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# PHYSICIANS AND THE DEATH PENALTY

*David J. Rothman\**

About nine years ago I left the relatively comfortable confines of the Arts and Sciences Department of Columbia University to join the medical faculty. The Medical School was beginning to have the sense of, even by law school standards, a rather pigeon-holed and tightly knit curriculum, which left amazingly little room for anything in the outside society to filter in. 1982 was, as a handful of you will know, the year that Texas started using lethal injections.<sup>1</sup> This became one of the very first issues that I could begin to address, joining an older interest that I had in criminal justice with work that I had done with various litigating groups in the area of mental health, particularly, the Mental Health Law Project, and my newer territory, medicine. As I listened this afternoon, the link between law and medicine seemed to me to be quite extraordinary.

I have to tell you something, and you probably know it already, but if you really want to curry favor with a medical audience, if you're going to deliver a message that you think the medical audience isn't going to like, but you want to try and win them over, so at least they'll listen to you with something approximating an open mind, then you open with an anti-lawyer joke. That is the surest technique that I know of to get doctors to lean back and relax. The tension this kind of humor reflects between the legal and medical communities, an ongoing kind of difficulty which I think

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<sup>1</sup> TEX. CRIM. PROC. CODE ANN. § 43.14 (West 1979 & Supp. 1995); see also Kurt Anderson, *A "More Palatable" Way of Killing: Texas Carries out the First Execution by Lethal Injection*, TIME, Dec. 20, 1982, at 28.

is important in a variety of ways, evaporates when we take on the issues that we are talking about today.

I am going to say something about that today. Before I enter into that territory though, I want to address a few points that just came up. Ursula [Bentele] started to talk about being in South Africa and the sense of embarrassment that we are in New York discussing the death penalty. I find that when I am writing about health policy, I often also invoke South Africa because it is the only other modern industrial country that doesn't have national health insurance, and it's eminently conceivable that South Africa will beat us to it.<sup>2</sup> It would be shameful, and I guess a counterpart to [Professor Bentele's] remarks, if that debate takes place and the South Africans say, 'well, not only does New York have the death penalty, but the Americans do just fine without national health insurance. . . why should we have it?' This coupling of us with South Africa seems awfully grim, to put it mildly.

When Bryan [Stevenson] was talking about his own encounters with death row inmates and his ability to be able to talk to them, hold them, comfort them as well as do legal work with them, I had to think about the enormous difficulties—and this I think you know about as well—the enormous difficulties that you have with medical students and house-staff, and indeed with physicians, in getting them to deal with the subject of death and dying: not to abandon the dying patient; to recognize that death may be something other than a medical failure. Death does not intrude into the four years of medical school curriculum almost anywhere. You don't talk about death. You read textbooks which will talk about all the untoward consequences of disease. Recently somebody showed me some materials on HIV disease, mapping the entire course of the illness, of course, but leaving out that at the end, death would come. So I think that both medicine and law have an enormous

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<sup>2</sup> See, e.g., Jesse Jackson, *Two Parties But Only One Agenda*, L.A. TIMES, Apr. 21, 1991, at M5; William F. May, *The Ethics of Health Care Reform*, THE DALLAS MORNING NEWS, Mar. 6, 1994, at 1J; see also *South Africa: National Health Insurance Considered*, REUTER NEWSWIRE AFRICA, Oct. 26, 1994 (reporting that, according to South Africa's Health Department Director-General Coen Slabber, that nation's department of health is considering national health insurance).

amount that they could share in and around dealing with such issues, and I'll come back to this in a minute. Medicine is, of course, confronting the moral and physical reality of death in yet one other way, and that is the enormous and difficult questions involving physician-assisted suicide, or euthanasia, involving doctors and death.

These are problematic questions. Many of us may differ in one way or another as to what is the doctor's role in death in the patient's examining room, or if you will, in the hospital room. The little bit of a note of hope that I can hold out for you today—and I must say, it's a little surprising—is medicine's, not simple reluctance, but down-right refusal to play the role of hand-maiden to the executioner.<sup>3</sup> There may turn out to be legal advantages to be found in suits against various statutes because of that. But the one piece of good news is that ultimately the American Medical Association ("AMA"), which you properly think of as having an historically forceful role, was, to put it gently, retrogressive when it came to policy issues. The AMA on these issues has been quite staunch and I may be at least able to tell you in shorthand-form why some of that has happened.

As Ursula [Bentele] mentioned before, my Ph.D. is in history. Which gives me, if you will, the prerogative of opening by telling you that the confounding of the role of executioner and physician goes back a very long time. But it goes back in a very curious way. Public execution of a condemned criminal was common, particularly if that criminal had done something awful, regicide being the most awful.<sup>4</sup> Those of you who know Foucault's *Discipline and Punish*,<sup>5</sup> will remember the opening page of what happens to the regicide, Damiens. He is quartered, torn apart. It is absolutely

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<sup>3</sup> See Sheryl Stolberg, *Doctor's Dilemma: Physicians Attending Executions? Increasingly, Many Are Wrestling with Their Consciences—And Saying No*, L.A. TIMES, Apr. 5, 1994, at E1 ("Many medical ethicists, as well as the AMA [American Medical Association], have concluded that doctors should have no role in executions other than to arrive afterward to certify that an inmate is dead.").

<sup>4</sup> "Regicide" is the act of killing a king. NEW SHORTER OXFORD DICTIONARY 2527 (4th ed. 1993).

<sup>5</sup> MICHEL FOUCAULT, *DISCIPLINE AND PUNISH: THE BIRTH OF THE PRISON* 3-5 (1979).

brutal, and the executioner played the role of ‘he who would dismember;’ or, in other words, the executioner became expert, through the nature of his “profession,” in the breaking of bones and in the tearing apart of bodies. It is not astonishing then, that in Sixteenth and seventeenth century communities, people with broken bones would turn to the executioner to heal them. There is a long record of the executioner who spent most of his day, or most of his occupation, breaking bones. He also became the one relatively expert in the setting of bones. This crossover, if you will, is wonderfully ironic and not a bad way of bringing us into these materials.

I emphasize the brutality that often accompanied capital punishment because it leads us into a reckoning with what is, I think, one of the central themes in the history of capital punishment, and that is that, for a long time, it was public, it was visible. Indeed, it was designed to be a spectacle of punishment literally on the spectacle that is the scaffold. But with the Enlightenment, moving out into the eighteenth century, and surely by the nineteenth century, you begin to render the execution invisible. And the question as to why you render the execution invisible actually begins to take us, in a slightly roundabout way, to the wonderful appeal of the lethal injection.

Some of the reasons you moved the execution away from the scaffold and confined it behind walls had to do with a fear of public disorder. After all, the original assumption was that seeing a hanging would serve as a general deterrent to crime. But the prisoner about to be executed who carried himself with particular nobility, or who used the occasion to scoff at the justice of God and the State—or its miscarriage—started to curry some appeal with the public; and by the seventeenth century, even more so by the eighteenth century, you begin to see a concern that the execution will become the moment of a riot; the execution will become a moment in which, as opposed to seeing this as deterrence, the crowd might begin to identify with the man about to be executed.

This theme is of an important order, but I suspect that the second element which I will describe for you is even more important. But that’s the beginning, it’s true, it’s there. I mean, sometimes it’s difficult for us to remember, as we go through our

urban life, the beginning of a greater sensibility about what constitutes cruelty and what constitutes, ultimately, behavior which we will not sanction, and, indeed, that we cannot see. You begin to get people writing about the fact that they couldn't go to the execution because it was so gruesome. You begin to get people, by the way, for whom, along with the whole notion of brutality, the execution of course also becomes something that is not acceptable. There's something of a civilizing process that goes along with the nineteenth century, a sense captured in the development of organizations like the Society for the Prevention of Cruelty to Animals, which some of you of course will know precedes the Society for the Prevention of Cruelty to Children. That kind of 'you don't skin cats, we don't do that' kind of ethos also begins to have some influence in the realm of capital punishment; indeed, in the realm more generally of criminal punishment. So what you do is not necessarily abandon the sanction altogether, but what you do is begin to move it out of the public's vision and, in a variety of ways, try with time to bring about 'humane' ways of doing it or ways that will not necessarily offend the sensibilities. So you make it invisible. No one can see the agonies of the gallows. You monkey around, as they do in France. It's a doctor, after all, who invents the guillotine.

You then think about the electric chair as we heard this afternoon, botched in its first attempts, continuously botched—you need a psychoanalyst, I think, to begin to reckon with the persistent botching stories. A day or two before, I saw Bryan [Stevenson] on a recent trip to Alabama. I was in Atmar, where the old electric chair was, and they took us in to see it. The first story we're told, of course—and it's told with that kind of nervous humor—is how they screwed up putting the leads in, so that when they put the guy into the chair and they turned it on, nothing happened. Then—again the nervous laughter—they send him back out, they fix the leads, and they do him in. You can't even get the leads right? Well you "can't" for a variety of reasons that speak to our problems with this, if you will, repression. I'm not comfortable with using that kind of language, but I think you know what I'm driving at, in terms of the executioners' not being able to quite handle the execution.

The move to lethal injection is—I am altogether persuaded, as I suspect most of you are—is that move which attempts to have it seem that one can carry out the business of execution humanely, by ‘putting someone to sleep.’ One of the recent writers on this asked who was being put to sleep, was it the offender or was it the public? You can sense that kind of appeal: “Let’s see whether or not we can keep capital punishment and simultaneously make it palatable, so that it doesn’t”—I don’t mean this in a legal sense, but in an aesthetic sense—“fall under the rubric of a ‘cruel’ punishment.” The problem, of course—it is not an enormous problem, but it is a problem—the problem, of course, is that you end up using medical paraphernalia, if not physicians themselves. An injection can involve first a sedative, a paralyzing agent, and then a compound that will stop the heart from beating. The issue always remains of course, who does it? When Texas started using doctors, as I suggested to you at the beginning, the AMA said, ‘No. We will not do lethal injections.’<sup>6</sup> The ‘do-no-harm’ principal is obvious. The other part of the Hippocratic Oath states, ‘I will not deliver a poison to anyone.’ I mean, it really crosses the line.

From the initial objections to using physicians for injection, the AMA and, interestingly, the New York State Medical Association as well, started defining what actually constitutes participation beyond the actual lethal injection. Could you insert the line? Could you prescribe the drug? Could you pronounce death? Could you certify death? A sideline: the FDA [Food and Drug Administration] certifies the drugs that are used to kill animals; it has been unwilling to certify the drugs that are used to kill people.<sup>7</sup> But that’s a side bar - we need not travel down that road. Generally speaking, the New York Medical Association and the AMA both have defined broadly what constitutes participation.<sup>8</sup> So it is not

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<sup>6</sup> Committee on Ethical and Judicial Affairs, American Medical Association, *Physician Participation in Capital Punishment*, 270 J. AM. MED. ASS’N 365 (1993) (citing a 1980 report by the American Medical Association’s Council on Ethical and Judicial Affairs). See also Don Colburn, *Lethal Injection: Why Doctors Are Uneasy About the Newest Method of Capital Punishment*, WASH. POST, Dec. 11, 1990, at Z12.

<sup>7</sup> See *Heckler v. Chaney*, 470 U.S. 821 (1985).

<sup>8</sup> See Colburn, *supra* note 6, at Z12; Pieter Kark, *Physicians Shouldn’t*

only the lethal injection but it is also the line, it is also prescribing, it is also—and this gets terribly interesting—it is also pronouncing death.

The fear about pronouncing is very clear: you have the condemned person in the process of execution. For one or another reason, whether it be lethal injection or the electric chair or gas, or any other method, the execution process has been short-circuited (I'll use that as a metaphor for all of them). The doctor comes over, examines the prisoner with his stethoscope, and says, 'No, no, he's still alive, zap him more, more gas, more potassium chloride please'. That is unacceptable within medicine. Unacceptable. You cannot be pronouncing when the goal of your pronouncing is, if you will, to tell the executioner to 'do more'. The only participation that has been sanctioned in New York and by the AMA is certifying after someone else has pronounced,<sup>9</sup> which really moves the physician out of the execution chamber altogether. Now, to the die-hard anti-capital punishment groups within the medical establishment: 'Die-hard,' we'll say, 'that's all helpful, but it only goes to a point. We have not been able to get the AMA or other physician groups, except a handful, to do anything frontally about capital punishment.' This is something of a hedge point, and that point being raised is certainly correct. The AMA has not come out against capital punishment. It has come out against the physician's role in capital punishment.<sup>10</sup> I reckon, and you'll reckon quickly too, with the import of that distinction. The AMA is not going to be in the front of the campaign against capital punishment. But it is, I think, very important nevertheless that the physician's role cannot be legitimating capital punishment—indeed, that the physician's role begins to complicate the administration of capital punishment.

Some of you may be alert to the controversies going on now in Illinois, where the state of Illinois has moved to keep "secret" the

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*Participate in Executions*, SYRACUSE HER. J., Mar. 23, 1995, at D3; *Physician Participation in Capital Punishment*, *supra* note 6.

<sup>9</sup> See Colburn, *supra* note 6, at Z12; Kark, *supra* note 8, at D3; *Physician Participation in Capital Punishment*, *supra* note 6.

<sup>10</sup> See Colburn, *supra* note 6, at Z12; *Physician Participation in Capital Punishment*, *supra* note 6.



identity of a physician who participates in capital punishment, and has allowed that physician to be paid in cash.<sup>11</sup> I guess between capital punishment and the IRS, you go the route of capital punishment. The Illinois Medical Society, Physicians for Human Rights and several physicians in Illinois have moved in court to attack that statute and have won the first preliminary battle in the Illinois courts.<sup>12</sup> I should, of course, say that the Illinois Medical Association has declared unethical any physician participation in the delivery of capital punishment. So you're watching, I think, at least, some relatively important stances on the part of medicine to try to keep itself out of this realm and not allow the legitimacy of medicine to cloak what is the death penalty in its intrinsic and crude form.

Two final points. One, well then who does it? Technicians of course sometimes botch it. Occasionally people will suggest veterinarians. I know of a few veterinarians who have been incensed at the notion that all of a sudden they get to play the role of executioner. They are prepared to 'put down' animals, when the animal is in pain for example. But veterinarians, at least the ones I know, are not about to become part-time executioners. Will you find technicians ready to do it? You may well. The skills of starting the lines and injecting the compounds are not the most complicated medical skills. You don't have to be a neurosurgeon to insert a line. Some of the legal literature would sometimes have it appear as though that is the case.<sup>13</sup> It's not. But still, you do have this

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<sup>11</sup> ILL. REV. STAT. ch. 725, para. 5/119-5 (1993 & Supp. 1995). See also Anita Srikameswaran & Christi Parsons, *Doctors Assail Role in Execution: Put Code of Ethics First, Medical Group Urged*, CHI. TRIB., June 20, 1995, at 3; Sheryl Stolberg, *supra* note 4, at E1.

<sup>12</sup> See Andrea Gerlin, *Doctors Debate Their Role in Death Row Executions*, WALL ST. J., Aug. 5, 1994, at B1.

<sup>13</sup> See, e.g., Stacy A. Ragon, Comment, *A Doctor's Dilemma: Resolving the Conflict Between Physician Participation in Executions and the AMA's Code of Medical Ethics*, 20 DAYTON L. REV. 975, 983 (1995) ("Some health care professionals observe that administering lethal injections requires the same medical skills and methods that are used to 'preserve life.'"); Robert L. Risley, *Ethical and Legal Issues in the Individual's Right to Die*, 20 OHIO N.U. L. REV. 597(1994) (advocating physician-assisted suicide, and citing a pamphlet of the group Californians Against Human Sufferings stating that no one but "nurses and

very interesting potential tension about who gets to do it. There are a few—I don't know if they're serious or not—who suggest that we've got a lot of folks out there that are really expert about putting needles into arms. I guess it would fit with the new welfare policy, right? We could employ all. . .you can finish that paragraph without me playing it out. It is in the literature, whether it be taken seriously or not. I'm not so certain.

Let me close with a brief look at how New York has decided to handle this. It is absolutely intriguing, and, at least to my reading, very, very confusing. As you know, lethal injection is in the statute.<sup>14</sup> You well know I'm not a lawyer, so move on this as you will, with much greater skill than I can. In the new legislation, Section 658, Death Penalty Inflicted by Lethal Injection, "The punishment of death shall be inflicted by lethal injection; that is, by the intravenous injection of a substance or substances in a lethal quantity into the body of a person convicted until such person is dead."<sup>15</sup> That is our mode of execution. Now what is interesting is the next section, 660, Persons Authorized to be Present at Execution.<sup>16</sup> There are a variety of people authorized to be at the execution. For my purposes what's interesting is including a technician or technicians, corrections officers and a licensed physician or physicians among those who may be present at the execution—*may* be—they are not necessarily to be present, but they may be present at the execution, or may not. Then you drop down to part 661, 'Examination of Convicted Person's Body and Certificate':

1) immediately after the execution an examination of the body of the convicted person shall be made by the licensed physicians present at the execution.<sup>17</sup>

So I'm puzzled at the statute. Lethal injection would appear to be the only course. Physicians may be present. But when you get

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treating physicians could actually administer aid-in dying").

<sup>14</sup> Death Penalty—Imposition and Procedures—Assignment of Counsel § 32, 1995 N.Y. LAWS 1, 20-24 (repealing N.Y. CORRECT. LAW Art. 22-B (McKinney 1987) and amending the Correction Law by adding a new Article 22-B).

<sup>15</sup> *Id.*

<sup>16</sup> *Id.*

<sup>17</sup> *Id.*

down to this area of pronouncing, certifying, the language (a) grows fuzzy, and (b) goes from *may* to *shall* with no allowance for anyone else doing it. So, they also don't use the traditional language, at least that I know of, that makes it into the statutes, which is to make them pronounce and certify. "Immediately after the execution, the body of the convicted person shall be made by the licensed physicians . . ." That would seem to contradict both the AMA and New York State Medical Association principles.

I'm not trying to give you a legal reading. Those of you who are trained in this would do it better. But I was surprised on the one hand, at the inability of the drafters to do it right. At the same time, I was not surprised, because they are trying to weave their way through an area which, I think in a very good sense, has become problematic. You want lethal injection. You want, if you will, the legitimating force of medicine. You can't have it all the way. So you have to start to kind of monkey around with it, with difficulties and problems. Whether this will be something which will be useful in litigation you'll find out, you'll tell me, you'll explore. From my perspective, it's one of these occasions when medicine comes up against law, or if you will, medicine confronts the power of the state. Medicine has been prepared in this instance not to let the state dictate its ethic. There have been a lot of examples, historically, where the medical establishment has bowed down to the state. That does not seem to be the way it's going here, and I suspect it will not go that way in the future. Whether or not it will prove to be a significant barrier—that I will wait for you to tell me.

Thank you.