UNWILLING EXECUTIONERS?

Where and why do some doctors still help carry out the death penalty? Sophie Arie reports

Lethal injection is now the main method of execution in China and the United States, the two countries that execute the highest numbers of people. But the widespread use of lethal injection—seen as a medical and therefore more humane method of execution than hanging, shooting, or electrocution—has meant that doctors have become more actively involved in carrying out the death penalty than they were in the past.

The medicalisation of executions has put doctors in an extremely difficult position. While in principle assisting in the killing of a person (whether legal or not) goes against the ethics of their profession, many decide, for religious or political reasons, that it is better to participate than not.

“With lethal injection, doctors moved into centre stage,” says Dr James Welsh, researcher and adviser at Amnesty International’s UK office. “Doctors had to think more about whether that’s what they went into medicine to do.”

Doctors’ involvement in the United States

In America, some 34 states currently allow the death penalty and over 80% of those use lethal injection. All except Kentucky state either require or permit doctors’ participation in executions (www.deathpenaltyinfo.org/documents/FactSheet.pdf). State authorities go to some lengths to protect the identity of medical staff, who can be involved in different ways, from anaesthetising, injecting, and finding veins, to pronouncing and certifying death. Usually their participation is kept anonymous and they are often paid in cash.

Professional bodies such as the American Medical Association and the American College of Physicians have taken a common position since the early 1980s, when lethal injections were first used in the United States, against the involvement of doctors in carrying out the death penalty. “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 authorised execution,” say the AMA guidelines.

The AMA formally bans its 240 000 members from participating, including even pronouncing death, because the doctor would not be allowed to revive the prisoner if he or she was found to be still alive. It only acknowledges that a doctor can provide sedatives at the request of the prisoner before the execution and certify death afterwards.

In 2009, death penalty opponent Sister Helen Prejean, known for her book Dead Man Walking, began campaigning for medical boards to discipline doctors who participate in executions, believing this could ultimately make lethal injection no longer a feasible option for states. But when medical bodies have attempted to strike off or discipline physicians who have participated in executions, they have been overruled by courts in the states concerned.

Some states, such as Georgia and North Carolina, have won legal protection for doctors who participate by arguing that they are not practising medicine, just using their knowledge and skills, and therefore cannot be disciplined by medical bodies.

Medical bodies find themselves caught between the values of their profession and the values of their society. While the American College of Physicians is keen to make known its ethical objections, it and other bodies are careful not to enter into the political debate. Only the International Council of Nurses in the United States formally opposes the death penalty itself.

“The US bodies have focused on the ethical debate. But there is still something of a silence about the death penalty itself,” says Dr Welsh. “At the moment it’s a game of ping pong between the state and the US bodies.”

Are doctors willing?

In some cases, doctors have refused to cooperate when asked by a state, but one of the few surveys asking physicians for their opinion on the issue suggested that many strongly support the death penalty and the involvement of doctors in executions. A survey published in 2000 by the Archives of Internal Medicine (2000;160:2912-6) found that only 20% of over 500 physicians objected to any kind of involvement of medical professionals in executions. Some supported doctors carrying out lethal injections themselves and most supported medical staff support for a non-medical execution team.

Reasons for the doctors’ willingness to participate range from religious and political beliefs to the idea that it is important to try to minimise the suffering of convicts right up to their time of death.

Many participating doctors are prison doctors or are in practices that develop some kind of connection to their local prisons. In a rare report, in 2006, Dr Atul Gawande, American surgeon and writer, gathered testimonials from some participating doctors. Dr Carlo Musso, an emergency doctor, confirmed that his practice had taken up an $18 000 contract (£11 000, €13 000) to provide a medical presence at executions in Georgia. He provided cardiac monitoring and determination of death. Other colleagues helped with intravenous access. “As I see it this is an end of life issue, just as with any other terminal disease. It just happens that it involves a legal process instead of a medical process,” said Dr Musso. He said he donated part of the proceeds of the work to a street children’s shelter.

Little is known about the level of training given to non-medical staff who carry out lethal injections, but there have been numerous reports of botched executions in which the team has been slow to find a vein (often prisoners are overweight or are drug users), excessive doses of drugs have been used, or individuals have had adverse reactions and suffered for up to half an hour before finally dying.

Since 2006 a wave of court cases has exposed shocking practices that led to protracted pain for the convict. One case, that of Michael Morales in California, in 2007, in which two anaesthetists refused at the last minute to participate, highlighted the fact that non-medical execution staff were often failing to anaesthetise prisoners correctly at the beginning of the three-drug lethal injection procedure. This meant that prisoners remained conscious but unable to signal their pain when the lethal muscle paralysing drug pancuronium bromide was injected. Judge Jeremy Fogel ruled that the risk of this happening made the whole procedure unconstitutional. He also later found that the state’s execution teams “almost uniformly have no knowledge of the nature or properties of the drugs that are used or the risks or potential problems associated with the procedure.” The case gave new impetus to those who argue that lethal injection goes against the American constitution and forced several states to revise their protocols. But it also strengthened the argument that medical professionals should be present at executions to ensure they are not botched. “Physician participation in executions, though looked upon with disdain, is more
In China

Much less is known about the situation in China, which is the world’s number one executioner. Between 5000 and 10000 people are thought to be executed every year, says Phelim Kine, a US based China researcher for Human Rights Watch. And since 2009, China has switched almost wholesale from execution by a shot in the head to lethal injection. “Trained medical staff” carry out intravenous injections, according to state media, and forensic doctors pronounce the death and generate a computerised report. Chinese state media have reported the multiple benefits of this method of execution, even claiming, cryptically, that it causes “less pollution.”

Amnesty International reports that 24 seat buses have been converted into execution vehicles and Human Rights Watch says that 65% of all organs transplanted in China come from executed convicts. State media have reported that 164 hospitals around the country are accredited to carry out transplants using organs from convicts (source: Human Rights Watch).

In recent years China has come under international pressure to change this practice and it is currently testing a voluntary organ donor system. The total number of executions is also thought to have dropped by around 30% between 2007 and 2008 after all death sentence cases were reviewed and many found to be flawed.

Little is known about where China obtains the drugs it uses for lethal injections. It is thought to use a similar cocktail to that used in the United States, involving a barbiturate anaesthetic, sodium thiopental, followed by muscle paralysing pancuronium bromide and finally potassium chloride, which causes cardiac arrest. Several states in the United States have currently had to postpone executions because supplies of sodium thiopental have dried up, amid increasing objections by drug companies and international legislation against the misuse of the drug for executions. The only US producer of the drug, Hospira, stopped manufacturing it this January.

Executions elsewhere

Iran and Saudi Arabia, the other two countries with the highest numbers of executions, use older methods such as stoning, beheading, and hanging, and doctors are thought to be present only to certify deaths.

Medical involvement is similar in Pakistan, the fifth most enthusiastic user of the death penalty, where hanging is the only method used.

Guatemala toyed with lethal injection briefly in 1998 and 2000, broadcasting the executions, which were presented as medical operations, with clearly nervous staff dressed in surgical gowns and masked. In one case, the wails of the relatives were audible as staff took 18 minutes to find a vein. The public was shocked and Guatemala has not carried out any executions since 2000.

Thailand reverted to the firing squad after a period of using lethal injections.

The Philippines and Papua New Guinea continue to use the death penalty and little is known about the role of doctors in executions there.

Japan, which executes prisoners by hanging, is strikingly oblique about its use of the death penalty. In a report in January this year, the Council of Europe criticised the “atrocious practice” in Japan of “executions carried out under a shroud of secrecy and taking the death row inmates and their families by surprise.” In 2008 Japan executed 15 people, the highest number since 1975 (www.reprieve.org.uk/2010_03_29ray_of_hope_deathpenalty).

Worldwide trends

Globally though, the use of the death penalty is on the decline. In the United States, the numbers of death sentences dropped steadily over the seven years up to 2009, when 106 sentences were recorded (source: US Death Penalty Information Centre). New Mexico, New Jersey, and New York State have recently abolished the death penalty.

Worldwide, the number of executions is falling. According to Amnesty International, 527 people were executed worldwide in 2010, compared with 714 in 2009 (excluding China for lack of data) (http://blog.protectthehuman.com/death-penalty-report).

“There’s a long way to go, but gradually it will become more acceptable to oppose the death penalty,” says Dr Welsh. “It will take a mix of leadership within the medical profession and changing social values.”

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Cite this as: BMJ 2011;342:d3461