Physician Participation in Executions: Time To Eliminate Anonymity Provisions and Protest the Practice

In this issue, Farber and colleagues (1) have provided dramatic findings that warrant the attention of the profession. In their study, a large minority of physicians reported willingness to be personally involved in executions for capital cases. This image of a white-coated symbol of care working with or as the black-hooded executioner is in striking contrast to established physician ethics, which bar physicians from involvement with executions (2, 3). Farber and colleagues found that the most common rationale for physicians' willingness to participate was a sense of citizen obligation. This perception contrasts with the fact that the law goes out of its way to avoid obligating physician participation (4). It is also notable given decreasing public support for capital punishment as reports continue to emerge of executions of innocent or mentally ill people and of inadequate representation for death penalty defendants (5). Some U.S. political leaders and judges are promoting a moratorium on the death penalty, and a growing number of states are excluding mentally retarded persons (6, 7). Examination of the issue shows that medical involvement mostly serves to advance pro–death penalty political purposes, that traditional ethical positions opposing physician involvement are authentically derived and remain valid, and that physicians should take responsibility for reorienting the apparently confused minority.

Physician Involvement in Execution as a Conflict of Purpose

Professions have a key role in protecting values and services that may otherwise be vulnerable in society because of overshadowing by government, as is the case for executions, or by the private sector (8). Relationships that conflict with medical purposes need to be carefully regulated. Efforts to sway medical judgment or to use the medical mantle toward other ends have caused recurrent controversy. Consider, for instance, the effort of the Sunbeam Corporation to "stand beside the white coat" by securing American Medical Association (AMA) endorsement of its products. Although the AMA broke the deal, its reputation received a considerable blow, and Sunbeam eventually filed for bankruptcy. Or consider the anger over the Tuskegee experiment, now considered a national legacy of shame, in which physicians performing government experiments withheld treatments known to be effective. Physician involvement in executions constitutes a conflict of roles or interest more profound than that seen in the many other cases that understandably engendered the public's moral outrage.

Conflicts of purpose, role, or interest can arise because of physicians' conditions of remuneration. Physicians must always be concerned about how to preserve their primary fiduciary relationship to patients when they are employees of an institution with different interests or when remuneration does not fit with activities that benefit the patient. Physicians employed or paid by a prison may have a compromised relationship to the prisoner-patient if the prison acts against the inmate's health. When prisons use torture, for instance, the compromise can be extreme (9). When penitentiary physicians participate in, train technicians or nurses to perform, or provide lethal substances for executions, the conflict is profound.

Conflicted roles, and financial conflicts of interest in particular, tend to be managed in one of three ways, according to severity. The relationship that is causing the conflict can be barred; limited, and the remainder disclosed and subjected to peer review; or disclosed, and any compromise of the professional's judgment taken into account. Codified medical ethics has always applied the most stringent approach to physician involvement in executions: It is totally barred.

The findings of Farber and colleagues indicate that some physicians are morally confused. Their readiness to actively participate in executions diminishes with increasing proximity to the final act, from which ethics demands dissociation. This diminished willingness does not offer much comfort when set against the reality that since the death penalty was reinstated in the United States in 1977, physicians have been involved at every stage, whether preparing for, participating in, or monitoring executions or attempting to harvest prisoners' organs for transplantation (10). Furthermore, these efforts of physicians to distance themselves have mandated involvement of nurses (who are also professionally barred

from participation by their codes of ethics) and have led penitentiary physicians to train medical technicians in lethal injection (11). One of the reasons for establishing limits to legitimate relationships in medicine is that it may be difficult to recognize conflicts of purpose and understand how to manage them. Farber and colleagues' findings illustrate the need for bolstering awareness of these limits.

Medicalization as Misguided Distortion

Death penalty advocates sought medicalization and physician involvement to increase the public acceptability of the practice. Although the electric chair was introduced as a more humane method than hanging, gruesome cases involving torturous suffering threatened to make electrocution unconstitutional under the clause of cruel and unusual punishment (12, 13). Indeed, successful physician objection overturned efforts by some states and the federal courts to require physician participation. Statutes have stopped short of barring physicians from executions, perhaps for fear of undermining the constitutionality of lethal injection, which is now used for federal executions and in 34 of the 38 states that allow capital punishment. Execution facilities are chillingly clinical in appearance, but lethal injection is no more a medical procedure than is killing with a knife or a gun. Fred Leuchter developed lethal injection at the request of the New Jersey Department of Corrections for the explicit purpose of killing (14). He was later found to have used misleading credentials and to have documented connections to neo-Nazi groups. The U.S. Supreme Court illustrated the disassociation of lethal injection with medicine when it stopped short of treating it as a medical procedure (15).

Lethal injection is not reliably humane; rather, it is less unpalatable to observers than other methods. Because pancuronium is included in the "cocktail," the procedure seems peaceful. However, since the person is totally paralyzed, pancuronium may only mask suffering. Paralysis preempts expression of pain, but the sensation of suffocation, the pain of cardiac arrest and other effects of potassium injection, and the frightening sensation of paralysis may all be experienced if the sedative is insufficiently effective (16). Paralysis precludes the visions of wild death struggles, hanging bodies with protruding tongues, and steam emanating from the head of the person in the electric chair. It also seems to prevent the otherwise inevitable release of urine and stool when death occurs. Physicians who argue that their involvement helps to reduce suffering should be aware that their presence and the "painless" appearance of lethal injection facilitate the performance of a practice from which they are supposed to dissociate themselves.

Dr. Guillotin is one example of a physician who was initially motivated by the argument of humane treatment (17). He became shocked and disillusioned by the impact of his efforts, which instead facilitated capital punishment, and indeed his name is now considered a symbol of killing. Furthermore, medical expertise is not required to find or use a method of killing that minimizes suffering. Humane methods for killing animals have been considered since before the times of modern medicine. Using a razor-sharp knife to sever the soft tissues of the neck is an ancient method that is, in the era of anatomy and physiology, thought to cause immediate loss of intracerebral pressure and irreversible unconsciousness. Dr. Guillotin may have based his method on medical knowledge, but a similar method has existed for thousands of years.

Authentic Professional Ethics

Professional associations' opposition to physician involvement in capital punishment has been established and reestablished over time using authentic procedures. For instance, the AMA's Council on Ethical and Judicial Affairs (CEJA) deliberates resolutions referred from the House of Delegates, and CEJA positions must be approved by the House of Delegates before they become policy. The difference between membership in and representation by the AMA (a popular misconception cites AMA membership as if it were synonymous with political representation) may explain Farber and colleagues' finding that AMA members were more inclined to participate in executions. Since so many physicians belong to state or specialty societies, most of which have seated delegates, the House of Delegates represents about 98% of physicians in the United States. Thus, Farber and colleagues' finding does not undermine the authenticity of the AMA's position on this matter. Furthermore, the position specifically opposing physician participation in executions was first passed in 1980 and was expanded and reaffirmed in 1992 and 1997.

Professional activism in this area is important and effective. The British Medical Association set the precedent after a British Royal Commission on Capital Punishment concluded that effective lethal injection would necessitate physician administration and thus was unacceptable. Their advocacy turned the United Kingdom away from lethal injections in the 1950s (18). More recently, legal requirements for physician involvement have been overturned, and the legal provision in one state that concealed the identity of involved physicians has also finally fallen under pressure from many professional societies. In addition, some health care institutions are dissociating themselves from lethal injection (19, 20). In this hard-fought effort to keep the white coat clean, the findings of Farber and colleagues provide a wake-up call. It is time to eliminate moral confusion by reestablishing the deliberate dissent of the medical profession regarding physician involvement in executions.

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