

Volume 2 | Number 1 (Spring/Summer 2016)

[www.jheonline.org](http://www.jheonline.org)

ISSN 2474-2309

doi:10.22461/jhea.4.7169



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**CASE STUDY**

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**COMMENTARY**

# First Do No Harm

KATE PAYNE, RN, JD & CINDY MACLEAN, JD

**Keywords:** *Dr. R is a well-respected and trusted physician by the inmates he cares for in a correctional setting. He has been instructed by the warden, his employer, to assist in various aspects of lethal injection executions carried out at the prison. Dr. R does not administer the lethal drugs but monitors the process, and has on occasion, helped by ordering additional drugs if the inmate's heart appears not to have stopped or has provided intravenous access when another health professional was unable. This commentary will address legal questions raised by Dr. R's or any other health care professional's participation in executions.*

**Keywords:** *death penalty, lethal injection, physician involvement, Eighth Amendment, execution methods, code of ethics*

## LEGAL COMMENTARY

It is difficult if not impossible to untangle the legal questions from the ethical ones in Dr. R's situation. One thing is certain: Dr. R may have been placed in an untenable position by his employer depending on his views about physician participation in executions. There is a direct conflict between his calling to provide compassionate care for the sick with the state's demand that he participate in the execution of men and women who have been his patients.

Is it legal for him to participate? Is it ethical? If the answer to either is yes, what can or can't he do? If the answer is no, is that the end of it? There are few other areas where the law and ethics collide so directly as with the involvement of physicians or other healthcare professionals in executions. It's a paradox on many levels. The death penalty consistently has been found to be legal—constitutional—despite continued challenges. One can support the death penalty but oppose any or all participation of healthcare professionals in executions.

Many human rights organizations, as well as many individual physicians, oppose the death penalty and actively seek its abolition, but insist that as long as it occurs, the method used must cause the "least possible pain and suffering of the inmate."<sup>1</sup> One could find both opponents and supporters of the death penalty making this argument, a paradox indeed. Like Dr. R, health care professionals have long cared for inmate populations, but it is impossible to determine how many have participated in executing their former patients. Doctors are reluctant to publicize their participation for fear of professional sanctions or legal action.<sup>2</sup> Almost all medical and nursing associations oppose their members' participation in executions. The list includes the Society for Correctional Physicians, whose code of ethics has a very specific prohibition that correctional physicians "Not be involved in any aspect of execution of the death penalty."<sup>3</sup>

Prior to the introduction of lethal injection in the late 1970's, physician participation in the state-sponsored executions was mostly limited to certifying the death of the prisoner. Over time, state legislatures changed their execution methods from hanging and firing squads to the gas chamber and electrocution, claiming they were making the death penalty more humane with each

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<sup>1</sup> "Human Rights Watch. So Long as they die: lethal injections in the United States," April 2006 accessed June 1, 2009, <http://hrw.org/reports/2006/us0406>.

<sup>2</sup> Gawande A. "When law and ethics collide — why physicians participate in executions," *New England Journal of Medicine* 354 (2006):1221-9.

<sup>3</sup> Society for Correctional Physicians, *Code of Ethics*.

step. As each method was found to be constitutionally inadequate on grounds of cruel and unusual punishment, such changes appeared to be prompted more by states' attempts to preserve the death penalty than by humanitarian concerns.<sup>4</sup>

Lethal injection looked like a valid constitutional option, with an intravenous cocktail designed to anesthetize the inmate with a short acting barbiturate, followed by a neuromuscular blocking agent to paralyze the diaphragm and stop breathing, and topped off with potassium chloride to interfere with electrical function at the cellular level, creating a fatal heart attack. The inmate appeared to die peacefully, since the neuromuscular blocking agent paralyzes not only the breathing muscles but all other skeletal muscles, including the eyes.

In the early part of this decade, courts began to hear evidence that inmates actually may suffer excruciating pain when the barbiturate is ineffective, leaving him fully aware of the burning pain and cardiac effects of the potassium chloride while unable to respond or communicate.<sup>5</sup> Since the entire execution process had become medicalized with the introduction of IVs, heavy narcotics and anesthesia, states found it necessary to request professional help, and thus the instant controversy. Further evidence emerged that some of the states' protocols, particularly the use of paralyzing agents, was absolutely forbidden in euthanizing domestic animals. All this led to constitutional challenges to lethal injection protocols in several states.<sup>6</sup>

The righteous tension between state governments and medical associations on the subject of physician participation in state-sponsored executions cannot be underestimated either. The state has an obligation to the public to ensure that capital punishment is both certain and free from unnecessary suffering, and it is reasonable from that standpoint to call for professional assistance with lethal injection. Only a licensed physician can order barbiturates, paralyzing agents and potassium from a pharmacy. Further, professional competence is required to perform minor surgical procedures like cut-downs to get the drugs flowing and to monitor vital signs once the lethal cocktail commences.

Like the state, medical associations have parallel but equally weighty obligations to the public to ensure that its membership can be counted upon to provide care to patients consistent with current standards as well as time-honored traditions of compassion and trust. On this ground, Dr. R could refuse to participate because to do so would present both a breach of trust and a real conflict of interest. He has engendered the trust of the inmate population, not as one who assists in their deaths but rather as someone with a long history of enhancing the quality of their lives.

Consistently, medical societies have found that assisting with executions is a violation of medical ethics, and a few state associations have proposed sanctions for participating physicians. In a case that highlights the competing interests at stake when executions are medicalized, the North Carolina Supreme Court held that the state medical board overstepped its authority by threatening to discipline physicians who participated in the death penalty.<sup>7</sup> Some courts have ruled that a physician must participate. In California and Florida, physicians have simply refused, temporarily leaving the capital punishment system in limbo. Adding to the chaos, the U.S. Supreme Court has affirmed that physicians and nurses, including those that work in prisons, have a right to refuse to participate in executions in any way.<sup>8</sup>

The argument that a physician, in the role of compassionate caregiver, may choose to relieve an inmate's suffering by participating in execution ignores the crucial role of professionalism in the public interest. Some have argued that, legally and ethically, physicians need to participate in executions. Death, they argue, is not the only issue.<sup>9</sup> Dr. R, with his existing relationship with his patients, may feel a profound need to see them through to the end, to make sure their suffering is minimal. Given the number of stories about botched executions, some even argue that medicine should take control of the death penalty and develop a more robust protocol.

The difficulty with this argument is that society awards special status to the professions and to physicians in particular, on the condition that members of the profession adhere to certain well-established standards of care and codes of conduct. Physicians have traditionally been counted upon to be healers, to enhance the quality of their patients' lives; in addition, they have been trusted not to kill. The public's reliance on adherence to these traditions makes professional integrity a significant public interest. An important component of the public trust is the assurance that the profession itself will remain free from political influence. But where medical professionals participate in lethal injection, the state effectively co-opts the profession to carry out a political act.

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<sup>4</sup> Denno D. "When Legislatures Delegate Death: The Troubling Paradox Behind State Uses of Electrocution and Lethal Injection and What it Says About Us," *Ohio State Law Journal* 63 (2002): 63-103.

<sup>5</sup> Koniaris LG, Zimmers TA, Lubarsky DA, and Sheldon JP. "Inadequate anesthesia in lethal injection for execution," *The Lancet* 365 (2005):1412-4.

<sup>6</sup> A Liptak, "Critics Say Execution Drug May Hide Suffering," *The New York Times*, October 7, 2003, Page A 1.

<sup>7</sup> North Carolina Department of Correction v. North Carolina Medical Board, 363 NC 189 (2009).

<sup>8</sup> "When Legislatures Delegate Death," 63-103.

<sup>9</sup> D Waisel, "Physician participation in capital punishment," *Mayo Clinic Proceedings*, 82 (2007):1073-80.

The government can be viewed as appropriating the imprimatur of the medical profession by engaging physicians in executions, thus thwarting the public interest in upholding the ethics of the profession. In this case, the argument goes, the warden is attempting to make Dr. R a tool of the state, leading to a loss of public trust, a “violation of medical ethics....to put their medical skills at the service of the state to facilitate the commission of crimes against humanity.”<sup>10</sup>

In an effort to circumvent codes of medical ethics, some state legislatures and courts have held that a doctor’s participation in lethal injection is not the practice of medicine. If this feels like a ham-fisted solution to a highly nuanced dilemma, it is, for both practical and moral reasons. First, it is virtually impossible to untangle the various acts from their professional roots. Execution procedures in states with these laws demand the professional competence of a licensed physician while denying that the services are medical in nature. Even the execution manuals have a hard time parsing out professional obligations from the reality of the situation: they often require swabbing the lethal injection site with alcohol to prevent infection prior to the insertion of the IV line. If this weren’t so serious, it would be ridiculous: there is virtually no chance the condemned inmate will suffer the effects of an infected IV site.

The moral problem with these laws is one of human dignity: they dehumanize the person on the receiving end of the medical services. According to them, common medical procedures—starting IVs, delivering drugs and monitoring their effectiveness—are not the practice of medicine if used on those who are less than human. While these laws may be legally sufficient to sanitize the participation of physicians in executions, they remain morally repugnant because they deny the intrinsic human worth of the condemned inmate.

In the seminal U.S. Supreme Court case on capital punishment, *Furman v. Georgia* Justice Brennan said, “At bottom, then, the Cruel and Unusual Punishments Clause prohibits the infliction of uncivilized and inhuman punishments. The State, even as it punishes, must treat its members with respect for their intrinsic worth as human beings. A punishment is ‘cruel and unusual,’ therefore, if it does not comport with human dignity... The true significance of these punishments is that they treat members of the human race as nonhumans, as objects to be toyed with and discarded. They are thus inconsistent with the fundamental premise of the Clause [the Cruel and Unusual Punishments Clause] that even the vilest criminal remains a human being possessed of common human dignity.”<sup>11</sup>

In the final analysis, the answer to Dr. R’s participation seems to depend on what one believes of the value of professional codes of ethics, of his membership in the profession, of human dignity, and of the death penalty. State legislatures have the constitutional authority to execute prisoners by lethal injection, and physicians have the legal freedom to participate or not. Such participation serves the state’s interests in reliability and certainty, and it serves to reduce an inmate’s suffering, both physical and existential. On the other hand, participation in executions breaches the public trust that physicians will abide by their professional codes of medical ethics. While undoubtedly a violation of medical ethics, each physician is free to determine if participating in executions is consistent with his or her own personal code of conduct.

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<sup>10</sup> GJ Annas, “Toxic tinkering — Lethal-injection execution and the Constitution,” *New England Journal of Medicine*, 359 (2008):1512-18

<sup>11</sup> *Furman v. Georgia*, 408 U.S. 269 (1972).