

## Beneficence versus maleficence: Can this PA participate in an execution?

### CASE

Mr. Y is a 32-year-old male who has been in fairly good health since his arrival at the state penitentiary 16 years ago. He has been on death row since his conviction for killing a 16-year-old friend. When Mr. Y was 28 years old, he developed hypertension, which is presently controlled at 128/78 mm Hg with atenolol (Tenormin), 25 mg daily. He has had the occasional cold, flu, and GI upsets, all brief illnesses that were treated symptomatically. The PA working at the prison has cared for Mr. Y for the past 10 years. Mr. Y's execution is set to take place in 10 days. The method of execution is lethal injection. Mr. Y asks the PA if he will place the IV and be present at the execution in case something goes wrong.

### THE ETHICAL QUANDARY

The PA asks, "May I place the IV and be present at Mr. Y's execution? Is it unethical to do this? I would like to be there to make sure nothing goes wrong and to ease his suffering, which I think it is part of my job."

### DISCUSSION

The principle of *beneficence* involves being of benefit to the patient and taking positive steps to actively prevent harm. In this case, beneficence involves making sure all the steps in preparing for an execution by lethal injection—placing the IV properly, mixing and administering the drugs correctly—are taken appropriately. In this case, however, beneficence seems to conflict with

the principle of *nonmaleficence*—the obligation not to harm others. In this case, nonmaleficence means not participating in the killing of a person.

**Medical indications (beneficence and nonmaleficence)** Mr. Y is healthy, other than his well-controlled hypertension.

**Patient preference (autonomy)** Mr. Y has decision-making capacity and is able to make informed choices.

**Quality of life (beneficence, nonmaleficence, and autonomy)** Mr. Y's quality of life in prison is adequate. He is well fed and has exercise and some recreation.

**Contextual features (justice)** In the United States, the death penalty is legal, and 38 states permit executions. In 37, the main method of inducing death is lethal injection.<sup>1</sup> The mixture of drugs includes sodium thiopental, a sedative hypnotic used to induce sleep; pancuronium bromide, a paralytic used to eliminate any untoward movement of the inmate in the death process; and potassium chloride, used to obtain cardioplegia.

This process of lethal injection was designed by Dr. A. Jay Chapman, who was asked by the Oklahoma legislature to find a less expensive, less violent, more "humane" way to execute prisoners than the one provided by the state's electric chair, which was expensive to repair.<sup>2</sup> The lethal injection formula was first used in Texas in 1982. These three drugs have become standard for lethal injection, but the doses given

have varied in the 37 states permitting executions.

Curfman and colleagues have commented on concerns about inadequate or inappropriate administration of the agents:

*The use of [the] neuromuscular blocker, pancuronium bromide, as part of the protocol has been especially controversial, since it has no anesthetic properties and only paralyzes the person, which can mask inadequate anesthesia if a sufficient dose of sodium thiopental has not been administered. The person may be alert and aware and may suffocate owing to paralysis of the respiratory muscles, but there is no way to know it. Also, the subsequent intravenous administration of potassium chloride would cause excruciating pain in a conscious person, but this too would be concealed by paralysis.*<sup>3</sup>

The various state statutes require or permit the presence of a physician at the execution, and the level of physician involvement during the execution also varies among the states. One state requires the presence of a "physician's" assistant.<sup>4,5</sup>

In 1980, the Council on Ethical and Judicial Affairs of the American Medical Association (AMA) prohibited physicians from participation in capital punishment.<sup>6</sup> Their report stated in part that "An individual's opinion on capital punishment is the personal moral decision of the individual ... [but] a member of a profession dedicated to preserving life ... should not be a participant in a legally authorized execution."<sup>6</sup> In 1992, the AMA issued a further statement, which noted that participation in executions is

*... defined generally as actions which would fall into one or more of the fol-*

### CONTACT US

#### Do you have an ethical quandary?

Please e-mail your ethics question to [jaapa@aapa.org](mailto:jaapa@aapa.org). We will consider it for discussion in a future installment of PA Quandaries

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“More than 40% of physicians see nothing wrong with a physician actively injecting the condemned prisoner with lethal agents.”

lowing categories: (1) an action which would directly cause the death of the condemned; (2) an action which would assist, supervise, or contribute to the ability of another individual to directly cause the death of the condemned; (3) an action which could automatically cause an execution to be carried out on a condemned prisoner.... Physician participation in an execution includes, but is not limited to, the following actions: prescribing or administering tranquilizers and other psychotropic agents and medications that are part of the execution procedure; monitoring vital signs on site or remotely (including monitoring electrocardiograms); attending or observing an execution as a physician; and rendering of technical advice regarding execution. In the case where the method of execution is lethal injection, the following actions by the physician would also constitute physician participation in execution: selecting injection sites; starting intravenous lines as a port for a lethal injection device; prescribing, preparing, administering, or supervising injection drugs or their doses or types; inspecting, testing, or maintaining lethal injection devices; and consulting with or supervising lethal injection personnel.<sup>6</sup>

The AAPA has reaffirmed its position on executions in the AAPA Policy Manual<sup>7</sup> and in Guidelines for Ethical Conduct for the Physician Assistant Profession: “Physician assistants, as health care professionals, should not participate in executions because to do so would violate the ethical principle of beneficence.”<sup>8</sup>

**Case analysis** At first glance, this case seems straightforward. *Primum non nocere*—first, do no harm—is a principle we apply daily. The Hippocratic oath states: “I will prescribe regimens for the

good of my patients according to my ability and my judgment and never harm anyone. To please no one will I prescribe a deadly drug, nor give advice which may cause his death.”<sup>9</sup> On the other hand, we also practice medicine to benefit our patients by actively removing or preventing harm. At times, taking positive steps to benefit our patients may even endanger us as providers, as during infectious disease epidemics. Nonmaleficence in this case involves refraining from an action, whereas beneficence means performing an action.

Some in the medical community support a physician’s active participation in executions. Waisel argues not the right or wrong of capital punishment but rather for the participation of physicians in lethal injection in order to provide a more humane manner of death—to decrease the suffering of the inmate by providing venous access, preparing the agents, and administering them.<sup>10</sup> He says, “Physician participation in capital punishment does have associated harms. But the question is whether potential benefits are sufficiently clear and the potential harms are poorly explained, we should permit physician participation in capital punishment.”<sup>10</sup>

Clark has a different position and incorporates beneficence, nonmaleficence, and justice to support it.<sup>11</sup> He argues that what may appear to provide a more humane manner of death and to decrease the suffering of the inmate in fact causes the death of an otherwise healthy person. When physicians cause death, it is counter to all other actions and the basic conception of healing and caring. “Participation in taking a life of a healthy person at the command of the state not only fails the test of beneficence but also fails the test of nonmaleficence.”<sup>11</sup> “If the principle

of justice mandates that each person should be treated fairly and equitably, the physician participation in executions clearly violates the principal of justice. Since it is not a proven deterrent, it allows for errors.”<sup>11</sup>

**Final comments** In their survey of physicians, Farber and colleagues made some unsettling observations, including that 43% of physicians believe nothing is wrong with physicians actively injecting the condemned inmate with the lethal agents.<sup>12</sup> Only 3% were aware of the AMA’s guidelines on executions.<sup>12</sup>

On January 7, 2008, the US Supreme Court heard oral arguments in the case of *Baze v Rees*,<sup>13</sup> where the question was whether lethal injection as currently practiced violates the constitutional prohibition against “cruel and unusual punishment.” The Court’s decision should be issued by July of this year and may well affect health care providers’ participation in executions. **JAAPA**

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