YANKEE DOODLING Douglas Kamerow

Killing me softly

Can the prevention of suffering justify the involvement of doctors in capital punishment?

Ninety four per cent of the world's executions occur in four countries. China executes the most people, at least 1000 and maybe as many as 8000 a year. Iran and Saudi Arabia are next, with around 100. The United States is fourth. In 2006 we killed 53 convicted murderers, down from 60 in 2005. In the 30 years since 1977, when the US Supreme Court moratorium on capital punishment ended, about 1000 Americans have been executed, a third of them in Texas, the rest in 33 other states.

Putting someone to death is not easy or pretty. As Elizabeth Weil pointed out in a recent *New York Times Magazine* article on the subject, each time a new method of capital punishment has been introduced it has been because the then current method was found to be barbaric and uncivilised. Death by hanging can lead to a dangling, kicking, prolonged struggle or a gruesome rope beheading. Firing squads are hard to control and sometimes inaccurate, leaving the victims alive. Gas chambers take a long time, and death by suffocation is not attractive. Electrocutation commonly results in grotesquely charred flesh and occasionally in flaming heads and other body parts. And sometimes it doesn't work.

Which is why we now do virtually all of our executions in the US by lethal injection. Nice and clean, sterile setting, looks like a hospital. People dressed in white, alcohol swabs, cardiac monitors, intravenous lines. When all goes right, three quick intravenous injections—sodium thiopental to put the condemned to sleep, a paralysing agent so as not to offend the witnesses with any gasps or jerky movements, and potassium chloride to stop the heart—and in a few minutes, a “humane” and certifiable death.

But things don't always go right. Several recent widely publicised fiascos have made that clear. In Florida, poorly trained technicians placed two IVs in the arms of a condemned man named Angel Diaz. Neither one was in a vein. The potassium infused subcutaneously, causing chemical burns. His painful death took more than 30 minutes, during most of which he was awake and speaking. This led Governor Jeb Bush to declare a moratorium on executions in Florida until they can figure out a better way to execute the 372 others on death row there.

And that, unfortunately, is where the medical profession comes in. If lethal injection is going to be done correctly, you need someone with medical expertise to do it. Or at least to train the people who do it and to supervise them. The US constitution specifies that no “cruel or unusual punishment” is allowed. Leaving aside for a minute the argument that capital punishment itself is cruel, certainly making people suffer needlessly is.

Surgeon Atul Gawande interviewed four doctors and a nurse who had participated in executions for a compelling article in the *New England Journal of Medicine* last year (2006;354:1121-9). Some of them stated that if capital punishment is legal, then executions should be done competently, and that means with medical supervision. One of the doctors compared executions to other end of life situations. When a patient is dying it is up to a physician to make sure the death is as pain-free and comfortable as possible, whether death is caused by nature or the state. And some of the participating doctors were state employees, whose job it was to care for prisoners. The men and women on death row were their patients.

Others argue that there can be

“**Sometimes it is going to go wrong and we're going to feel bad. If we can't accept that then we shouldn't be killing people on behalf of the state**”

no doctor-patient relationship between the doctor who facilitates an execution and the person to be executed, because the doctor is not putting the “patient's” welfare first. Since at least 1980, the policy of the American Medical Association has been that physicians may not participate in executions because they are members of “a profession dedicated to preserving life when there is hope of doing so.” Does that take precedence over preventing the suffering that will occur if doctors are *not* involved in lethal injections?

Other countries don't seem to have the same problem figuring out how to execute their criminals. Weil wrote that China has a “suite of hyper-efficient lethal-injection vans that drive around the provinces carrying trained teams that execute the condemned.” No mess, no fuss.

And that is the real problem: we don't want a mess. We want these evil people to disappear, to be dead, but most of us don't want to feel bad about how they died. In the more remote past, hangings were public; the citizenry attended and saw everything. Now we do it in secret, we can't bear to watch, and we want it to be painless.

There are lots of reasons to be against capital punishment: it's immoral, it reduces the state to the level of the killer, and it is irreversible if we find we've made a mistake. But if there is even one killer, one crime that is so heinous to “deserve” a capital sentence we have to accept that killing people is not pleasant. Sometimes it is going to go wrong and we're going to feel bad. If we can't accept that then we shouldn't be killing people on behalf of the state—with or without the help of doctors.

Douglas Kamerow is former US assistant surgeon general and the *BMJ's* US editor dkamerow@bmj.com