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law and citizens in conflict with the law should have access to highly qualified, well-trained and ethically sensitive psychiatrists. There is concern that where the death penalty is still practised that there will be division within professional bodies, leading to the withdrawal of some of the most skilled practitioners from the legal process. The College will support psychiatrists who become ethically involved in the legal process and also those who take an ethical stance in seeking changes in the law, even if this brings them into conflict with the authorities and with their colleagues.

In previous statements, the College identified the following stages of involvement and advice:

1. Legal proceedings before and during trials

These include:

- Investigation
- Assessment of fitness for trial
- Assessments to enable legal authorities to arrive at an appropriate verdict
- Sentencing

It may be ethically justifiable to give an opinion to the court on fitness to stand trial; even if the consequence of being fit were that a possible guilty verdict would lead to the death penalty. At this point, although acting for the organisation, there may be sufficient distance from the decision around death and it is in the interests of the individual to have a fair trial. The involvement of more experienced practitioners may elucidate mental disorders that others may not recognise. Each case should be judged on its merits.

It is ethically justifiable to enter into the defence of a person with a mental disorder and/or to seek a lesser sentence than the death penalty when the individual or those acting for him/her seek this opinion. It may be reasonable to take such instruction from the court itself, but this then changes the relationship with the defendant and needs to be fully explained. The finding that there is no mental disorder leaves a serious dilemma for the psychiatrist, as this statement to the court may appear to be directly related to a person's death. Psychiatrists in this position must be aware of their own needs for support and opportunities to discuss with peers who have experience in this field.

It is quite contrary to the medical ethic for a professional opinion to recommend the death penalty. There is debate about the involvement of psychiatrists on the prosecution side. It can be argued that working for the prosecution seeking the death penalty is in reality working for the judicial system, the prosecution being an arm of the judicial process, and the point can thus be made that to exclude the psychiatric testimony for the prosecution is unjust as it perpetuates an unbalanced system. On the other hand, the concerns must be that the psychiatrist will provide evidence that will harm the defendant, which is contrary to traditional medical ethics. There is need for caution and sound legal advice when offering opinion about risks of further offending, as this may be used to justify the death penalty in sentencing. There is no ethical consensus on this issue of psychiatric testimony and it should remain a matter for the individual's conscience.

When dealing with capital cases, psychiatrists should be aware of the public interest likely to be aroused and the feelings of the victim's family.

2. The involvement of psychiatrists post-sentencing

These include:

- Therapies for a person awaiting execution
- Assessment of fitness for execution
- Execution itself
- Confirmation of death

It is appropriate to treat patients on a voluntary basis while they are awaiting execution. The sole purpose of treatment is the patient's best interest and there is no organisational involvement.

Treating a patient on an involuntary basis requires careful consideration. If recovery means the person is then fit for execution then there is a dilemma. The psychiatrist may seek to treat on the conditions that the death sentence is commuted; if this is the case then the dilemma is resolved; if this cannot be obtained then each case needs to be assessed on its own merits. Discussion with peers is vital.

A psychiatrist should not certify that a person is fit for execution. This is too close to the decision to end a person's life.

A psychiatrist should not take part in an execution, nor should he or she confirm the death of an executed person.

Conclusion

The College recognises the complexity of these issues, but maintains that the death penalty is contrary to the medical ethic. The College will support psychiatrists who refuse to be involved in the process and those who decide to take up limited involvement in an ethically justifiable manner as described above. The College also aligns itself with those organisations and individuals who seek abolition of the death penalty such as the Council of Europe Bio-ethics Committee.

April 2003

Bridging the Gaps: Health Care for Adolescents

Council Report CR114, June 2003, Royal College of Paediatrics and Child Health, £10, 60 pp.

Bridging the Gaps: Health Care for Adolescents arose out of an Intercollegiate Working Party on Adolescent Health, led by the Royal College of Paediatrics and Child Health, together with seven other colleagues including the Royal College of Psychiatrists. This report cogently argues the case for a clear focus by government, policy makers, practitioners and NHS Services on adolescent health care. It offers an overview of the healthcare of adolescents in the UK at the start of the 21st century and points to the many current health (including mental health) needs of this important age band, who are in transition and make up 13–15% of the population in developed countries.

Covering the size and nature of young people's major health needs, service development and the concept of adolescent healthcare as a speciality, there follows a series of important recommendations for promoting better health across primary care, school health services and young people in special circumstances. The report goes on to cover secondary care in accident and emergency situations, out-patient care and transition, and in-patient healthcare.

In the context of major developments in services for children and adolescents, this report recognises very clearly the rights of young people who are making the transition to adult autonomy.

The task set to us all is large, but the recognition of the needs of this group, the importance of their views and their perspective on what services they need, together with recommendations for training that stress the imperative of a developmental understanding of adolescence, are very much to be welcomed. Communicating with and listening to adolescents are key to this report. A valuable read, and no doubt with the current pace and nature of change within the NHS and Society, it is a Council Report we will be revisiting sooner rather than later, with even more emphasis on the importance of mental health and emotional well-being.

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https://doi.org/10.1192/pb.27.10.397 Published online by Cambridge University Press