2004

Restored to Health to Be Put to Death: Reconciling the Legal and Ethical Dilemmas of Medication to Execute in Singleton v. Norris

Kursten Hensl

Follow this and additional works at: https://digitalcommons.law.villanova.edu/vlr

Part of the Civil Rights and Discrimination Commons, Criminal Law Commons, and the Disability Law Commons

Recommended Citation
Available at: https://digitalcommons.law.villanova.edu/vlr/vol49/iss2/2

This Note is brought to you for free and open access by the Journals at Villanova University Charles Widger School of Law Digital Repository. It has been accepted for inclusion in Villanova Law Review by an authorized editor of Villanova University Charles Widger School of Law Digital Repository.
Notes

RESTORED TO HEALTH TO BE PUT TO DEATH: RECONCILING THE LEGAL AND ETHICAL DILEMMAS OF MEDICATING TO EXECUTE IN SINGLETON v. NORRIS

Imagine a person convicted and sentenced to death for felony murder. While awaiting execution, this person has become trapped in a world of insanity marked by frightening hallucinations and irrational delusions. A doctor has implanted a device in his ear to steal his thoughts; his food transforms into worms and his cigarettes into bones.\(^1\) His cell is possessed by demons; his victim is still alive and awaits his arrival on earth as her groom.\(^2\) With treatment this person may be potentially freed from the painful symptoms of psychosis and temporarily rendered competent in the eyes of the law. Should he refuse treatment, this person will be administered mind-altering, side-effect-producing drugs against his will. If successful, the forced medication may enable him to escape insanity, only to deliver him to a more troubling reality. This person will now understand that he has been involuntarily restored to health so that he may be put to death.

I. Introduction

The exclusion of the mentally incompetent from capital punishment is not a new development.\(^3\) Anglo-American common law has prohibited the execution of the insane since medieval times.\(^4\) It was not until 1986,\(^5\) }

---

2. See id. at 1033 (Heaney, J., dissenting) (discussing delusions experienced by Singleton).
4. See Ford, 477 U.S. at 406-09 (summarizing history of prohibition); Brodsky et al., supra note 3, at 2 (noting that execution of insane had been prohibited by common law for over seven hundred years); Dupler, supra note 3, at 1 (noting that states had prohibited execution of insane for approximately two centuries); see also Bruce Ebert, Competency to Be Executed: A Proposed Instrument to Evaluate an Inmate’s Level of Competency in Light of the Eighth Amendment Prohibition Against the Execution of
however, that the Supreme Court gave credence to this generally accepted
prohibition in the landmark decision of Ford v. Wainwright.\footnote{5}

Nonetheless, recent advances in psychopharmacology have since un-
dermined Ford's ban on the execution of the incompetent, as various
antipsychotic medications have proven effective in the treatment of mental
illness and the restoration of competency.\footnote{6} Consequently, states have
systematically relied on these medications to treat and restore the compe-
tence of mentally ill inmates facing execution.\footnote{7} As a result, the once
permanent exemption from execution due to mental infirmity has be-
come a mere delay until competence is successfully restored.\footnote{8}

Issues arise, however, when inmates refuse restorative treatment.\footnote{9} For
some, the forced administration of medication provides an ideal solution

\footnote{5. 477 U.S. at 409-10, 417 (holding execution of insane unconstitutional). For further discussion of Ford, see infra notes 40-54 and accompanying text.}

\footnote{6. See Brent W. Stricker, Seeking an Answer: Questioning the Validity of Forcible Medication to Ensure Mental Competency of Those Condemned to Die, 32 McGEORGE L. REV. 317, 318 (2000) (commenting that today states may avoid prohibition against executing insane due to antipsychotic medication). For further discussion of the development and use of antipsychotic medications to treat mental illness and to restore competency, see infra notes 55-67 and accompanying text.}


\footnote{8. See Radelet & Barnard, supra note 4, at 298 (noting re-eligibility of persons restored to competency); David L. Katz, Note, Perry v. Louisiana: Medical Ethics on Death Row—Is Judicial Intervention Warranted?, 4 GEO. J. LEGAL ETHICS 707, 712 (1991) ("[A]dvances in psychopharmacology enab[le] physicians to return sanity to the condemned insane.").}

to the problem of incompetent persons facing execution. Arguably, both the inmate’s medical interests and the state’s interest in punishment are satisfied. Still, to juxtapose a person’s treatment needs with a state’s interest in punishment is quite unsettling when the collateral effect of the treatment is the facilitation of execution. While the Court has addressed the forcible use of medication to treat and to restore competency for trial, it has never addressed the issue with regard to incompetent persons facing execution. Consequently, this issue has raised several ethical dilemmas for health care professionals involved in the treatment of condemned, incompetent inmates.

This Note considers the constitutionality of forcibly treating and restoring competency to mentally ill inmates facing execution. In particular, this Note explores the Eighth Circuit’s recent decision in Singleton v. Norris, where in a case of first impression, that court upheld the constitutionality of forcibly treating and restoring competency to mentally ill inmates facing execution. In particular, this Note explores the Eighth Circuit’s recent decision in Singleton v. Norris, where in a case of first impression, that court upheld the constitutionality of forcibly treating and restoring competency to mentally ill inmates facing execution.

10. See Singleton, 319 F.3d at 1026 (holding that forcible medication treats symptoms, restores competency and enables execution); Kristen Wenstrup Crosby, Comment, State v. Perry: Louisiana’s Cure-To-Kill Scheme Forces Death-Row Inmates to Choose Between a Life Sentence of Untreated Insanity and Execution, 77 MINN. L. REV. 1193, 1213 (1993) (comparing use of medication to restore competency for trial and to execute).

11. See Singleton, 319 F.3d at 1025-26 (finding medication satisfied Singleton’s best medical interest and state’s interest in punishment).

12. See Rebecca A. Miller-Rice, The “Insane” Contradiction of Singleton v. Norris: Forced Medication in a Death Row Inmate's Medical Interest Which Happens to Facilitate His Execution, 22 U. Ark. Little Rock L. Rev. 659, 659 (2000) (discussing Arkansas Supreme Court holding in state proceedings involving Charles Singleton in 1999); cf. Singleton, 319 F.3d at 1037 (Heaney, J., dissenting) (noting problems with forcibly medicating to enable execution); Perry, 610 So. 2d at 747 (holding that medicating to execute is cruel and excessive punishment).

13. See infra notes 70-89 and accompanying text (discussing further Court’s dealings with respect to forced administration of medicine to treat inmates and to restore competency in defendants facing trial).


15. See Singleton, 319 F.3d at 1036-37 (Heaney, J., dissenting) (noting dilemmas faced by professionals when treating inmates facing execution). For further discussion of ethical dilemmas related to the restoration of competency for execution, see infra notes 189-210 and accompanying text.

16. 319 F.3d 1018 (8th Cir. 2003).
tionality of the forcible administration of medication to treat and restore competency in a condemned inmate.\footnote{17} Part II examines the historical and legal developments regarding the execution of mentally ill inmates and the forcible medication of both inmates and defendants.\footnote{18} Part III provides a comprehensive analysis of Singleton:\footnote{19} Section A describes the facts of the case,\footnote{20} Section B delineates the Eighth Circuit’s reasoning,\footnote{21} Section C advances a critical examination of the Eighth Circuit’s analysis and conclusions of law\footnote{22} and Section D considers the implications and ethical dilemmas presented by the court’s decision.\footnote{23} Finally, Part IV recommends solutions for reconciling the dilemmas presented in Singleton.\footnote{24}

II. BACKGROUND

Historically, mentally incompetent persons have been ineligible for execution, and mental illness has been deemed a valid reason to stay an execution.\footnote{25} Many reason that the execution of mentally incompetent persons is an inhumane practice, devoid of any deterrent or retributive value.\footnote{26} Even so, the last three decades have witnessed a steady increase in

\footnote{17. See id. at 1023 (noting this was case of first impression for Eighth Circuit); see also Richard E. Redding & Kursten Hensl, Treating the Illness But Killing the Patient: The Ethical Dilemma of Restoring Competency for Execution, 130 COMMONWEAL 9, 9 (2003) (noting that Singleton was first ruling of its kind).}

\footnote{18. See infra notes 25-112 and accompanying text (discussing historical background and case law relevant to Singleton analysis).}

\footnote{19. See infra notes 113-88 and accompanying text (discussing Singleton analysis).}

\footnote{20. See infra notes 113-27 and accompanying text (discussing facts of Singleton).}

\footnote{21. See infra notes 128-52 and accompanying text (discussing reasoning of Eighth Circuit in Singleton).}

\footnote{22. See infra notes 153-88 and accompanying text (providing critical analysis of Eighth Circuit’s reasoning in Singleton).}

\footnote{23. See infra notes 189-210 and accompanying text (discussing implications of Singleton).}

\footnote{24. See infra notes 211-18 and accompanying text (stating recommendations).}

\footnote{25. See Ford v. Wainwright, 477 U.S. 399, 406-09 (1986) (summarizing history of prohibition); Brodsky et al., supra note 3, at 2 (noting prohibition dates back hundreds of years); Dupler, supra note 3, at 1 (same); Ebert, supra note 4, at 32 (same); Harding, supra note 4, at 109-10 (same); Radelet & Barnard, supra note 3, at 38 (same). By 1986, every state implementing the death penalty in the United States prevented the execution of the mentally incompetent as a matter of executive discretion. See Radelet & Barnard, supra note 4, at 297 (examining contemporary ban); see also Christopher Slobogin, Mental Illness and the Death Penalty, 24 MENTAL & PHYSICAL DISABILITY L. REP. 667, 667 (2000) (noting mental illness is often considered “a mitigating factor in most death penalty statutes”); Ward, supra note 4, at 35 (describing limitation on death penalty); Taylor, supra note 3, at 1045 (noting history of prohibition).}

\footnote{26. See Ford, 477 U.S. at 406-10 (outlining rationales for excluding insane from execution); Collins, supra note 14, at 1236-41 (delineating rationales for ban on execution as practical, religious and humane); Radelet & Barnard, supra note 3, at 59-42 (discussing rationales for not executing insane); Schopp, supra note 4, at 998-1010 (same); Katz, supra note 8, at 709-10 (same); see also “Mindless Vengeance”:}
the number of mentally ill persons on death row. This trend has been commonly attributed to the development of psychosis in inmates awaiting execution. Accordingly, states implementing the death penalty have attempted to circumvent the constitutional confines of the Eighth Amendment by administering different antipsychotic medications to treat and restore competency in persons facing execution. As a result, the inmate’s medical interests in the alleviation of the symptoms of psychosis


27. See 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, 371 (1999) (commenting that many inmates suffer from mental illness); National Mental Health Association, supra note 7 (noting increase of mentally ill on death row). Estimations suggest that approximately five to ten percent of condemned inmates suffer from mental illness. See id. (providing estimated percentage of mentally ill on death row); see also Slobogin, supra note 25, at 667 (noting high number of mentally ill on death row). Similarly, multiple commentators have noted that “[a]pproximately 70% of all death row [inmates had been] diagnosed with schizophrenia or psychosis” in 1981. See Keith Alan Byers, Incompetency, Execution, and the Use of Antipsychotic Drugs, 41 ARK. L. REV. 361, 375 (1994) (noting importance of pharmacological treatment due to high number of mentally ill inmates on death row); Nancy S. Horton, Restoration of Competency for Execution: Furiosus Solo Fureo Punitur, 44 SW. L.J. 1191, 1204 (1990) (noting high percentage of mentally ill death row inmates).

28. See Salguero, supra note 4, at 171-72 (commenting that conditions common to death row, as well as painful awareness of one’s pre-determined death, often result in mental deterioration and incompetence). Similarly, research has indicated that the psychological stress and living conditions commonly associated with death row may trigger severe mental deterioration and psychoses or exacerbate an underlying, pre-existing mental illness. See Ward, supra note 4, at 38 (explaining traumatizing conditions on death row); American College of Physicians et al., supra note 14 (“Prolonged death row confinement is associated with many . . . mental health problems.”).

29. See Harding, supra note 4, at 121 (noting increased role of medication in treatment of mentally ill inmates and restoration of competency and its impact on Ford); Katz, supra note 8, at 712 (“[A]dvances in psychopharmacology enable physicians to return sanity to the [traditionally] condemned insane . . . ;” see also Horstman, supra note 7, at 847 (“Obtaining artificial sanity through mandatory drugging, which is often unwanted, is contrary to [society’s evolving standards of decency].”); Taylor, supra note 3, at 1065 (noting that forcibly medicating “death row inmates to produce competency for execution is merely an attempt to circumvent the national consensus against execution of the insane [and the Eighth Amendment].”). For a more extensive discussion of the use and effectiveness of antipsychotic drugs in treatment and the restoration of competency, see infra notes 55-67 and accompanying text. Singleton v. Norris provides a specific example of the use of these drugs by a state to treat and restore competency in an individual facing execution. 319 F.3d 1018, 1025-26 (8th Cir. 2003) (noting that Singleton’s symptoms were controlled and he regained competency after receiving antipsychotic medications in 1997). But see id. at 1032, 1037 (Heaney, J., dissenting) (commenting that while receiving medication Singleton still experienced symptoms of psychosis and was irrational).
and protection from harm are no longer the exclusive purposes of treatment.\textsuperscript{30} To the contrary, these medications have become instrumental in the delivery of punishment and have facilitated the re-eligibility of the mentally ill for execution.\textsuperscript{31} The Supreme Court and other courts have been called on to delineate the standard by which inmates may be found competent for execution and the circumstances under which incompetent defendants and inmates may be forcibly medicated.\textsuperscript{32} Although the Court has yet to address the forcible administration of medication to treat and restore competency in inmates facing execution, related case law provides the relevant framework for the Eighth Circuit's analysis in \textit{Singleton}.\textsuperscript{33}

A. \textit{Laying the Groundwork: Excluding the Insane}

A contentious issue at best, the death penalty has been recognized as an appropriate and constitutionally permissible form of punishment in the United States since colonial times.\textsuperscript{34} To determine whether the imple-

\textsuperscript{30.} See Ladds & Convit, \textit{supra} note 9, at 526 ("Ordinarily, clinicians seek to treat patients for clinical reasons."); Katz, \textit{supra} note 8, at 713 (noting that when doctors determine whether treatment is "appropriate" or "necessary," they must do so in accordance with patients' best interests).

\textsuperscript{31.} See Harding, \textit{supra} note 4, at 121 (noting that with restoration of competency inmate becomes "death eligible"). \textit{But see} Douglas Mossman, \textit{Denouement of an Execution Competency Case: Is Perry Pyrrhic?}, 23 BULL. AM. ACAD. PSYCHIATRY & L. 269, 275-76 (1995) (arguing that competency-inducing medication that could be used to treat defendants pretrial and while in prison should not be viewed as instrument of punishment). Many contend that simply because medication may restore competency and treat an inmate facing execution, it is not a causal factor or action bringing about the punishment of death and should not be characterized as such. \textit{See id.} (focusing on "assignment of responsibility" for inmate's execution and emphasizing offender's own behavior, jury's decision and legalization of death penalty as factors actually causing death of inmate). \textit{But see id.} at 276 (recognizing that "medical and social science findings are often vehicles for fulfilling legal ends").

\textsuperscript{32.} See \textit{infra} notes 70-112 and accompanying text (discussing related cases).

\textsuperscript{33.} See \textit{infra} notes 128-52 and accompanying text (discussing Eighth Circuit's analysis in \textit{Singleton}).

\textsuperscript{34.} See Nina Rivkind \& Steven F. Shatz, \textit{Cases and Materials on the Death Penalty} 20-26 (2001) (discussing history of death penalty in United States). The Supreme Court did question the constitutionality of death penalty statutes in 1972. \textit{See generally} Furman v. Georgia, 408 U.S. 238 (1972) (plurality opinion) (characterizing death penalty as violation of Eighth Amendment's bar on "cruel and unusual punishment" because of historical underpinnings and arbitrary, selective and infrequent imposition of penalty). The Court went on to clarify the constitutionality of the death penalty in a series of cases following \textit{Furman} by focusing on the limits imposed by the Eighth Amendment in the states' implementation of the penalty. \textit{See generally} Woodson v. North Carolina, 428 U.S. 280 (1976) (plurality opinion) (finding North Carolina's mandatory death penalty scheme unconstitutional and incompatible with contemporary standards of decency); Jurek v. Texas, 428 U.S. 262 (1976) (upholding Texas's death penalty scheme as constitutional due to its narrowed scope and guided application); Gregg v. Georgia, 428 U.S. 153 (1976) (plurality opinion) (holding Georgia death penalty scheme constitutional because of its ability to limit arbitrary application of penalty); \textit{see also} Rhonda K. Jenkins,
mentation of the death penalty accords with the Eighth Amendment ban on cruel and unusual punishment, the Supreme Court has consistently turned to "the evolving standards of decency" and the contemporary values of society in its inquiry. Generally, the standards and societal values guiding the Court have been inferred from the common law, legislative enactments and community sentiment.

In Ford, the Court implemented a similar analysis when considering the constitutionality of executing an "insane" inmate. Ford was convicted of murder in 1974 and sentenced to death. Following the rapid deterioration of Ford's mental health while awaiting execution, his treating psychiatrist diagnosed him with paranoid schizophrenia. Nonethe-

Comment, Fit to Die: Drug-Induced Competency for the Purpose of Execution, 20 S. Ill. U. L.J. 149, 151 (1995) (remarking that death penalty has been "traditionally accepted" by American law "as an appropriate form of punishment for heinous crimes").


36. See Ford v. Wainwright, 477 U.S. 399, 406-10 (1986) (plurality opinion) (discussing role of common law and contemporary values in determining whether execution of insane violates Eighth Amendment); Coker v. Georgia, 433 U.S. 584, 593-97 (1977) (plurality opinion) (remarking that Court should rely on common law practices and objective evidence of current social values when considering constitutionality of punishments under Eighth Amendment); see also Horton, supra note 27, at 1195 (quoting Trop language); Schopp, supra note 4, at 1015-16 (discussing Court's consistent acceptance of historical prohibition on execution of insane as objective evidence of "contemporary standards of decency").

37. See Ford, 477 U.S at 409 (interpreting common law restrictions on execution of insane as evidence of societal standards supporting prohibition of practice).

38. See McCleskey v. Kemp, 481 U.S. 279, 301 (1987) (citing Gregg, 428 U.S. at 179) (finding state legislative decisions to be most representative of societal standards); see also Ford, 477 U.S. at 408-09 (pointing to state legislation as "widespread evidence" of societal contempt for execution of insane).

39. See Woodson, 428 U.S. at 298-99 n.34 (referring to public opinion polls on death penalty as evidence of community sentiment against mandatory death sentences and non-individualized application of death penalty).

40. See Ford, 477 U.S. at 406 (remarking that Court relies on common law and objective evidence of contemporary standards and values to determine whether form of punishment violates Eighth Amendment).

41. See id. at 401 (introducing facts of Ford).

42. See id. at 402-03 (discussing Ford's behavioral changes, mental deterioration and subsequent diagnosis while awaiting execution). Ford developed pervasive persecutory delusions. See id. (discussing Ford's psychotic symptoms). After extended evaluation and assessment, he was diagnosed with a severe mental disease similar to "[p]aranoid [s]chizophrenia [w]ith [s]uicide [p]otential." See id. (explaining conclusion of Ford's treating psychiatrist that schizophrenia was mental disorder severe enough to substantially affect Ford's present ability to assist in his own defense); see also Am. Psychiatric Ass'n, Diagnostic and Statistical Manual of Mental Disorders 297-311 (Text Revision, 4th ed. 1994) [hereinafter DSM-IV-TR] (discussing symptoms, etiology and associated features of illness).

A diagnosis of schizophrenia requires at least two "positive symptoms." See id. at 312 (noting positive symptoms). These symptoms may include delusions, halluci-
less, three court-appointed psychiatrists found Ford competent for execution.43

In its inquiry, the Court relied on the extensive historical underpinnings and contemporary values exemplified by the common law and the nationwide use of statutory provisions and executive discretion to prohibit the execution of the mentally incompetent.44 Accordingly, the Court held that the Eighth Amendment ban on cruel and unusual punishment prohibits the states from executing incompetent persons.45 Recognizing the stark contrast between the death penalty and other available punishments,
the Court also held that due process mandates affording inmates full and fair procedures when determining competency for execution.46

B. Setting a Standard: Competency for Execution

Although the Ford Court concluded that an inmate must be competent for execution and the procedures employed to determine competency must comply with a heightened standard of reliability, the majority facing execution must know "of their impending [punishment] and the reason for it").

Still, commentators have asserted that the Court did not provide a clear rationale for its decision in the Ford case. See Schopp, supra note 4, at 996 (noting that while Court discussed various rationales in support of its holding, it did not resolve underlying issues, such as appropriate standard of competency to face execution and whether Eighth Amendment precludes execution of incompetent as cruel and unusual punishment). See generally Byers, supra note 27, at 371-75 (reviewing various rationales underlying preclusion of incompetent from capital punishment); Harding, supra note 4, at 109-13 (detailing common law tradition and various rationales rejecting application of death penalty to insane persons); Radelet & Barnard, supra note 3, at 39-42 (discussing various explanations as to why incompetent persons should not be executed); Schopp, supra note 4, at 998-1009 (describing standard rationales offered by commentators and courts when requiring that inmate be competent for execution); Taylor, supra note 3, at 1049-52 (summarizing common law and contemporary rationales supporting exclusion of insane from execution).

Nonetheless, the majority in Ford indicated that regardless of the underlying rationale, the Eighth Amendment forbids the execution of the insane. See 477 U.S. at 410 ("[W]hether 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."). Many professional organizations have agreed that persons should not be executed if they cannot understand the reasons for their punishment. See, e.g., CRIMINAL JUSTICE MENTAL HEALTH STANDARDS 290 (1989) (setting forth in Standard 7-5.6 that convict is incompetent to be executed if he "cannot understand the nature of the pending proceedings, what he or she was tried for, the reason for the punishment, or the nature of the punishment").

46. See Ford, 477 U.S. at 414-15 (reasoning that for process to be constitutional, reliable and just, inmates must be afforded opportunity to present evidence in support of their incompetency, to cross-examine witnesses and to challenge state experts' often conflicting opinions). In Ford, the Court held that the specific state procedures utilized to determine competency for execution were inadequate. See id. at 416 (holding Florida procedures designed to determine competency for execution were inadequate due to multiple problems in scheme). Due to the irreversible and severe nature of the punishment involved in capital cases, the Court reasoned that the procedures designed to determine an inmate's competency for execution must adhere to a "heightened standard of reliability." See id. at 411 (recognizing that grave interests at stake in death penalty case warrant application of stringent standards to any fact-finding procedure involved in proceedings).

The Court also held that a fair and reliable determination of competency could not fall entirely within an executive's discretion. See id. at 416 (finding that Florida governor's implicit involvement in prosecutorial process precluded impartial and reliable executive decision regarding Ford's competency for execution). Furthermore, the Court stated that traditionally, the decision to delay an execution because of mental incompetence did not belong to the executive. See id. (noting that history does not support placing this decision in hands of executive).
did not articulate a specific standard of competency for execution. Nevertheless, Justice Powell suggested in his concurring opinion that persons must be "[ ] aware of the punishment they are about to suffer and why they are about to suffer it." Justice Powell also indicated that only persons "cured of [their] disease" should be executed.

47. See Byers, supra note 27, at 363 (noting that in its determination of Ford, Supreme Court did not provide standard for defining competency for execution); Schopp, supra note 4, at 996 (noting that while Supreme Court in Ford held execution of "insane" unconstitutional and rejected Florida procedure used to determine competency, Court did not provide appropriate competency standard and related procedures to be used); Wallace, supra note 4, at 318 ("There is no majority agreement in Ford on a substantive ‘standard of competence for execution.’"); see generally, G.B. Melton et al., Psychological Evaluations for the Courts: A Handbook for Mental Health Professionals and Lawyers 182-85 (2d ed. 1997) (noting that Supreme Court did not provide standard of competency for execution because Ford did not raise issue).

Similar to the Court's approach, few states provide a clear standard of the competence required for execution. See Brodsky et al., supra note 3, at 4 (noting that "[f]ew states have legislative or judicial standards explicitly defining incompetency or insanity to be executed"); see also Harding, supra note 4, at app. 1 (reviewing various states' death penalty codes); Ward, supra note 4, at app. 1 (providing various standards of competency for execution embodied in state statutes and common law). Furthermore, one commentator acknowledged that twenty-one of thirty-seven states implementing capital punishment in 1994 did not provide a competency standard. See Brodsky et al., supra note 3, at 4 (illustrating lack of clear competency standard for inmates facing execution). Moreover, states have not been required to include a standard in the various procedures used to determine a person's competency for execution. See Harding, supra note 4, at 134 (concluding that Ford Court's failure to provide standard left issue open to state discretion). Thus, standards are inconsistent and varied across states, which may result in the arbitrary and unreliable administration of the death penalty. See id. at 108 (stating that current competency-to-execute model has great propensity to result in decisions that violate Eighth Amendment's prohibition against arbitrary, capricious and unpredictable imposition of death penalty).

48. Ford, 477 U.S. at 422 (Powell, J., concurring) (suggesting competency standard required by Eighth Amendment). Recognizing that heightened standards apply in various states, Justice Powell contended that knowing the nature of and reasons for punishment were the basic elements of competency required by the Eighth Amendment. See id. at 422 n.3 (Powell, J., concurring) (noting various standards used in different states and validating use of heightened standards at states' discretion). Commentators have noted that Justice Powell's "standard" closely resembles that required by the common law. See Byers, supra note 27, at 363 (comparing Justice Powell's recommended standard to common law requirement that person know of conviction and pending execution); Ebert, supra note 4, at 35 (noting that Justice Powell's standard "essentially parallels the common law requirement"); Jenkins, supra note 34, at 167 (noting similarity between Justice Powell's standard and common law requirement); see also Mark A. Small & Randy K. Otto, Evaluations of Competency to Be Executed, 18 CRIM. JUST. & BEHAV. 146, 148 (1991) (discussing common law test for competency for execution); Wallace, supra note 4, at 318 (noting that common law standard for competency for execution "was whether the condemned was aware of the conviction and the impending fate").

49. Ford, 477 U.S. at 425 n.5 (admitting that some condemned inmates may become incompetent and never regain their mental faculties, thus avoiding execution altogether).
Many commentators assert that Justice Powell’s approach is too broad and ambiguous, resulting in the execution of truly incompetent persons. Others contend that his basic standard of competency fails to acknowledge the fluid and unpredictable nature of chemically restored competency and mental illness. As a result, important factors such as the duration, maintenance and relapse of competency are not addressed when determining whether a person should be executed. Furthermore, the standard does not delineate how competency should be induced and maintained. Thus, it remains unclear whether chemically induced and maintained competency satisfies the Eighth Amendment ban on the execution of the otherwise mentally incompetent.

C. Restoring Competency: The Efficacy of Antipsychotic Medication

Although a determination of legal incompetence does not turn on the presence of a mental illness, research has indicated that psychosis and schizophrenia are significantly related to legal incompetence. Moreover, without effective treatment of the underlying mental illness, the likeli-
hood of successfully restoring competency is low.\textsuperscript{56} Prior to the emergence of antipsychotic medication, the treatment modalities available for severe mental illness were largely unsuccessful.\textsuperscript{57} Since that time, however, many psychotropic drugs have been developed and improved, now effectively controlling and reducing the thought disorders, delusions and hallucinations commonly associated with psychosis and incompetence.\textsuperscript{58}

Morse, \textit{supra}, at 316 (discussing relationship between incompetence, schizophrenia and psychosis).

56. \textit{See} Morse, \textit{supra} note 55, at 316 (noting that before advent of antipsychotic medication "spontaneous remission was . . . the best hope for restoring competence"). With antipsychotic medication, however, persons suffering from psychosis may be rendered competent. \textit{See} Byers, \textit{supra} note 27, at 375-76 (arguing that these drugs may enable psychotic, incompetent persons to improve their rational thinking processes). \textit{But see} Morse, \textit{supra} note 55, at 316 (clarifying that while perhaps most efficient, antipsychotic medication is not only means by which competency may be restored). Some commentators have considered psychotherapy, behavioral techniques, such as positive reinforcement and aversive conditioning, and educational approaches as potential ways to treat psychotic symptoms as opposed to strong, intrusive medications typically accompanied by severe side effects. \textit{See} Bruce J. Winick, \textit{New Directions in the Right to Refuse Mental Health Treatment: The Implications of Riggins v. Nevada}, 2 WM. & MARY BILL RTS. J. 205, 223-24 (1993) (discussing antipsychotic medication and less intrusive alternatives for incompetent defendants facing trial); \textit{see also} Sell \textit{v.} United States, 123 S. Ct. 2174, 2185 (2003) (noting position of American Psychological Association that therapies not involving medication may be effective in restoration of competence of psychotic defendants). \textit{But see id.} (providing position of American Psychiatric Association that other treatments for psychosis are not as effective as medication).


Chlorpromazine, discovered in the 1950s, was one of the first drugs to effectively reduce the "positive symptoms" of schizophrenia, such as thought disorders, delusions and hallucinations, but had little effect on the "negative symptoms" associated with schizophrenia, which include social isolation, poverty of speech and flat affect. \textit{See} Carlson, \textit{supra} note 42, at 513-14 (describing effects of drug on symptoms of schizophrenia); Morse, \textit{supra} note 55, at 316 (characterizing chlorpromazine as "the most important early antipsychotic medication").

The consensus among psychiatrists, legislatures and courts appears to favor the use of antipsychotic medication in the treatment of psychosis and the restoration of competency. This form of treatment, however, has also evoked significant concerns. Notwithstanding their therapeutic benefits, antipsychotic medications have become notorious for several adverse and potentially irreversible side effects, including severe motor im-

antipsychotic drugs); T. Howard Stone, *Therapeutic Implications of Incarceration for Persons with Mental Disorders: Searching for Rational Health Policy*, 24 AM. J. CRIM. L. 283, 305 (1997) (stating that seventy percent of patients with schizophrenia experience improvements when using antipsychotic drugs). But see Carlson, *supra* note 42, at 517 ([N]ot everyone is helped; the symptoms of up to one-third of all schizophrenic patients are not substantially reduced by antipsychotic drugs.); Donald J. Kemna, *Current Status of Institutionalized Mental Health Patients' Right to Refuse Psychotropic Drugs*, 6 J. LEGAL MED. 107, 110 (1985) (noting that although medicine is effective in treating symptoms of psychosis, effects are temporary and do not last once drug is out of bloodstream); Mossman, *supra* note 31, at 274 (noting shortcomings of medications). Some commentators also suggest that these medications may be effective, but prolonged maintenance may be problematic and periodic breaks may be appropriate. See Winick, *supra* note 56, at 222-23 (discussing use of medication).

Some of the most commonly administered antipsychotic medications include Haldol, Mellaril, Prolixin and Thorazine. See Byers, *supra* note 27, at 376 (listing various drugs used to treat and control symptoms of psychosis); Steve Tomashefsky, Note, *Antipsychotic Drugs and Fitness to Stand Trial: The Right of the Unfit Accused to Refuse Treatment*, 52 U. CHI. L. REV. 773, 773 n.3 (1985) (providing examples of various antipsychotic drugs). These medications have been found to reduce symptoms commonly associated with schizophrenia and incompetence by blocking dopamine receptors in the brain and thereby altering chemical balances in the brain. See Carlson, *supra* note 42, at 513 (noting mechanism of drugs); see also Washington v. Harper, 484 U.S. 210, 214 (1990) (describing how medications work); Byers, *supra* note 27, at 376 (noting that by altering brain chemistry, antipsychotic medications allow incompetent persons to “think more clearly” and prevent emotions “from interfering with rational [thought] process[es]”); Jenkins, *supra* note 34, at 169 (acknowledging that psychotropic drugs alter brain chemistry, which reduces symptoms of mental illness and facilitates organization of thought processes); Aaron M. Nance, Comment, *Balking at Buying What the Eighth Circuit Is Sell-ing: United States v. Sell and the Involuntary Medication of the Incompetent, Non-dangerous Pretrial Detainees Cloaked with the Presumption of Innocence*, 71 UMKC L. REV. 685, 711 (2003) (“Antipsychotic drugs by their very nature, work by altering the chemistry in the brain.”).


60. See Bruce A. Arrigo & Jeffrey J. Tasca, *Right to Refuse Treatment, Competency to Be Executed, and Therapeutic Jurisprudence*, 23 LAW & PSYCHOL. REV. 1, 3 (1999) (“Although psychopharmacological interventions initially appeared to be curative . . . subsequent clinical protocols revealed that there were some significant problems associated with drug therapy.”); Harding, *supra* note 4, at 122 (discussing concerns and questions about use of medication to restore competency); Horton, *supra* note 27, at 1204 (commenting that while preferred as more effective treatment than past methods, antipsychotic medications have also been considered “chemical straitjackets”). But see Harding, *supra* note 4, at 121 (noting increased role of antipsychotic medication in treatment of mentally ill inmates facing execution); Horstman, *supra* note 7, at 846 (noting “many state laws require automatic medication of inmates found to be insane”).
pairment and, in rare cases, death. Moreover, the inconsistent restorative effects of these drugs have been considered particularly problematic for persons facing trial and execution.

Many commentators contend that these medications do not cure mental illness or incompetence, but rather, simply treat presenting symptoms. This distinction is particularly important in light of Justice Powell. See Carlson, supra note 42, at 517 (noting severity of side effects); Horton, supra note 27, at 1204 (noting that continued administration of antipsychotic medications may result in “movement disorders such as dystonia, akathesia and tardive dyskinesia”).

[D]ystonia results in severe muscle spasms of the face, throat, lips and tongue. Akathesia creates restlessness to such a degree that patients are unable to remain stationary and are constantly in a period of agitated frustration. Tardive Dyskinesia, the most common and serious of psychotropic drug side effects, causes repetitive involuntary spasms of the arm, hands, trunk, face and especially the mouth where common motions like licking, sucking and chewing are grossly exaggerated.

Id. at 1204 n.131; see also Carlson, supra note 42, at 517 (describing tardive dyskinesia as “syndrome [involving] peculiar facial tics and gestures, . . . tongue protrusion, cheek puffing, and a pursing of the lips” that may affect speech and is seen in ten percent of persons receiving antipsychotics); Nance, supra note 58, at 710 (describing side effects of these medications). Furthermore, these side effects are often irreversible and may persist after the medication is removed, despite the use of other medications designed to counter or lessen the side effects of antipsychotics. See Horton, supra note 27, at 1204-05; see also Nance, supra note 58, at 710-11 (noting severity and often irreversibility of side effects of antipsychotic medications). Approximately ten to twenty-five percent of persons treated with these medications demonstrate tardive dyskinesia. See id. at 710 (describing side effects of antipsychotic medications). The American Psychiatric Association has reported studies indicating that sixty percent of cases of tardive dyskinesia are mild, while ten percent are often severe. See id. (quoting majority opinion in Riggins v. Nevada, 504 U.S. 127 (1992)). But see Mossman, supra note 31, at 274 (“Although [antipsychotic medications] can have disastrous side effects, so can most medicines.”).


63. See Bachand, supra note 55, at 1061 (noting that most agree that reduction of symptoms after taking antipsychotic medication illustrates effect of treatment, not cure of disease); Harding, supra note 4, at 121 (discussing “‘cure’ versus ‘treatment’” debate over antipsychotic medications); id. (“[W]hile mentally incompetent condemned inmates can be ‘treated,’ they can never be ‘cured.’”); Horton, supra note 27, at 1204 (commenting that medications “merely mask the debilitating symptoms of major mental disorders; the drugs do not cure [them]”); Kemna, supra note 58, at 110 (“Although antipsychotic medication is effective in treating . . . symptoms . . . it does not cure mental illness.”); Taylor, supra note 3, at 1059 (“[A]ntipsychotic drugs produce an ‘artificial competency’ at best.”). Although medication may reduce symptoms, it does not mean that the underlying illness has been cured. See Harding, supra note 4, at 122 (commenting that favorable reaction to treatment is not equivalent to cure); see also Horstman, supra note 7, at 846 (“Artificial sanity is not a substitute for true sanity.”); Taylor, supra note 3, at 1046 (noting that improvement from medication is demonstrative of effective treatment, not cure). But see generally Geoffrey C. Hazard, Jr. & David W. Louisell, Death, the State, and the Insane: Stay of Execution, 9 UCLA L. Rev. 381, 384 (1962) (discussing idea that any improvement in inmate’s symptoms indicates that medication may cure incompetence). The debate regarding whether medications cure or treat mental illness and incompetence takes on an especially important
ell's assertion in *Ford* that an inmate must be "cured of his disease" to be executed. Commonly referred to as "artificial sanity," the competency induced by these drugs is often temporary and inconsistent. Consequently, the transient nature of chemically restored competence may preclude an accurate assessment of the individual's actual awareness and understanding of the impending execution. Thus, many conclude that the impermanent effects of the medication should not be construed as the competency for execution required by *Ford*.

D. *Forcing Treatment: The (Mis)use of Medication in Treatment and Competency Restoration*

Issues arise when inmates and defendants refuse antipsychotic medication, although such medication may be effective in the treatment of role when assessing competency to face execution. *See* Harding, *supra* note 4, at 123 (discussing dilemma of whether inmate who has been forcibly medicated and who demonstrates reduction in symptoms and return of competency may be considered cured and subject to execution under *Ford*).


65. *See* Sell v. United States, 123 S. Ct. 2174, 2185 (2003) (noting that different medications produce different levels of success and side effects); L. Goodman & A. Gilman, THE PHARMACOLOGICAL BASIS OF THERAPEUTICS 158-63 (5th ed. 1975) (discussing length of time these medications remain in body and produce effects); Horton, *supra* note 27, at 1204 (noting that symptoms and psychotic conditions recur without continued receipt of medication); Crosby, *supra* note 10, at 1213 ("The competence of an insane inmate treated with antipsychotic medication is . . . temporary and unpredictable."); Horstman, *supra* note 7, at 846-47 (noting temporary effects of antipsychotic medication); Taylor, *supra* note 3, at 1059 (noting that effects of these medications last only as long as chemicals remain in body). The inconsistency of the effects and competency produced by antipsychotic medications becomes particularly problematic when death row inmates are forcibly treated. *See* Crosby, *supra* note 10, at 1216 (noting these medications do not affect individuals same way each time they are administered); Horstman, *supra* note 7, at 847 (noting problems related to inconsistent effects of forced treatment in inmates facing execution). Furthermore, "artificial competency' raises questions of reliability and predictability," which jeopardize the fair and consistent imposition of the death penalty. *See* Taylor, *supra* note 3, at 1059-61 (discussing lack of concern for reliability and predictability in death penalty context demonstrated by Justice Powell's definition of competency).


67. *See* Horstman, *supra* note 7, at 847 ("Since an inmate cannot truly be made permanently sane, it follows that the inmate cannot be made competent to be executed . . ."). Some courts have addressed the issue of "artificial" sanity and competence in the trial context, yielding mixed results. *See* Crosby, *supra* note 10, at 1201 (noting disagreement among state courts regarding sufficiency of "artificial competency" for competence to stand trial); Taylor, *supra* note 3, at 1060-61 (noting cases concerning sufficiency of "artificial sanity"). *See generally* Gov't of Virgin Islands v. Crowe, 391 F. Supp. 987, 989 (D.V.I. 1975) (holding that person is competent for trial even if that competency is maintained by antipsychotic medication); State v. Hampton, 218 So. 2d 311, 311-12 (La. 1969) (holding that use of medication to restore competence does not matter so long as person is ultimately competent).
mental illness and the restoration of competency. Consequently, the Court has delineated the conditions under which these persons may be involuntarily medicated for purposes of treatment, prison safety and restoring competency for trial.


In 1990, the Supreme Court considered whether, under the Fourteenth Amendment, a state could forcibly treat a mentally ill inmate with antipsychotic drugs. In 1976, Harper was convicted of robbery and sentenced to prison. In 1982, following a diagnosis of schizophrenia and in accordance with Washington state policy, the state forcibly medicated Harper when he refused medication. In 1985, Harper sought relief in state court alleging that the forced medication violated his constitutional
rights. Although the trial court found the policy procedures constitutional, the Washington Supreme Court reversed.

On appeal, the Supreme Court weighed Harper’s significant interest in remaining free from the medication against the state’s interest in maintaining prison security. The Court concluded that a state may “treat a prison inmate who has a serious mental illness with antipsychotic drugs against his will if the inmate is dangerous to himself or others and the treatment is in the inmate’s medical interest.” The Court further held that the medication must be medically appropriate and the least intrusive means available to treat the inmate. Accordingly, the Court found the state policy constitutional, asserting that a medical determination of the need for involuntary medication was appropriate so long as the implemented procedures afforded due process.

74. See id. (noting Harper’s claim in state court). Harper asserted that the involuntary administration of drugs without a judicial hearing violated his due process, equal protection and free speech rights and sought multiple forms of relief. See id. (discussing nature of Harper’s claims).

75. See id. at 217-18 (discussing trial and state supreme court dispositions). While both courts recognized Harper’s liberty interests, the Washington Supreme Court held that the “highly intrusive nature” of the medication warranted greater procedural protections and held that a judicial hearing was necessary before Harper could be forcibly medicated. See id. at 218 (noting reasoning of state supreme court).

76. See id. at 221-27 (discussing Harper’s interests and state’s interests).

77. Id. at 227 (stating holding of case). The Court reasoned that the state’s legitimate interest in prison security outweighed Harper’s significant liberty interest in refusing medication because of the risk of dangerousness posed by his illness and related behavior. See id. at 222, 225-26 (weighing interests involved in case). Harper exhibited a long history of assaultive behavior, which was attributed to his mental illness. See id. at 227 n.11 (reviewing Harper’s history of dangerous behavior). Relying on the general acceptance of antipsychotic medications in the psychiatric community and their effectiveness in treating mental illness and violent behavior, the Court found the medication to be in Harper’s medical interest. See id. at 226 n.9 (referring to Brief for Amicus Curiae American Psychiatric Association et al.). The Court also addressed the side effects of the medication, but relied on its therapeutic effects and the judgment of medical professionals when finding it medically appropriate. See id. at 226-27 (determining medical appropriateness of medication).

78. See id. at 223 (noting that forcible medication could only be administered if medically appropriate and for treatment purposes). The Court held that drugs are medically appropriate when administered for treatment purposes because of their ability to effectively treat mental illness and control violent behavior, thus fulfilling the state’s interest in prison security. See id. at 223-27 (discussing circumstances justifying forcible administration of medication). The Court dismissed the use of physical restraints and seclusion as alternative, less intrusive means to effectively treat Harper and fulfill prison interests. See id. at 226-27 (comparing antipsychotic medication with alternative forms of treatment).

79. See id. at 231-32 (concluding that inmate’s interests are better protected if medical professionals determine need for medication). The Court found that a judicial hearing was not necessary because the “Constitution does not prohibit the State from permitting medical personnel to make . . . decision[s] under fair procedural mechanisms.” See id. at 231 (noting that medical professionals can determine need for forcible medication under Fourteenth Amendment). Accordingly,
2. Riggins v. Nevada \(^{80}\)

In 1992, the Court was faced with the issue of whether the forcible administration of medication to restore competency for trial violated a defendant's Sixth and Fourteenth Amendment rights. \(^{81}\) In 1987, after being arrested for robbery and murder, Riggins was administered antipsychotic medication while awaiting trial. \(^{82}\) When found competent to stand trial, Riggins motioned for a suspension of the medication, asserting that its side effects would negatively affect his appearance and right to a fair trial. \(^{83}\) Providing no explanation, the district court denied the motion and Riggins was involuntarily medicated throughout trial. \(^{84}\) He was convicted and sentenced to death. \(^{85}\)

the Court found the state policy constitutional because it afforded appropriate due process protection by providing the right to notice, presence and the cross-examination of witnesses. \textit{See id.} at 235 (finding state policy constitutional and sufficient under due process).

81. \textit{See id.} at 132-33 (stating issue of case).
82. \textit{See id.} at 129 (providing initial facts of case). While in custody, Riggins complained of "hearing voices in his head and having trouble sleeping." \textit{Id.} (describing symptoms for which Riggins was administered medication). He was subsequently prescribed Mellaril, which was periodically increased before trial. \textit{See id.} (noting medication administered to Riggins while in custody).
83. \textit{See id.} at 130 (noting lower court's determination of Riggins as competent and defense motion to terminate Riggins's medication before trial). In 1988, three court-appointed psychiatrists assessed Riggins's competency while receiving the medication; two found him competent to stand trial and one found him incompetent. \textit{See id.} at 130 (discussing competency determination). At trial, Riggins motioned for the discontinuation of the medication, asserting that the drugs would affect his demeanor and negatively impact his due process rights under the Fourteenth Amendment and Nevada Constitution. \textit{See id.} at 130 (explaining Riggins's argument against continued medication so that jurors could see his "true mental state"). The court subsequently held the medication necessary to ensure his competence for trial. \textit{See id.} (basing this decision on Nevada law, which prohibits incompetent persons to stand trial).
84. \textit{See id.} at 131 (discussing denial of Riggins's motion and his continued receipt of medication during trial). The Court noted that the district court denied the motion "with a one page order... [giving] no indication of the court's rationale." \textit{Id.} (describing court's order).
85. \textit{See id.} at 131-32 (discussing disposition of Riggins's case). At trial, Riggins relied on an insanity defense. \textit{See id.} at 131 (describing Riggins's testimony at trial). On appeal to the Nevada Supreme Court, Riggins argued that the medication rendered him unable to assist in and prejudiced his defense, as it altered his appearance at trial. \textit{See id.} (discussing Riggins's arguments on appeal). Furthermore, Riggins asserted that the state failed to justify the medication and did not explore alternative, less intrusive treatments. \textit{See id.} at 132-33 (discussing Riggins's liberty interests claims on appeal). In affirming his conviction and sentence, the Nevada Supreme Court found that expert testimony describing the effects of the medication adequately protected Riggins's interests at trial. \textit{See id.} at 132 (discussing Nevada Supreme Court opinion).
When considering Riggins’s claim, the Court relied on Harper. Extending the Harper standard to a pretrial detainee, the Court held that once Riggins attempted to terminate the medication, the state was required to prove that the drug was essential, medically appropriate and the least intrusive means available to render Riggins competent. The Court emphasized that the trial court failed to make a substantive determination of whether the medication was necessary or the least intrusive means available to achieve competency. Consequently, the Court held that the potential impact of the medication on Riggins’s appearance, defense and ability to assist violated his Sixth and Fourteenth Amendment rights.

3. United States v. Sell

In 2002, the Eighth Circuit considered the constitutionality of a state’s forcible administration of medication for the sole purpose of restoring...
ing a defendant’s competency for trial.\(^9\) Sell was charged with federal fraud and money laundering in 1997.\(^{92}\) Because Sell was diagnosed with a delusional disorder, the trial court designated him legally incompetent to stand trial in 1999.\(^{93}\) In 2000, a U.S. magistrate judge ordered the forcible medication of Sell, following a showing that he was dangerous and that the medication was necessary to restore his competency.\(^{94}\) Although the district court reversed the finding of dangerousness, it upheld the forced medication to restore Sell’s competency for trial.\(^{95}\)

Referencing Harper and Riggins, the Eighth Circuit delineated the conditions under which a defendant may be involuntarily medicated for the sole purpose of restoring competency for trial.\(^{96}\) First, the govern-

---

\(^{91}\) See Sell, 282 F.3d at 562 (stating issue in case).

\(^{92}\) See id. (describing indictment charging Sell with fifty-six counts of mail fraud, six counts of Medicaid fraud and one count of money laundering). Sell was subsequently released on bond in 1997. See id. at 563 (discussing facts of case). In 1998, Sell was arrested for intimidating a witness and attempted murder. The court subsequently revoked his bail when he lost control over himself at a court hearing. See id. (discussing Sell’s behavior when re-arrested and his subsequent revocation of bail). While in custody, Sell’s mental health began to deteriorate and the court ordered psychological examinations. See id. (noting court’s decision to hospitalize Sell for reasonable period of time to determine if he would attain competency necessary to stand trial).

\(^{93}\) See id. (discussing Sell’s diagnosis and subsequent hospitalization as attempt to restore him to competency).

\(^{94}\) See id. at 564-65 (noting federal magistrate judge’s order that Sell was dangerous and “medication was likely to restore him to competency”). Sell had been granted a full judicial hearing after the doctors in the hospital where he was being held found him in need of medication to treat his symptoms and to restore his competency. See id. at 563-64 (discussing hospital proceedings and Sell’s judicial hearing in 1999).

\(^{95}\) See id. at 565 (discussing district court’s holding that Sell could be forcibly medicated regardless of dangerousness). The court had found that the record lacked evidence of Sell’s dangerousness, but the restoration of competency for trial was a valid reason to continue the forcible medication. See id. (discussing district court’s holding).

\(^{96}\) See id. 565-67 (summarizing Court’s holdings in Harper and Riggins and delineating its own test for forcible administration of medication to restore competency for trial). In designing its own test, the Eighth Circuit incorporated pieces of the Supreme Court’s analysis in Harper and Riggins. See id. at 567 (describing test). The court also integrated the reasoning set forth in United States v. Weston, 255 F.3d
ment must present an essential interest, outweighing the defendant's liberty interest in refusing medication. Second, medication must be the least intrusive means by which the government interest may be fulfilled. Lastly, the medication must be proven "medically appropriate" by a clear and convincing evidentiary standard. To be medically appropriate, medication must be in the medical interests of the defendant, it must be likely to restore competency and its benefits must outweigh any potential side effects.

Applying these standards, the Eighth Circuit held that the government interest in prosecuting serious charges justified the forcible administration of medication. The court also found that the medication was medically appropriate and the most effective, least intrusive means to restore competency without substantial side effects. Further, the court clearly limited this holding to the trial context.

873 (D.C. Cir. 2001). See Sell, 282 F.3d at 567 ("Medication is medically appropriate if ... it is likely to render the patient competent.").

97. See id. (describing first prong of analysis). The Eighth Circuit incorporated this standard from Riggins. See id. (citing Riggins v. Nevada, 504 U.S. 127, 135 (1992), for the proposition that "government must prove an overriding state interest").

98. See id. (describing second prong of analysis).


100. See id. (defining "medically appropriate" under newly established standard). Compare Harper, 494 U.S. at 227 (requiring dangerousness when determining whether medication is medically appropriate), with Weston, 255 F.3d at 876 (noting that medication is medically appropriate if it induces competence).

101. See Sell, 282 F.3d at 568 (balancing Sell's interest in refusing medication against government's interest in prosecuting his charges). The court found that due to the seriousness of the charges, the government's interest in restoring competency to effectuate trial was "paramount." See id. (discussing government interest).

102. See id. at 568-69 (noting that medication was most effective in restoring Sell's competency). The court relied on various doctors' testimony that the medication was most effective in treating delusional disorders and found that no alternative means were provided. See id. (finding that recovery was possible by administering medication). The court also found limited side effects, which could be controlled by modifying the medication. See id. at 569 (discussing one doctor's opinion that medication was beneficial for treatment of Sell's disorder). Thus, relying on professional opinion and related evidence of the drug's effectiveness, the court found that the medication was medically appropriate for Sell's condition. See id. at 570-71 (considering medical appropriateness of medication).

103. See id. at 571 (limiting forcible use of medication to restore competency solely to trial context). The court cautioned, "an entirely different case is presented when the government wishes to medicate a prisoner . . . to render him competent for execution." Id. The court made explicit reference to the Singleton case when issuing this cautionary statement. See id. (citing Singleton v. Norris, 267 F.3d 859 (8th Cir. 2001)).
At least one state supreme court has considered the use of forced medication for the restoration of competency in inmates facing execution. Perry, a chronic schizophrenic, was convicted and sentenced to death for multiple counts of murder in 1985. Subsequently, the trial court found that without medication, Perry would remain "incompetent for execution." The trial court accordingly ordered Perry to be forcibly medicated to render him competent for execution.

On appeal, the Louisiana Supreme Court comprehensively analyzed the common law, U.S. Supreme Court precedent, state court precedent and the ethical issues involved in Perry's claim. Applying state law, the court held the forcible administration of medication to restore competency for execution unconstitutional as cruel and unusual punishment. Emphasizing the ultimate effect of the medication, the court distinguished Harper, asserting that the forcible administration of medication to effectuate execution was not narrowly confined to prison safety or the inmate's

---

104. 610 So. 2d 746 (La. 1992) (holding that state may not medicate condemned inmate against his will to carry out death sentence while under influence of medication).

105. See id. at 747 ("The fundamental question raised by this case is whether the state can . . . medicat[e] an incompetent death row prisoner against his will with antipsychotic drugs and carry[ ] out his death sentence while he is under the influence of the drugs.").

106. See id. at 748 (describing facts, disposition and mental illness issues in case). Perry presented a long history of mental illness marked with numerous hospitalizations. See id. (describing Perry's mental illness). Perry's mental illness created legal issues throughout the trial and related proceedings. See id. (discussing facts of case). The court eventually ordered Perry's hospitalization and treatment with antipsychotic medication, which rendered him competent for trial. See id. (describing Perry's treatment while awaiting trial). He was subsequently sentenced to death and the appellate court affirmed his sentence. See id. (noting disposition of case).

107. Id. (noting court's finding that Perry was incompetent for execution without medication). Following sentencing, medical experts evaluated and diagnosed Perry with a schizoaffective disorder, which could be treated, but never "permanently cured." See id. (describing Perry's chronic mental illness).

108. See id. (noting court's order for medication, even if forcible).

109. See generally id. at 749-71 (discussing reasoning of court). The case had been remanded to the Louisiana Supreme Court following the Supreme Court's decision in Harper and after the state recommended the forcible medication. See id. at 748 (noung procedural history of case). In the course of its analysis, the court considered the holding in Ford, the Louisiana and U.S. Constitutions, as well as Perry's rights to privacy and liberty. See id. at 749-51, 755-59 (discussing various foundations for court's ruling).

110. See id. at 771 (holding that subjecting insane prisoners to execution under pretense that they can be made "sane" through medication constitutes cruel and unusual punishment). The court concluded that the forcible administration of medication to render one competent for execution violated the person's liberty interests, contradicted the person's best medical interests, compromised the ethical guidelines of medical professionals and undermined the protections of the Eighth Amendment. See id. at 768-71 (explaining court's holding).
best medical interests, but rather, served as a “tool for punishment.”111 Qualifying this use of medication as inhumane and socially unacceptable, the court stayed Perry's execution until competency could be restored without the medication.112

III. MEDICATING TO EXECUTE: SINGLETON V. NORRIS113

A. Factual Summary

Charles Laverne Singleton was convicted of aggravated robbery and capital felony murder and sentenced to death in 1979.114 While awaiting execution, Singleton's mental health significantly deteriorated and he was subsequently diagnosed with schizophrenia.115 Consequently, Singleton's

111. See id. at 751-55 (distinguishing Harper and qualifying use of medication in this instance as “antithetical to the . . . healing arts” and an “instrument of . . . execution.”). The court specifically found that Harper implied that medication could not be used for punishment purposes. See id. at 751-52 (distinguishing Harper). Furthermore, the court found that the administration of medication leading to execution was not medically appropriate or in Perry's ultimate medical interests. See id. 752-53 (discussing problems with use of medication in inmates facing execution).

112. See id. at 761-71 (discussing principles of humane treatment, Eighth Amendment and holding of case). Similarly, the court regarded the use of medication in this context as a violation of the evolving standards of decency and the ethical standards of the medical profession. See id. at 765-69 (applying principles of humane treatment).

113. 319 F.3d 1018 (8th Cir. 2003), cert. denied, 2003 U.S. LEXIS 6184 (Oct. 6, 2003).

114. See id. at 1020 (discussing facts of case). On direct appeal, the Arkansas Supreme Court found overwhelming evidence of Singleton's guilt. See id. at 1020-21 (discussing facts of alleged crime). Witnesses placed Singleton entering and exiting the scene of the crime and the victim identified him as her attacker before she died en route to the hospital. See id. (discussing testimony regarding alleged crime). Singleton's death sentence was affirmed, but his life sentence for the robbery was set aside. See id. at 1021 (discussing ruling of Arkansas Supreme Court). His execution was set for June 4, 1982, after he was denied post conviction relief. See id. (discussing decision of state supreme court in 1981); see also Chris Adams, Death Watch: Delusional Justice, 27 CHAMPION, May 2003, at 46 (noting Singleton’s death sentence); Redding & Hensl, supra note 17, at 9 (discussing facts of case); Leslie Newell Peacock, Too Sane to Live? Or Too Sick to Die? (Apr. 17, 1998), available at http://www.arktimes.com/041798coverstory.htm (same).

115. See Singleton, 319 F.3d at 1030-31 (Heaney, J., dissenting) (discussing deterioration of Singleton's mental health and his diagnosis while on death row). Singleton was initially treated with various medications for depression and anxiety before being diagnosed with schizophrenia. See id. at 1030 (Heaney, J., dissenting) (noting Singleton’s extensive receipt of medication and his initial psychological problems).

Singleton's symptoms have included a number of disturbing delusions and hallucinations. See id. at 1031-33 (Heaney, J., dissenting) (describing Singleton's various delusions and hallucinations while on death row). At times, Singleton also lost excessive weight, would strip off his clothes and spoke in an unintelligible and nonsensical language. See id. at 1031 (Heaney, J., dissenting) (discussing Singleton’s behavior and symptoms while on death row). Furthermore, Singleton reported hearing voices, demonstrated paranoid and disorganized thought processes
treated psychiatrist prescribed antipsychotic medication for the duration of his incarceration. His compliance had been sporadic; at times he was forcibly medicated. The efficacy of the medication was similarly unpredictable and inconsistent.

Throughout the case, Singleton filed multiple petitions to stay his execution, including repeated Ford claims alleging ineligibility for execution as a result of his incompetence. Singleton also requested a suspension of the medication to allow for a competency assessment uninfluenced by its effects. Both state and federal courts repeatedly denied these petitions through 1997.

and experienced frightening hallucinations. See id. at 1031-32 (Heaney, J., dissenting) (discussing Singleton's behavior and symptoms while on death row).

116. See id. at 1031 (Heaney, J., dissenting) (noting that Singleton required extensive medication for his mental illness while on death row). Singleton had been treated with Prolixin for his symptoms. See Peacock, supra note 114 (describing Singleton's treatment in custody).

117. See Singleton, 319 F.3d at 1031 (Heaney, J., dissenting) (noting Singleton's inconsistent acceptance of psychotropic medication while on death row).

118. See id. at 1034 (Heaney, J., dissenting) (discussing Singleton's treatment plan and unpredictability of medication). The medication occasionally alleviated his troubling symptoms. See id. at 1026 (finding that medication controlled Singleton's symptoms and induced competency). Records stated that Singleton's symptoms would "resurface" with the removal of medication and, at times, would diminish while on the medication. See id. at 1031 (Heaney, J., dissenting) (discussing symptoms experienced by Singleton when taken off his medication in 1991); see also Peacock, supra note 114 (discussing Singleton's symptoms without medication). In 1997, one of Singleton's treating psychologists reported that without medication, Singleton was not competent and would continue to experience psychosis and further deterioration. See Singleton, 319 F.3d at 1032-33 (Heaney, J., dissenting) (discussing treating psychologist's impressions of Singleton's mental health status).

Nevertheless, records also suggested that Singleton's medications often required modification and that he still experienced psychotic symptoms despite his receipt of increased dosages of medication. See id. at 1031-32, 1034 (Heaney, J., dissenting) (noting Singleton's doctor's observations and impressions). In 1993, 1997, 1999 and 2000, Singleton experienced unrelenting hallucinations and delusions, despite his receipt of medication. See id. at 1031-33 (Heaney, J., dissenting) (identifying various instances in which Singleton voluntarily and involuntarily received psychotropic medications, but still demonstrated psychotic symptoms and incompetence). The continued existence of symptoms caused Singleton's doctors to question his competency while on the medication. See id. (noting that doctors questioned Singleton's competency notwithstanding his receipt of antipsychotic medication).

119. See Singleton, 319 F.3d at 1021-22 (discussing Singleton's various appeals and stays of execution). Singleton was initially denied post-conviction relief in 1981, and his execution was set for June 4, 1982. See id. at 1021 (noting Singleton's initial execution date). His subsequent petitions also asserted "ineffective assistance of counsel [and] use of invalid aggravating factors." Id. at 1021 (discussing Singleton's post-conviction claims).

120. See id. at 1021 (discussing Singleton's Ford claims).

121. See id. at 1021-22 (noting that trial court, Arkansas Supreme Court, district court and Eighth Circuit repeatedly denied Singleton's petitions).
In 1997, in light of Singleton’s refusal to take the medication and a medical committee’s finding that he was dangerous when unmedicated, the state ordered Singleton’s forcible medication. With treatment, Singleton’s symptoms diminished and a new execution date was set. In 2000, the district court denied Singleton’s petition for a writ of habeas corpus, which the Eighth Circuit reversed, granting a stay of execution. Upon rehearing, Singleton asserted that the forced administration of medication, initially constitutional under Harper, became unconstitutional once his execution date was set because it was no longer in his best medical interest. In February 2003, the Eighth Circuit affirmed the district court order, holding that an incompetent prisoner may be forcibly administered antipsychotic medication to treat symptoms and restore competency, despite an impending execution date. Singleton’s stay of execution was vacated and the state was permitted to maintain his eligibility for execution through the use of forced medication.

B. Narrative Analysis

In Singleton, the Eighth Circuit examined two interconnected issues of first impression. First, the Eighth Circuit considered whether a state could forcibly administer medication to an inmate once an execution date

122. See id. at 1021 (noting medical review panel’s finding that Singleton was dangerous to himself and others and in need of medication).

123. See id. (discussing effect of medication and setting of new execution date for March 2000).

124. See id. at 1021-22 (noting denial of Singleton’s petition in February 2000). Singleton argued in his habeas petition that the use of forced medication to restore his competency and effectuate his execution was unconstitutional. See id. at 1021 (explaining habeas claim). In October 2001, the Eighth Circuit reversed the district court’s denial of Singleton’s petition and sentenced Singleton to life in prison without the possibility of parole. See Associated Press, Death Row Case Raises Insanity Defense Paradox (Feb. 11, 2003), available at http://www.cnn.com/2003/LAW/02/11/execution.insanity.ap/ (noting procedural history of case). On remand, the district court found that Singleton was not Ford-compotent prior to the time at which his involuntary medication regime began in 1997; however, the court did not determine with certainty whether Singleton would relapse into psychosis without medication. See Singleton, 318 F.3d at 1022 (discussing district court findings). The district court did not determine Singleton’s present competence, although he admitted to his competence when medicated. See id. (discussing Singleton’s competence).

125. See Singleton, 318 F.3d at 1020 (noting Singleton’s claim).

126. See id. at 1020, 1026-27 (affirming district court order and discussing holding of case).

127. See id. at 1026-27 (stating disposition of case).

128. See id. at 1023 (stating two issues of case). While this Note will deal only with the issues concerning forcible medication, competency and subsequent execution of an inmate, the Eighth Circuit also addressed issues of mootness and Singleton’s use of successive habeas corpus petitions. See id. at 1022-23 (discussing additional questions of law presented by Singleton case); see also Adams, supra note 114, at 46 (noting auxiliary issues of case).
had been scheduled. Second, the court considered whether, under Harper, a state could execute an inmate who had been forcibly medicated and rendered competent.

At the outset, the court identified the relevant Supreme Court precedent guiding its analysis. The court first acknowledged Ford and Justice Powell’s suggested standard of competency for execution. The court next reviewed Harper, outlining the circumstances under which a state could forcibly medicate a mentally ill inmate. The court also discussed Riggins and the limits on forcibly medicating a defendant to restore competency for trial.

Subsequently, the Eighth Circuit decided to apply the standards enumerated in Sell, despite the court’s previous caveat concerning the limited scope of the Sell holding. Embarking on its analysis, the court first weighed Singleton’s liberty interest in refusing medication against the state’s interest in capital punishment. Considering both Singleton’s preference to take the medication and the medication’s limited side ef-

129. See Singleton, 319 F.3d at 1023 (noting first main issue of case).
130. See id. (noting second main issue of case).
131. See id. ("We are guided in our inquiry by Ford v. Wainwright and Washington v. Harper."). For further discussion of Ford, see supra notes 40-49 and accompanying text. For a further discussion of Harper, see supra notes 71-79 and accompanying text.
132. See Singleton, 319 F.3d at 1023 (Powell, J., concurring) ("'The Eighth Amendment forbids the execution of only those who are unaware of the punishment they are about to suffer and why they are to suffer it.'" (quoting Ford v. Wainwright, 477 U.S. 399, 422 (1986))). For a further discussion of the Ford case and Justice Powell’s concurring opinion, see supra notes 40-49 and accompanying text.
133. See Singleton, 319 F.3d at 1024 ("[A] state may forcibly administer antipsychotic drugs to 'a prison inmate who has a serious mental illness . . . if the inmate is dangerous to himself or others and the treatment is in the inmate's medical interest.") (quoting Washington v. Harper, 494 U.S. 210, 227 (1990)). For a further discussion of the Harper case and the conditions required for forcible medication, see supra notes 70-79 and accompanying text.
134. See Singleton, 319 F.3d at 1024 (reviewing Court’s holding in Riggins). For a further discussion of the Riggins case and the use of forced medication to restore and maintain competency in defendants facing trial, see supra notes 80-89 and accompanying text.
135. See Singleton, 319 F.3d at 1024-25 (reviewing Sell standard and finding it applicable to Singleton). The Sell court warned that "'an entirely different case is presented when the government wishes to medicate a prisoner in order to render him competent for execution.'" Id. at 1024 (quoting United States v. Sell, 282 F.3d 560, 571 (8th Cir. 2002)). For further discussion of the Eighth Circuit’s decision in Sell, see supra notes 90-103 and accompanying text.
136. See Singleton, 319 F.3d at 1025 (weighing state’s and Singleton’s interests). The court fully acknowledged an essential government interest in effectuating a lawfully imposed capital sentence. See id. ("Society's interest in punishing offenders is at its greatest in the narrow class of capital murder cases . . . "). The court further noted "society's compelling interest in finding, convicting, and punishing those who violate the law." Id. (quoting Moran v. Burbine, 475 U.S. 412, 426 (1986)).
The court found the state's interest superior. Second, relying on the district court's finding that Singleton would become psychotic and potentially incompetent without it, the court concluded that the medication was the least intrusive means available to treat and ensure his competency for execution.

When considering whether the medication was medically appropriate, the court first concluded that the medication effectively restored Singleton's competency with minimal side effects. Due to the drug's effectiveness, the court also found that the medication was in his best medical interest. The court rejected Singleton's claim that the medication was not in his "ultimate best medical interest" because of his impending execution, noting "[e]ligibility for execution is the only unwanted consequence of the medication." Focusing only on the benefits of the medication, the court asserted that the best medical interests of an inmate "must be determined without regard to whether there is a pending date of execution."

Furthermore, the court noted that when a state has a duty to provide treatment to an inmate, additional motives of the state are "irrelevant." The court similarly dismissed Singleton's Perry-based argument that Ford prohibits the execution of an "artificially competent" person. In conclusion, the court upheld the constitutionality of the forcible administration of medication, despite a set execution date and the execution of an inmate who has been forcibly restored to competence under the Eighth Amendment.

Guided by Supreme Court and state court precedent, "scholarly commentary and the ethical standards of the medical profession," Circuit Judge Heaney filed a dissenting opinion, which three judges joined.

137. See id. at 1025 (finding state's interest superior).
138. See id. (considering whether medication was least intrusive way to fulfill state's interest). The court noted Singleton's admission that he was competent while on the medication in its holding that the medication was needed to restore his competency and enable his execution. See id. at 1025-26 (discussing Singleton's admission of competency when medicated).
139. See id. at 1026 (deferring to district court findings when examining medical appropriateness of medication).
140. See id. (finding medication to be in Singleton's "best medical interest" regardless of his impending execution).
141. Id. (rejecting Singleton's argument that medication was not in his medical interest). The court further held that Singleton's assertions of his due process interests in life and liberty were foreclosed by his lawfully imposed sentence and the Harper medication regimen. See id. (considering Singleton's due process arguments).
142. Id. (holding forced medication constitutional, despite Singleton's impending execution date).
143. See id. at 1027 (declining to inquire into additional state motives).
144. See id. at 1026-27 (distinguishing Perry).
145. See id. (stating holdings of case).
146. Id. at 1030 (Heaney, J., dissenting) (noting basis of his dissent).
First, Judge Heaney addressed whether an incompetent inmate receiving treatment could be executed under the Eighth Amendment.\textsuperscript{147} Referencing Justice Powell in Ford, he concluded that antipsychotic medication provides “artificial sanity,” and because the medicated person is not cured, execution is unconstitutional.\textsuperscript{148} Criticizing the majority’s analysis as “unsound,” he also examined the forcible administration of medication when the ultimate effect of the treatment would be the facilitation of execution.\textsuperscript{149} Subsequently, Judge Heaney asserted that once an execution date has been set, forcible medication is no longer justified because of the impossibility of discerning state motives.\textsuperscript{150} Lastly, he addressed the various ethical dilemmas encountered by the medical community as a result of the court’s decision.\textsuperscript{151} Recognizing that medical professionals are forced into the irreconcilable position of providing necessary treatment that ultimately results in death, Heaney concluded that a stay of execution was appropriate.\textsuperscript{152}

\textbf{C. A Critical Examination}

The Eighth Circuit faced a considerable challenge in Singleton, the ramifications of which will undoubtedly impact the fate of many mentally ill inmates facing execution.\textsuperscript{153} Embarking on this difficult task, the Eighth Circuit became the first federal appellate court to consider the constitutionality of forcibly medicating a condemned incompetent inmate.\textsuperscript{154} More importantly, however, Singleton represents the first federal

\textsuperscript{147} See id. at 1033 (Heaney, J., dissenting) (distinguishing treatment from “being cured”).

\textsuperscript{148} See id. at 1033-34 (Heaney, J., dissenting) (emphasizing Justice Powell’s suggestion that inmate be “cured of his disease” before being executed).

\textsuperscript{149} See id. at 1035 (Heaney, J., dissenting) (discussing Harper in light of Singleton’s pending execution).

\textsuperscript{150} See id. at 1036 (Heaney, J., dissenting) (noting inability to discern state motives once execution date is set). “[I]t will often be difficult to determine whether the State is medicating the inmate to protect him from harming himself or others, or whether the State is medicating the inmate to render him competent for execution.” Id.

\textsuperscript{151} See id. at 1036-37 (Heaney, J., dissenting) (noting ethical conflicts resulting from court’s decision).

\textsuperscript{152} See id. at 1037 (Heaney, J., dissenting) (recommending permanent stay of execution).

\textsuperscript{153} See id. at 1023-27 (evaluating constitutionality of forcibly medicating and restoring competency to inmate, rendering him eligible for execution).

\textsuperscript{154} See id. at 1023 (noting issue as “one of first impression” for Eighth Circuit); see also Redding & Hensl, supra note 17 and accompanying text (explaining issue of whether forcibly medicating inmate for execution was constitutional); Psychotic Death Row Inmate May Be Forcibly Medicated for Execution, 72 CRIM. L. REP. 20 (2003), available at http://litigationcenter.bna.com/pic2/lit.nsf/c9136ec2a0a6115985256a0f0012e350/31549692a30d60e585256cd30058363?OpenDocument&Highlight=2 (same).
examination of the medical appropriateness of treatment that ultimately facilitates execution.\textsuperscript{155}

Utilizing the \textit{Sell} standard, the court attempted to apply an aggregation of Supreme Court case law dealing with the forcible medication of defendants facing trial and inmates held in prison.\textsuperscript{156} By extending the \textit{Sell} standard to \textit{Singleton}, however, the Eighth Circuit simplified the perplexing effects of treatment in this context.\textsuperscript{157} As a result, the court implemented a constrained, result-oriented approach, entailing the subtle modification of existing precedent and resulting in an inherently flawed analysis.\textsuperscript{158} Thus, the court in \textit{Singleton} may have compromised its significant legal responsibility and further exacerbated a paradoxical issue for medical professionals and courts.\textsuperscript{159}

1. \textit{Sell-ing Out on a Context-Based Inquiry}

The Eighth Circuit improperly expanded the scope of the \textit{Sell} test by extending its standards to \textit{Singleton}.\textsuperscript{160} Disregarding \textit{Sell}'s explicit warning that "[a]n entirely different case is presented" when forcible medication is used in the restoration of competency for execution, the court misapplied standards clearly limited to the trial situation.\textsuperscript{161} The concerns underlying the forcible restoration of competency are context-specific.\textsuperscript{162} At trial,

\begin{itemize}
\item \textsuperscript{155} \textit{See \textit{Singleton}, 319 F.3d at 1025-26} (evaluating medical appropriateness of medicating condemned inmate). \textit{But see \textit{State v. Perry, 610 So. 2d 746, 758-60 (La. 1992)}} (demonstrating state court evaluation of medical appropriateness of medicating condemned inmate).
\item \textsuperscript{156} \textit{See \textit{Singleton}, 319 F.3d at 1024-25} (applying \textit{Sell}). For further discussion of the integration of Supreme Court case law in the \textit{Sell} test, see \textit{supra} notes 96-100 and accompanying text and Laura Hermer, \textit{The Involuntary Medication of Condemned Convicts}, Health Law & Policy Institute (May 5, 2003), available at http://www.law.uh.edu/healthlawperspectives/Mental/030530Involuntary.html (characterizing \textit{Sell} test as "strained agglomeration of present law governing the forcible medication of inmates and criminal defendants").
\item \textsuperscript{157} \textit{Cf. \textit{Singleton}, 319 F.3d at 1035-36} (Heaney, J., dissenting) (noting problems with applying \textit{Harper}-based standard to inmate facing execution).
\item \textsuperscript{158} \textit{See id. at 1023-25} (integrating fragments of Supreme Court holdings into \textit{Sell} standards); \textit{id. at 1035-36} (Heaney, J., dissenting) (noting problems with majority's reasoning); \textit{see also} \textit{Hermer, supra} note 156 ("\textit{Sell}'s mix-and-match approach suggests an ends-oriented approach . . . ").
\item \textsuperscript{159} \textit{See \textit{Singleton}, 319 F.3d at 1035-37} (Heaney, J., dissenting) (noting resultant ethical dilemmas and confusion regarding state motives in forcibly medicating the condemned). For a further discussion of \textit{Singleton}'s effect on medical professionals, see \textit{infra} notes 189-210 and accompanying text.
\item \textsuperscript{160} \textit{See \textit{United States v. Sell, 282 F.3d 560, 571 (8th Cir. 2002)}} (holding that involuntary medication was only way for government to achieve its interest in fairly trying \textit{Sell} and that medication was medically appropriate for \textit{Sell}); \textit{cf. \textit{Singleton, 319 F.3d at 1024-25}} (disregarding limits on \textit{Sell} test).
\item \textsuperscript{161} \textit{Singleton, 319 F.3d at 1024-25} (dismissing narrow holding of \textit{Sell}).
\item \textsuperscript{162} \textit{See id.} (noting forcible use of medication for execution is "entirely different" than use of medication for trial purposes (quoting \textit{Sell, 282 F.3d at 571}); \textit{see also} \textit{Crosby, supra} note 10, at 1209 (noting differences between competency restoration for trial and for execution). For a general discussion on the context-specific nature of competency, see Stephen L. Golding & Ronald Roesch, \textit{Competency for
competency restoration involves a state interest in prosecution and a defendant's interest in receiving a fair trial. With regard to execution, however, competency restoration involves different, conflicting interests, namely, effectuating an execution, while conforming to the protections prescribed by the Eighth Amendment to prevent the unlawful execution of a convicted inmate.

Nonetheless, the court disregarded these inherent differences and automatically translated the conditions justifying the forcible restoration of competency for trial to a case involving a pending execution. By equating the state's interest in effectuating execution with an interest in attaining a fair trial, the court failed to aptly consider the concerns and ultimate effect of forcibly medicating Singleton. As a result, the court produced an inherently flawed analysis of Singleton's claim.

2. Treat or Kill: Medical Interests versus State Motives

By extending Sell to Singleton, the court engaged in a constrained analysis, involving the inconsistent application of precedent and contradictory reasoning. These shortcomings were perhaps most evident in the


163. See generally Riggins v. Nevada, 504 U.S. 127, 133-36 (1992) (weighing Riggins's interest in full and fair trial against state's interest in obtaining adjudication of Riggins's guilt or innocence); Sell, 282 F.3d at 566-68 (citing Riggins for proposition that forcible administration of antipsychotic drugs may interfere with defendant's right to fair trial and noting state's essential interest in bringing defendant to trial); see also Crosby, supra note 10, at 1202-03 (noting issues involved in trial context).

164. See Singleton, 319 F.3d at 1025 (noting state interest and Eighth Amendment requirements); see also Crosby, supra note 10, at 1203 (discussing medication and Eighth Amendment competency requirement). Moreover, Eighth or Fourteenth Amendment violations that result in wrongful executions cannot be rectified. See id. at 1214 ("An error in determining competence for execution is final.").

165. See Singleton, 319 F.3d at 1024-25 (applying Sell standards to Singleton, which require that governmental interest in punishing offenders outweigh individual's interest in being free from unwanted antipsychotic medication and that there is no less intrusive way of fulfilling government interest). "In this case, the best medical interests of [Singleton] must be determined without regard [for his] pending date of execution." See id. at 1026 (evaluating best medical interests and determining that medication is in Singleton's short term interest despite ultimate consequence of execution).

166. Cf. id. at 1026-27 (disregarding state motives and ultimate effect of forcible medication, which is Singleton's scheduled execution).

167. See id. at 1035 (Heaney, J., dissenting) (suggesting difficulty in differentiating state motive to protect prisoner from harm from its motive to medicate to execute).

168. Compare id. at 1025 (noting medication was needed to fulfill state's interest in execution because Singleton had to be competent to be executed), with id. at 1027 (refusing to consider state's motive to execute because state had duty to provide medication).
court's consideration of the medical appropriateness of the medication.\textsuperscript{169}

First, the court failed to incorporate the Harper element of "dangerousness," when it found the forcible administration of medication appropriate for Singleton's treatment.\textsuperscript{170} Instead, the court relied on proof that the medication could effectively restore competency with limited side effects.\textsuperscript{171} Thus, Singleton arguably maintained his liberty interest because the Harper test was not satisfied.\textsuperscript{172}

Second, even if the state court demonstrated dangerousness, the court's analysis "remain[ed] unsound."\textsuperscript{173} Although the court relied on the restorative effects of the medication when finding it "medically appropriate," it quickly discounted their deadly implications when considering Singleton's "best medical interests."\textsuperscript{174} Instead, the court focused solely on the immediate benefits of the medication and the state's intent to provide treatment.\textsuperscript{175} In a puzzling conclusion, the court did not find the side effect of death to be at odds with Singleton's best medical interests and briefly dismissed this collateral effect of the medication, stating that "[e]ligibility for execution is the only unwanted consequence of the medi-

\textsuperscript{169} See id. at 1035 (Heaney, J., dissenting) (noting that state may use appropriate reason for medication to mask true reason that state wants to qualify inmate for execution); cf. id. at 1026 (finding medication appropriate despite consequence of eligibility for execution because execution was only recognized side effect and sentence had been lawfully imposed).

\textsuperscript{170} See id. at 1025-26 (failing to consider whether Singleton was dangerous). Although the court alluded to a medical review panel's finding of dangerousness, it did not include this element in its analysis. Compare id. at 1021 (noting 1997 finding of Singleton's dangerousness by medication review panel), with id. at 1025-26 (considering medical appropriateness without addressing dangerousness); see id. at 1035 (Heaney, J., dissenting) (noting that Due Process Clause of Fourteenth Amendment requires state showing that forcible medication is necessary because inmate is dangerous to himself or others); Hermer, supra note 156 (noting court did not consider dangerousness and that Singleton did not pose threat to himself or others while unmedicated).

\textsuperscript{171} See Singleton, 319 F.3d at 1025 (considering medical appropriateness of drug from which Singleton suffered no major side effects and which he preferred to receive). For discussion of the Eighth Circuit's incorporation of this element from Weston, see supra note 99 and accompanying text.

\textsuperscript{172} Cf. Singleton, 319 F.3d at 1026 (implying his interests were foreclosed only by lawful death sentence and Harper procedure).

\textsuperscript{173} Id. at 1035 (Heaney, J., dissenting) (questioning whether Harper is satisfied when medication results in execution because of faulty assumption that state operates with one motive in inmate's interest).

\textsuperscript{174} Compare id. at 1025 (considering effect of competency for "medically appropriate" prong, noting that Singleton is competent while medicated), with id. at 1026 (disregarding effect of competency for "best medical interest" prong where effect of competency is execution).

\textsuperscript{175} See id. at 1026-27 (considering "best medical interests" and concluding that competency is in best interest); see also id. at 1035 (Heaney, J., dissenting) (noting court's focus on state's intent, although intent may be deceptive).
Essentially, the court held that it was in Singleton's best medical interest for the state to restore his immediate health, at all costs, to enable his subsequent execution.\(^{177}\)

Third, the court's willful disregard of the state's ulterior motives for restoring competency was pretextual and inconsistent with the analysis.\(^{178}\) Specifically, the court had to find a state motive to execute Singleton and to restore the requisite competency in order to justify the forcible medication.\(^{179}\) Furthermore, under Harper, justification for forcible medication arguably "evaporates" when an execution date is set because the state motives become indiscernible.\(^{180}\) Thus, by ignoring Singleton's impending execution and the state's motives, the court allowed for the facilitation of an execution under the guise of providing appropriate treatment.\(^{181}\)

3. The Ford "Cure" for Incompetence

Notwithstanding the court's determination that forcible medication was appropriate in this context, the court also considered the constitutionality of executing a forcibly medicated inmate.\(^{182}\) Handicapped by insufficient guidance in Ford, the Singleton rationale further precluded an accurate assessment of Singleton's competency by disregarding Justice Powell's suggestion that only a person "cured of his disease" should be executed.\(^{183}\) In doing so, the court failed to consider the inconsistent effects of the medication when reviewing Singleton's competency determination.\(^{184}\) Had the Eighth Circuit distinguished "treatment" from "being cured" and combined the amassed scholarly and scientific literature...
describing the temporary effects of antipsychotic medication with the high degree of reliability required by Ford in competency determinations, it could have reasonably deduced that chemically induced competency does not satisfy the vital safeguards of the Eighth Amendment.\textsuperscript{185}

Relying solely on Singleton's periodic alleviation of symptoms, the court disregarded the quality of his competency in favor of the state interest in execution.\textsuperscript{186} Thus, by avoiding the issues of chemical competency and dismissing Singleton's "artificial competency" claim, the court may have effectively circumscribed the protections afforded by the Eighth Amendment.\textsuperscript{187} Indeed, "[t]o execute a man who is severely deranged without treatment and arguably incompetent when treated, is the pinnacle of . . . 'the barbarity of exacting mindless vengeance.'"\textsuperscript{188}

D. Harmful Implications: Treating to Kill

The Singleton decision imposes significant ethical dilemmas on medical professionals providing treatment to incompetent condemned inmates.\textsuperscript{189} In effect, these professionals are forced into the irreconcilable position of either restoring competency that will facilitate execution or withholding treatment that may alleviate the painful symptoms of psychosis.\textsuperscript{190} Thus, although legally permissible, the forcible administration of medication to effectuate execution invokes serious concerns for the medi-

\textsuperscript{185.} See id. at 1033-35 (Heaney, J., dissenting) (concluding that artificial sanity does not satisfy Eighth Amendment in this case because Singleton's medications were often changed and he still displayed some symptoms). For further discussion of Ford's reliability requirements, see supra notes 47-54 and accompanying text.

\textsuperscript{186.} See Singleton, 319 F.3d at 1030-34 (Heaney, J., dissenting) (noting that majority's holding finds Singleton fit for execution, but stating that Singleton's sanity is fluid and that he exhibits symptoms and often requires adjustments to medications).

\textsuperscript{187.} See id. at 1033-34 (Heaney, J., dissenting) (stating difference between treatment and cure and asserting that "drug-induced sanity" is not true sanity for purposes of Eighth Amendment).

\textsuperscript{188.} Id. (Heaney, J., dissenting) (asserting Singleton was not competent for execution (quoting Ford, 477 U.S. at 410 (Marshall, J.))).

\textsuperscript{189.} See id. at 1036-37 (Heaney, J., dissenting) (examining ethical dilemmas of holding); Redding & Hensl, supra note 17, at 9-10 (noting ethical conflicts when healing professionals are asked to aid in subsequent delivery of punishment); cf. Kermani & Kantor, supra note 14, at 98-99 (surmising ethical dilemmas of treating condemned); Frederick R. Parker & Charles J. Paine, Informed Consent and the Refusal of Medical Treatment in the Correctional Setting, 27 J.L. MED. & ETHICS 240, 245 (1999) (noting it is unjust for physician to provide treatment for any purpose other than sole benefit of patient); Horstman, supra note 7, at 847 (noting ethical dilemma of restoring competence in condemned); American College of Physicians, supra note 14 ("Physician participation in executions represents a significant challenge to the morality of the medical profession.").

\textsuperscript{190.} See Singleton, 319 F.3d at 1026 (expounding two alternatives presented by Singleton); Redding & Hensl, supra note 17, at 10 (presenting two choices faced by medical professionals); American College of Physicians, supra note 14 (same).
Ultimately, the question remains: "Is it ethical for a medical professional . . . to participate in treatment that will ultimately facilitate an execution?"

Encapsulated in the Hippocratic Oath, the time-honored precept "above all, do no harm" has guided the ethical obligations of the medical profession for centuries. Consequently, several professional organizations have incorporated this standard into their self-regulatory ethics codes. Extending this principle, the American Medical and Psychiatric Associations, as well as the World Medical and Psychiatric Associations, have clearly stated that medical professionals should not participate in lawful executions. Furthermore, the American Medical Association Council on Ethical and Judicial Affairs, the American Psychiatric Association and the National Mental Health Association have asserted that professionals are ethically prohibited from restoring competency for execution.

191. See generally Singleton, 319 F.3d 1036-37 (Heaney, J. dissenting) (noting ethical dilemmas faced by physicians forced to treat condemned and that majority holding forces physicians to practice contrary to ethical standards); Salguero, supra note 4, at 175-79 (noting dilemma of choosing to treat mentally ill inmates facing execution if healed); Taylor, supra note 3, at 1061-64 (same); American College of Physicians, supra note 14 (same).

192. Redding & Hensl, supra note 17, at 10 (questioning forcible treatment of condemned inmates); see also Kirk Heilbrun & Harry A. McClaren, Assessment of Competency for Execution? A Guide for Mental Health Professionals, 16 BULL. AM. ACAD. PSYCHIATRY & L. 205, 205 (1988) (questioning mental health professionals' role in assessing competency for execution); Radelet & Barnard, supra note 4, at 298 (questioning ethics of providing care to condemned); Ward, supra note 4, at 84-86 (noting difficulty of deciding whether to treat condemned).

193. See Kermani & Kantor, supra note 14, at 98 (expounding Hippocratic oath and noting that some believe it is violated when psychiatrists take part in medicating for execution); Salguero, supra note 4, at 173-74 (discussing tenets of Hippocratic oath); Katz, supra note 8, at 713-14 (noting history of ethical principle that physician should "above all do no harm"); American College of Physicians, supra note 14 (same).

194. See generally AM. PSYCHIATRIC ASS'N BYLAWS ch. 8, § 1 (1990) (incorporating Hippocratic oath); American Psychological Association, Ethical Principles of Psychologists and Code of Conduct, 57 AM. PSYCHOL. 1060-73 (2002), available at http://www.apa.org/ethics (same); see also Katz, supra note 8, at 714 (noting adoption of Hippocratic Oath by American Psychiatric and Medical Associations); American College of Physicians, supra note 14 (noting World Medical Association and International Code of Medical Ethics espousal of these Principles).


196. See National Mental Health Association, supra note 7 (opposing restoration of competency to enable execution). The American Medical Association Council on Ethical and Judicial Affairs has stated that professionals may not restore competency to a condemned inmate until the pending execution is vacated. See Horstman, supra note 7, at 848 (limiting professionals' involvement in restoring
National and international ethics codes prohibit medical professionals' involvement in execution and the restorative treatment that ultimately facilitates execution for various reasons. First, this practice jeopardizes the fiduciary nature of the traditional physician-patient relationship. Although treating a prisoner of the state, the physician maintains an ethical duty to avoid harm, to act in the individual's best medical interest and to maintain confidentiality. By providing treatment and potentially disclosing information that may ultimately facilitate execution, however, physicians are forced to compromise their ethical duties and the welfare of their patient for state interests.

Second, although "temporally and physically" removed from the execution, physicians who provide treatment and restore competence to condemned inmates become causal factors in the subsequent punishment. Arguably, an incompetent inmate cannot be executed without the restorative treatment provided by a medical or mental health professional. Furthermore, by providing treatment, these physicians become active part-

197. See generally Salguero, supra note 4, at 176-79 (noting ethical implications of treating condemned, both in declaring incompetence and restorative treatment); Horstman, supra note 7, at 847-48 (noting professional guidelines against participation); Katz, supra note 8, at 714-15 (discussing reasons for prohibition, namely that Hippocratic Oath protects patients from harm); American College of Physicians, supra note 14 (same).

198. See Radelet & Barnard, supra note 4, at 299-300 (discussing confidentiality and fiduciary relationship with death row patient and noting that physician will be unable to treat patient if patient believes physician will report back to those who will bring patient harm); Katz, supra note 8, at 721 (noting impact on physician-patient relationship).

199. See Radelet & Barnard, supra note 4, at 298-300 (naming "beneficence and confidentiality" as two ethical principles affected by dilemma); Salguero, supra note 4, at 177-79 (acknowledging duty as healer for condemned inmates); American College of Physicians, supra note 14 (noting beneficence as guiding principle jeopardized by treatment of condemned).

200. See Radelet & Barnard, supra note 4, at 299-300 (exploring ethical dilemma regarding confidentiality and "to do no harm"); American College of Physicians, supra note 14 (noting dilemma that credibility of physicians is linked to their ability to follow central mission, namely, to do no harm).

201. See State v. Perry, 610 So. 2d 746, 752-55 (La. 1992) (qualifying administration of antipsychotic drugs as part of punishment); Salguero, supra note 4, at 177-78 (implicating physicians as causal factors in execution); Katz, supra note 8, at 715-16 (explaining causal link, namely, that execution would not occur "but for" actions to restore competency). But see id. at 720-21 (expounding that if punishment is just then it is actions of criminal that is causal link to death, not treatment to restore competency).

202. See Katz, supra note 8, at 715-16 (explaining causal link that execution would not happen "but for" restorative treatment).
participants in the execution process and, in essence, unsuspected arms of the penal system.\textsuperscript{203} In effect, the provision of medication initially intended for treatment purposes becomes a tool of punishment.\textsuperscript{204}

In addition to breaching ethical obligations, the professional involvement with treatment that ultimately results in execution may compromise the overall integrity of the medical profession.\textsuperscript{205} Consequently, the public may perceive the medical profession as effecting harm, rather than providing beneficial treatment, and "the credibility of medicine as a therapeutic endeavor" could be significantly undermined.\textsuperscript{206} As a result, many professional medical organizations conclude that certain practices in which a state has a vested interest, such as the forcible restoration of competence to individuals facing execution, are "ethically intolerable."\textsuperscript{207}

In sum, the participation of medical professionals in the restorative treatment of the condemned generates many ethical problems.\textsuperscript{208} By providing treatment, professionals run the risk of breaching their ethical obligations and forfeiting their patients' interests into the hands of the state.\textsuperscript{209} Furthermore, by abandoning the traditional role of "healer," medical professionals may simultaneously undermine the credibility of those professionals still intending to "do no harm."\textsuperscript{210}

\textsuperscript{203} See Parker & Paine, supra note 189, at 245 (noting that by providing treatment doctor may be perceived as "arm of the penal system"); see also American College of Physicians, supra note 14 (noting medication fulfills state interest, not patient's).

\textsuperscript{204} See, e.g., Perry, 610 So. 2d at 752-55 (holding that use of medication against one's will to render competence for execution constitutes punishment, rather than treatment).

\textsuperscript{205} See Salguero, supra note 4, at 180-81 (explicating state interest in "integrity of the medical profession"); Katz, supra note 8, at 724-25 (noting state interest in integrity of profession); see also American College of Physicians, supra note 14 (noting that physician serves interest of state and not patient).

\textsuperscript{206} American College of Physicians, supra note 14 (commenting that restoring competency for execution undermines positive perception of treatment professionals).

\textsuperscript{207} See id. (asserting that certain legitimate state interests may be incompatible with "treatment role" of doctors and medical professionals).

\textsuperscript{208} See Parker & Paine, supra note 189, at 245 (discussing ethical dilemmas of medicating condemned); Salguero, supra note 4, at 175 (discussing various conflicts involved when "psychiatric participation in capital proceedings is required"); Horstman, supra note 7, at 847-48 (considering ethical dilemmas and conflicts between legal and medical communities surrounding treatment to execute); Katz, supra note 8, at 713-17 (expounding various ethical violations encompassed by inducing competence to condemned inmates).

\textsuperscript{209} See American College of Physicians, supra note 14 (noting practice serves state, rather than patient interests).

\textsuperscript{210} See id. (noting negative effect because physician credibility depends on separation from activities that conflict with central mission of doing no harm).
IV. CONCLUSION AND RECOMMENDATIONS

Although mentally incompetent persons are categorically excluded from the death penalty, a live issue remains as to whether these persons should be involuntarily restored to health in order to be put to death. While the Eighth Circuit has condoned the forcible administration of medication to treat and restore the competency of condemned inmates, this practice imposes significant ethical dilemmas for medical and mental health professionals.

As a result, numerous national and international, professional and medical organizations have condemned medical professionals' involvement in the forcible restoration of competency for execution as an ethical violation of their duty to heal and to avoid harm. Furthermore, at least one state supreme court has denounced the forcible medication of condemned inmates as cruel and unusual punishment. While the Supreme Court has yet to rule on the issue at hand, it has recently addressed the application of Eighth Amendment protections to a comparable class of "incompetent" persons, holding the execution of the mentally retarded unconstitutional and in violation of the "evolving standards of decency." Accordingly, should the Supreme Court examine issues similar to those presented by Singleton, it will face a great challenge. By incorporating the same "evolving standards of decency," most readily exemplified by state precedent, medical and professional organizations' ethical codes and both national and international consensus, the Court may reach a more socially acceptable and medically appropriate resolution, aligned with all potentially involved parties' best interests. Until that time, however, persons who are "severely deranged without treatment, and

211. See Arrigo & Williams, supra note 27, at 367-68 (noting dispute over circumstances in which it is appropriate for mentally ill offender to be put to death and issue "remains mostly unresolved by the Court").

212. See Singleton v. Norris, 319 F.3d 1018, 1036-37 (8th Cir. 2003) (Heaney, J., dissenting) (noting ethical conflicts faced by medical professionals when treating condemned inmates); see also American College of Physicians, supra note 14 (discussing restoration of competency for execution and ethical dilemmas for physicians). For further discussion on the ethical dilemmas related to the Eighth Circuit decision, see supra notes 189-210 and accompanying text.

213. See Katz, supra note 8, at 725-27 (discussing national and international consensus); see also American College of Physicians, supra note 14 (noting various professional organizations prohibiting participation).

214. See State v. Perry, 610 So. 2d 746, 771 (La. 1992) (holding forcible medication to restore competency for execution unconstitutional as cruel and unusual punishment).


216. See Singleton, 319 F.3d at 1025 (addressing constitutionality of forcibly medicating to render competent for execution).

arguably incompetent when treated" should be exempt from execution and thus spared from "the barbarity of exacting mindless vengeance"\textsuperscript{218} and the same inescapable fate imposed on Charles Laverne Singleton.\textsuperscript{219}

\textit{Kursten B. Hensl}

\textsuperscript{218} Singleton, 319 F.3d at 1030 (Heaney, J., dissenting) (quoting Ford v. Wainwright, 477 U.S. 399, 410 (1983) (Marshall, J.)).

\textsuperscript{219} See Brian Cabell, \textit{Arkansas Executes Mentally Ill Inmate}, available at http://www.cnn.com/2004/LAW/01/06/arkansas.executions/index.html (reporting that Singleton was administered lethal injection at 8:02 p.m. and pronounced dead at 8:06 p.m. on January 7, 2004). Despite the forced medication, Singleton heard voices until the very end. See Kevin Drew, \textit{Executed Mentally Ill Inmate Heard Voices Until End}, available at http://www.cnn.com/2004/LAW/01/06/singleton.death.row./index.html ("The voices inside Charles Singleton's head varied, in volume and number, regardless of whether he had taken medication for schizophrenia.").