

To the Editor:

Black and Sade recently wrote in JAMA about legal and ethical concerns around possible physician participation in the criminal justice system at the time of the execution of an inmate.¹ Since the Supreme Court reinstated the death penalty in 1976, articles and editorials discussing this subject periodically appear in prestigious medical journals besides JAMA, including the New England Journal of Medicine², the Annals of Internal Medicine³, and the Lancet⁴. A common feature of these articles is that they are written by individuals (or are surveys of community practicing physicians) who do not indicate any significant experience in providing health care to inmates in a correctional setting. It may be instructive to understand the perspective of physicians who do make such care a major part of their clinical practice.

The Society of Correctional Physicians (SCP) was established in 1992 through the efforts of Armond Start, MD, then Medical Director of the Oklahoma Department of Corrections, and Ron Shansky, MD, then Medical Director of the Illinois Department of Corrections. SCP is a national professional organization that has among its goals the advancement of research, education, and training in correctional medicine by academia and government. Membership is limited to doctors of medicine or osteopathy who hold a license to practice medicine by an appropriate board of licensure that does not limit their practice solely to the correctional setting, and who are engaged in the practice, teaching, or research of correctional medicine.

In 1997, SCP adopted a Code of Ethics for physicians practicing in a correctional setting. The Code specifically states that "the correctional health professional shall not be involved in any aspect of the execution of the death penalty."⁵ The primary reason for this stance is that the Society strongly believes that correctional health professionals are obligated to respect human dignity and act in ways that merit trust and prevent harm. They must ensure autonomy in decisions about their inmate-patients and promote a safe environment.

Physicians who work in corrections are frequently faced with "dual loyalty" conflicts, where two or more ethical principles may be in opposition. For example, health care staff may identify an elderly patient who is being physically abused by a younger inmate in order to extort prescribed controlled substances from the patient. The elderly patient may not want the abuse reported to authorities for fear of reprisal by other inmates. Staff need to consider and balance the principles of autonomy (the patient's expressed desire), non-maleficence (possibly putting the patient at risk of physical harm), and justice or fairness (maintaining proper security in the

correctional facility). Participation in the carrying out of a death sentence would present an irremediable ethical conflict for the correctional physician.

Black and Sade point out that one source of difficulty in implementing this seeming simple precept is that various community groups do take different approaches to the matter. A professional society's ethical principle may not be consistent with the statements and positions of a licensing board, a legislature, or a court. Similarly, there is not unanimity within the world of corrections.

The National Commission on Correctional Health Care (NCCHC), while not a membership organization, is a leader in setting standards for health services in corrections. Growing out of an AMA program based on a study of jail health care in the early 1970s, NCCHC also operates a voluntary accreditation program for correctional facilities that meet its standards. In the early 1980's, the NCCHC Board of Directors adopted a Position Statement opposed to physician participation in executions, which in 1992 was incorporated into their standards. Their current 2003 Standards for Health Services in Prisons include the non-mandatory standard that "The correctional health services staff do not participate in inmate executions."⁶

The American Correctional Association (ACA) claims to be the oldest and largest international correctional association in the world.⁷ Originally an organization of state commissioners of corrections and facility wardens (the National Prison Association), ACA has long had a focus on the security side of corrections. A membership association, ACA also promulgates standards for the operation of correctional facilities and operates a voluntary accreditation program used by about 80% of state correctional systems and the Federal Bureau of Prisons. ACA began to incorporate health services in its standards in 1989. However, there is currently no ACA position statement or standard restricting correctional health professionals' involvement in executions

The Supreme Court is now considering a case that will apparently involve reviewing methods of performing lethal injection, to help lower courts determine whether such methods are constitutional.⁸ The case was heard January 7, 2008, with a decision expected by the end of summer. The Society of Correctional Physicians hopes that the Court recognizes that these ethical principles are vitally important, and that correctional physicians should not be made a part of the legal apparatus for conducting an execution.

Along with the AMA, SCP believes that physicians should not participate in executions except to the extent of signing a death certificate. Execution

should not be performed as part of a physician managed medical process, and pretending that physician involvement can be “de-medicalized” by legislative and/or judicial fiat is naïve at best.

Ideally the Court should make an affirmative decision about whether any manner of execution is constitutional, and if so, specify that manner, so no ambiguity remains. Rather than trying to make execution a medical procedure, the Court, if it holds execution to be constitutional, should specify several manners of execution that are judicially acceptable and determined to constitute neither “cruel” nor “unusual” punishment. The executioners should be specially trained members of the criminal justice system, whether prison security staff or court personnel.

As with community practicing physicians, correctional physicians should be encouraged to focus on caring for their patients. Outside groups should not try to increase the burden of “dual loyalty” ethical conflicts above those that are already inherent in medical practice.

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¹ Black, L, and Sade, RM. Lethal Injection and Physicians. *JAMA*. 2007;298(23):2779-2781.

² Gawande, A. When Law and Ethics Collide —Why Physicians Participate in Executions. *N Engl J Med*. 2006;354(12):1221-1229.

³ Farber, NJ, et. al. Physicians’ Willingness to Participate in the Process of Lethal Injection for Capital Punishment. *Ann Intern Med*. 2001;135(10):884-888.

⁴ Koniaris, LG, et. al. Inadequate Anesthesia in Lethal Injection for Execution. *The Lancet*. 2005;365(9468):1412-1414.

⁵ Society of Correctional Physicians web site. Code of Ethics at <http://www.corrdocs.org/framework.php?pagetype=aboutethics&bgn=2>.

⁶ Standards for Health Services in Prisons. Chicago, IL: National Commission on Correctional Health Care; 2003:135-136.

⁷ American Correctional Association web site, at <http://www.aca.org>.

⁸ Liptak, A. States Hesitate to Lead Change on Executions. *The New York Times*. January 3, 2008:1.