AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 1
(I-22)

Introduced by: Jeena Kar, DO

Subject: Prohibition of Death Penalty for Persons with Serious Mental Illness

Referred to: Reference Committee

Whereas, The Supreme Court has barred capital punishment for intellectually disabled and for juveniles, it has not barred the death penalty for those with serious mental illness; and

Whereas, Race and ethnicity influence prosecution charging with a capital crime, and therefore influence likelihood of being sentenced to death[1-4].

Whereas, African-Americans[5,8-9] and Hispanic-Americans who kill European-Americans[5] are more likely to receive the death penalty; and

Whereas, APA's "Position Statement on Issues Pertaining to Capital Sentencing and the Death Penalty" endorses that defendants charged with capital crimes should not be sentenced to death or executed if, at the time of the offense, they had: firstly, a mental disorder or disability that significantly impaired their capacity to appreciate the nature, consequences or wrongfulness of their conduct, to exercise rational judgment in relation to their conduct, or to conform their conduct to the requirements of the law, or, secondly, if they had significant limitations in both their intellectual functioning and adaptive behavior; and

Whereas, As of January 2021, Ohio law prohibits imposing the death penalty on or carrying it out against individuals whose severe mental illness at the time of the offense significantly impaired their judgment, capacity, or ability to appreciate the nature of their conduct;[6] and

Whereas, Ohio's legislature gained the support of the American Psychiatric Association, the American Psychological Association, the National Alliance on Mental Illness (NAMI), Mental Health America (MHA), and state-level coalitions of mental health advocates; and

Whereas, Organizations are increasingly looking to distance themselves from capital punishment and major pharmaceutical corporations refuse to provide drugs for executions as a matter of corporate ethics (and compliance with European Union business regulations); and

Whereas, It is not unethical for psychiatrist to weigh in on capacity, as they are not the one making the decision for capital punishment, and as such, psychiatrists involved in rendering this opinion would not be considered as acting in opposition to the AMA code of ethics; therefore be it

RESOLVED, That our AMA-RFS support that defendants charged with capital crimes should not be sentenced to death or executed if, at the time of the offense, they had a mental disorder or disability that significantly impaired their capacity to appreciate the nature, consequences or wrongfulness of their conduct, to exercise rational judgment in relation to their conduct, or to conform their conduct to the requirements of the law.

Fiscal Note: Minimal

References:

1. Beck, J. C. & Shumsky, R. (1997). A comparison of retained and appointed counsel in cases of capital murder. Law and Human Behavior, 21(5), 525-538.
2. Bowers, W. J. (1983). The pervasiveness of arbitrariness and discrimination under post-Furman capital statutes. Journal of Criminal Law and Criminology, 74(2), 1067-1100.
3. Bowers, W.J. (1988). The effect of execution is brutalization, not deterrence. In K.C. Haas and J.A. Inciardi (Eds.). Challenging capital punishment: Legal and social science approaches (49-90). Newbury Park, CA: Sage.
4. Sorensen, J.R. & Wallace, D.H. (1995). Capital punishment in Missouri: Examining the issue of racial disparity. Behavioral Sciences and the Law, 13(1), 61-81.
5. Thomson, E. (1997). Research note: Discrimination and the death penalty in Arizona. Criminal Justice Review, 22(1), 65-76.
6. Ohio bars death penalty for people with severe mental illness. Death Penalty Information Center. (2021, January 11). Retrieved January 23, 2022, from https://deathpenaltyinfo.org/news/ohio-passes-bill-to-bar-death-penalty-for-people-with-severe-mental-illness
7. Paternoster, R. (1991). Prosecutorial discretion and capital sentencing in North and South Carolina. In R. M. Bohm (Ed.), The death penalty in America: Current research (pp. 39-52). Cincinnati, OH: Anderson.
8. Vito, G. F., Koester, P., & Wilson, D. G. (1991). Return of the dead: An update of the status of Furman-commuted death row inmates. In R. M. Bohm (Ed.), The death penalty in America: Current research (pp. 89-99). Cincinnati, OH: Anderson.
9. Vito, G. F., Wilson, D. G., & Latessa, E. J. (1991). Comparison of the dead: Attributes and outcomes of Furman-commuted death row inmates in Kentucky and Ohio. In R. M. Bohm (Ed.), The death penalty in America: Current research (pp. 101-111). Cincinnati, OH: Anderson.

Relevant AMA Policy:

9.7.3 Capital Punishment - Code of Medical Ethics

Debate over **capital punishment** has occurred for centuries and remains a volatile social, political, and legal issue. An individual's opinion on **capital punishment** is the personal moral decision of the individual. However, as a member of a profession dedicated to preserving life when there is hope of doing so, a physician must not participate in a legally authorized execution.
Physician participation in execution is defined as actions that fall into one or more of the following categories:
(a) Would directly cause the death of the condemned.
(b) Would assist, supervise, or contribute to the ability of another individual to directly cause the death of the condemned.
(c) Could automatically cause an execution to be carried out on a condemned prisoner.
These include, but are not limited to:
(d) Determining a prisoner's competence to be executed. A physician's medical opinion should be merely one aspect of the information taken into account by a legal decision maker, such as a judge or hearing officer.
(e) Treating a condemned prisoner who has been declared incompetent to be executed for the purpose of restoring competence, unless a commutation order is issued before treatment begins. The task of re-evaluating the prisoner should be performed by an independent medical examiner.
(f) Prescribing or administering tranquilizers and other psychotropic agents and medications that are part of the execution procedure.
(g) Monitoring vital signs on site or remotely (including monitoring electrocardiograms).
(h) Attending or observing an execution as a physician.
(i) Rendering of technical advice regarding execution.
and, when the method of execution is lethal injection:
(j) Selecting injection sites.
(k) Starting intravenous lines as a port for a lethal injection device.
(l) Prescribing, preparing, administering, or supervising injection drugs or their doses or types.
(m) Inspecting, testing, or maintaining lethal injection devices.
(n) Consulting with or supervising lethal injection personnel.
The following actions do not constitute physician participation in execution:

(o) Testifying as to the prisoner's medical history and diagnoses or mental state as they relate to competence to stand trial, testifying as to relevant medical evidence during trial, testifying as to medical aspects of aggravating or mitigating circumstances during the penalty phase of a **capital** case, or testifying as to medical diagnoses as they relate to the legal assessment of competence for execution.
(p) Certifying death, provided that the condemned has been declared dead by another person.
(q) Witnessing an execution in a totally nonprofessional capacity.
(r) Witnessing an execution at the specific voluntary request of the condemned person, provided that the physician observes the execution in a nonprofessional capacity.
(s) Relieving the acute suffering of a condemned person while awaiting execution, including providing tranquilizers at the specific voluntary request of the condemned person to help relieve pain or anxiety in anticipation of the execution.
(t) Providing medical intervention to mitigate suffering when an incompetent prisoner is undergoing extreme suffering as a result of psychosis or any other illness.
No physician should be compelled to participate in the process of establishing a prisoner's competence or be involved with treatment of an incompetent, condemned prisoner if such activity is contrary to the physician's personal beliefs. Under those circumstances, physicians should be permitted to transfer care of the prisoner to another physician.
Organ donation by condemned prisoners is permissible only if:
(u) The decision to donate was made before the prisoner's conviction.
(v) The donated tissue is harvested after the prisoner has been pronounced dead and the body removed from the death chamber.
(w) Physicians do not provide advice on modifying the method of execution for any individual to facilitate donation.
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