PHYSICIAN PARTICIPATION IN CAPITAL PUNISHMENT: A QUESTION OF PROFESSIONAL INTEGRITY

ANDREW SIKORA AND ALAN R. FLEISCHMAN, MD

ABSTRACT The death penalty is legal in 36 states, and physicians are expected to attend and participate in executions. Yet, every major medical and health-related organization opposes physician participation in capital punishment. This article argues that it is unethical for physicians within the role as medical professional to participate in capital punishment, and that such acts erode the foundation of trust at the heart of medical practice. We believe that it is important for professional groups and medical societies to impose sanctions on members who choose to participate in executions.

There were 74 people executed by capital punishment in the US in 1997.[1] In all but one of the 36 states where the death penalty is legal, a physician is expected to attend such executions, and in 28 of the states, a physician is legally required to participate.[2] Yet, every major medical and health-related organization is unanimous in opposition to physician participation in capital punishment.[3–9] The American Medical Association, in its code of ethics, issued initially in July 1980 and updated in June 1994 and June 1996, based on actions by its Council on Ethical and Judicial Affairs, states:

> 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.[10(section 2.06)]

Mr. Sikora is a doctor of medicine/doctor of philosophy student, Albert Einstein College of Medicine; Dr. Fleischman is Senior Vice President, New York Academy of Medicine, and Clinical Professor of Pediatrics and Clinical Professor of Epidemiology and Social Medicine, Albert Einstein College of Medicine.

Correspondence: Alan R. Fleischman, MD, Senior Vice President, New York Academy of Medicine, 1216 Fifth Avenue, New York, NY 10029. (E-mail: afleischman@nyam.org)

 © 1999 THE NEW YORK ACADEMY OF MEDICINE

This discordance between professional standards and actual practice is quite remarkable in that, although physicians continue to participate in executions, none, to our knowledge, have been censured or reprimanded by a professional organization. Unlike physician assistance in suicide, recently the subject of a passionate national debate, physician participation in execution has received almost no attention from the media and arouses little controversy among the general public.

Even though many Americans and many physicians in their role as citizens view capital punishment as morally acceptable, it is within the role as medical professional that the ethicality of physician involvement in capital punishment should be assessed. The active involvement of physicians in harming persons as agents of the state must be evaluated in light of the beneficence obligations physicians maintain toward those they treat and in light of a basic tenet of the profession: first, do no harm. The redefinition of the relationship between doctors and their patients represented by physician involvement in capital punishment is inconsistent with the integrity of medicine as a profession.

Involvement of physicians in capital punishment is occurring at a time of substantial erosion in individual patient and societal trust in physicians and the medical establishment.[11] In fact, the call for doctors to become executioners may be viewed as analogous to other current demands made of physicians, such as gag orders that forbid discussion of treatment options or criticism of institutional policies, which create conflicts related to dual agency.[12] Each of these demands requires physicians to abandon historical duties and obligations to patients and become technicians rather than professionals whose primary concern is patient welfare. Thus, although few physicians are asked to participate in executions, discussion of physician involvement in capital punishment has contemporary relevance to many ethical concerns.

To consider an ethical analysis of physician involvement in capital punishment, we first must define what constitutes involvement in this process. Involvement in capital punishment includes the design of protocols and procedures to be used; prescription of lethal medications; and direct participation by supervising, assisting, or witnessing execution in a medical capacity and monitoring vital signs to pronounce death.[10] Not all interactions between physicians and prisoners who will be executed constitute participation in capital punishment. There needs to be a clear and sharp ethical distinction between providing prisoners with medical care and participating in executions. Even after sentencing, prisoners remain persons with medical needs related or unrelated to their status as prison-

ers. Physicians may, and should, provide needed medical evaluation and treatment to the condemned so long as such care is guided by concern for the patient's welfare and respect for the rights of competent persons to consent to or refuse treatment.

A consistent rationale for precluding physician involvement in capital punishment can be found within the concept of professional integrity.[13] Professional integrity constitutes the value system of the professional group and defines the boundaries of acceptable practice. The concept of professional integrity provides a rationale for consistent ethical behavior over time and in the face of diverse situations. This concept describes group adherence to a body of ethical values and principles by which individuals navigate through a complex moral landscape in which choices rarely are unambiguously right or wrong, and not all possible consequences can be foreseen. However, professional integrity, unlike personal integrity, is determined not only by individual conscience, but also by the duties and obligations that accompany membership in a specific profession. These duties and obligations create distinctive norms that unite the membership of a given profession and describe professional expectations common to all members.

To assist in understanding professional integrity with respect to medicine, it is helpful to look to the proper goals of medicine. An international group, under the auspices of the Hastings Center, has recently done a careful review that resulted in a modern interpretation of the time-honored explicit and implicit goals of medicine.[14] They concluded that, through the use of knowledge, care, and compassion, the three overarching goals of medicine are (1) to save and extend life; (2) to promote, maintain, and restore health; and (3) to ameliorate and relieve suffering. While these goals may come into conflict, the primary duty of the physician is to benefit the patient and avoid actions that decrease the well-being of the patient. In addition to being guided by the welfare of the patient, medical interventions ought to fulfill the following criteria: voluntary and uncoerced consent, reasonable utility, and benefits proportional to the risks and harms.

The duties and obligations of the physician are encompassed in a special relationship between physician and patient. This relationship, based on mutual respect, obligates the physician responsible for the care of a patient to refrain from harming the patient except to obtain proportional benefit. The physician should act in the patient's best interest except, rarely, when doing so compromises obligations to other patients or persons. While the doctor-patient relationship is framed most often in terms of duties and obligations of the physician to the patient, it should be noted that professional integrity places certain limits on what may be expected by patients from their physicians.[15] Doctors are obligated

only to perform those procedures that have a reasonable chance of bettering the health of their patients. Physicians are said to violate professional integrity if they provide harmful, futile, or irrelevant treatment, even if asked.

Such violations of professional integrity must be distinguished from matters of personal conscience, for which individual physicians might find certain actions personally morally objectionable. An example of such a distinction between breaches of professional and personal integrity might be found in the controversial area of abortion. Although many physicians find participation in abortion procedures to be unacceptable personally, the medical profession, through its organizations, has taken a view consistent with that of the society: abortion under certain circumstances is both legal and ethical, and it remains a matter of individual conscience for the patient and the physician to decide on participation. The physician who chooses to participate in performing abortions justifies that action as consistent with beneficence-based obligations to the woman who requests the procedure. In contrast, with capital punishment, although society has agreed that under certain circumstances it is legal, the medical profession has deemed participation by physicians in this activity is not a matter of conscience, but is unethical because execution is the direct infliction of harm with no redeeming medical benefit to the patient.

Some might argue that capital punishment could be reconciled with the goals of medicine and a physician's professional integrity. There are essentially three justifications argued for physician involvement in capital punishment: participation as a nonmedical act, involvement as an obligation to society, and involvement to avoid preventable suffering to the "patient" condemned to die.

The first justification proposes that physicians, when employing the specialized knowledge and tools of their profession toward capital punishment, are not practicing medicine *per se*, but rather are acting directly as agents of the state. This argument suggests that capital punishment is not a clinical transaction; therefore, physicians ought not be bound by medical ethics when acting in pursuit of such "nonclinical" ends.[16] It certainly is true that physicians may play roles in our society distinct from their professional role as doctor. However, it appears duplicitous to argue that physicians simply can step in and out of their professional roles and obligations at will while continuing to use the special knowledge and skills uniquely attributed to physicians. This argument trivializes the concept of professional integrity in which consistency and moral accountability are valued and has the potential to undermine trust in the profession. As long as physicians use the knowledge and techniques attributed to medicine, they ought to be bound by the ethical standards of the profession.

The second justification for physician involvement in capital punishment hinges on the duty of physicians to society. This duty is said to obligate physicians to act at the behest of the state without consideration of the health and welfare of the patient or population. As moral agents, however, physicians are obligated to evaluate state requests and determine whether those requests are consistent with the goals and ends of medicine. This assessment begins with the physician's primary duty to advocate for the interests of an identified patient. There are times in clinical practice when obligations to the public good may outweigh duties to individual patients. This is the classic conundrum of public health, in which obligations to the health of the general population are weighed against the civil rights of or potential harms to the sick individual. Such professional obligations of the physician (e.g., reporting individuals with certain diseases, notifying sexual contacts of affected individuals, informing authorities of intended harms to others, etc.) are examples in which the sanctity of the doctor-patient relationship is breached to prevent harms to others in society.

In contrast, in the context of capital punishment, it is much harder to quantify the proportional benefit accruing to others as a result of executing the prisoner. There is currently no evidence that capital punishment *per se* deters other potential killers.[17] In addition, society may prevent a criminal from hurting others by imposing lifetime incarceration in a secure prison facility rather than execution. Even if capital punishment were determined in the future to have a deterrent effect, involvement of a physician in such drastic and irrevocable harm cannot be justified merely because it may influence the behavior of hypothetical others at risk of becoming killers. In each of the examples in which a physician legitimately acts to discharge public health obligations while compromising duties to the patient, there are specific, identifiable persons who will be harmed if this breach in the doctor-patient relationship does not occur.

The third, and most compelling, argument for physician involvement in capital punishment seeks neither to sidestep nor to trivialize the doctor-patient relationship, but finds justification in duties owed patients by their physicians. According to this rationale, physicians must become involved in the killing of prisoners to allow them a dignified and humane death. This is thought to fall within an essential component of the physician's ethical obligations, the duty to relieve suffering of a person in an inevitable dying process. From this perspective, the condemned prisoner is equivalent to a patient in the dying process, and participation in the provision of a humane and painless death is justified because the potential for increased pain and suffering is avoided. Many prisoners subject to capital punishment might prefer the involvement of a physician to ensure the

most humane death possible. However, merely because a physician possesses the technical skill to fulfill a request does not make it an ethical pursuit.

An argument is made analogous to the involvement of physicians in torture. Here, the goal of physician participation may be to regulate the administration of punishment to ensure that it is halted before the point of killing or irreversibly maiming the victim, while at the same time ensuring the desired societal end of obtaining information. An additional example of contemporary concern is that of a physician confronted by a family about to return to a country and culture in which clitoridectomy is performed routinely on young girls. The participation by the physician in this "female circumcision" might ensure that the procedure is done aseptically and with minimum harm and suffering, assuming that it is inevitable that such mutilation will occur. In both of these cases, although physician participation might be rationalized on humanitarian grounds, the physician's professional integrity ought to preclude participation. The infliction of direct harm or mutilation of healthy persons without medical benefit, regardless of intent and societal goals, is not a part of the ethical practice of medicine and should not be condoned by a medical practitioner.[18]

An additional complication in the discussion of physician involvement in capital punishment comes in the event that a prisoner wishes to die and requests physician involvement in hastening death. This request might be analogized to a suffering patient who requests euthanasia or assistance in suicide. Many have argued that physician involvement in assisted suicide or euthanasia may be ethical, even though illegal, under certain circumstances.[19] Why then should physician involvement in assisting the death of a consenting prisoner be found unethical even though legal? In examining this seeming paradox, the question of the voluntary nature of the request must be raised. The inherently coercive nature of the request by the prisoner is far different from the possibility of coercion in the request of the dying patient for assistance in hastening death.

Much of the argument opposing physician involvement in assisted suicide revolves around the obligations of physicians to alleviate the predisposing factors that result in the request. Thus, the field of palliative care and concern about pain and symptom management, as well as the provision of psychosocial services to suffering patients, has grown and developed in part in an attempt to decrease requests for physician involvement in assisted suicide. This has not altered the basic argument about the ethicality of physician involvement in hastening death, but it does point out the importance of the obligation to create an environment in which the choice for death is uncoerced and, to the greatest extent possible, voluntary. A request by a prisoner for physician assistance in death by capital

punishment is coercive inherently and ought not to be confused with a voluntary choice among reasonable options.

If there is a powerful argument against the direct involvement of physicians in capital punishment, a more difficult quandary is faced by psychiatrists asked to treat death row prisoners who become mentally ill while awaiting execution. A significant number of inmates awaiting execution manifest psychotic symptoms and mental incapacity[20]; thus, according to long-standing legal tradition, the inmates become ineligible for execution. However, if the psychiatric condition abates after treatment, the prisoner again may become eligible for execution. Under Maryland law, if a death row inmate becomes incompetent due to mental illness and requires treatment, the sentence is commuted to life imprisonment without parole.[21] However, in any jurisdiction where such a law does not exist, the psychiatrist is in the unenviable and difficult position of choosing whether or not to treat a suffering psychotic prisoner whose mental health might be enhanced, thereby facilitating execution. Choosing not to treat such a patient involves abandoning important ethical standards in medicine.[22]

It is inappropriate for the state to place psychiatrists in such an untenable position. Laws similar to the Maryland statute should be in effect universally so that the condemned receive life imprisonment with no parole if they become psychotic and mentally incompetent. Until such laws exist, psychiatrists ought not provide treatment specifically to re-establish competence so that a prisoner may be executed.

Finally, we must consider the potential societal consequences if physicians do choose to participate in capital punishment. Using medical knowledge and skills to participate in the killing of an otherwise healthy individual is not merely an abdication of professional responsibility, but also is an assault on the foundation of trust that undergirds medical practice and makes it possible. A physician approaches a patient not merely as a skilled technician, but also as a representative of a profession dedicated to the welfare of that patient. For this reason, violations of professional integrity have far-reaching consequences in society. In the profession of medicine, in which the power to heal is entwined intimately with the power to harm, trust in the doctor is critical. Without the trust of individual patients, as well as societal confidence in the profession in general, the therapeutic potential of medicine is limited dramatically. Ironically, certain states require that physicians who participate in capital punishment remain anonymous, thus affirming publicly that physician involvement is acceptable, while insulating individual physicians from public and professional accountability.

Violating professional integrity in the area of participation in capital punish-

ment might be seen as a trivial transgression of medical ethics by some, but we believe it ought to be viewed as major erosion of the foundation of medicine. In this regard, it is important to raise the question: What should the consequences be for participation in capital punishment by individual physicians in light of the general agreement by virtually all professional organizations and societies that it is unethical? We believe it is important for professional groups and medical societies to impose sanctions on members who participate in capital punishment, while these organizations work to support legislation prohibiting physician involvement in execution. Many in medicine have complained about legislative and regulatory efforts that have an impact on medical practice, yet are rightfully criticized for being unwilling to regulate practice effectively. If organized medicine believes that certain practices are unethical and counter to professional integrity, then it is the obligation of those in the profession to censure its members for participation in such activities. It is time that medical organizations both define professional ethical boundaries and stand prepared to criticize members who stray beyond these borders.

REFERENCES

1. Herbert B. Death penalty dilemma. *New York Times Week in Review.* January 4, 1998: 11.
2. American College of Physicians, Humans Rights Watch, and National Coalition to Abolish the Death Penalty. Breach of trust: physician participation in executions in the United States. Chicago: American College of Physicians; 1994.
3. American Public Health Association. Participation of health professionals in capital punishment. *Nation's Health.* 1985;15(9):20.
4. Rosner F, Halpern AL, Kark PR, et al. Physician involvement in capital punishment. *NY State J Med.* 1991;91:15–28.
5. American College of Physicians Ethics Manual, third edition. *Ann Intern Med.* 1992; 117:947–960.
6. American Medical Association, Council on Ethical and Judicial Affairs. Physician participation in capital punishment. *JAMA.* 1993;270:365–368.
7. American Psychiatric Association. *The Principles of Medical Ethics, with Annotations Especially Applicable to Psychiatry.* Washington, DC: American Psychiatric Association; 1992.
8. *Standards for Health Services in Prisons.* Chicago, IL: National Commission on Correctional Health Care; 1992:10.
9. New York Academy of Medicine. *Statement of the New York Academy of Medicine: Physician Involvement in Capital Punishment.* New York, NY: New York Academy of Medicine; March 1996.
10. American Medical Association, Council on Ethical and Judicial Affairs. *Code of Medical Ethics.* Chicago, IL: American Medical Association; 1997.
11. Mechanic D. Changing medical organization and the erosion of trust. *Milbank Q.* 1996; 2:171–189.
12. Angell M. The doctor as double agent. *Kennedy Inst Ethics J.* 1993;3:279–286.
13. Blustein J, Fleischman AR. Abortion and the pro-life maternal fetal medicine physician: a problem of integrity. *Hastings Cent Rep.* 1996;25:22–26.

14. Callahan D. The goals of medicine: setting new priorities. *Hastings Cent Rep.* 1996; 26(suppl):S1–S27.
15. Blustein J. Doing what the patient orders: maintaining integrity in the doctor-patient relationship. *Bioethics.* 1993;7:289–314.
16. Applebaum P. The parable of the forensic psychiatrist: ethics and the problem of doing harm. *Int J Law Psychiatry.* 1990;249:252–254.
17. Radlet M, Allers R. Deterrence and the death penalty: the view of experts. *J Criminal Law Criminol.* 1996;87:1.
18. Council on Scientific Affairs, American Medical Association. Female genital mutilation. *JAMA.* 1995;274:1714–1716.
19. Coleman CH, Fleischman AR. Guidelines for physician-assisted suicide: can the challenge be met? *J Law Med Ethics.* 1996;24:5–12.
20. Bonnie RJ. Healing-killing conflicts: medical ethics and the death penalty. *Hastings Cent Rep.* 1990;20:12–18.
21. Maryland Code Article 27, §75A (1987).
22. Freedman AM, Halpern AL. Psychiatrists and the death penalty: some ethical dilemmas. *Curr Opin Psychiatry.* 1998;11:1–15.