriateness. Will the “administration of the drugs” be “*medically appropriate, i.e.,* in the patient’s best medical interest in light of his medical condition”?¹⁰⁴

B. Lower Courts

Although the Supreme Court has not addressed the issue of forced medication for the purpose of restoring a death row inmate’s competency to be executed, several state and lower federal courts have done so. As will be described below, almost all of these courts have invalidated such orders.

1. Louisiana

In 1992, the Louisiana Supreme Court in *State v. Perry* cogently framed the issue as follows:

The fundamental question raised by this case is whether the state can circumvent the centuries old prohibition against execution of the insane by medicating an incompetent death row prisoner against his will with antipsychotic drugs and carrying out his death sentence while he is under the influence of the drugs.¹⁰⁵

104. *Id.* The Court also emphasized that *prior to* applying the foregoing test, a trial court should first consider whether forced medication would be permissible or warranted on other grounds. *See id.* at 181-82 (“A court need not consider whether to allow forced medication [for the purpose of rendering a criminal defendant competent to stand trial] if forced medication is warranted for a *different* purpose, such as . . . the individual’s dangerousness, or . . . where refusal to take drugs puts his health gravely at risk.”). In this regard, the Court observed that “courts typically address involuntary medical treatment as a civil matter, and justify it” on grounds such as when it is “in the best interests of a patient who lacks the mental competence to make such a decision” or “where the patient’s failure to accept treatment threatens injury to the patient or others.” *Id.* at 182. Accordingly, the Court opined that a criminal court “should ordinarily determine whether the Government seeks, or has first sought, permission for forced administration of drugs on these other . . . grounds” before approving “forced administration of drugs for purposes of rendering a defendant competent to stand trial.” *Id.* at 183. After setting forth its analytical approach, the Court determined that the orders affecting Sell could not stand and that the case should be remanded for further proceedings consistent with the opinion. *Id.* at 186. The magistrate’s orders had been premised primarily on a finding that Sell was dangerous. *Id.* at 183. But, because the district and circuit courts had determined that the findings of dangerousness were clearly erroneous, the Court was of the view that the “lower courts had not adequately considered trial-related side effects, the impact on the sentence of Sell’s already-lengthy confinement, and any potential future confinement that might lessen the importance of prosecuting him.” *See* Douglas Mossman et al., *AAPL Practice Guideline for the Forensic Psychiatric Evaluation of Competence to Stand Trial*, 35 J. AM. ACAD. PSYCHIATRY & L. S3, S11 (Supp. 2007), available at <http://www.aapl.org/pdf/Competence%20to%20Stand%20Trial.pdf> (summarizing *Sell*). For a detailed discussion of the Texas Legislature’s statutory responses to the *Sell* test, see Shannon, *supra* note 83, at 322-49.

105. *State v. Perry*, 610 So. 2d 746, 747 (La. 1992). The state had convicted the inmate, Michael Owen Perry, and sentenced him to death “for murdering his mother, father, nephew and two cousins in a senseless criminal episode in 1983.” *Id.* at 748. He had a “long history of mental illness,” had first been diagnosed with schizophrenia at the age of sixteen, and had been committed several times to mental institutions by his parents. *Id.*

In *Perry*, the trial court had conducted a hearing to determine Perry's competence to be executed and thereafter "found that the inmate was insane but susceptible to being made able to understand the link between his crime and punishment by antipsychotic drugs."¹⁰⁶ In turn, the "trial court ordered the state to administer antipsychotic drugs to the prisoner for this purpose, without his consent if necessary."¹⁰⁷ Perry did not consent, and instead sought review in the state courts and by the United States Supreme Court.¹⁰⁸ Although the Supreme Court granted certiorari, accepted briefs, and heard oral arguments, the Court "vacated the trial court's order and remanded the case for further proceedings in light of *Washington v. Harper*."¹⁰⁹ In turn, the Louisiana "trial court reinstated its order" to compel medication.¹¹⁰ On appeal, the Louisiana Supreme Court affirmed the trial court's determination that Perry was incompetent to be executed without the use of antipsychotic drugs but reversed the lower court's "order requiring the state to medicate Perry with antipsychotic drugs without his consent."¹¹¹ Accordingly, the Louisiana Supreme Court stayed Perry's execution but left open the possibility that the state could still pursue an execution should Perry ever achieve or regain competency "independently of and without the influence of antipsychotic drugs."¹¹²

In reaching its decision, the Louisiana court in *Perry* first contrasted the issue before it from the situation involved in *Washington v. Harper*, which the court construed as "a case involving the forcible medical treatment of a mentally ill prisoner in his own best medical interest and for the safety of himself and others in the prison."¹¹³ The *Perry* court distinguished *Harper* for two reasons: (1) that "forcing a prisoner to take antipsychotic drugs to facilitate his execution does not constitute medical treatment but is antithetical to the basic principles of the healing arts"¹¹⁴ and (2) that unlike the prison regulation in *Harper*, which met due process requirements because it rationally sought "to further both the best medical interest of the prisoner and the state's own interest in prison safety," the State in *Perry* had not made either showing by seeking "forcible medication

106. *Id.* at 747.

107. *Id.*

108. *See id.* (noting that the Louisiana Supreme Court initially denied review but that the United States Supreme Court granted certiorari in *Perry v. Louisiana*, 494 U.S. 1015 (1990)).

109. *Id.* (citing *Perry*, 498 U.S. at 38, and *Washington v. Harper*, 494 U.S. 210 (1990)). For a discussion of *Harper*, see *supra* notes 56-71 and accompanying text.

110. *Perry*, 610 So. 2d at 747.

111. *Id.*

112. *Id.*

113. *Id.* at 751.

114. *Id.* The court, in part relying on the Hippocratic Oath from the fifth century B.C., observed that, "[u]nder the oath, the physician pledges to do no harm and to act only in the best medical interests" of that doctor's patients and that "medical treatment cannot occur when the state orders a physician to administer antipsychotic drugs to an insane prisoner in an attempt to render him competent for execution." *Id.* at 752 (emphasis added).

of a prisoner by court order as an instrument of his execution.”¹¹⁵ As to the first point, the court reasoned that because a physician is supposed “to alleviate suffering and to do no harm,” a forced medication order requires the doctor “to act unethically and contrary to the goals of medical treatment.”¹¹⁶ In addition, the court summarized the ethical conundrum raised by the situation as follows:

If any physician administers drugs forcibly and thereby enables the state to have the inmate declared competent for execution, the doctor knowingly handles the prisoner harmfully and contrary to his ultimate medical interest. The physician's abstention from dispensing the drugs, however, perpetuates suffering that ordinarily the physician is duty-bound to allay by treatment.¹¹⁷

Accordingly, the court concluded that the action sought by the State did “not constitute medical treatment but form[ed] part of the capital punishment sought to be executed by the state.”¹¹⁸ Because the purpose was not for medical treatment, the court concluded that the trial court order was contrary to *Harper*.¹¹⁹

Separate from its analysis of federal constitutional issues, the court also determined that the trial court’s order violated the Louisiana state constitution.¹²⁰ As part of its analysis of the state constitutional issues, the court observed the following relating to concerns about medical ethics:

When antipsychotic drugs are forcibly administered to further the state’s interest in carrying out capital punishment, and therefore *not* done in the prisoner’s best medical interest, the intrusion represents an *extremely severe* interference with that person’s liberty. The object of the intrusion is hostile in the utmost instead of beneficent, and the trustful,

115. *Id.* at 751.

116. *Id.* at 752.

117. *Id.*

118. *Id.* at 753.

119. *Id.* at 755 (observing also that *Harper* “strongly implies that antipsychotic drugs absolutely may not be used as a tool for punishment”); see also Holland Sergent, Comment, *Can Death Row Inmates Just Say No?: The Forced Administration of Drugs to Render Inmates Competent for Execution in the United States and Texas*, 35 TEX. TECH L. REV. 1299, 1311 (2004) (suggesting that *Harper* and *Perry* created a “questionable loophole” that could undermine *Perry* in that *Perry* would afford protection to a death row inmate “when the state admits that its purpose is medicating to execute, rather than dangerousness”); Bruce A. Arrigo & Christopher R. Williams, *Law, Ideology, and Critical Inquiry: The Case of Treatment Refusal for Incompetent Prisoners Awaiting Execution*, 25 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 367, 378 (1999) (contending that the “applicability of *Perry* only extends to those cases in which the state admits its purpose: medicate to execute”).

120. *Perry*, 610 So. 2d at 755-56.

communicative doctor-patient relationship essential to the effective humane administration of antipsychotic drugs cannot exist.¹²¹

Thus, the *Perry* court rejected the State's desired medication order on both federal and state constitutional grounds.

2. South Carolina

One year following the Louisiana Supreme Court's decision in *Perry*, the South Carolina Supreme Court reached a similar result in *Singleton v. State*.¹²² Like the court in *Perry*, the *Singleton* court determined that *Harper* and *Riggins* controlled the analysis of "whether the State can administer, by force, medication to treat [the defendant] Singleton's incompetence in preparation for execution."¹²³ And, similar to *Perry*, the *Singleton* court determined that its state constitution "would be violated if the State were to sanction forced medication solely to facilitate execution."¹²⁴ Unlike *Perry*, however, beyond citing and briefly discussing *Harper* and *Riggins*, the *Singleton* court based its holding regarding forced medication solely on state constitutional grounds and did not further examine the question under federal due process analysis.¹²⁵ The court reasoned, however, that its state constitutional protection of a right of privacy, as well as federal due process, "require that an inmate can only receive forced medication where the inmate is dangerous to himself or others, and then only when it is in the inmate's best medical interest."¹²⁶

121. *Id.* at 758. The court also reasoned that an execution following forced medication to make the inmate competent did "not measurably contribute to the social goal of retribution." *Id.* at 767. More than a decade following the decision in *Perry*, the Louisiana state legislature enacted a set of procedures to be applied to situations involving a death row inmate's mental incompetence to proceed to execution. See LA. REV. STAT. ANN. § 15:567.1 (2012) (codifying 2004 La. Acts No. 720), available at http://legis.la.gov/leg_docs/04RS/CVT3/OUT/0000LVUA.PDF. Subsection F of the statute makes explicit that a competency examination of the death row inmate "shall be conducted only when the petitioner is not under the influence of any psychotropic medication." § 15:567.1(F). Thus, the statute requires the examiner to evaluate the inmate's mental condition in an un-medicated state. *Id.* Ironically, despite the state supreme court's holding in *Perry*, the original bill had included language that would have required a court to order medication treatment for an inmate found to be incompetent to proceed to execution if the inmate first refused any offered treatment. S.B. 781, 2004 Leg., Reg. Sess., § 15:567.1(L) (La. 2004) (Original Bill), available at http://legis.la.gov/leg_docs/04RS/CVT7/OUT/0000LD1V.PDF. During the legislative process, however, the state senate committee amended the bill to remove the invalid provision. S.B. 781, 2004 Leg. Reg. Sess., amend. No. 5 (La. 2004) (Senate Committee Amendments), available at http://legis.la.gov/leg_docs/04RS/CVT4/OUT/0000LK3Q.PDF.

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

123. *Id.* at 60 (discussing *Washington v. Harper*, 494 U.S. 210 (1990), and *Riggins v. Nevada*, 504 U.S. 127 (1992)).

124. *Id.* at 60-61 (recognizing that the Louisiana Supreme Court had relied on a state constitutional ground in *Perry*).

125. See *id.* at 60 (recognizing that *Harper* and *Riggins* control the federal due process analysis of the issue; the court, however, provided no further discussion of the federal issue given its resolution of the case under state constitutional grounds).

126. *Id.* at 61.

The court also gave weight to the adopted positions of the AMA and the APA “in their respective ethical codes opposing participation by medical professionals in the legally-authorized execution of a prisoner.”¹²⁷ The court concluded that “justice can never be served by forcing medication on an incompetent inmate for the sole purpose of getting him well enough to execute.”¹²⁸

3. *United States Court of Appeals for the Eighth Circuit*

In contrast to the other state and lower federal court decisions regarding the forced administration of medication to a death row inmate found incompetent to be executed, in 2003 the Eighth Circuit Court of Appeals, sitting en banc, reached a contrary result in *Singleton v. Norris*.¹²⁹ The facts in *Singleton v. Norris*, however, differed somewhat from those in *Perry* and *Singleton v. State*. In *Norris*, the State of Arkansas had convicted Charles Singleton in 1979 of capital murder and aggravated robbery and sentenced him to death.¹³⁰ While Singleton was on death row in 1997, Arkansas placed him “on an involuntary medication regime after a medication review panel unanimously agreed that he posed a danger to himself and others.”¹³¹ The medication restored Singleton’s competency to be executed, and in early 2000 the state scheduled his execution.¹³² In February 2000, Singleton filed a petition for habeas corpus and urged “that the State could not constitutionally restore his *Ford* competency through use of forced medication and then execute him.”¹³³ The district court denied the petition, and while the appeal was pending, Singleton’s doctors did not renew the 1997 involuntary medication order upon an annual review of the order.¹³⁴ Thereafter, Singleton continued to take his medication voluntarily.¹³⁵ Thus, at the time of the *Norris* appeal, there was no forced medication order in place.¹³⁶ The court nonetheless deemed there to be a live controversy, reasoning that should the inmate “refuse to take his

127. *Id.* (noting the “causal relationship between administering a drug which allows the inmate to be executed, and the execution itself” and that the medical associations “opine that the administration of the drug is responsible for the inmate’s ultimate death”). For further discussion of the positions of the AMA and the APA, see *supra* notes 27-38 and accompanying text.

128. *Id.* at 62. Singleton also apparently had organic brain damage, and the medical testimony indicated that he likely would not become competent even if the state had been allowed to forcibly administer medication. *See id.* at 61.

129. *Singleton v. Norris*, 319 F.3d 1018 (8th Cir. 2003) (en banc).

130. *Id.* at 1020.

131. *Id.* at 1021. The court also observed that “Singleton was placed under a *Harper* involuntary medication order in 1997.” *Id.* at 1022 (referring to *Washington v. Harper*, 494 U.S. 210 (1990)).

132. *See id.* at 1021 (noting that once on medication, “Singleton’s psychotic symptoms abated”).

133. *Id.*

134. *Id.* at 1022.

135. *Id.*

136. *See id.*

medication, the State would be obligated to medicate him to control his psychotic symptoms, thereby reviving his claim.”¹³⁷

After reviewing the Supreme Court’s opinions in *Harper* and *Riggins*, and its own opinion in *Sell*,¹³⁸ the *Norris* court framed the issue as “whether the antipsychotic medication is medically appropriate for Singleton’s treatment.”¹³⁹ Singleton had contended “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.”¹⁴⁰ The court stated that “Singleton presents the court with a choice between involuntary medication followed by execution and no medication followed by psychosis and imprisonment. Faced with these two unpleasant alternatives, he offers a third solution: a stay of execution until involuntary medication is no longer needed.”¹⁴¹ In rejecting Singleton’s contentions, the court recognized that the medication had been effective in treating the symptoms of Singleton’s mental illness and that “[e]ligibility for execution is the only unwanted consequence of the medication.”¹⁴² In turn, the court took the view that the “best medical interests of the prisoner must be determined without regard to whether there is a pending date of execution” and held that “the mandatory medication regime, valid under the pendency of a stay of execution, does not become unconstitutional under *Harper* when an execution date is set.”¹⁴³

Judge Heaney, writing for a four-judge dissent in *Norris*, expressed skepticism that the state’s motive in medicating Singleton was solely “to improve his well-being.”¹⁴⁴ Although the State had conceded in its brief and at oral argument that it could “not medicate Singleton for the express purpose of rendering him competent for execution,” the dissent was concerned that the State’s interest in vigorously pursuing the goal of carrying out a sentence of execution could “lead it to obscure the true reasons for forcibly medicating an inmate into competence.”¹⁴⁵ As the dissent explained,

137. *Id.*

138. *United States v. Sell*, 282 F.3d 560 (8th Cir. 2002), *vacated*, 539 U.S. 166 (2003). The court in *Norris* issued its opinion prior to the Supreme Court’s resolution of *Sell*.

139. *Norris*, 319 F.3d at 1025 (calling it the “core of the dispute”).

140. *Id.* at 1026. The court also observed that “Singleton does not dispute that the antipsychotic medication is in his medical interest during the pendency of a stay of execution. He has stated he takes it voluntarily because he does not like the symptoms he experiences without it.” *Id.*

141. *Id.*

142. *Id.*

143. *Id.* In addition, the court also reasoned that it was not unconstitutional for a state to execute “a prisoner who became incompetent during his long stay on death row but who subsequently regained competency through appropriate medical care.” *Id.* at 1027.

144. *Id.* at 1035 (Heaney, J., dissenting).

145. *Id.* at 1035 & n.10.

The problem with pinning the constitutionality of a prisoner's execution to the State's intent in forcibly medicating him is that it will often be difficult to determine whether the State is medicating a prisoner to protect him from harming himself or others, or whether the State is medicating the inmate to render him competent for execution. Moreover, such an inquiry rests on the faulty assumption that the State maintains one exclusive motive for its actions In light of the record, it is simply illusory for our court to conclude that it can discern the State's single, directed motivation for forcibly medicating Singleton.¹⁴⁶

Accordingly, the dissent was of the view that once the state sets an execution date, the state's "true motivation for administering the medication" is called into question.¹⁴⁷

The dissenting judges also expressed grave concern that the majority had "created a serious ethical dilemma for the medical community as a result of its opinion" and that the court's decision would "inevitably result in forcing the medical community to practice in a manner contrary to its ethical standards."¹⁴⁸ After referencing the AMA's and the APA's ethical standards, the dissent urged that the majority opinion had placed "doctors who are treating psychotic, condemned prisoners in an untenable position: treating the prisoner may provide short-term relief but ultimately result in his execution, whereas leaving him untreated will condemn him to a world . . . filled with disturbing delusions and hallucinations."¹⁴⁹

4. *United States Court of Appeals for the Sixth Circuit*

In contrast to the majority opinion in *Singleton v. Norris*, a 2009 decision by a panel of the Sixth Circuit called into question the constitutionality of "rendering a prisoner competent for execution through involuntary medication."¹⁵⁰ The court in *Thompson v. Bell* recognized that the Supreme Court has not "squarely addressed" the issue but opined that the "logical inference" from the Court's decisions in *Harper*, *Riggins*, and

146. *Id.* at 1036.

147. *See id.* (indicating that once the execution date is set, any justification under *Harper* for medicating the death row inmate evaporates). The dissenting judges also examined Singleton's long medical and psychiatric history from his years on death row. *Id.* at 1030-33. At times, Singleton voluntarily took antipsychotic medication, but the state ordered medication at other times. *Id.* at 1030. The dissent also chronicled numerous instances of Singleton's bizarre ideations and behavior. *See id.* at 1030-32 (detailing delusions such as Singleton's belief of demon possession, an implanted device in his ear, stolen thoughts, being a victim of voodoo curse, food turning to worms, cigarettes becoming bones and beliefs that he was God and the Supreme Court, he was hearing voices, and his murder victim was not dead). The dissent also observed that in 2000, a psychiatrist who evaluated Singleton's competency "determined that Singleton was not competent . . . when he was off his medication in 1997, and that he would clearly be psychotic if his medication was discontinued." *Id.* at 1032.

148. *Id.* at 1036-37.

149. *Id.* at 1037.

150. *Thompson v. Bell*, 580 F.3d 423, 439-41 (6th Cir. 2009), *cert. denied*, 131 S. Ct. 102 (2010).

Sell “is that subjecting a prisoner to involuntary medication when it is not absolutely necessary or medically appropriate is contrary to the ‘evolving standards of decency’ that underpin the Eighth Amendment.”¹⁵¹ The court’s analysis was dicta, however, given its view that Thompson had failed to state a claim.¹⁵² The court observed that Thompson was “not being forcibly medicated” at the time and that “[a]lthough he may be right that the state would forcibly medicate him if he stopped taking his medication voluntarily,” he had not presented those facts to the court.¹⁵³

5. Pennsylvania

Although not directly on point, in 2008 the Pennsylvania Supreme Court issued two decisions on the same day in cases that presented the identical issue of whether the state could compel antipsychotic medication to incompetent death row inmates to render them competent to decide whether to pursue actions under Pennsylvania’s Post Conviction Relief Act (PCRA).¹⁵⁴ In both *Commonwealth v. Sam* and *Commonwealth v. Watson*, the court held that the state could involuntarily medicate the death row inmates to render them competent to be able to consult with their attorneys regarding their pursuit of statutory post-conviction appeal rights.¹⁵⁵ Neither case, however, involved the question of competence for execution. In fact, in *Sam* the court was careful to point out that the issue of forcing medication for the purpose of execution competence was not before it.¹⁵⁶ In resolving the cases, the court reviewed the requested medication orders under the four *Sell* factors¹⁵⁷ and assigned great weight to the state’s interest in obtaining finality to the cases and appeals.¹⁵⁸ Although one could certainly suggest that a state would have a similar interest in a case’s

151. *Id.* at 440 (quoting *Trop v. Dulles*, 356 U.S. 86, 101 (1958)).

152. *See id.* at 441.

153. *Id.* The court accordingly affirmed the district court’s dismissal of Thompson’s “chemical competency claim” but “without prejudice to Thompson raising a chemical competency claim in the future should he be forcibly medicated.” *Id.*

154. *See Commonwealth v. Sam*, 952 A.2d 565 (Pa. 2008); *Commonwealth v. Watson*, 952 A.2d 541 (Pa. 2008) (considering the issue as it related to the two inmates’ competency to make decisions to pursue relief under the state’s PCRA, 42 PA. CONS. STAT. ANN. §§ 9541-9546 (West 2007)).

155. *See Sam*, 952 A.2d at 588; *Watson*, 952 A.2d at 563 (providing guidance to the lower courts in the event that the medication did not restore either inmate’s competency).

156. *See Sam*, 952 A.2d at 578 (observing that the issue of competency to be executed was not before the court but was “a distinct and unripe question we do not address here”); *id.* at 587 (“In this case . . . we are not called upon to determine whether appellee may be forcibly medicated in order to be rendered competent for execution.”).

157. *Sell v. United States*, 539 U.S. 166, 180-81 (2003). For a discussion of the four *Sell* factors, see *supra* notes 95-104 and accompanying text. *See also Sam*, 952 A.2d at 573-83; *Watson*, 952 A.2d at 554-62 (discussing *Sell* and considering the facts of each case under the *Sell* factors). The parties had assumed that the *Sell* factors should apply. *Sam*, 952 A.2d at 575 (“[T]he parties assume that *Sell*’s four-factor test applies.”).

158. *Sam*, 952 A.2d at 576-77; *Watson*, 952 A.2d at 556-58.

finality if the issue involved competency for execution, any decision making regarding the pursuit of post-conviction appeal rights occurs at a much earlier stage in the proceedings than the period following the setting of an execution date.¹⁵⁹ In addition, the *Watson* court indicated that Pennsylvania had even offered a conversion of the inmate's sentence in that case to a life term if he in turn would drop challenges to his convictions.¹⁶⁰

C. Synthesis

The weight of lower court authority supports the view that a state cannot involuntarily medicate a death row inmate who has been found incompetent to be executed for the purpose of restoring that inmate's competence for execution.¹⁶¹ Moreover, the Supreme Court's decisions in *Harper*, *Riggins*, and *Sell* have all emphasized the need for courts to consider the medical appropriateness of medication treatment.¹⁶² It is difficult to conceive of any medical appropriateness for treatment that inexorably facilitates an execution.¹⁶³ Ultimately, however, the Supreme

159. See *Sam*, 952 A.2d at 578-79 (discussing generally the additional procedural steps that would need to ensue prior to the finality of an execution, including the Governor's issuance of a warrant of execution); see also *Bonnie*, *supra* note 25, at 1182-83 (suggesting that with regard to the seeking of post-conviction remedies prior to the setting of an execution date, the prisoner could have "an incentive to seek treatment" and that "mental health professionals should have no ethical qualms about providing requested treatment on a consensual basis").

160. See *Watson*, 952 A.2d at 557 (observing additionally that "almost a quarter century has passed" since *Watson*'s sentencing); see also Dominic Rupprecht, Comment, *Compelling Choice: Forcibly Medicating Death Row Inmates to Determine Whether They Wish to Pursue Collateral Relief*, 114 PENN ST. L. REV. 333, 347-57 (2009) (discussing *Sam* and *Watson*).

161. See *Thompson v. Bell*, 580 F.3d 423, 439-41 (6th Cir. 2009), *cert. denied*, 131 S. Ct. 102 (2010); *State v. Perry*, 610 So. 2d 746, 747 (La. 1992); *Singleton v. State*, 437 S.E.2d 53, 60-61 (S.C. 1993).

162. See *Sell*, 539 U.S. at 181; *Riggins v. Nevada*, 504 U.S. 135 (1992); *Washington v. Harper*, 494 U.S. 226 (1990).

163. See ABA Task Force, *supra* note 24, at 676 (citing *Sell*, 539 U.S. at 166, *Perry*, 610 So. 2d at 746, and *Harper*, 494 U.S. at 210) (observing that treatment "with the purpose or likely effect of enabling the state to carry out an execution . . . is unethical" and that when treatment is unethical, it cannot be medically appropriate); Michaela P. Sewall, Note, *Pushing Execution over the Constitutional Line: Forcible Medication of Condemned Inmates and the Eighth and Fourteenth Amendments*, 51 B.C. L. REV. 1279, 1309 (2010) (arguing that *Sell* cannot support an order to medicate to restore competence for execution because "in cases of execution, medical appropriateness is impossible to achieve" and that the ordered medication "simply becomes a component of capital punishment to be inflicted by the state"). But see *Singleton v. Norris*, 319 F.3d 1018, 1026 (8th Cir.) (en banc) (observing, somewhat extraordinarily, that "[e]ligibility for execution is the only unwanted consequence of the medication" and that the "best medical interests of the prisoner must be determined without regard to whether there is a pending date of execution"); Julie D. Cantor, *Of Pills and Needles: Involuntarily Medicating the Psychotic Inmate When Execution Looms*, 2 IND. HEALTH L. REV. 117, 146-54 (2005) (arguing that the treatment provided to the inmate in *Norris* was in his medical interests and was ethical). See also Jacob M. Appel, *Capital Punishment, Psychiatrists and the Potential "Bottleneck" of Competence*, 24 J.L. & HEALTH 45, 62 (2011) (observing that the "most significant puzzle left unsolved by the *Sell* ruling is the meaning of the requirement that the treatment be 'medically appropriate'"); Entzeroth, *supra* note 37, at 656-57 (arguing that the court in *Singleton v. Norris* did not adequately consider "the Eighth Amendment problems raised by executing prisoners who can only be rendered competent through the

Court will need to address the constitutionality of a state seeking court-ordered medication to restore the competency of a death row inmate who is incompetent for execution because of a serious mental illness.¹⁶⁴

Even if, however, the Texas courts in *Ex parte Staley*¹⁶⁵ or the United States Supreme Court ultimately declare as unconstitutional the forced medication of a death row inmate for the purpose of restoring competency for execution, the ethical concerns addressed in this Article will continue to pose challenges to psychiatrists and attorneys.¹⁶⁶ Although a court could not thereafter permissibly order the administration of medication to treat the inmate's symptoms of serious mental illness to restore competency for execution, the treating physician would still recognize that appropriate treatment for the inmate's psychiatric illness would in all likelihood restore the defendant's competency to be executed. Correspondingly, the defense attorney would remain in a position—as a matter of legal ethics—of needing to advise against any voluntary treatment because such treatment would lead to the inmate's competency for execution. Accordingly, as posited above, the inmate, despite needing antipsychotic medication for the symptoms of his or her untreated mental illness, might not seek or obtain such treatment.¹⁶⁷

V. THE MARYLAND SOLUTION

One state, Maryland, has approached this issue with a statutory solution. Specifically, the Maryland General Assembly has promulgated legislation that addresses the disposition of a death row inmate who is found incompetent to be executed.¹⁶⁸ In Maryland, if a court determines that an inmate on death row is incompetent to be executed, then the court must strike the death sentence and instead impose a sentence of life imprisonment without the possibility of parole.¹⁶⁹ This statutory approach

administration of antipsychotic medication”); Zonana, *supra* note 38, at 769 (distinguishing the decision in *Norris* given that Charles Singleton “was not refusing medication and was ‘volunteering’ to be executed” but noting that the case had raised “ethical concerns for future cases as it states that physicians should not take into account the legal consequences of treatment”). Dr. Zonana, a past president of the AAPL, also observed that the decision in *Norris* did not take “account of physician ethical guidelines.” Zonana, *supra* note 38, at 764, 769.

164. See Entzeroth, *supra* note 37, at 660 (recognizing that the Supreme Court has avoided the issue but “will likely be forced to confront it”); Donald P. Judges, *The Role of Mental Health Professionals in Capital Punishment: An Exercise in Moral Disengagement*, 41 HOUS. L. REV. 515, 548 (2004) (positing that “[a]bsent intervention and further clarification by the U.S. Supreme Court, . . . 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”).

165. *Ex parte Staley*, No. WR-37034-05, 2012 Tex. Crim. App. Unpub. LEXIS 482, at *3 (Tex. Crim. App. May 14, 2012) (per curiam).

166. See discussion *supra* notes 1-6 and accompanying text.

167. See *supra* notes 53-55 and accompanying text.

168. MD. CODE ANN., CORR. SERVS. § 3-904 (LexisNexis 2012).

169. CORR. SERVS. § 3-904(h). That subsection provides the following:

addresses the legitimate ethical concerns of both the legal and medical professions. A significant punishment remains in place, albeit not death, but the ethical quandary of requiring a physician to prescribe medication to treat appropriately the symptoms of the inmate's mental illness, yet which would likely result in execution, is avoided.¹⁷⁰

The ABA, APA, American Psychological Association, and NAMI have all embraced the Maryland approach.¹⁷¹ Although not taking a position either to support or oppose the death penalty generally, the ABA adopted the other entities' recommendations, which included the following in subsection (d):

If, after challenges to the validity of the conviction and death sentence have been exhausted and execution has been scheduled, a court finds that a prisoner has a mental disorder or disability that significantly impairs his or her capacity to understand the nature and purpose of the punishment, or to appreciate the reason for its imposition in the prisoner's own case, the sentence of death *should be reduced to the sentence imposed in capital cases when execution is not an option*.¹⁷²

(h)(1) If the court finds the inmate to be incompetent, the court shall:

- (i) stay any warrant of execution that was previously issued and has not yet expired; and
 - (ii) remand the case to the court in which the sentence of death was imposed.
- (2) The court in which the sentence of death was imposed shall strike the sentence of death and enter in its place a sentence of life imprisonment without the possibility of parole.
- (3) The sentence of life imprisonment without the possibility of parole imposed under paragraph (2) of this subsection is mandatory and may not be suspended wholly or partly.

Id.

170. *Id.* Another subsection of the Maryland statute provides that “[a]n inmate is not incompetent under this section merely because the inmate’s competence depends on continuing treatment, including the use of medication.” CORR. SERVS. § 3-904(b). Instead, a lack of execution competence is based on whether the inmate, because of a mental disorder, “lacks awareness . . . of the fact of the inmate’s impending execution . . . and . . . that the inmate is to be executed for the crime of murder.” CORR. SERVS. § 3-904(a)(2); *see also* Sewall, *supra* note 163, at 1321 (noting the Maryland statute and observing that although “failure to carry out a death sentence may deprive society and the victim’s family of a measure of the retributive value of the original sentence, an inmate’s assured future of lifetime confinement” protects society and provides a “harsh criminal punishment for heinous crimes while maintaining respect for basic human dignity”).

171. *See* ABA Task Force, *supra* note 24, at 668, 676 (setting forth the ABA’s recommendation and report, noting that the recommendation “had been previously adopted by” the other identified organizations, and observing that the recommendation embraced the Maryland statutory approach).

172. *Id.* at 668 (emphasis added). NAMI has endorsed this approach but also favors a categorical exclusion from the death penalty for persons with serious mental illnesses. *See* NAT’L ALLIANCE ON MENTAL ISSUES, PUBLIC POLICY PLATFORM OF NAMI § 10.8.1 (10th ed. 2012), *available at* http://www.nami.org/Template.cfm?section=NAMI_Policy_Platform&Template=/ContentManagement/ContentDisplay.cfm&ContentID=38245; *see also* Ronald S. Honberg, *The Injustice of Imposing Death Sentences on People with Severe Mental Illnesses*, 54 CATH. U. L. REV. 1153, 1153, 1166-67 (2005) (praising the ABA Task Force’s recommendations as being “a formulation that is both sensible . . . and politically viable” but stating that “NAMI would like to see a per se prohibition on executing people with mental illness” given NAMI’s view that executing people with severe mental illnesses is

In the subsection of the supporting report regarding this particular recommendation, the ABA concluded that “[o]nce an offender is found incompetent to be executed, execution should no longer be a permissible punishment.”¹⁷³ In reaching this position, the ABA was expressly concerned about the unethical aspect of requiring physicians to provide “treatment with the purpose *or likely effect* of enabling the state to carry out an execution of a person who has been found incompetent for execution.”¹⁷⁴ In turn, the ABA determined that commuting the death sentence automatically to a lesser punishment was the “only . . . sensible policy.”¹⁷⁵

VI. RECOMMENDATION FOR THE TEXAS LEGISLATURE

Article 46.05 of the Texas Code of Criminal Procedure is inadequate in addressing the medication issue described in this Article and fosters a continuation of the ethical dilemma and injustice it seeks to avoid.¹⁷⁶ Although the statute properly precludes the execution of an individual who is incompetent to be executed, by continuing to require repeat evaluations and determinations of the defendant’s competency, the statutory structure creates ongoing pressure to restore the defendant’s competency to allow the execution to proceed. As described above, if the defendant is suffering from a serious mental disability, a treating physician will likely need to prescribe clinically appropriate medication(s) to treat the symptoms of the defendant’s illness.¹⁷⁷ The treating physician, however, will no doubt recognize that to do so will, in all likelihood, result in the restoration of the defendant’s competency and correspondingly permit the defendant’s execution. As the Louisiana Supreme Court recognized twenty years ago in *State v. Perry*, the provision of medical treatment to restore a defendant’s competence to be executed “is antithetical to the basic principles of the healing arts” and “does not measurably contribute to the social goal of retribution.”¹⁷⁸ Simultaneously, the ethical defense attorney will be

“grievously inappropriate”). Mr. Honberg is the National Director for Policy and Legal Affairs at NAMI. Honberg, *supra*, at 1153 n.**.

173. ABA Task Force, *supra* note 24, at 676. In effect, the ABA adopted the Report of the Task Force on Mental Disability and the Death Penalty. See *supra* notes 33-38 and accompanying text (discussing Task Force and report highlights).

174. ABA Task Force, *supra* note 24, at 676 (emphasis added).

175. *Id.*; see also Bonnie, *supra* note 25, at 1175 (arguing that a legislative approach like that enacted in Maryland is the “only one sensible solution”); Sergent, *supra* note 119, at 1320 (urging the approach of commuting death sentences in such cases given that forcible medication for execution competency would “be offensive to humanity”).

176. TEX. CODE CRIM. PROC. ANN. art. 46.05 (West Supp. 2012).

177. See *supra* notes 30-32 and accompanying text.

178. *State v. Perry*, 610 So. 2d 746, 751, 767 (La. 1992); see also ABA Task Force, *supra* note 24, at 676 (citing *Sell v. United States*, 539 U.S. 166 (2003), *Perry*, 610 So. 2d at 746, and *Washington v. Harper*, 494 U.S. 210 (1990)) (observing that when treatment is unethical, it cannot be medically appropriate).

endeavoring to pursue all legal means to avoid or delay the client's execution, which can include fighting attempts to provide medication to the inmate, even though the treatment would be in the client's medical interests as a treatment for the symptoms of the inmate's mental illness.

A straightforward solution to the ethical quandary addressed in this Article would be the adoption of legislation to amend Article 46.05 of the Texas Code of Criminal Procedure in a manner similar to Maryland's statutory approach.¹⁷⁹ That is, upon a determination by the trial court that the defendant is incompetent to be executed (and following any appeal), the court should vacate the death sentence and substitute a life sentence without the possibility of parole.¹⁸⁰ This approach would also be consistent with the ABA recommendation that "[o]nce an offender is found incompetent to be executed, execution should no longer be a permissible punishment."¹⁸¹ Accordingly, we propose that the Texas Legislature consider and adopt the following language to amend subsection (m) of Article 46.05 of the Texas Code of Criminal Procedure:

(m) If a stay of execution is issued by the court of criminal appeals and the court of criminal appeals adopts the trial court's determination under Subsection (k) that the defendant is incompetent to be executed, the court of criminal appeals shall remand the case to the trial court and order the trial court to strike the sentence of death and enter in its place a sentence of life imprisonment without the possibility of parole. Any sentence of life imprisonment without the possibility of parole imposed under this Subsection is mandatory and may not be suspended wholly or partly. Upon entry of the new sentencing order, if the defendant's lack of competency to be executed is the result of a mental disorder or mental disability, the state shall immediately initiate appropriate procedures to afford treatment for the defendant's mental disorder or mental disability. Periodically shall order that the defendant be reexamined by mental health experts to determine whether the defendant is no longer incompetent to be executed.¹⁸²

If enacted, this provision would obviate the ethical dilemma described in this Article. After the entry of an order to strike the death sentence and substitute life without parole, prison psychiatrists could proceed to treat the

179. See MD. CODE ANN., CORR. SERVS. § 3-904 (LexisNexis 2012) (providing for the striking of the death sentence and the substitution of a term of life imprisonment without the possibility of parole).

180. *Id.*

181. ABA Task Force, *supra* note 24, at 676; see also Sergent, *supra* note 119, at 1323 (urging that Texas follow Maryland's approach to this issue); Ronald J. Tabak, *Executing People with Mental Disabilities: How We Can Mitigate an Aggravating Situation*, 25 ST. LOUIS U. PUB. L. REV. 283, 305 (2006) (discussing the Task Force process and urging that legislators and courts give serious consideration to adopting the ABA Task Force's recommendations).

182. We have set forth our proposed new language with underlined text and have identified language to be deleted by striking out current legislative language in TEX. CODE CRIM. PROC. ANN. art. 46.05(m) (West Supp. 2012).

symptoms of the inmate's serious mental illness, *without* the ethical concern that such treatment could lead to the inmate's execution. Even if the inmate refused medication, any subsequent process to authorize involuntary treatment would not be particularly demanding.¹⁸³ In addition, the inmate's defense counsel could advise the inmate that taking the prescribed medication voluntarily would not be counter to the inmate's legal interest of avoiding execution. Moreover, although the death penalty would no longer be available with regard to the defendant, there still would be a significant punishment meted out for the inmate's crimes.¹⁸⁴

VII. CONCLUSION

The ethical, moral, and legal circumstances surrounding the issue of how the Texas criminal justice system treats a death row inmate whose execution date has been set, yet who has been determined to be incompetent to be executed because of a serious mental illness, are fundamentally different from any other incompetency issue addressed in our criminal justice system. As a matter of federal constitutional law, it is impermissible for the state to execute an inmate who is incompetent.¹⁸⁵ Yet, there are issues of medical and legal ethics at stake with respect to subsequent treatment of the inmate's mental illness. It is unethical for a psychiatrist to administer medication to such an inmate that would treat the symptoms of the inmate's mental illness but likely render the prisoner competent to be executed.¹⁸⁶ Additionally, to avoid the state's carrying out of the death penalty, the inmate's defense attorneys must also contest efforts by the state

183. See, e.g., *Harper*, 494 U.S. at 214-16; *Policy Manual*, *supra* note 52, § I.67.1

184. As a stopgap alternative to enacting the proposed legislation set forth in this Part, the Texas Legislature could appoint a task force of interested stakeholders to review and study the issue further and recommend statutory language to resolve this continuing issue. For example, in 2001 the legislature passed Senate Bill 553, which created a task force to review procedures relating to a defendant's competency to stand trial. Act of May 11, 2001, 77th Leg., R.S., ch. 350, § 1, 2001 Tex. Gen. Laws 641, available at <http://www.capitol.state.tx.us/tlodocs/77R/billtext/html/SB00553F.htm>. The task force "included representatives from the judiciary, medical schools, agencies, prosecutors, defense attorneys, psychologists, psychiatrists, and law schools." BRIAN D. SHANNON & DANIEL H. BENSON, *TEXAS CRIMINAL PROCEDURE AND THE OFFENDER WITH MENTAL ILLNESS* 46 (4th ed. 2008), available at http://www.namitexas.org/resources/nami_tcp_guide2008.pdf. Ultimately, the task force drafted a complete rewrite of the former laws regarding competency to stand trial. See Task Force Report, Tex. S.B. 533, 78th Leg., R.S., at 11-12 (2002), available at <http://www.lrl.state.tx.us/scanned/interim/77/sb1.pdf> (discussing the need for a major overhaul and total rewrite of the relevant statutes for filing in the next legislative session). In the ensuing 2003 legislative session, the resulting legislation "was supported by prosecutors, the defense bar, the judiciary, and organizations of psychiatrists and psychologists, [and it] moved rapidly through the legislative process with little debate or controversy." SHANNON & BENSON, *supra*, at 46-47.

185. *Panetti v. Quarterman*, 551 U.S. 930, 934-35 (2007); *Ford v. Wainwright*, 477 U.S. 399, 416-17 (1986).

186. See Brief of APA & AAPL, *supra* note 30, at 5 (stating that "it is the policy of the APA that a physician not administer medication for the purpose of rendering an individual who has been sentenced to death competent to be executed").

to medicate their client involuntarily—even if the attorneys are aware that medication treatment would be appropriate medical care for the inmate’s mental illness. Even if the Texas courts, or United States Supreme Court, ultimately declare unconstitutional any attempt by the state to seek an order for the forcible administration of medication to render such an inmate competent to be executed, the ethical quandary will nonetheless remain present. If the inmate seeks or obtains treatment, competency likely will be restored. If the prisoner objects to the medication, it will remain unethical for the psychiatrist to provide treatment. As the ABA, APA, American Psychological Association, and NAMI have all determined, “[t]here is only one sensible policy here”—legislation along the lines that we have proposed by which the death sentence would be commuted to life in prison without possibility of parole.