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the college

Results of elections in 2003 – Dean, Editor, Council, and the Court of Electors

Dean

The results of the ballot for the office of Dean were as follows:

Number of ballot papers despatched	9374
Number of ballot papers returned	2738
Number of invalid ballot papers	2
Number of valid ballot papers counted	2736

First stage

Dinesh Bhugra	1296
Hubert Lacey	884
Ilana Crome	556

Second stage

Dinesh Bhugra	1566
Ilana Crome	–
Hubert Lacey	1079
(non-transferable)	91

Professor Dinesh Bhugra was therefore elected Dean to take office from 2 July 2003.

Editor

No ballot was necessary.

Professor Peter Tyrer was elected Editor to take office from 2 July 2003.

Council – Elected Fellows and Elected Members

The results of the ballot for Elected Fellows on Council were as follows:

Number of ballot papers despatched	9402
Number of ballot papers returned	1758
Number of invalid ballot papers	5
Number of valid ballot papers counted	1753

First stage

Professor Pamela Jane Taylor	838
Professor Ilana Belle Crome	539
Dr Saroj Chhabra	376

Second stage

Professor Pamela Jane Taylor	584.34
Professor Ilana Belle Crome	734.20
Dr Saroj Chhabra	433.60

Professor Ilana Belle Crome and Professor Pamela Jane Taylor were therefore elected as Fellows on Council.

The results of the ballot for Elected Members on Council were as follows:

Number of ballot papers despatched	9402
Number of ballot papers returned	1769
Number of invalid ballot papers	9
Number of valid ballot papers counted	1760

First stage

Dr Philip Sugarman	603
Dr Kwame Julius McKenzie	549
Dr Geetha Oommen	236
Dr Balakrishnan Somasunderam	197
Dr Waquas Waheed	175

Second stage

Dr Kwame Julius McKenzie	606.00
Dr Philip Sugarman	603.00
Dr Geetha Oommen	252.00
Dr Balakrishnan Somasunderam	233.00
Dr Waquas Waheed	–
(Non transferable	66.00)

Dr Kwame Julius McKenzie and Dr Philip Sugarman were therefore elected as Members on Council.

Court of Electors

Number of ballot papers despatched	9402
Number of ballot papers returned	1942
Number of invalid ballot papers	4
Number of valid ballot papers counted	1938

First stage

Dr Jeremy Bolton	452
Professor John Charles Gunn	414
Professor Ramalingam Chithiramohan (Mohan)	284
Professor Ilana Belle Crome	254
Dr Kedar Nath Dwivedi	172
Dr Annie Y. H. Lau	120
Dr Morad El-Shazly	101
Dr Harish Gadhvi	74
Dr Ashokkumar G. Patel	67

Final stage

(quota for election=276.86)

Dr Jeremy Bolton	276.86
Professor Ramalingam Chithiramohan (Mohan)	276.86
Professor Ilana Belle Crome	276.86
Professor John Charles Gunn	276.86
Dr Annie Y. H. Lau	275.94
Dr Kedar Nath Dwivedi	261.18
Dr Morad El-Shazly	173.26
Dr Harish Gadhvi	42.17
Dr Ashokkumar G. Patel	–
(Non-transferable	78.01)

Dr Jeremy Bolton, Professor Ramalingam Chithiramohan (Mohan), Professor Ilana Belle Crome, Dr Kedar Nath Dwivedi, Professor John Charles Gunn and Dr Annie Y. H. Lau were therefore elected to fill the six vacancies on the Court of Electors.

Psychiatry and the death penalty

Revised statement from the Ethics Sub-Committee

This statement by the Royal College of Psychiatrists follows a review of previous statements published in the *Bulletin* in 1992 (re-confirmed in 1997) and in 1994.

Although there is no death penalty in the UK, there are members in countries that still retain the death penalty and there are UK members, primarily from the Forensic Faculty, who may be asked overseas for professional opinions where the death penalty is a legal option. The purpose of this statement is twofold; first, to help members and other psychiatrists who may be faced with ethical dilemmas if their work is related to capital cases; and second, to contribute to the debate on the use of the death penalty. This statement is intended to apply to psychiatrists involved in the capital process as both clinicians and experts.

The College considers that the death penalty is not compatible with the ethic upon which medicine is based; to act in the best interests of the patient. It recognises the complexity of lawmaking, and the range of public and professional opinion. It also recognises that the state or other legal bodies might wish to have a professional opinion on a person where the death penalty may be an option. The issues raised are similar in kind to those faced by psychiatry when the duties to the patient and to society may be in conflict and when opinion is asked for by a court rather than by a patient. However, there are specific ethical issues when professional judgement relates to a person's death.

There are two general ethical principles when working as a doctor with social systems that might cause death or undue suffering. The first is to maximise patient welfare over the concerns of the social systems, which may have quite different goals. The second is that when involvement with the organisational process is inevitable, there is then a judgement as to how closely to participate in the decisions and actions that may lead to death. Both these principles are in play at different points in the process of medical involvement in the death penalty.

The College supports individual psychiatrists who do not wish to take any part in a process that might end in a person's death. It also believes that the

https://doi.org/10.1192/pb.27.10.396-a Published online by Cambridge University Press

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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.27.10.396-a Published online by Cambridge University Press