

9.7.3 Capital Punishment

Debate over capital punishment has occurred for centuries and remains a volatile social, political, and legal issue. An individual's opinion on capital punishment is the personal moral decision of the individual. However, as a member of a profession dedicated to preserving life when there is hope of doing so, a physician must not participate in a legally authorized execution.

Physician participation in execution is defined as actions that fall into one or more of the following categories:

- (a) Would directly cause the death of the condemned.
- (b) Would assist, supervise, or contribute to the ability of another individual to directly cause the death of the condemned.
- (c) Could automatically cause an execution to be carried out on a condemned prisoner.

These include, but are not limited to:

- (d) Determining a prisoner's competence to be executed. A physician's medical opinion should be merely one aspect of the information taken into account by a legal decision maker, such as a judge or hearing officer.
- (e) Treating a condemned prisoner who has been declared incompetent to be executed for the purpose of restoring competence, unless a commutation order is issued before treatment begins. The task of re-evaluating the prisoner should be performed by an independent medical examiner.
- (f) Prescribing or administering tranquilizers and other psychotropic agents and medications that are part of the execution procedure.
- (g) Monitoring vital signs on site or remotely (including monitoring electrocardiograms).
- (h) Attending or observing an execution as a physician.
- (i) Rendering of technical advice regarding execution.

and, when the method of execution is lethal injection:

- (j) Selecting injection sites.
- (k) Starting intravenous lines as a port for a lethal injection device.
- (l) Prescribing, preparing, administering, or supervising injection drugs or their doses or types.
- (m) Inspecting, testing, or maintaining lethal injection devices.
- (n) Consulting with or supervising lethal injection personnel.

The following actions do not constitute physician participation in execution:

- (o) Testifying as to the prisoner's medical history and diagnoses or mental state as they relate to competence to stand trial, testifying as to relevant medical evidence during trial, testifying as to medical aspects of aggravating or mitigating circumstances during the penalty phase of a capital case, or testifying as to medical diagnoses as they relate to the legal assessment of competence for execution.
- (p) Certifying death, provided that the condemned has been declared dead by another person.
- (q) Witnessing an execution in a totally nonprofessional capacity.;
- (r) Witnessing an execution at the specific voluntary request of the condemned person, provided that the physician observes the execution in a nonprofessional capacity.
- (s) 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.
- (t) Providing medical intervention to mitigate suffering when an incompetent prisoner is undergoing extreme suffering as a result of psychosis or any other illness.

No physician should be compelled to participate in the process of establishing a prisoner's competence or be involved with treatment of an incompetent, condemned prisoner if such activity is contrary to the physician's personal beliefs. Under those circumstances, physicians should be permitted to transfer care of the prisoner to another physician.

Organ donation by condemned prisoners is permissible only if:

- (u) The decision to donate was made before the prisoner's conviction.
- (v) The donated tissue is harvested after the prisoner has been pronounced dead and the body removed from the death chamber.
- (w) Physicians do not provide advice on modifying the method of execution for any individual to facilitate donation.

AMA Principles of Medical Ethics: I

Background report(s):

CEJA Report 3-A-16 Modernized *Code of Medical Ethics*

CEJA Report 6-A-95 Capital punishment—competence to be executed

CEJA Report A-I-92 Physician participation in capital punishment

CEJA Report A-A-80 Capital punishment

6. PHYSICIAN PARTICIPATION IN CAPITAL PUNISHMENT: EVALUATIONS OF PRISONER COMPETENCE TO BE EXECUTED: TREATMENT TO RESTORE COMPETENCE TO BE EXECUTED

HOUSE ACTION: RECOMMENDATIONS ADOPTED AND REMAINDER OF REPORT FILED

INTRODUCTION

At the December 1992 meeting of the House of Delegates, the Council on Ethical and Judicial Affairs issued a report titled *Physician Participation in Capital Punishment*. In that report, the Council both reiterated its view that physicians should not participate in executions and described which physician activities constitute participation in an execution. The Council reserved judgment on the issues of (a) testimony by physicians regarding the competence of a condemned prisoner to be executed and (b) treatment of an incompetent prisoner by a physician to restore the prisoner's competence to be executed. After consulting with professional associations and other interested persons, the Council on Ethical and Judicial Affairs developed the following analysis on these two issues.

TESTIMONY REGARDING COMPETENCE TO BE EXECUTED

In its earlier report, the Council discussed the propriety of a physician testifying to a defendant's competence to stand trial. Ethical concerns are raised because the physician's testimony may ultimately contribute to the prisoner's execution. Without a finding of competence, the defendant cannot stand trial. Nevertheless, the Council concluded that it is acceptable for physicians to provide testimony. While there may be heavy reliance on physician testimony, the physician does not make the formal determination of competence that results in the defendant's ability to stand trial and be sentenced to execution. It is the judge who determines whether the defendant is competent to stand trial, weighing in part the testimony of the physician. The Council came to a similar conclusion regarding physician testimony about the defendant's competence during the trial or sentencing phase of a capital case. In both settings, physician testimony is ethically permissible. A jury or judge decides the guilt or innocence of the defendant and whether the death penalty should be imposed. As a matter of information, only about three percent of criminal homicides in Florida result in a death sentence.

Although physicians may ethically testify at the pre-trial, trial or sentencing phases, some physicians have strongly held beliefs against involvement in the process that may lead to a defendant's execution. There is no compelling reason to insist that these physicians act against their consciences.

Different concerns are raised when a physician is asked to testify to the competence of a condemned prisoner to be executed. The question of competence to be executed may arise after the final decision to execute has been made. Under the law, incompetent prisoners cannot be executed. If a physician's examination and testimony support a finding of the defendant being competent, this information will be considered by a judge or hearing officer in determining legal competence prior to carrying out the sentence.

As the Council's previous report emphasized, physicians must not use their professional knowledge and skills to help cause the death of prisoners. This is not to say that physicians should not participate in determining competence, since without physician participation, individuals might be punished unjustifiably. It is the responsibility of the physician to fully evaluate the prisoner applying medical criteria to assess the prisoner's mental status. Physician participation in the process can be justified on the basis of the importance of having physicians assist in the administration of justice. Physicians' participation in the proceedings assists society in ensuring that individuals are treated fairly and punished only when it is appropriate. The important principle in this situation is that the physician is acting as an advocate of justice, not as a source of punishment. The physician is acting as an expert advisor, providing important information that assists in the pursuit of a just result. While it is difficult to estimate the degree of reliance placed on physician testimony, in some instances it may prove to be the decisive factor.

The concerns with physician participation in evaluations of competence raise difficult ethical issues, but in the end physician participation appears more like than unlike physician participation in other forensic evaluations in capital cases. Participation in evaluation of a competence to be executed therefore is not unethical per se. However, certain safeguards are necessary. Psychiatric evaluation should be only one aspect of the information taken into account by the ultimate decision maker, a role that is legally assumed by a judge or hearing officer. Prisoners' rights to due process at the competence hearing should be carefully observed.

TREATMENT TO RESTORE COMPETENCE TO BE EXECUTED

More complicated ethical dilemmas arise when physicians are asked to provide treatment to restore competence of a condemned person who has been found incompetent for execution. Such prisoners are often psychotic and may be experiencing severe psychic torment accompanied by self-destructive behavior and, if left untreated, could suffer serious harm. Their treatment will usually involve the administration of psychotropic medications. Even in cases with milder psychiatric illness, a prisoner could suffer without treatment. On the other hand, responding to the state's request to provide treatment so that the prisoner's competence can be reevaluated to determine if the sentence can be carried out raises the specter of so close an involvement as to transgress the boundary of direct participation in execution itself. Such dilemmas would be avoided if states were to adopt the solution recommended to the U. S. Supreme Court by the AMA and APA in their amicus curiae brief, *Perry v. Louisiana*: commutation of the incompetent prisoner's sentence to life imprisonment without the possibility of parole. This would allow treatment of a prisoner's psychiatric disorder without further ethical concerns. Maryland has taken this approach by statute, and its consideration by other jurisdictions is encouraged.

In the absence of commutation, there is no simple answer to the ethical dilemma with which physicians are confronted. Some commentators have suggested that a critical issue is whether the prisoner has consented to treatment. There are problems with the consent issue. If the prisoner is incompetent to be executed, it is very unlikely that he/she would be competent to consent to treatment. The problems with incompetence could be avoided if the prisoner had completed an advance directive. However, the prisoner's consent is not sufficient to justify treatment if treatment would violate a physician's ethical obligations.

On balance, the arguments generally weigh against treatment to restore competence since the prisoner would be considered worse off with treatment and execution than to continue without treatment. Physicians are obligated to serve the interest of their patients first when they are providing treatment.

There may, however, be exceptional circumstances in which treatment is justified even though it may have the unintended effect of restoring competence for execution. As noted in the Council's earlier report on physician participation in capital punishment, a physician's obligation to avoid unethical participation in executions does not require total abandonment of the condemned. Appropriate comfort and medical care for death row prisoners can be provided with the individual's informed consent, or in emergencies, with implied consent. If prisoners lack competence to provide informed consent to treatment, therapeutic interventions, including the use of psychotropic medications, can be provided in accordance with ethical principles and state law. Psychotic prisoners may engage in harmful activity such as repetitive head-banging, attempts at self-castration, enucleation of their eyes, or eating their own feces. Severe paranoia can lead to refusal of all food and fluids. Catatonia, should it develop, can be life-threatening, resulting in pneumonia, pulmonary thromboembolism and circulatory collapse.

In such instances in which there is extreme suffering, medical intervention which is intended to mitigate the level of suffering is ethically permissible. On the other hand, if treatment is primarily directed to restore competence to be executed, it is ethically unacceptable. The Council recognizes that it will not always be easy to distinguish between these situations, perhaps even to determine when treatment initiated to reduce extreme suffering should be stopped. While even brief treatment of a severe psychotic disorder may have the unintended effect of restoring the prisoner's competence for execution, there is no alternative at this time than to rely upon the treating physician to exercise judgment in deciding when and to what extent treatment is necessary to reduce suffering. The cumulative experience of physicians applying these principles may lead to future refinements.

To minimize the ethical conflict to which the treating physician is subject, treatment should be provided in a properly secured general medical or psychiatric facility, not a cell block. The task of reevaluating the prisoner's competence to be executed should be performed by an independent examiner. Given the ethical conflicts involved, physicians who would prefer not to be involved with treatment of an incompetent, condemned prisoner should be permitted to be excused or to transfer care of the prisoner to another physician.

TREATMENT OF COMPETENT PRISONERS TO BE EXECUTED

When a condemned prisoner requires medically necessary psychiatric intervention but is not affected by psychiatric disease as to be incompetent to be executed, then treatment is appropriate.

RECOMMENDATIONS

The Council on Ethical and Judicial Affairs recommends that the following treatment be adopted:

1. Physician participation in evaluations of a prisoner's competence to be executed is ethical only when certain safeguards are in place. A physician can render a medical opinion regarding competency which should be merely one aspect of the information taken into account by the ultimate decisionmaker, a role that legally should be assumed by a judge or hearing officer. Prisoners' rights to due process at the competency hearings should be carefully observed.
2. When a condemned prisoner has been declared incompetent to be executed, physicians should not treat the prisoner to restore competence unless a commutation order is issued before treatment begins.
3. If the incompetent prisoner is undergoing extreme suffering as a result of psychosis or any other illness, medical intervention intended to mitigate the level of suffering is ethically permissible. It will not always be easy to distinguish these situations from treatment for the purpose of restoring the prisoner's competence and, in particular, to determine when treatment initiated to reduce suffering should be stopped. However, there is no alternative at this time other than to rely upon the treating physician to exercise judgment in deciding when and to what extent treatment is necessary to reduce extreme suffering. The cumulative experience of physicians applying these principles over time may lead to future refinements.

Treatment should be provided in a properly secured, general medical or psychiatric facility, not in a cell block. The task of reevaluating the prisoner's competence to be executed should be performed by an independent physician examiner.

4. Given the ethical conflicts involved, no physician, even if employed by the state, should be compelled to participate in the process of establishing a prisoner's competence to be executed if such activity is contrary to the physician's personal beliefs. Similarly, physicians who would prefer not to be involved with treatment of an incompetent, condemned prisoner should be excused or permitted to transfer care of the prisoner to another physician.

(References pertaining to Report 6 of the Council on Ethical and Judicial Affairs are available from the Ethical Standards Division Office.)

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. 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

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 and 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 governor³⁰ 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 illnesses or maladies may manifest themselves. Under the foregoing analysis, a physician may counsel or 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 providing 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) an 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.

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REPORTS OF JUDICIAL COUNCIL

The following reports, A-C, were presented by Samuel R. Sherman, M. D., Chairman:

A. CAPITAL PUNISHMENT

(Reference Committee on Amendments to Constitution and Bylaws, page 254)

HOUSE ACTION: ADOPTED AS FOLLOWS:

INTRODUCTION

Since the start of this year, the Judicial Council has received a variety of inquiries from individual physicians and medical societies on physician involvement with capital punishment. Four states have recently passed legislation authorizing capital punishment by intravenous injection of lethal substances. No executions have, in fact, been performed under such statutes. None of the statutes requires a physician to inject the toxic substance.

Individual physician response to this method of execution has been more emotive than conclusive. Some physicians have favored such proposals; others have opposed them. Much of the discussion has turned on whether capital punishment itself is supported or opposed. Not surprisingly, those favoring capital punishment tend to support such legislation, while those opposing capital punishment do not.

Debate over capital punishment has occurred for centuries and remains a volatile social, political and legal issue in our own time. The Judicial Council doubts that this report will resolve this debate, nor does the Council intend this report to do so. The rightness or wrongness of capital punishment is a personal moral decision that each individual in our society must personally resolve. The concern of this report is limited to a question of professional responsibility and decision-making, viz., active participation by physicians in capital punishment.

DISCUSSION

Those arguing in favor of capital punishment by drug injection assert that it is more humane and less painful than other methods. Historical examples, such as the development of the guillotine by two French physicians or a 19th century American physicians' study favoring electrocution or drug overdose to hanging, are typically cited as examples of medical involvement with recommendations for more humane methods of execution. Those favoring death by injection also assert that it is less likely to be subject to social or legal objection and that it will be less expensive than other methods. If medical technicians are used, physicians need not be actively involved in administering the drug or participating in the execution.

Those arguing against this method of execution assert that it manipulates the profession into a position condoning capital punishment, even though physicians are trained to save life, not take it. Physicians are not trained to administer drug overdoses, nor is this typically contemplated within the practice of medicine. If medical technicians are used, a physician may still be involved with prescribing the drug or supervising the injection. Finally, the contrary argument goes, physician participation projects a poor public image.

The Judicial Council imagines that all of the above, pro and con, may be true. The factor that predominates, however, is that professional standards in medicine always rest on the most fundamental of concepts, "primum non nocere," above all do no harm. It is harmful to take a life. Regardless of one's personal moral decision on capital punishment, professional decisions are always tempered by this concern. Knowledge of or capabilities in pharmacology, toxicology, catheterization, or injection do not require the services of a physician in this setting. Whatever conclusions on methods of capital punishment that society may have reached through its elected representatives in the legislature, the active participation by physicians in executions is not required.

(Judicial Council — A)

As a final point, those opposing death by injection have claimed that a physician should not even be available to certify the death of the executed individual. In the rare instances when capital punishment occurs in this country by other methods, a physician could and would presumably be available to declare that the individual was dead. This determination has not traditionally been considered to constitute professional sanction (or disapproval) of capital punishment. A pronouncement of death is, rather, legally required by a designated class of individuals (typically physicians) under state law so that public records may certify to the fact of death. This is true in all instances of death, not just death by execution. Certification of death by a physician is not a part of the act of execution and is not, therefore, improper.

CONCLUSION

The Judicial Council recommends that the House of Delegates adopt the following:

1. An individual's opinion on capital punishment is the personal moral decision of the individual.
2. 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.
3. A physician may make a determination or certification of death as currently provided by law in any situation.