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Why it's not OK for doctors to participate in executions

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A plea for direct physician participation in executions is presented by Sandeep Jauhar in a *New York Times* Op-Ed (“*Why It’s OK for Doctors to Participate in Executions*”—April 21, 2017). Jauhar’s article is not a discussion of the ethics of capital punishment. He describes his own opposition “as a matter of principle, as a doctor.” However, since capital punishment is legal in 31 states, with required physician participation in several, he acquiesces to a utilitarian stance rather than the principled approach he acknowledges is expected of a physician in this circumstance.

Jauhar argues for physician participation from a perspective that should arouse concern in any health care provider, particularly palliative care clinicians. His argument is based on what is described as a duty of physicians to alleviate suffering while likening the situation of a terminally ill patient with that of a prisoner destined for execution—“It is not a stretch to think of death-row inmates who have exhausted their appeals as having a disease with 100% mortality.” Observing that executions are a fait accompli “the best protection against a botched execution is to have a doctor trained in anesthesia or palliative care be present when things go awry.” Jauhar advocates associating with an activity of debatable ethical standing while using in his rationale a distorted connection to palliative care.

Jauhar acknowledges the statements of several professional organizations in strong opposition to clinician participation in executions. These organizations include the American Medical Association, American College of Physicians, American Society of Anesthesiologists, American College of Correctional Physicians, as well as the American Nurses Association. (The American Academy of Hospice and Palliative Medicine has not published a statement on this issue).

This analysis will dispute Jauhar’s recommendation

from two points of view. First, physician participation in executions represents a violation of the basic principles of medical intervention. Second, a counterargument is presented asserting that physician participation in executions is a disavowal of professional duties and responsibilities.

Palliative care practice involves a wide array of intervention settings. These can range from symptom management for a patient continuing active treatment for a life-limiting illness to providing palliative sedation for symptom relief at the end-of-life. Across this spectrum the consistent theme is patient-centered goal direction. Interventions are done or withheld with the consent of the patient or an appropriate representative. The goal in end-of-life care is an application of holistic efforts to reduce suffering. While some end-of life interventions can conceivably shorten the lifespan while relieving symptoms, the intent is symptom relief rather than the potential but unintended consequence of hastened death (“double effect”). In an execution, the “patient” is not in any sense of the word an autonomous decision-maker, and the explicit goal of the process is to cause death. Physician participation in capital punishment disregards the basic principles of medical intervention.

The work of the Israeli philosopher Avishai Margalit (“*The Ethics of Memory*”, “*On Betrayal*”) describes thick and thin inter-person relationships. Thick relationships are those most close to us such as with family or friends. They can extend to relationships based on common history or geography. The perspective of an individual or a “thick” group toward those more distant, all of mankind, constitutes a thin relationship. Margalit characterizes ethics as the principles determining appropriate behavior in a thick relationship while morality governs the expectations of a

thin relationship. Proposed here is an application of this construct to the interaction of health care providers with their patients and each other.

While provider/patient interactions can occur without prior history or connection, the intimacy and trust expectations qualify as a thick relationship. The principles of intervention previously discussed form the basis for the ethics of that relationship. The provider also has a relationship with others of their specialty and profession. While many of these connections may be close personally or geographically, there is a mutual responsibility irrespective of connection or distance among the members of a profession for consistent and appropriate behavior, a thin relationship in the context of this discussion. Trust in the ability to approach these professionals by the general population for help that will be in its best interests depends on such behavior. Members of a profession share a moral

responsibility to maintain this expectation.

Physician participation in executions is a violation of the basic ethical principles of medical intervention arising from the nature of the relationship between physicians and their patients. Likewise, participation by physicians or other providers in executions is immoral when the obligation of the provider to maintain the integrity of their profession is considered.

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Footnote

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