Physicians’ Attitudes About Involvement in Lethal Injection for Capital Punishment

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Background: Physicians could play various roles in carrying out capital punishment via lethal injection. Medical societies like the American Medical Association (AMA) and American College of Physicians have established which roles are acceptable and which are disallowed. No one has explored physicians’ attitudes toward their potential roles in this process.

Methods: We surveyed physicians about how acceptable it was for physicians to engage in 8 actions disallowed by the AMA and 4 allowed actions involving lethal injection. Questions assessing attitudes toward capital punishment and assisted suicide were included. The impact of attitudinal and demographic variables on the number of disallowed actions deemed acceptable was analyzed via analysis of variance and multiple logistic regression analysis.

Results: Four hundred eighty-two physicians (51%) returned questionnaires. Eighty percent indicated that at least 1 of the disallowed actions was acceptable, 53% indicated that 5 or more were acceptable, and 34% approved all 8 disallowed actions. The percentage of respondents approving of disallowed actions varied from 43% for injecting lethal drugs to 74% for determining when death occurred. All 4 allowed actions were deemed acceptable by the majority of respondents. Favoring the death penalty ($P<.001$) and the acceptance of assisted suicide ($P<.001$) were associated with an increased number of disallowed actions that were deemed acceptable.

Conclusions: Despite medical society policies, the majority of physicians surveyed approved of most disallowed actions involving capital punishment, indicating that they believed it is acceptable in some circumstances for physicians to kill individuals against their wishes. It is possible that the lack of stigmatization by colleagues allows physicians to engage in such practices.

Arch Intern Med. 2000;160:2912-2916

Physicians have been involved in the execution of prisoners for hundreds of years. Since 1977, lethal injection has been used by many states as their primary method of executing violent felons. Although the United Nations has called for a ban on the use of the death penalty, the annual number of executions in the United States has risen since 1977. Accompanying this rise has been an increase in the use of lethal injection, thereby increasing the need for biomedical knowledge and skills in the execution process.

The Council on Ethical and Judicial Affairs of the American Medical Association (AMA) has published guidelines stating that it is unethical for physicians to engage in many aspects of lethal injection, including selecting fatal injection sites or starting intravenous lines; prescribing or administering the drugs used in the process; inspecting, testing, or maintaining lethal injection equipment; consulting with or supervising personnel; and monitoring vital signs or declaring the individual dead. This view is shared by the American College of Physicians, which holds that it is unethical for physicians to participate in executions. There is also a consensus in the ethics literature that physicians should not participate in lethal injections, since participation violates the principle of nonmaleficence, or doing no harm.

Despite these statements, physicians are participating in lethal injections. As of 1991, Oklahoma required physicians to order the drugs used in the lethal injection, pronounce the prisoner dead, and inspect the intravenous line started by a technician to ensure its proper function. Physicians have been required to perform cutdowns on prisoners when adequate veins could not be found.
METHODS

We conducted a cross-sectional mail survey of 1000 randomly selected practicing physicians in the United States, identified through the AMA Physician Masterfile. The AMA Physician Masterfile is a comprehensive list of US physicians and is not limited to AMA members. Students, residents, and nonpracticing physicians were excluded. The study was approved by the Institutional Review Board of Christiana Care Health System.

Each physician received an anonymous questionnaire along with a $5 incentive. A second questionnaire was mailed to all nonrespondents. All responses received before October 1, 1998, were included in the analysis.

The questionnaire asked respondents how acceptable it is for physicians to be involved in different aspects of lethal injections. Responses were based on a 4-point Likert-type scale (from very acceptable to very unacceptable). The aspects that were tested included those actions disallowed by the AMA (starting intravenous lines for the purpose of giving lethal drugs, monitoring vital signs during the execution, selecting injection sites for the lethal drugs, administering the lethal drugs, determining death during the execution, maintaining or inspecting lethal injection devices, supervising personnel who give the lethal drugs, and ordering lethal drugs for the prison pharmacy), along with those actions allowed by the AMA (evaluating a prisoner psychiatrically to determine if the execution can proceed, giving tranquilizers the night before an execution, performing an autopsy after the execution, and signing the death certificate after the individual has been declared dead). Respondents were also asked about the propriety of evaluating a prisoner psychiatrically to determine if the execution can proceed, an action supported by the AMA (on the condition that the physician does not treat the prisoner so that the execution can proceed). Attitudes toward the death penalty in general, as well as toward assisted suicide, were assessed via 3-point Likert-type scales (oppose, favor, or oppose/favor for attitudes regarding the death penalty; yes, no, or unsure for attitudes regarding assisted suicide), while the respondents’ opinions about how the death penalty affects the murder rate were obtained via a 5-point Likert-type scale (from significantly decreases it to significantly increases it).

Data were entered for analysis manually by 2 individuals with a cross-check of 30% of the sample; no errors were detected. The number of disallowed actions that the respondents deemed as very acceptable or somewhat acceptable was calculated as a separate variable. The effects of attitudes toward the death penalty and assisted suicide and the effect of the death penalty on the murder rate, along with sociodemographic variables on the number of disallowed actions deemed acceptable, were analyzed via $t$ tests and analyses of variance. Multiple logistic regression models were employed to analyze the significant variables associated with the number of disallowed actions seen as acceptable.

RESULTS

Of the 1000 questionnaires, 24 were returned undelivered, 29 physicians had retired from practice, and 2 physicians had died. Of the 945 physicians who were eligible and received surveys, 482 (51%) returned questionnaires. Respondents’ demographic and professional characteristics are shown in Table 1. The responding physicians had an average age of 50 years and were largely male, white, and married. Most of the physicians were of the Protestant or Catholic faiths, and most reported being very or somewhat religious. The practices of most respondents were in urban or suburban settings and most were in private practices; a variety of specialties were represented. Physicians spent an average of three fourths of their time seeing patients, with slightly more than 40% of their time in primary care.

As seen in Table 2, most of the respondents either favored the death penalty in all cases or favored/opposed it depending on the circumstances. Although a significant percentage of respondents felt that the death penalty has no effect on the murder rate, a larger percentage felt that it somewhat or significantly reduces the murder rate. There were an equal number of physicians who felt that assisted suicide should or should not be allowed.

The percentage of respondents approving of the disallowed actions varied from a low of 43% for administering the lethal drugs to a high of 74% for determining death (Figure 1). For 5 of the 8 disallowed actions, a majority of respondents approved of physicians carrying out the procedure. In addition, 53% of respondents approved of 5 or more of the disallowed actions, while 34% approved of all 8 disallowed actions. Only 20% of respondents felt that none of the actions was acceptable.

The 3 actions deemed acceptable by the AMA were generally approved of by the responding physicians (Figure 2); the respondents also approved of the psychiatric evaluation of prisoners for the purpose of determining competence for execution. Of interest, 19 physicians viewed the use of tranquilizers the night before...
the execution as unacceptable, yet deemed 5 or more of the disallowed actions as appropriate.

Attitudes toward the death penalty and assisted suicide were associated with the number of disallowed actions deemed acceptable by respondents (Table 3). Physicians who were in favor of the death penalty approved of more disallowed actions than physicians who were opposed to capital punishment ($P<.001$). Physicians who believed that capital punishment reduced the murder rate approved of more disallowed actions than physicians who believed that capital punishment had no effect or actually increased the murder rate ($P<.001$). Physicians who approved of assisted suicide or were unsure as to what was appropriate approved of more disallowed actions than physicians who opposed assisted suicide ($P<.001$).

While most demographic characteristics, including previous experience with violent crimes, had no significant association with the number of disallowed actions deemed acceptable, some practice characteristics were associated (Table 4). Physicians in private practice approved of significantly more disallowed actions than...
others (P = .008), while those practicing in academic or Veterans Affairs settings deemed fewer of the disallowed actions to be appropriate (P = .01 and P = .02, respectively).

All significant attitudinal and demographic variables were entered into a multiple logistic regression model. Only the attitudes toward the death penalty (P < .001) and toward assisted suicide (P < .001) had a significant effect on the number of disallowed actions deemed acceptable (R² = 0.20).

Despite long traditions of ethics that disallow killing by physicians and medical societies disallowing physician involvement in lethal injection, many of the respondents in this study indicated they thought it was acceptable for physicians to participate in the various components of lethal injection, even to the extent of injecting the lethal drugs. These results are consistent with the statements of many physicians who have publicly supported their profession’s role in executions. For example, in 1789, Joseph Guillotin, a physician and social reformer who opposed the death penalty, proposed changes in the method of executions in France in order to provide a painless way of executing prisoners. Indeed, some physicians argue that their involvement in capital punishment affords a more rapid and humane death for convicts. Others support physician involvement in capital punishment by viewing executions as a shared public responsibility. Many physicians cite the need to provide care to the prisoner even at the time of the execution, and others argue that physicians should be free to individually decide whether to participate in capital punishment. The results of our survey suggest that the published opinions supporting physician involvement in capital punishment may be widely shared.

What should we make of these results? Opinion polls like that reported here do not determine what is morally right or wrong. By the same token, physicians’ moral duties are not determined by the ethical codes of the AMA, the American College of Physicians, or any other professional organization. Nevertheless, we are troubled by the number of respondents who approved of professional involvement in many aspects of lethal injection executions. No matter what physicians think about the death penalty itself, long traditions in medical ethics disallow killing by physicians. In lethal injections, competent adults are killed, generally against their wishes. Even supporters of capital punishment are unlikely to argue that executions are in felons’ best interests. Thus, physician participation in lethal injections violates central principles of medical ethics, such as autonomy, beneficence, and nonmaleficence. Some other actions of physicians may not always adhere to the principles of beneficence and nonmaleficence; for example, patients may be enrolled in clinical trials in which they may be receiving only the placebo (lack of benefit) or in a phase 1 trial in which harm from the medication is possible. However, in these situations, the physician is not acting on behalf of the government in a direct attempt to end
the life of the individual against his or her will. Therefore, the results of this study also raise a central question about whether a government can ever involve itself in medical processes and technology for societal purposes without raising ethical concerns.

Some may disagree with our view on the grounds that medical professionals already involve themselves in causing death when participating in abortions, assisted suicide, or voluntary euthanasia. However, these differ from capital punishment in important ways. Abortion involves the removal of unborn fetuses, whose moral status is controversial. Moreover, an argument can be made that abortion serves the best interest at least of the patient involved. Similarly, assisted suicide and voluntary euthanasia arguably can promote patients’ best interests by relieving their suffering. The same argument cannot be made for capital punishment. In lethal injections carried out by physicians, the physicians do not promote patients’ best interests, nor is it plausible to argue that physicians’ clinical skills are necessary to ensure that lethal injections are conducted humanely.

To be clear, the results of this survey do not establish whether physicians ought to involve themselves in lethal injections. Some, like us, will be concerned that some physicians do approve of professional involvement in lethal injections. Others may condone involvement or at least be unperturbed by these findings. We believe that this latter group will need to provide a coherent ethical argument for why physicians’ ethical duties should be expanded to include lethal injection.

This study has several limitations. First, we did not attempt to assess whether physicians would actually participate in the process of lethal injection. Studies of physicians have shown that the percentage of respondents willing to actually be involved in assisted suicide or voluntary euthanasia is far less than the percentage of those approving of these actions. Thus, one might suspect that the physicians involved in this study are less willing to be personally involved in the process of capital punishment. However, at least some physicians in this group might be willing to participate in the death penalty. Further research in this regard is necessary. Second, there is a possibility of nonrespondent bias, given the response rate of 51%. However, this rate is similar to the average response rate for physicians in mailed surveys. In addition, the age, sex, and specialty distribution of our survey is similar to that of physicians in practice in the United States in 1996. Even if all of the remaining nonrespondents disapproved of colleague involvement in the process of capital punishment, there would still be a substantial proportion of physicians (>25%) who would approve of 5 or more disallowed actions involving the process of lethal injection for the purpose of capital punishment.

In general, physicians in this study conformed the actions of their colleagues in participating in cases of lethal injection for the purpose of capital punishment. These attitudes might allow for continued involvement of physicians despite the prohibitions by several medical associations. Furthermore, while the attitudes toward capital punishment itself are controversial, the data clearly demonstrate the willingness of many physicians to con-done their profession’s role in the killing of individuals against their wishes.

Accepted for publication May 1, 2000.

This work was supported by a grant from the Osler Fund, Department of Medicine, Christiana Care Health System, Philadelphia, Pa. Dr Ubel is a recipient of a Career Development Award in health services research from the Department of Veterans Affairs, Washington, DC, and is also a Robert Wood Johnson Generalist Physician Faculty Scholar (Robert Wood Johnson Foundation, Princeton, NJ).

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REFERENCES