

Medicine and Capital Punishment: Friend or Foe?

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### Abstract

Recent botched lethal injections have fueled the debate concerning execution methods in the U.S. and the physician's role in the procedure. The federal and state governments, medical organizations, and individual physicians are all at odds regarding the issue. There are reasons supporting the view of physician-assisted execution, which are typically the opinions of the government and reasons condemning it, which are usually adopted by medical organizations. It is the choice of the individual physician as to their level of participation in lethal injections.

The debate over the enforcement of the death penalty has picked up as of late due to the highly-publicized recent botched lethal injection in Oklahoma. “Clayton Lockett, 38, struggled violently, groaned and writhed after drugs were administered by Oklahoma officials Tuesday night, eyewitnesses say. He lifted his head and shoulders as if struggling to sit up on a gurney, fighting against restraints, according to an eyewitness account...” (Zoraya, 2014). Lockett was convicted of shooting a young woman and watching two accomplices bury her alive in 1999. This lethal injection, just like most others mandated by the state, called for the participation of a physician. The physician’s identity is protected by the criminal justice system so that they do not experience repercussions or discrimination from medical organizations. The role of the doctor on hand during the execution of Lockett is unknown, meaning that he/she could have taken a hands-off approach and merely pronounced Lockett dead or he/she could have actually administered the injections (Martin, 2014). It is much less likely for lethal injections to go wrong when a physician is involved in its implementation, but botched executions still occur under the watchful eye of a medical practitioner.

As a result of such a graphic and seemingly painful death imposed by government authorities, the regulations and methodologies of capital punishment in America are being closely scrutinized by U.S. officials and the public alike. In addition, the medical community is particularly conflicted about how to address the physician’s role in America’s crime and punishment processes, and above all, how that participation or lack thereof influences the general role of the medical field in society. The death penalty has always been a much disputed topic in the United States, with state and federal regulations ever-evolving with the times and shifting American principles. The current debate is fraught with a complex network of issues

including religion, ethics, politics, healthcare, and economics. Considering this broad range of implications, capital punishment is rarely an issue observed from an objective point of view, but this paper will explore several areas of focus surrounding the death penalty from both positive and negative perspectives including authorized methods of execution, opinions of the medical community, the physician's role in the death penalty, as well as the current state of lethal injection in the U.S.

Capital punishment has been utilized by governing bodies all over the world, most widely used in ancient times as far back as 1750 BC (Lethal Injections, 2008). For nearly as long as executions have been enforced, those practicing medicine have been involved in some way. Sometimes, it is merely to pronounce the prisoner dead, other times it is to assist in administration. Historically, medically trained individuals have helped to carry out a decision made by their governing body and did not determine on their own accord the put the condemned to death. Abolishment of the punishment first began in nations like Venezuela and San Marino in the 1860's. As of 2004, a total of 81 countries had eliminated capital punishment from their criminal justice system, including those in Western Europe. Over the last four decades, nearly all criminals punished to death in the U.S. have been convicted of homicide. Since 2002, the Court ruled that death penalty must be imposed through the finding of a jury, not a single judge, allowing more members of society to weigh in on the decision (The Columbia Encyclopedia, 2008). According to some scholars, the fact that the death penalty has been abolished in other modern nations and not our own is *not* because Americans revel in the concept of the death penalty, but due to the differences in political institutions. The U.S. Congress lacks the power to impose a national repeal, because legislative power over criminal

law is given to the states by the Constitution, meaning that in order for capital punishment to be repealed, there must be 52 separate acts-one for each U.S. nation/district (Garland, 2012).

There are five different authorized methods prescribed in the United States today-lethal injection, electrocution, lethal gas, firing squad, and hanging- in jurisdictions of 35 states as well as the U.S. Military and U.S. Government (Death Penalty Information Center, 2014). (\*Note: I have found conflicting statistics regarding the number of states that enforce the death penalty, from 34 states to 38 states.) The most commonly used method, also considered to be the optimal method, is lethal injection, followed by electrocution, both of which are legal in the majority of states that enforce the death penalty. Many states have outlawed the use of lethal gas, firing squad, and hanging. Though, some jurisdictions will allow alternate methods of death should the convict choose. These three methods have resulted in many botched executions, causing the prisoners a great deal of pain prior to death. For example, lethal gas typically takes six to eighteen minutes of apparent suffering and agony to kill the prisoner, and there are often extended periods of time during which the prisoner violently convulses (Death Penalty Focus, 2014). In an effort to make the process more humane, state and federal governments have adopted lethal injection as the most commonly used method. Lethal injection is not a perfected procedure, but it is considered to be the most civilized and Constitutional by the standards of U.S. law. For the purposes of this paper, lethal injection will be chief method of execution discussed.

Currently, seventeen states and the Federal government approve lethal injection as the sole method of execution. It is a relatively new method of execution, first adopted by Oklahoma in 1977 (Lethal Injections, 2008). Since then, there have been approximately 1,200

executions in the U.S. by lethal injection (Death Penalty Information Center, 2014). “The statutes of lethal injection typically provide that: ‘The punishment of death must be inflicted by continuous, intravenous administration of a lethal quantity of an ultrashort-acting barbiturate in combination with a chemical paralytic agent until death is pronounced by a licensed physician according to accepted standards of medical practice,’” (Death Penalty Focus, 2014). Prior to injection, the inmate is led into the execution chamber and strapped to a gurney by his wrists and ankles and connected to a cardiac monitor. An IV of harmless saline solution is injected into two viable veins, one in each arm. Only one line is meant to inject the lethal medications, but the other is kept open in case of blockage or malfunction. These IV lines lead out to a separate infusion room where the physician is stationed to monitor the inmate’s vitals. While the prisoner is receiving the saline drip, the warden may signal for the execution chamber to be made visible to witnesses. There is usually a combination of three different drugs administered to the prisoner; the first is a barbiturate (an anesthetic) rendering the prisoner unconscious; the second is a muscle relaxant that paralyzes the respiratory system; the third is potassium chloride causing cardiac arrest (Lethal Injections, 2008). Otherwise, the prisoner is given only one injection—an overdose of anesthesia. The dose is meant to be strong enough to both render the patient unconscious and cause a swift death by cardiac arrest. Throughout the execution, the physician’s ultimate purpose is to facilitate a quick and painless death. If the injection process is not carried out properly, things can go awry at any stage, causing the prisoner excruciating pain and suffering (Boehnlein, 2013). Once the execution is complete, the physician pronounces the prisoner dead, assuming that the medications served their purpose.

Individual medical practitioners and medical organizations as a whole all have the prerogative to take a unique stance on the physician's role in lethal injection. These opinions tend to be unwavering considering the grave implications once a decision has been made on the issue. One cannot change their mind from day to day. There is currently an extensive tug of war going on between state governments and medical organizations such as the American Medical Association, the American Board of Anesthesiology, Physicians Committee for Responsible Medicine, the American Medical Student Association, and many others. The debate has tentacles grasping all major organized realms within the United States, and the world for that matter, including religious, judicial, political, economic, and ethical entities. In the large majority of states that do enforce the death penalty, physicians are legally sanctioned to participate in in executions (Alper, 2009). Interestingly, state medical boards are the only body with the ability to reprimand doctors for ethical violations, and the government is not able to force doctors to participate. Medical associations virtually unanimously disagree with physician participation, but not all practicing physicians are in agreement with their professional organizations. Ty Alper, clinical professor of law at UCal Berkeley who has represented death row inmates himself, stated during a recent interview with NPR that, "... Most medical associations-The American Medical Association and state-based medical associations have ethical guidelines that prohibit the participation of doctors in executions. But it's important to keep in mind that those are just the *guidelines* of those medical associations. And the majority of doctors are not members of those associations. So the guidelines don't have any enforcement teeth" (Martin, 2014). Thus, the American government, medical

organizations, and physicians are left with strongly opposing opinions, incomplete guidance, and questionable authority.

The main argument against physician-assisted execution is that the act is contrary to the Hippocratic Oath and a physician's responsibility to "do no harm" and preserve life whenever possible (Section Four: Physician-assisted suicide and capital punishment: What role should physicians play? 2014). The American Medical Association (AMA) even opposes physicians from attending, or viewing, an execution from a professional position. Many believe that the act of killing is inconsistent with the principles of medical ethics. Ideally, a death by lethal injection should not be painful or cause suffering. The individual should feel as if they are being put to sleep, similar to anesthesia prior to a surgery. Unfortunately, the process of a lethal injection is not a perfect science, like most procedures in the medical field, and they can go wrong. In the case of a botched execution, of which there have been many, death can be slow and agonizing. The physician then becomes part of a painful death, one that is not due to a patient's life-threatening illness, but one that is required by the government. In this case, the physician is seen as doing the exact opposite of their professional duty.

In addition, it is a belief of many medical associations that by assisting in the procedure of a lethal injection, the physician is not using his/her training and medical knowledge in an ethical manner, the way that it is meant to be. Some think that medical practices are incorrectly used to carry out government mandates, blurring the lines of medicine's role in society. During the reign of Hitler and Nazi Germany, many 'medical procedures' such as lethal gas were used to eradicate masses of people deemed 'lesser' (Section Four: Physician-assisted suicide and capital punishment: What role should physicians play?, 2014). With a great stretch of the

imagination, one can see similarities in the terrifying events of euthanasia and modern-day lethal injection in that both are medically-based procedures used to put people to death who are not otherwise physically ill. As a result, medical organizations are afraid that the public may begin to view the medical profession in an imposing and destructive light. The environment of the execution chamber and the presence of a medical team during a lethal injection can give the impression of a medical procedure (Boehnlein, 2013). This could further the negative associations between the practice of medicine+ and the death penalty.

On the other hand, there are valid arguments supporting the physician's participation in government-mandated executions, the most prominent of which is that a physician's aid during the lethal injection procedure spares the prisoner unnecessary pain (Section Four: Physician-assisted suicide and capital punishment: What role should physicians play? 2014). This view is based upon the foundation that the execution will occur with or without a physician's participation. The criminal will be put to death as a result of a decision by a jury, made using the proper protocol of the judicial system and U.S. law, which has nothing to do with the physician and his or her own beliefs. Therefore, some physicians take the stance that it is their responsibility to lessen the pain of the individual who is already condemned to die. They believe that by "administering or supervising lethal injection, (they) are acting in accordance with their duty to ease suffering" (Section Four: Physician-assisted suicide and capital punishment: What role should physicians play? 2014). In this way, the Hippocratic Oath is used in support of physician-assisted capital punishment. Interestingly, both camps use the same evidence in an effort to prove very different points.

There have been relatively few interviews conducted with doctors who have participated in lethal injections, because participants can be unwilling to speak, afraid of potential repercussions from medical organizations or their patients who may disagree with the act. Of those interviews that have been made public, the doctor's identity usually remains anonymous. They shed valuable light onto why a physician may choose to participate in lethal injection. Some doctors "view it (the death penalty) in a way as similar to terminal illness, and they can relieve suffering" (Martin, 2014). In one interview conducted by Atul Gawande, a doctor, who was also a former marine, recounted a conversation that he had with a nurse while witnessing his first execution by lethal injection:

"The warden told the nurse that he would start the IV himself, though he had never started one before. 'Are you, as a doctor, going to let this person stab the inmate for half an hour because of his inexperience?' the nurse asked me. 'I wasn't.' He said, 'I had no qualms. If this is to be done correctly, if this is to be done at all, then I am the person to do it...As a marine and as a nurse,...I hope I will never become someone who has no problem taking another person's life.'" (Gawande, 2007).

This interview is an example of a well-intentioned doctor using his medical training to do what he feels is right. He believes that he is following his professional oath and his moral responsibility in that situation. This instance lends validity to a doctor's participation, and shows the internal struggle that he/she must endure.

There is another factor that plays into execution by lethal injection that physicians have no say in, nor does the U.S. government for that matter, which is the difficulty in sourcing medications for injections. "A nationwide shortage of sodium thiopental, an anesthetic that is

part of the three-drug cocktail used in lethal injections, has thrown capital punishment in the United States into disarray, delaying executions and forcing the change of execution protocols in several states” (Horne 2014). For example, Texas currently has 317 inmates waiting on death row, but only enough medication to perform two lethal injections (Horne, 2014). Recently, the medical manufacturers that do produce the medications for lethal injections have banned the usage of their drugs for that purpose. The single manufacturer of said drugs in the US, Hospira, just announced last month that they will no longer produce the drug. Now, states are forced to look overseas for medications for current execution procedures, and even then they are not easily found.

The alternative to looking overseas for medications is no better. States have been turning to compounding pharmacies within the U.S., which can be seedy are not well regulated (Semel, 2014). Compounding pharmacies traditionally mix small batches of drugs to meet a particular customer’s order. In this case, the customers are state governments. Disclosure of the exact combination of medications used is often times non-existent. The exact cocktail of drugs used, their sourcing locations, and whether they will work as intended can all remain unknown (Semel, 2014). The scarcity of drugs will greatly impact the future of the process of lethal injection in the United States.

Ultimately, individual physicians have the final say as to whether or not they will participate in government mandated executions. As members of a very influential and powerful profession, physicians must navigate the many modern societal issues to determine exactly what sort of doctor they want to be, how they want to interact with their patients, and be known by their peers. Will he be on the board of a medical organizations and vehemently

oppose physician participation in lethal injections? Will he rock the boat and participate in injections in order to ease the suffering of inmates, but risk intense scrutiny from his peers? Will he take a laissez-faire approach and remain neutral on the issue? These are not easy choices to make. Most importantly, a physician needs to be able to face himself in the mirror every morning and know that he is contributing to humanity to the best of his ability, following both the U.S. legal system and his own ethical compass.

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