Caring to Death: Health Care Professionals and Capital Punishment

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Caring to death

Health care professionals and capital punishment

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Abstract

The aim of this article is to describe the role of health care professionals in the capital punishment process. The relationship between the protocol of capital punishment in the United States and the use of health care professionals to carry out that task has been overlooked in the literature on punishment. Yet for some time, the operation of the medical sciences in prison have been ‘part of a disciplinary strategy’ ‘intrinsic to the development of power relationships’. Many capital punishment statutes require medical personnel to be present at, if not actively involved in, executions. Through analyses of these statutes, show the degree to which these professionals have become part of the state’s executive apparatus.

Keywords: capital punishment • health care professionals • power/knowledge • Foucault

CAPITAL PUNISHMENT: FIGURES OF TERROR

On 2 March 1757 Damiens the regicide was condemned ‘to make the amende honorable before the main door of the Church of Paris’ . . . [O]n a scaffold that will be erected there, the flesh will be torn from his breasts, arms, thighs and calves with red-hot pincers, . . . and then his body drawn and quartered by four horses and his limbs and body consumed by fire . . . Though a strong, sturdy fellow, this executioner found it so difficult to tear away the pieces of flesh that he set about the same spot two or three times . . . The horses tugged hard, each pulling straight on a limb, each horse held by an executioner. After a quarter of an hour, the same ceremony was repeated and finally, after several attempts, the direction of the horses had to be changed . . . [T]he executioner Samson . . . drew out a knife from his pocket and cut the body at the thighs . . . [T]he flesh had to be cut almost to the bone . . . One of the executioners . . . said shortly afterwards that when they had lifted the trunk to throw it on the stake, he was still alive . . . (Foucault, 1977/1995: 3–5)

On July 18, 1996, in Indiana, Tommie Smith was not pronounced dead until an hour and 20 minutes after the execution team began to administer the lethal combination of intravenous drugs. Prison officials said that the team couldn't find a vein in Smith's arm and had to insert an angio-catheter into his heart, a procedure that took 35 minutes. According to authorities, Smith remained conscious during that procedure. (Death Penalty Information Center, 1999)
On May 8, 1997, in Oklahoma, Scott Carpenter was put to death. Two minutes after the lethal chemicals began flowing into the body of Carpenter at 12:11 AM, he began to make noises, his stomach and chest began pulsing, and his jaw clenched. In total, his body made 18 violent convulsions, followed by 8 milder ones. His face, which first turned a yellowish gray, had turned a deep purple and gray by 12:20 AM. He was officially pronounced dead at 12:22 AM. (Death Penalty Information Center, 1999)

INTRODUCTION
The aim of this article is to describe the role of health care professionals in the capital punishment process. The relationship between the protocols of capital punishment in the United States and the use of health care professionals to carry out the task of killing prisoners has been overlooked in the literature on punishment. Yet for some time the operation of the medical sciences in prisons has been ‘part of a disciplinary strategy . . . intrinsic to the development of power relationships’ (Sim, 1990: 9).

In considering the important role health care providers play in administering death to the condemned (whether through finding veins for lethal injections or checking for vital signs of life or death), we reject the idea that doctors and nurses are not part of a state’s penal machinery (Bessler, 1998). We also reject the idea that the administration of lethal injections to the condemned and the preparation of prisoners for death are not medical procedures. Health care professionals who take part in execution protocols are state functionaries who exercise their power over captive prisoners in a manner separated by time, but not method, from earlier forms of execution (Foucault, 1977/1995). We argue that the use of a therapeutic discourse within the death penalty protocol (and its eventual co-optation by a legal discourse) provides evidence of an ongoing sanitization of the capital punishment process that has historical links with previous state-sanctioned methods of execution and crime control.

Lethal injection is the primary or secondary method of execution in 34 of the 38 American states with death penalty statutes. The remaining four states use electrocution as the sole method of execution. The United States government and military also use lethal injections as the sole method of execution. Eleven states explicitly deny that lethal injection is a medical procedure, indemnify health care executioners against legal harm, and shield their names from the public, while other state laws are silent regarding execution protocols. A Pennsylvania Department of Corrections fact sheet on execution protocol, for example, states that

The Department of Corrections engages the services of individuals technically competent by virtue of training or experience to carry out the lethal injection procedure . . . The state does not identify injection team members because of the confidentiality of the execution policy, for security reasons and out of respect of the privacy of those involved. (PA DOC, 1999)

Seven states authorize pharmacists to dispense lethal drugs to prison personnel (ACP, 1994, 17; possibly in violation of US drug laws, see 21 USCA s. 353 and 21 USCA s. 801).

All death penalty statutes require either a warden or a physician to pronounce death, but only Idaho's capital punishment statute specifically declares that a physician must administer lethal drugs to the prisoner (ID ST s. 19-2716). Louisiana's death statute
protects health care professionals from legal and ethical difficulties, but in doing so creates a space for non-medical personnel to administer medical techniques. ‘No licensed health care professional shall be compelled to administer a lethal injection’ (LA RS s. 15:569(c)). New Jersey requires the prisoner to be ‘sedated by a licensed physician, registered nurse, or other qualified personnel, by either an oral tablet or capsule or an intramuscular injection of a narcotic or barbiturate such as morphine, cocaine or demoral’ (NJ ST 2C:49-2). All other death penalty statutes leave the administration of death to the warden or director of corrections.

Wardens or directors of corrections are free to perform executions themselves, enlist health care professionals to help, or use trained personnel to prepare prisoners for death, insert needles, and regulate other medical procedures. Although these health care personnel may be doctors or nurses, quite often they are physician’s assistants (Campbell v. Wood, 1994). Most wardens simply follow standard operating procedures, and do not take into consideration the prisoner’s overall health, size, or lifestyle. Lethal injections are particularly difficult to administer to habitual drug abusers. Ignoring individual factors leads to botched executions. Washington State’s execution protocol for hanging uses a ‘physician assistant’ to perform a ‘medical inspection’ that focuses on ‘the prisoner’s height, weight, and veins’, but not the ‘prisoner’s vertebrae, his bone density, the mineral content of his bones . . .’ (Campbell v. Wood, 1994: 726.) Delaware’s capital punishment statute denies the necessity of ‘detailed procedures for the administration of the death penalty’, and gives the Commissioner of Corrections the ‘authority to develop procedures for the administration of the death sentence’ (DE ST TI 11 s. 4209). This discretion allows for obfuscating individual responsibility for the administration of death, as is the case with North Carolina’s Department of Corrections’ execution protocol. The procedures never say who is in charge of the prisoner.

The inmate is secured with lined ankle and wrist restraints to a gurney in the preparation room outside the chamber. Cardiac monitor leads and a stethoscope are attached. Two saline intravenous lines are started, one in each arm, and the inmate is covered with a sheet.

. . . Appropriately trained personnel then enter behind the curtain and connect the cardiac monitor leads, the injection devices and the stethoscope to the appropriate leads. The warden informs the witnesses that the execution is about to begin. He returns to the chamber and gives the order to proceed.

The saline intravenous lines are turned off and the thiopental sodium is injected which puts the inmate into a deep sleep. A second chemical agent, procuronium bromide (the generic name for Pavulon), follows. This agent is a total muscle relaxer. The inmate stops breathing and dies soon afterward.

The warden pronounces the inmate dead and a physician certifies death has occurred. The total cost of the execution supplies is $346.51. (NC DOC, 1999)

Through analyses of these and other death penalty statutes, we point out the duality of the roles health care professionals play in the execution process (caring versus killing), and show the degree to which these professionals have become part of the state’s executive apparatus (Rothman, 1995; Michalos, 1997). We also consider official documents from various health care professional organizations (ICN, 1991; ACP, 1994; ANA, 1995) and the theoretical literature regarding punishment, social control, and governmentality to
demonstrate the contradictions of health care professionals’ involvement in the death penalty process (Foucault, 1977/1995, 1978/1990; Ignatieff, 1978; Cohen and Scull, 1985; Garland, 1990; Rose and Miller, 1992; Blomberg and Cohen, 1995; Bergali and Sumner, 1997). By treating prisoners as patients, and by participating in the state’s search for less disagreeable forms of execution, nurses and doctors (as carriers of scientific knowledge, but also as agents of care) are intrinsic to the death process, not mere accouterments to it (ACP, 1994; Ragon, 1995; Dubber, 1996; Schoenholtz et al., 1996).

THE LEGAL POSITION OF MEDICAL PERSONNEL
Medical science and power are represented in prison by the trained personnel who operate the machines used to carry the lethal solutions to the condemned’s body. Yet the law does not fully reflect this reality. South Dakota’s death penalty statute (like many others) states that: ‘Any infliction of the punishment of death by administration of the required lethal substance or substances in the manner required by this section may not be construed to be the practice of medicine’. Having redefined medicine, it further adds that

An execution carried out by lethal injection shall be performed by a person selected by the warden and trained to administer the injection. The person administering the injection need not be a physician, registered nurse or licensed practical nurse or registered under the law of this or any other state. (SD ST s. 23A-27A-32)

South Dakota’s legislators avoided directly using health care professionals because, like most state legislators, they are aware that ‘pharmacology, toxicology, catheterization or injections do not require the services of a physician’ (Michalos, 1997: 153). The South Dakota statute denies that there is an ethical (or legal) problem in procuring health care professionals to insert tubes into prisoners or in obtaining the necessary medicines used to extinguish life (Heckler v. Chaney, 1985). The law focuses on the criminal subject, his crime and punishment, not on the executioner. Idaho’s capital punishment statute is no different than South Dakota’s. Both eliminate the ethical conflict in requiring medical personnel to perform or administer death by denying the health care professional’s role in death. It states that

any infliction of the punishment of death by administration of the required lethal substance or substances in the manner required by this section shall not be construed to be the practice of medicine and any pharmacist or pharmaceutical supplier is authorized to dispense drugs to the director or his designee, without prescription, for carrying out the provisions of this section, notwithstanding any other provision of law. (ID ST s. 19-2716)

The law can only mask what it in fact allows. Health care professionals are involved in execution protocols. Kansas’s death penalty statute gives the secretary of corrections full power to control the death process (KS ST s. 22–4001). The secretary ‘shall designate one or more executioners’ to carry out the lethal injection in a ‘swift and humane manner’. The secretary’s discretion, however, is circumscribed by a legal requirement to ‘appoint a panel of three persons to advise the secretary on the type of substance or substances to be administered’ to the condemned prisoner. The Kansas penal authority relies
on scientific knowledge to exercise its power over the condemned. The panel must consist of one pharmacologist, one toxicologist, and one anesthesiologist, all of whom will be ‘paid compensation, subsistence allowances, mileage and other expenses’ as provided by law.

Health care professionals play an important role in the execution of death sentences. Yet the laws hide their involvement, averting our gaze from the essential role played by health care personnel in executing prisoners. Although acknowledging the need for medical technology and scientific-administrative expertise to carry out death sentences legally, states are reluctant to admit that health care professionals are carrying out the task of death. New York’s capital punishment statute, for example, makes a distinction between a ‘licensed physician’, who ‘may be present’ at an execution, and the ‘execution technician or technicians’ whose name or names ‘shall never be disclosed’. The law separates physicians (who are responsible for certifying death) from execution technicians, who presumably are not physicians but may be (NY Correct s. 660). New York’s law creates a hierarchy of status and secrecy in the death process. The physician has an unofficial ‘observer’ status that is more protected than the invited witnesses (whose names can be disclosed after the execution), because his identity cannot be revealed (though this is not explicit in the statute), though less secret than the ‘executioner-technician’, whom the law fully explicitly protects.

Oklahoma’s capital punishment statute obscures the distinction between witnesses and participants in the process of punishment. It states that the warden ‘must invite’ a physician, the district attorney of the county in which the crime occurred, the judge who presided over the sentence of death, the chief of police of the municipality in which the crime occurred, as well as the sheriff of the county where the conviction occurred, and the cabinet secretary of public safety (OK ST T 22 s. 1015b). Yet even if it was clear that a physician must take part in an execution, his or her actions would not constitute the practice of medicine, nor would the purchase of drugs needed to administer the injection be considered lethal substances. Delaware frankly admits that its law governing lethal injections ‘permits correctional officers to obtain controlled substances for the execution in violation of the Federal Drug Abuse Prevention and Control Act . . . and the Federal Food, Drug and Cosmetic Act’ (DE ST TI 11 s. 4209). Oregon’s statute allows the director of corrections to purchase ‘lethal substances’ from ‘any wholesale drug outlet . . . registered with the State Board of Pharmacy’, and then states that the ‘lethal substance or substances’ purchased ‘are not controlled substances when purchased, possessed or used for purposes of this section’ (OR ST s. 137.473(1) and (3)).

Montana’s execution statute allows any person trained by the warden to administer death. ‘The person administering the injection need not be a physician, registered nurse, or licensed practical nurse licensed or registered under the laws of this or any other state’. Yet the ‘identity of the executioner must remain anonymous. Facts pertaining to the selection and training of the executioner must remain confidential’ (MT ST 46-19-103(6)).

Idaho’s capital punishment statute denies that administering lethal injections constitutes the practice of medicine, and protects against ‘unnecessary suffering’ by using ‘expert technical assistance’. If Idaho’s director of the Department of Corrections cannot obtain expert technical assistance to carry out the lethal injection, the method of execution switches to firing squad (ID ST s. 19-2716). Utah’s death statute separates
executions by ‘shooting’, which are carried out by a ‘five-person firing squad of peace officers’, from death by lethal injection, which is carried out by ‘two or more persons trained in accordance with accepted medical practices’. Certification of death by a physician is listed only in the section on lethal injection (UT ST s77-19·10(2)(3)). The medicalization of the death penalty is thus recognized even as it is being denied.

Whether called a ‘physician’ or an ‘execution technician’, the Kansas statute makes clear that health care personnel are important because of the knowledge they have and the image of care they project. Their role in the execution helps disperse and dilute responsibility for the act of killing. According to John Bessler, the multi-layered process has become so complex that ‘no one in the entire criminal justice system is now fully accountable for death sentences’ (Bessler, 1998: 709). Focusing on the rationalization of punishment, Garland (1990: 182) writes that penal agents today ‘avoid the bad conscience and cultural infamy that used to attach to the executioner or the jailer by claiming to be more than merely instruments of punishment’. And Markus Dubber, in his account of capital punishment processes, stresses that participants in death penalty procedures ‘shift the moral focus of punishment in order to minimize their sense of responsibility’ (Dubber, 1996: 545).

From the standpoint of lethal injections, the ‘agent of welfare’, in Foucault’s words, the doctor or nurse, is less necessary than what he or she represents: the care of the soul in the care of the state. Their purpose is to transform executions from terrifying to peaceful and to render submissive the condemned prisoner. Health care personnel help make lethal executions ‘humane’, ‘ultra fast’, and constitutional (Gregg v. Georgia, 1976). Death penalty states use health care personnel to alleviate the pain of death or to offer the illusion of alleviating pain. If punishment was once harsh, it is now peaceful. Maryland’s penitentiary historian states that ‘the worst physical pain’ from lethal injection is ‘the prick of a needle’ (MD DOC, 1999). Arizona’s historical fact sheet on the death penalty similarly dismisses the possibility of pain from a lethal injection, and describes the pain a prisoner feels from lethal gas as akin to a heart attack. ‘Death by lethal injection is not painful and the inmate goes to sleep prior to the fatal effects of the Pavulon and Potassium Chloride’ (AZ DOC, 1999).

In the process of preparing prisoners for execution, health care workers’ labor is transformed. It becomes part medical, part penal – a matter of pacifying the ‘patient’, minimizing pain, and enhancing the legitimacy and efficiency of the process.

THE IMAGE OF THE EXECUTION

David Garland suggests that the representation of punishment in quasi-scientific terms ‘promotes a particular image of the state and of its authority, and of its relationship to offenders and other citizens’ (Garland, 1990: 257). By replacing the electric chair with a gurney and a hooded executioner with a doctor or a nurse, lethal injections offer the spectacle of calm. As Robert Johnson has written: ‘Executions today are disturbingly, even chillingly, dispassionate’ (Johnson, 1998: 25). Lethal injections offer the promise of a humanitarian solution to a criminal act, the cure for an ill, rather than the threat of societal retribution or punishment. Their appeal lies not in reducing pain to the prisoner, but in imposing a ‘medical veneer’ to the act of killing. ‘The veneer creates a “false image about an act which is quite final and quite dehumanizing”, because the
injection is given by health professionals, who are considered to have the “highest developed quality of love for humanity” (Salguero, 1986: n. 80). By minimizing the condemned’s resistance, the procedures of control become more total.

Because lethal injections were viewed as matters of administration and not proper subjects for public debate, it is not surprising that the first executions by lethal injection were notable chiefly for what did not happen. They were neither occasions in the history of science nor landmarks in any principled debate about lethal injections as a means of execution. There were no reports of states that had passed or considered lethal injection legislation sending medical or scientific observers to Texas... [T]he practice of lethal injection was a nonevent. (Zimring and Hawkins, 1986: 120)

Texas had acted on its own, without regard for the public or the medical community. ‘Representatives of the American medical profession do not appear to have been consulted formally in advance’ of the Texas lethal injection statute (Zimring and Hawkins, 1986: 113).

By contrast, two medical doctors were present at William Kemmler’s electrocution in New York State in 1890 (the first in the US), and the decision to use the electric chair was a matter of public debate (Denno, 1994). Over the 100 years that separate Kemmler’s death by electricity from Charles Brooks’ execution by lethal injection in Texas, had the public come to accept capital punishment so completely that it no longer cared about the method? Or did the authorities correctly assume that the public would view a medicalized death as more humane than an electrical death?

Michael Ignatieff writes that the introduction of medical personnel into prisons was not simply a benevolent innovation but was ‘part of the wider imposition of discipline and regulation’ (Sim, 1990: 5). The prison is now ‘part of a larger design of intervention – a more complex medico-legal-police machine involving the assessment, classification, and differentiation of potential delinquents’ (Salvatore and Aguirre, 1996: 8). Moreover, by making the agent of execution a doctor or a nurse, and in using drugs to ease the prisoner’s pain during execution, the state is not simply applying its knowledge about the effects of drugs on the body. What makes medicalized penal practices different than the mere dispensation of drugs to one in need is that, in using lethal doses of ‘sodium thiopental or other equally or more effective substance sufficient to cause death’ (CRSA 16-11-401), states are using the criminal’s captive body as a vehicle to exercise their power and demonstrate their mastery of knowledge about life and death to society at large.

HEALTH CARE PROFESSIONALS’ CONDUCT AND PROFESSIONAL ORGANIZATIONAL STATEMENTS

The use of health care professionals in the execution protocol is a form of risk management within the prison. The state relies on the fact that: ‘Nursing theory tends to present care as a collaborative interaction between nurse and patient, which aims at promoting the well-being of the latter’ (Gastaldo and Holmes, 1999: 235). But nursing care is also an exercise of control over the patient. Nursing care is as much about power as it is about caring (Gastaldo and Holmes, 1999).

Although the state uses knowledge of the body’s response to pain from injections to
minimize prisoners’ fears of execution and allay the public’s concern about torture, the medical profession’s leadership professes reluctance to have its members placed in this role. The American Medical Association’s (AMA) position on physician participation in capital punishment is that

An individual’s opinion on capital punishment is the personal moral decision of the individual. A physician, as a member of a profession dedicated to preserving life when there is hope of doing so, should not be a participant in a legally authorized execution. (ACP, 1994: xi)

For the AMA, ‘Medicine is at heart a profession of care, compassion, and healing. Physician-assisted punishment does not encompass these virtues . . . The unacceptability of physicians’ involvement in executions should be recognized as a mature principle of medical ethics’ (Schoenholtz et al., 1996: 1559). But a doctor is not required to belong to the AMA, and no professional penalties are imposed upon doctors who participate in lethal injections. As Salguero (1986) states, the Hippocratic oath is

binding only on those parties who have agreed to it; that is, the members of the medical profession. As such . . . the Oath is of little relevance to the resolution of questions of medical ethics when the interests of society, which is not a party to the Oath, are involved. (Salguero, 1986: n. 38)

Historically, the role of nurses has been to promote and protect human life (ANA, 1995). Perhaps even before Florence Nightingale, nursing has been associated with a humanitarian perspective in which empathy, compassion, caring, respect, and protection of life constituted the basic values of the nursing profession. The position statements of the American Nurses Association as well as the International Council of Nurses are similar. Both forbid nurse participation directly or indirectly in corporal or capital punishments

Regardless of the personal opinion of professional nurses regarding the morality of capital punishment, it is a breach of the nursing code of ethical conduct to participate either directly or indirectly in a legally authorized execution (ANA, 1999).

The ANA is strongly opposed to all forms of participation, by whatever means, whether under civil or military legal authority. Nurses should refrain from participation in capital punishment and not take part in assessment, supervision or monitoring of the procedure or the prisoner; procuring, prescribing or preparing medications or solutions; inserting the intravenous catheter; injecting the lethal solution; and attending or witnessing the execution as a nurse. The fact that capital punishment is currently supported in many segments of society does not override the obligation of nurses to uphold the ethical mandates of the profession (ANA, 1995: 2).

The ICN recognizes the responsibility of the nurse to a prisoner sentenced to death by the state continues until the actual execution procedure is initiated; and considers participation by nurses, either directly or indirectly, in the immediate preparation for and the carrying out of state-authorized executions to be a violation of nursing’s ethical code. The nurse’s first responsibility is towards her patients, notwithstanding considerations of national security and interest. (ICN, 1991: 18, 111)

The positions of the International Council of Nurses (ICN) and the American Nurses Association (ANA) are that participation in executions is ‘contrary to the fundamental goals and ethical traditions of the profession’ (ICN, 1991; ANA, 1995; Trevelyan, 1998).
In practice, however, the nursing profession has not acted to sanction nurses who do participate in execution procedures, and there is only a small critical literature on their involvement in the death penalty in the US.¹

CONCLUSION
To quote Margaret Mead: ‘We have come full circle from the pre-Hippocratic days. Once again the patient does not know whether the approaching physician is coming in the guise of healer or killer’ (Koop, 1996: 2). The legally required intervention of doctors and nurses in a convict’s preparation for death represents a new relationship of power between prisoners and health care providers. When the prisoner becomes the patient, the relationship between doctors, nurses, and prisoners is less one of care than of control. The ends served have less to do with avoiding harm than with rendering the process of execution more efficient and the killing state more legitimate.

Nurses and doctors do not stand beside the killing apparatus; rather, they are an essential part of it. In spite of the position statements of the professional organizations, the participation of health care professionals before, during, and after the lethal injection procedure continues to be an integral part of the American deathwork.

Note
¹ Arizona’s capital punishment statute, which calls for ‘an intravenous injection of a substance or substances in a lethal quantity sufficient to cause death’, shields health care personnel from such retribution. ‘If a person who participates or performs ancillary functions in an execution is licensed by a board the licensing board shall not suspend or revoke the person’s license as a result of the person’s participation in an execution’ (ARS 13-704).

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