Opinion

Lethal Injection and Medical Ethics: Physicians in the Execution Chamber

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Synopsis: The advent of several recently botched executions has sparked debate over the practice of lethal injection in America. One interesting facet of this debate relates to the ethics of physician involvement in the practice. Here, a rule utilitarian argument against physician involvement based on patient consent is presented.

Introduction

In all 38 U.S states where capital punishment is legal, the preferred method is lethal injection. In total, 17 states require physician involvement, and 18 permit it (Black and Sade, 2007). For years, scholars have contested the physician’s role in this practice, but disagreement persists about the ethical reasoning involved. Several “botched” executions in states undertaking drug protocol changes have garnered substantial media attention (Porter, 2014; Pearce and Susman, 2014; Connor, 2014; Allen, 2014). Reports have detailed the unintentional but gruesome outcomes inmates can suffer at the hands of prison staff and medical professionals (Allen, 2014). Ongoing questions surrounding drug efficacy have fueled public debate and have led to high-profile legal cases (Associated Press, 2014; Denno, 2014; Base v. Rees, 2008). In this commentary, I will argue physician involvement in lethal injection procedures is unethical, even if legally permissible, as it encroaches on the patient’s right to informed and un-coerced consent. Physicians have an obligation to defend patient rights and abandon practices that infringe upon them.

Consent

A well-established tenet of both US law and medico-ethical standards is the patient’s right to give informed consent prior to a medical procedure (Fisher, 2013). Although inmates do lose certain rights upon conviction (mobility rights, civil freedoms, etc.), they still hold fundamental human rights including those related to informed consent. Consider the United Nations Office on Drugs and Crime and their statement on the issue of HIV testing in prisons: “…prisoners may be treated as if they were HIV-positive and lose privileges unless they submit to HIV testing. Such mandatory or compulsory forms of HIV testing violate ethical principles and the basic rights of consent, privacy and bodily integrity” (UNODC/UNAIDS/WHO, 2009).

When it comes to the lethal injection question, some have suggested that a physician could “easily condition his or her participation on the prisoner’s consent to his participation” (Nelson and Ashby, 2011). This reasoning does not reflect the elements of forcefulness and coercion at play in death penalty cases, which make any meaningful consensual practice impossible. In the case of lethal injection, the prisoner is forced into the procedure, and so considerations based on the legitimacy of the aforementioned “consent” are nonsensical, given that no decision-making or consent powers exist in the first place (Boehnlein, 2013). Consider Beauchamp and Childress (2001) and their seminal work on coercion and autonomy:

“Coercion occurs if and only if one person intentionally uses a credible and severe threat of harm or force to control another. [...] Coercion occurs only if a credible and intended threat displaces a person’s self-directedness. Coercion voids an act of autonomy; that is, coercion renders even intentional and well-informed behavior nonautonomous.”

Physicians who involve themselves in practices such as lethal injection are infringing on the prisoner’s rights of consent and bodily integrity as well as on the ethical principle of non-maleficence (“do no harm”). Even if we accepted the notion that physicians could condition their participation on the prisoner’s consent to his or her participation, such consent would be void due to coercion. It is not the imminent death of the patient, in and of itself, that makes the situation coercive. For
example, terminally ill patients face imminent death, yet active euthanasia practices can be completed with informed consent. Here, the coercion lies in the fact that the only viable alternative to the physician’s intervention includes the threat of a painful and potentially gruesome death at the hands of less-qualified prison staff. Either way, a physician who intervenes in these practices is one who infringes upon the medically relevant rights of the prisoner.

Legality and Morality

Proponents of physician intervention appear to be under the illusion that the debate over the moral and ethical legitimacy of capital punishment is not settled. They argue that since capital punishment is legal in certain states, physician intervention is ethical by default. However, the legal permissibility of an action does not in and of itself give a definitive answer as to whether or not a physician’s involvement in that action is ethical.

Consider a hypothetical state where a form of torture such as water-boarding is legal. In this scenario, a case favoring physician involvement in torture could be made analogous to the case for physician involvement in lethal injections. For instance, a physician could monitor vital signs or administer drugs as needed, ensuring the prisoner does not die in the middle of an intelligence recovery operation (Miles, 2006). But is there a line to be drawn? Should laws not condemn physicians who refuse to uphold ethical standards instead of encouraging them? It is likely that many proponents of physician involvement in lethal injection would not endorse involvement in torture with such ease. It is the forfeiture of consent that makes the example of torture seem especially egregious but equally makes physician participation in capital punishment unethical.

Rule Utilitarianism

One of the most compelling arguments in favor of physician intervention asserts that regardless of whether capital punishment is fundamentally unjust, physician involvement is nevertheless ethically permissible when the goal is to optimize comfort and minimize suffering for death row inmates facing execution. Given their medical expertise and extensive training, no other professionals within our society could carry out, oversee, and ensure the comfort of the prisoner as efficiently.

This line of reasoning relies on the philosophical doctrine of utilitarianism; often termed the “greatest good for the greatest number” (Bentham, 1907). Arguing in favor of intervention with respect to such cases seems to make sense from an act utilitarian point of view. A prisoner has been sentenced to death, and a physician can minimize the pain associated with the procedure. But problems arise when this philosophy is used to defend intervention in any case of lethal injection, as it assumes physicians are powerless in the face of established but unjust or unethical laws. Further, this position assumes defending medical ethical norms related to patient consent in the long term is unimportant or at least less important than mitigating pain in the short term. However, in democratic societies, public opinions (including those espoused by health care professionals) change laws. In addition, it has been asserted that defending ethical principles within the medical profession is crucial to ensure sustained levels of public trust in the profession (Black and Sade, 2007). Considering these arguments, it seems that physicians may have an obligation to follow a rule against participation when it comes to lethal injection, in order to ensure the “greatest good for the greatest number.”

Conclusion

Utility calculations in a single case with a single prisoner, admittedly, seem easy. But when we realize that the act of intervening in this one case may play a part in prolonging the acceptability of a practice that tears at the fabric of standard medical norms by disregarding the importance of patient consent, the utility calculation changes. The result is a crude but easy decision for physicians weighing the pros and cons of intervention. If one admits that medical professionals, as a rule, should not use their expertise on truly non-consenting individuals, it seems one must admit that physicians have an obligation to act as a silent protesters in a democratic state. They can do this by avoiding participation in lethal injection practices. Just as Americans have traditionally said, “We do not negotiate with terrorists,” physicians should declare, “We do not perform interventions on truly non-consenting individuals.”

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