CEJA Report A – I-92
Physician Participation in Capital Punishment

Resolution 5 (1-91), which was referred to the Board of Trustees, asked the Council on Ethical and Judicial Affairs to (a) develop a guideline which prohibits physician participation in state executions and (b) specify exactly which actions by physicians would constitute participation. The Council responds to the resolution with this report.

BACKGROUND

The question of physician participation in capital punishment has a long history .1 Physicians have been involved with finding execution methods that would be more humane than conventional methods. The most famous example is that of Dr. Guillotin, who developed a mechanism for execution which he believed to be far more humane and civilized than contemporary methods.[2] However, other physicians have disagreed with any physician participation in the death penalty.[1] The Oath of Hippocrates has historically been interpreted as prohibiting physician participation in executions. The Oath states in part:

> I will use treatment to help the sick according to my ability and judgment, but never with a view to injury and wrong-doing. Neither will I administer a poison to anyone when asked to do so nor will I suggest such a course.[1] During the 1970s, states began to consider use of lethal injection when executing condemned prisoners. By 1980, four states had selected lethal injection as the method by which executions would take place,[1] and, in 1982, Texas became the first state to execute a person using this method.[3]

Although physicians had been concerned with the possibility that states might require their presence or assistance with legal executions in the past, execution by lethal injection presented special problems for the medical profession.[1,4-6] Death by lethal injection requires that mechanisms which are ordinarily used to preserve life in a medical setting be used to cause death and that a person with at least some medical knowledge perform the procedure.[1]

In 1980, the Council on Ethical and Judicial Affairs (then Judicial Council) issued a report which prohibited the participation of physicians in capital punishment.[7] The Council considered all aspects of the problem and decided that physicians as professionals committed "to first of all do no harm," *primum non nocere,* could not ethically participate in executions. The Council's report was used as the basis for Current Opinion 2.06, which states:

> *CAPITAL PUNISHMENT*. An individual's opinion on capital punishment is the personal moral decision of the individual. A physician, as a member of a profession dedicated to preserving life when there is hope of doing so, should not be a participant in a legally authorized execution. A physician may make a determination or certification of death as currently provided by law in any situation.[7]

At about the same time or subsequent to the Council's original report, several other medical associations, including the World Medical Association,[8] the American College of Physicians,[9] the American Public Health Association,[10] the medical societies of the Nordic countries (Norway, Finland, Denmark, Iceland and Sweden),[11] the American Psychiatric Association,[12] and the Committee on Bioethical Issues of the Medical Society of the State of New York,[13] also adopted policies which prohibited physician participation in executions.

Today, in 37 states and the U.S. military, the death penalty can be administered for certain crimes. Thirteen states and the U.S. military specify lethal injection as the execution method, twelve require

A version of this Report was published as “Physician Participation in Capital Punishment: (JAMA. 1993; 270:365-368).
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electrocution, four use the gas chamber, and one uses hanging. In addition, seven states allow the condemned person to choose between lethal injection and one other previously specified method.[33]

Since the Council's report in 1980, many commentators have asked organized medicine to provide a clarification as to what constitutes "participation" by the physician.[14-16] This report specifies what is meant by participation. In updating its explanation of physician participation in execution, the Council does not abandon the principle that each individual physician has the right to his or her own personal view on the issue of capital punishment. This report addresses only the question of the extent to which a physician may ethically participate in, assist, or associate with the process of execution. This report does not take a position on the ethical propriety or morality of capital punishment.

RATIONALE AND OPPOSING VIEWS

Rationale

A physician's role is to use his or her medical knowledge and skills to alleviate pain and prolong life.[11,16] The medical tools and technology used by physicians are meant to facilitate the realization of this role.[1] Physician participation in executions contradicts the dictates of the medical profession by causing harm rather than alleviating pain and suffering.

Participation by physicians in execution by lethal injection is especially troublesome.[1,3-5] The process of execution by lethal injection employs the same devices and methods used by physicians to preserve life.[1] Using medical devices and methods for execution distorts the life-saving purposes of medical technology and medical tools. Physician participation in a process which has medical overtones but ultimately causes involuntary death further distorts the purpose and role of medicine and its professionals in the preservation of life. The use of physicians and medical technology in execution presents a conceptual contradiction for society and the public. The image of physician as executioner under circumstances mimicking medical care risks the general trust of the public.[1]

It is not simply the participation in a death-causing process that makes physician participation in capital punishment unethical. In other contexts, physicians may ethically act in ways that contribute to the death of a patient. The Council has previously stated that a physician may, with the informed consent of the patient, withhold or withdraw treatment even if the treatment is life sustaining.[17] Discontinuing life-sustaining treatment can be distinguished from participation in capital punishment in at least two ways. First, although death may ensue from the physician's actions, the individual patient is voluntarily choosing to risk death upon the withdrawal or withholding of care. With capital punishment, the physician is causing death against the will of the individual. Second, when life-sustaining treatment is discontinued, the patient's death is caused primarily by the underlying disease; with capital punishment, the lethal injection causes the prisoner's death. When physicians withdraw or withhold life sustaining treatment at the request of the patient, they do not violate the fundamental ethical principle of *primum non Nocere.* Physician participation in capital punishment, however, does violate that principle. Deliberately causing a death or participating in the process which intentionally causes death is a harm to the person executed.

Opposing Views

Opposing views hold that, when physicians decline to participate in executions, they are breaching their obligations as physicians and citizens.[1,4,13,18-22] According to one argument, physicians have a moral duty to ensure that the execution is carried out in the most humane and painless way possible.[4,22] Physician participation would not signal approval of the taking of a life, but compassion for the person to be executed. Further, the physician's duty as a citizen requires him or her to participate because the

executions take place with the authorization of the state.[13]

These arguments are not sufficiently compelling to justify physician participation in capital punishment. The procedures used for executions do not require the skills of a physician. Even when the method of execution is lethal injection, the specific procedures can be performed by non-physicians with no more pain or discomfort for the prisoner. While physician participation may potentially add some degree of humaneness to the execution of an individual, it does not outweigh the greater harm of causing death to the individual. Finally, the AMA's Principles of Medical Ethics do recognize that physicians have civic duties.[23]

However, medical ethics do not require the physician to carry out civic duties which contradict fundamental medical and ethical principles, such as the duty to avoid doing harm. Further, state approval or authorization of an act does not constitute a requirement on the part of any citizen to take action. For instance, voting in an election is authorized by the state but is not mandatory

DEFINITION OF PARTICIPATION

Proposed definitions of "physician participation"

Although several other medical societies and associations have stated that physicians should not participate in executions, only a few have defined "participation" with a significant degree of specificity.[13,14] Resolution 5 (I-91), which requested that the Council develop a definition of "participation," asked that the following be included as actions constituting "participation:"

> selecting fatal injection sites; starting intravenous lines as a port for a lethal injection device; prescribing or administering pre-execution tranquilizers and other psychotropic agents and medications, injection drugs or their doses or types; inspecting, testing or maintaining lethal injection devices; consulting with or supervising lethal injection personnel; monitoring vital signs on site or remotely (including monitoring electrocardiograms); attending, observing or witnessing executions as a physician; providing psychiatric information to certify competence to be executed; providing psychiatric treatment to establish competence to be executed; and soliciting or harvesting organs for donation by condemned persons.[14]

Also, the Council of the Medical Society of the State of New York approved a statement on May 10, 1990 which defined "participation" as including, among other things:

> 1) the determination of mental and physical fitness for execution; 2) the rendering of technical advice regarding execution; 3) the prescription, preparation, administration, or supervision of doses of drugs in jurisdictions where lethal injection is used as a method of execution; and 4) the performance of medical examinations during the execution to determine whether or not the prisoner is dead.[13]

The Council of the MSSNY specifically excludes the following from its definition of "participation:"

> 1) to serve as a witness in a criminal trial prior to the rendering of a verdict to determine guilt or innocence of an accused person; 2) relieve acute suffering of a convicted prisoner while he is awaiting execution 3) certify death, *provided that* the prisoner has been declared dead by someone else; and 4) perform an autopsy following the execution. (emphasis in original)[13]

Clarifications to the AMA Prohibition on Participation

There is a consensus among most medical societies that physician participation in state executions is

unethical.[7-14] There is also general consensus that the following functions constitute physician participation in executions: directly injecting a lethal agent into a person, starting an IV line which conducts a lethal agent, or rendering technical advice for the individuals performing the execution. However, a few actions by physicians that are considered to be included within the definition of "participation" need special explanation or clarification.

1. **Determination versus certification of death**. Determining death includes monitoring the condition of the condemned during the execution and determining the point at which the individual has actually died.[13] Certifying death includes confirming that the individual is dead after another person has pronounced or determined that the individual is dead.[13] Certifying death takes place after the execution procedure is complete, is a neutral medical act, does not implicate the moral beliefs of the physician concerning capital punishment, and cannot be construed to constitute physician participation in the death penalty.

Determining death has the potential to require physician involvement in the actual execution process.[1,15] There have been several cases where a condemned person did not die immediately upon being injected, gassed, electrocuted, or hanged.[24] A physician charged with determining death where initial attempts at execution failed would have to signal that death was not achieved and indicate that the execution attempt must be repeated. In some cases, the physician might have to specifically indicate which drug, what amount of electricity, or what amount or type of gas must be added or repeated in order to complete the execution.[15]

Determining death might require the physician to use his or her medical knowledge or skills in a participatory fashion in the execution.[25] The physician would potentially be put in the position of directing the specific action which would cause death to the condemned person.[15] For these reasons, determining death constitutes physician participation in execution and is unethical. Certifying death after another person has determined or pronounced death, however, would not involve the physician in the execution process and is permitted.

2. **Supervising or overseeing the preparation or administration of the execution process**. Supervising execution proceedings implicates concerns similar to those raised by determining the death of the condemned. If improper application of the chosen execution method occurred, the physician would be placed in the position of using his or her medical skills to assist the execution. The physician might be required to take specific corrective action that would contribute directly to the taking of life.[15] Supervising the preparation or administration of the execution process is therefore unethical.

3. **Physician participation in the processes leading to condemnation and execution**. Where are several ways in which physicians may be asked to participate in the legal processes which lead to the conviction, sentencing, and execution of an individual. A physician may be asked to evaluate and testify as to competence to stand trial, or, if the defendant is convicted, to testify as to the medical aspects of potentially aggravating or mitigating factors during the sentencing phase of the proceedings. Physicians may also be asked to evaluate competence to be executed or to provide treatment in order to restore competence so that the execution may take place.[15,18,26-29]

Testifying as to competence to stand trial or competence to be executed presents particular ethical dilemmas for psychiatrists, as psychiatrists are ordinarily the only medical professionals called on to make such competency determinations. The American Psychiatric Association stated in 1980 that: “[t]he physician's serving the state as executioner, either directly or indirectly, is a perversion of medical ethics and of his or her role as a healer and comforter.”[12]

A physician who testifies to the competence of an individual to stand trial in a capital proceeding may

ultimately contribute in some way to the individual's execution.[18] Had the physician not provided testimony supportive of a finding of competence, then the individual might not have stood trial, been convicted, been sentenced, etc. However, the physician's responsibility for the execution is attenuated. Defendants who are found competent to stand trial may be acquitted, or, if found guilty, may be sentenced to a penalty less severe than death. In addition, the physician does not make the formal determinations that lead to the defendant's execution. The judge determines whether the defendant is competent to stand trial. Similarly, other parties, including the judge, the trial jury, and the sentencing jury, decide whether the defendant is guilty and whether the death penalty should be imposed. The psychiatrist is not using medical skills to cause the death of the accused, and the psychiatrist's actions do not directly result in a death.

Similar considerations apply when a physician provides testimony during the trial id a capital case or during the sentencing phase of a capital case. Although the physician's actions may ultimately influence the decision to execute an individual, the actual determination to execute is made by the jury, which has the option of accepting or rejecting the psychiatrist's testimony. In addition, the psychiatrist's testimony may help exculpate the defendant.

In all cases where a physician is called upon to testify before and during the trial and sentencing of the accused, the physician is ethically obligated to give an objective medical evaluation of the accused or of the medical evidence in the case. The physician may not allow personal beliefs regarding the morality Of the capital punishment to influence the physician's medical evaluation.

Different concerns are raised when the psychiatrist is asked to testify to the competence of a condemned prisoner to be executed. There is a long-standing legal tradition, in both statutory and common law, which prohibits the execution of the incompetent.[26] In *Ford v. Wainwright* (1986), the Supreme Court held that executing an incompetent individual is unconstitutional.[27] When a psychiatrist evaluates an individual's competence to be executed, the psychiatrist is put in a position where his or her actions could set the process of execution in motion.[28] The death of the condemned may be directly dependent on the psychiatrist's use of medical skills. Additionally, most states' processes for determining competence do not include provisions for a psychiatrist's evaluation to be challenged under the usual protections of the adversarial system.[29] Similar to determining death during an execution, the physician might essentially be directing the process of execution to begin.[15] On the other hand, the physician's testimony might result in a halt to the process of execution, and, as in other contexts, the competency determination is not a medical determination made by physicians, but a legal determination made by the governor[30] or other state official.

Given the complexity of the ethical issues and the importance of the role of psychiatrists, the Council will defer guidelines on physician involvement in evaluations of a prisoner's competence to be executed until the Council has consulted further with the ethics committee of the American Psychiatric Association. The Council will also defer guidelines on the question whether physicians may treat an incompetent prisoner to restore the prisoner's competence to be executed.

4. **Actions Associated with Executions Which Do Not Constitute Physician Participation in Executions**. A physician's obligation to do no harm does not require him or her to totally abandon a condemned individual or to refrain from providing comfort or medical care to a person on death row. A physician may provide medical care to a condemned person if the individual gives informed consent, the medical care is used to heal, comfort, or preserve the life of the condemned individual, and the medical care would not enable or facilitate the execution of the condemned person. One often cited example is that a physician may perform an appendectomy on a condemned person who has acute appendicitis. Ethically, this is permissible because performing the appendectomy prolongs the life of the condemned individual, if even only for a short period.[18]

The wait for execution on death row may be long, and a variety of ill- nesses or maladies may manifest themselves. Under the foregoing analysis, a physician may counselor treat an individual for anxiety or depression with the patient's informed consent.[34] Any acute or chronic medical conditions which arise could be tended to, and the physician may use medical or personal skills to comfort the condemned person. For instance, the condemned individual might request medication that would relieve acute anxiety which occurred as a result of anticipating the impending execution.

Although the physician may not participate in an execution, he or she may witness the execution in a non-professional capacity. The physician may also witness the execution at the specific voluntary request of the condemned person as long as the physician takes no action which would cause the death of the condemned individual, assists in no way in the process which is used to execute the condemned individual, and does not otherwise violate the definition of physician participation in execution in this report.

A GENERAL DEFINITION OF PHYSICIAN PARTICIPATION

From the foregoing discussion, a general definition of physician "participation" can be constructed which would include the specific actions previously described while pr viding guidelines for determining whether other actions not mentioned or as yet unanticipated might also constitute "physician participation in executions." A general definition of physician participation in executions would be:

> An action by a physician which would fulfill one or more of the following conditions: 1) an action which would directly cause the death of the condemned (e.g., administering a lethal injection); 2) an action which would assist, supervise, or contribute to the ability of another individual to directly cause the death of the condemned (e.g., prescribing the drugs necessary for a lethal injection); 3) an action which could automatically cause an execution to be carried out on a condemned prisoner (e.g., determining whether death has occurred during an execution).

This definition would exclude actions such as testifying as to competence to stand trial certifying death (after another party had declared death), and providing medical care to the condemned for medical problems before the execution.

RECOMMENDATIONS

For the reasons described in this report, the Council on Ethical and Judicial Affairs recommends that the following guidelines be adopted in lieu of Resolution 5 (1-91) and that the remainder of the report be filed:

1. An individual's opinion on capital punishment is the personal moral decision of the individual. A physician, as a member of a profession dedicated to preserving life when there is hope of doing so, should not be a participant in a state execution. "Physician participation in execution" is defined generally as actions which would fall into one or more of the following categories: 1) a action which would directly cause the death of the condemned; 2) an action which would assist, supervise, or contribute to the ability of another individual to directly cause the death of the condemned; 3) an action which could automatically cause an execution to be carried out on condemned prisoner.

2. Physician participation in an execution includes but is not limited to the following actions: prescribing or administering tranquilizers and other psychotropic agents and medications which are part of the execution procedure; monitoring vital signs on site or remotely (including monitoring electrocardiograms); attending or observing an execution as a physician; and rendering of technical

advice regarding execution.

3. In the case where the method of execution is lethal injection, the following actions by the physician would also constitute physician participation in execution: selecting injection sites; starting intravenous lines as a port for a lethal injection device; prescribing, preparing, administering, or supervising injection drugs or their doses or types; inspecting, testing or maintaining lethal injection devices; consulting with or supervising lethal injection personnel.

4. The following actions do not constitute physician participation in execution: 1) testifying as to competence to stand trial, testifying as to relevant medical evidence during trial, or testifying as to medical aspects of aggravating or mitigating circumstances during the penalty phase of a capital case; 2) certifying death provided that the condemned has been declared dead by another person; 3) witnessing an execution in a totally non-professional capacity; 4) witnessing an execution at the specific voluntary request of the condemned person, provided that the physician observes the execution in a non-physician capacity and takes no action which would constitute physician participation in an execution; and 5) relieving the acute suffering of a condemned person while awaiting execution, including providing tranquilizers at the specific voluntary request of the condemned person to help relieve pain or anxiety in anticipation of the execution.

December 1992

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