PHYSICIAN, DO YOUR DUTY: THE OBLIGATIONS OF PHYSICIANS IN STATE EXECUTIONS

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Abstract

The most common arguments for and against physician participation in state executions focus on the duty of the physician. This article evaluates these arguments using Kant's duty-based approach to ethical decision-making. It will show that all of the prevailing arguments end in a philosophical stalemate. I will further argue that it is past time for physicians to turn the question around and demand a more substantive discussion about the duty-based roles of every member of society in the application of criminal justice.

Michael Morales was sentenced to death in 1983 for the premeditated rape, torture, and murder of 17-year old Terri Winchell (*People v. Morales, 1989*). Twenty-five years passed before Morales was finally scheduled for execution, which would have taken place on February 21, 2006, save for a successful appeal. A week before Morales was scheduled to die, his legal team convinced a judge that the State of California's lethal injection protocols could subject Morales to cruel and unusual punishment (*Morales v. Hickman, 2006a*).

At the time, the standard protocol for lethal injections in California was a three-tiered process that began with the anesthetic sodium thiopental to render the inmate unconscious, followed by pancuronium bromide to paralyze the inmate and halt breathing, and finally a lethal dose of potassium chloride to induce cardiac arrest (Schwarzenegger and Tilton, 2007, p. 1)[1]. Morales' legal team argued that if the initial dose of anesthetic did not sufficiently induce unconsciousness, Morales could be awake during the two final phases of the procedure. This would mean he could experience suffocation from the paralytic agent and extreme pain from the potassium chloride. Execution logs indeed showed that in six out of the previous eight executions at San Quentin State Penitentiary the initial dose of anesthetic was not adequately administered (*Morales v. Hickman, 2006a*).

Rather than stopping Morales' execution, however, the judge ordered that the state either needed to switch to a single-drug protocol, or to secure a physician's presence to ensure that the procedure was properly performed (*Morales v. Hickman, 2006a*).

[1] California subsequently amended its protocol to a single-drug method but never resumed executions because of ongoing legal challenges (California Department of Corrections and Rehabilitation, 2019). In 2019, Governor Gavin Newsom suspended the death penalty in the state on moral grounds (Egelko & Koseff, 2019).

The court would later require the physician to step in and personally administer the drugs if the prisoner was conscious or in pain (*Morales v. Hickman, 2006b)*. No physician would agree. The State of California has not executed a prisoner since.

The success of Morales' appeal triggered something of a crisis within both the United States penal system and in American medicine. Two questions emerged: Is lethal injection truly a more humane way to kill death row inmates, and what duty, if any, do physicians have to participate in state sponsored executions? This article will focus on the second question, though it bears mentioning that two death row inmates in Tennessee recently chose to die via the electric chair rather than risk the possibility of suffocation and pain posed by lethal injection (Associated Press, 2018).

I will limit my investigation to Kant's duty-based model as applied to the role of physicians in society. Because state sponsored executions themselves are the subject of ethical debate, the first section of this article will tackle the morality of the death penalty. I will then present the dueling arguments for and against physician participation, and will conclude by arguing that the role-specific duties of the physician fail to provide an adequate answer because we have not yet settled the question of whether the death penalty itself is ethical.

Duty and the Death Penalty

For better or worse, the United States remains one of the only developed countries in the world that still utilizes the death penalty (Smith, 2018). When it comes to physician participation in these executions several authors, including Waisel (2007), Nelson & Ashby (2011), and even the American Medical Association (1993), choose to separate the question of capital punishment's morality from the question of whether physicians should participate in it. As a general principle, I don't think any argument for or against participation in an activity is valid without first evaluating whether the activity itself is moral. If capital punishment *is not* moral then no one should participate in it, including judges, juries, physicians, and corrections officers. Whereas if capital punishment *is* moral then we need only evaluate whether it is within the role-specific duties of a physician to participate.

Since most arguments regarding the physician's role in the death chamber center on duty, it is reasonable to begin by investigating what the world's most dominant deontologist, Immanuel Kant, thought of capital punishment. He was, in short, very much for it. In *The Metaphysics of Morals*, Kant (1996) claims that the "principle of equality" demands a life for a life and that "there is no substitute that will satisfy justice" other than to kill a killer (p. 474). He believed that capital punishment was moral because he conceived of criminals as rational beings who choose to treat people badly. The criminal's "own evil deed draws the punishment upon himself," he said (Rachels, 2007).

Let us set aside the fact that modern neuroscience is casting doubt on the notion that violent criminals are always acting rationally (Presidential Commission, 2015), and allow that many criminals are indeed in full control of themselves when they commit their crimes. Rachels (2007) encapsulates Kant's argument concerning these fully rational people thus: "by treating others violently the criminal has chosen as her/his categorial imperative that *everyone* ought to be treated violently" (p. 139). Therefore, visiting violence upon the criminal comports with her/his own conception of how she/he wants to be treated (Rachels, 2007, p. 139).

This would seem to point us in the direction of accepting capital punishment as a morally acceptable act. Yet, I think there is a strong case to be made that Kant's conclusions are both impractical and conflict with his own philosophy. To the first point, a stable society of more than 300 million people cannot jump in and out of other people's categorial imperatives every time it needs to decide what to do in response to crime. On the second point, capital punishment is contrary to the duties Kant (2002) claims all human beings owe to themselves and others.

Kant (2002) specifically outlines four duties. First, we must treat *ourselves* as ends and never as means (p. 47). Second, we must treat *other people* as ends, never merely as means (p. 48). Third, it is not enough to simply refrain from actions that treat people as means, we must be proactive in our efforts to honor humanity as an end (p. 48). Finally, we must aspire to further the ends of others, since their ends and our ends are one and the same (p. 48).

It is, of course, reasonable to conclude that a murderer has committed the great Kantian sin of treating another person as a means rather than an end. The means may be revenge or spite or just the sheer sick pleasure of killing. However, that the murderer has used another person as a means does not free the rest of us (even those of us acting under the guise of the state) to do likewise. The murderer is still a human being, if a vile and dangerous one. To take the murderer's life treats him/her as a means – a means to satisfy justice – which is prohibited under Kantian ethics.

So, what are we to do? Kant's (2002) categorical imperative compels us to act in a way that honors our duties to self and others and is applicable universally in every circumstance (p. 37). Can we satisfy justice without treating a murderer as a means to an end? Yes, I think we can. One option is to incarcerate murderers so that they can no longer harm others, followed by proactively working to rehabilitate them. We may not always succeed in the second endeavor, and the murderer may never be set free from her/his imprisonment, but we will have acted in a way that seeks to harmonize with humanity as an end rather than as a means.

Morality and Duty in an Immoral World

That I can make a case for the inherent immorality of capital punishment under Kantian ethics does little to change the situation faced by physicians living in the United States today. The death penalty is both legal and popular here. Fully 54 percent of Americans favor the death penalty for people convicted of murder (Oliphant, 2018), and thirty-one states make use of it in their criminal proceedings (DPIC, 2018). All of them rely on lethal injection almost exclusively.

Lethal injection requires the insertion of a catheter into a prisoner's veins and administering between one and three different drugs to induce unconsciousness and death. It comes as no surprise that a physician's presence is highly sought after for these procedures. By virtue of their training and regular practice, physicians are more skilled and therefore less likely to make a mistake than a correctional officer. From the perspective of the state, the physician's presence at an execution helps ensure that the process goes smoothly and does not violate the Constitutional prohibition against cruel and unusual punishment (*Baze v. Rees, 2008*). But just because physicians are skilled at inserting intravenous lines doesn't automatically mean that they should be involved in executions. A series of arguments flow in both directions, and as I will show in the next section, these arguments all neutralize each other.

A Duty to Heal vs Not Harm

The most common argument against physician participation in state sponsored executions is that the physician has a duty to heal. *Beneficence* has been a binding ethical force for physicians since it was first codified in the Belmont Report (National Commission, 1978). Opponents of physician participation in executions argue that the purposeful killing of another person as a punishment is anathema to the physician's duty to use her/his skills for healing. As a result, nearly every professional medical association has forbidden physician participation in state sponsored executions, including the American Medical Association (1993) and the American Board of Anesthesiology (2014). The American Medical Association (n.d.) even goes so far as to prohibit physicians from monitoring vital signs or consulting with lethal injection personnel.

The physician's duty to heal is indeed a strong argument against participation in executions. Yet, this argument has not carried the day. In the case of lethal injection, the principle of *beneficence* comes into conflict with the principle of *non-maleficence*. Most often translated as "do no harm," non-maleficence can just as often mean "don't make it worse." Physicians are faced with untenable situations all the time, especially with their end-of-life patients. If a physician is unable to heal, they are obligated to provide comfort care. They have a duty to not make a bad situation worse.

Prisoners sentenced to death are undoubtedly in a bad situation. What makes their situation potentially worse is that they may indeed suffer unbearable pain if the placement of the intravenous lines or the delivery of the lethal drugs is performed in error. Baum (2001) has shown extensive evidence that lethal injections are regularly botched (pp. 64-65). As recently as 2006, an execution team in Florida pushed catheter needles through the veins of an inmate's arms and into the underlying tissue (Crair, 2014). The photographic evidence of the error is alarming (Crair, 2014). Because of cases like this, some physicians have concluded that they have an obligation under the principle of non-maleficence to ensure that no one suffers that kind of agony needlessly. Waisel (2007), for example, believes that forbidding physician participation is cruel, stating that participation "in a horrible detail to benefit another person is true altruism" (pp. 1078-1079).

That a physician has the skills necessary to ensure a painless death does not free that physician from his/her duty to be a healer, however. Just as the argument against physician participation on the grounds of beneficence met with opposition on the grounds of non-maleficence, so too does non-maleficence's power as an argument get canceled out by the principle of beneficence. These two role-specific duties of the physician are equally at odds with each other.

Medicalizing Death vs. It's Not Medicine

Another common argument against physician involvement in executions is that the physician's presence lends medical legitimacy to the act of killing. The physician's presence, combined with the medical processes employed, effectively normalizes executions. Gawande (2006), for example, observed that lethal injection only became the execution method of choice "because it borrowed from established anesthesia techniques [and] made execution like familiar medical procedures rather than the grisly, backlash-inducing spectacle it had become" (p. 1222). Truog, Cohen, & Rockoff (2014) agree, calling it "an attempt to cover the procedure with a patina of respectability and compassion that is associated with the practice of medicine" (p. 2375).

This argument has merit in large part because it's true. The lethal injection protocol was developed by a physician, Dr. A. Jay Chapman, in 1977 as a painless and speedy means of execution (Denno, 2007). The first instance of its use came in 1982, when Texas used the procedure to kill Charlie Brooks Jr. (Anderson, 1982). Two physicians were present in the execution chamber, which *Time Magazine* described as filled with "medical paraphernalia – intravenous tubes a cot on wheels and a curtain for privacy" and concluded that "the well-lighted cubicle might have been a hospital room" (Anderson, 1982). The headline for that *Time Magazine* piece was "A more 'palatable' way of killing" (Anderson, 1982).

The counterargument to this position is that lethal injection isn't a medical procedure at all. Those espousing this position point to medical associations' own words to prove their case. For example, in its opposition The American College of Physicians (1994) wrote that "execution is not a medical procedure and is not within the scope of medical practice" (p. 3). Truog and Brennan (1993) also state that execution of prisoners "lies far outside the medical sphere" (p. 1348).

Even Jay Chapman, the father of the lethal injection protocol, said he "would have no hesitation to participate in a judicial execution" because the act "cannot reasonably be construed to be the practice of medicine" (as cited in Denno, 2007, p. 69).

This perspective has led some advocates to conclude that since it's not a medical procedure, a physician would not be acting in a medical capacity by participating. Litton (2013), for example, points out that physicians are not acting in the role of physicians every moment of every day. When they go to the bank or take their kids to school they are not acting as physicians. Hence, the ethical principles that restrict their actions in the clinical setting are not operative while they are acting in other roles. Other ethical standards may still be applicable, of course, such as not stealing from the bank or not running a red light. But where lethal injection is concerned, if it's not a medical procedure then the code of conduct specific to a physician's role in the operating room are separate from her/his role in the death chamber.

Here again the arguments have neutralized each other. While executing prisoners is not within the realm of medicine, the means by which the state currently achieves its goals, lethal injection, very much is. The lethal injection procedure was developed by a physician, it uses the tools of medicine (such as catheters and barbiturates that are not used in any sphere outside of medicine), and it requires or solicits the assistance of those most likely to possess the *medical* skills and knowledge needed to safely administer it: physicians. So, we have a dichotomy in which the procedure is not strictly "medicine" on the one hand, because it kills rather than heals. On the other hand, it is dishonest to suggest that a physician's role in the death chamber is for anything other than to apply her/his medical expertise.

The Physician as Means vs. The Prisoner as Patient

The exclusive use of "medicalized" executions and the accompanying requirements for physicians to be present during the procedure calls into question whether physicians are being used as means rather than ends in themselves. The duty-based ethics of Kant (2002) forbids ever using a person merely as means to an end (p. 48). Gawande (2006) argues that "the medical assistance provided primarily serves the government purposes – not the inmate's needs as a patient" (p. 1229). Truog & Brennan (1993) likewise claim that it "prostitut[es] medical knowledge and skills to serve the purposes of the state and its criminal justice system" (p. 1348).

Yet, physicians conduct themselves in ways that advance the state's interests all the time. For example, when they report infectious diseases or elder abuse. A pure Kantian analysis might label these activities as immoral as well. What is relevant here is Kant's (2002) declaration that the "end" of human beings is their own happiness (p. 48). From a duty-based standpoint, we must ask whether the physician's participation in the execution chamber serves her/his own happiness, the happiness of the prisoner, and the overall happiness of humanity. It would be very difficult to argue compellingly that it does any of those things. Present evidence suggests that the physicians who participate in executions do so not out of a sense of professional or personal fulfillment, but because they felt obligated to do so (Gawande, 2006). Likewise, it is difficult to find evidence that prisoners are happier for having been executed, despite the rare occasion that a prisoner consents to his/her own execution (Nelson & Ashby, 2011, p. 32). As for humanity, the farthest we could go is to say that there may be a sense of relief that a violent criminal is dead, as well as some closure for the victim's family. To argue that executing prisoners contributes to the happiness of those involved or to the happiness of humanity would require a great deal more evidence than is currently available.

Counterbalancing the argument that executions use physicians as a means are advocates like Kenneth Baum (2001) who argue that people sentenced to death are no different from other terminally ill patients in need of a physician' care (p. 61). The patient (or prisoner) is at the end of his/her life, so the argument goes, and the physician can help ease their passing. This position is also held by Dr. Carlo Musso, who has participated in lethal injection executions, and who reasoned that "instead of dying from a carcinoma, the patient is dying from a court order" (Knapp, 2017).

This argument is admittedly weak, and it is so for three reasons. First, cancer is not willfully imposed upon a person as a form of punishment, whereas capital punishment is exactly that. Second, the cause of a cancer patient's death is still cancer, even if a physician removes life-sustaining treatment to allow the course of death to proceed unhindered. The cause of death for the prisoner is the lethal cocktail of drugs that are pushed into her/his veins for the sole purpose of ending her/his life. Third, at any time we may choose of our own volition to not execute a prisoner. We cannot at any time simply choose to not have cancer.

Conclusion

What I have sought to show in this article is that the arguments for and against physician participation in executions all end in a philosophical stalemate. Beneficence prohibits participation while non-maleficence requires it. Lethal injection medicalizes executions, yet executions aren't medicine. Prisoners need to be cared for at the end of life, yet the end of the prisoner's life is not something a physician treats so much as she/he facilitates.

The role specific duties of the physician do not clear an ethical path for their participation in state executions. As I noted earlier, if executing criminals is moral then it doesn't matter who participates. Anyone could be an executioner and feel just fine about it. The very fact that there is a question about whether physicians ought to participate suggests that there is something amiss with our conception of the death penalty.

If the arguments about the death penalty are going to come down to duty, then we must apply that duty universally. It cannot just be physicians who are subject to moral law. Our obligations to treat people as ends and never merely as means are *a priori* binding. Killing a person as recompense for their act of killing may feel morally righteous, but it is still treating them as a means. The means in this case is justice, and as I argued in the first section of this paper, there are other ways to both meet the needs of justice and still treat the criminal person as an end.

Physicians have been thrust into a debate that isn't their sole burden to bear. The question about whether physicians should participate in state-sponsored executions presumes that the death penalty is a) morally acceptable and/or b) inevitable. By continuing to accept the premise of the question, physicians are doomed to an endless point-counterpoint debate that doesn't adequately guide them in any direction. It seems past time for physicians, and by extension physician associations, to turn the question around and call for a higher level of public discourse about the role-specific duties of every person in the application of criminal justice.

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