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# Physicians, Medical Ethics, and Capital Punishment

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In the 1986 decision *Ford v. Wainwright,* the United States Supreme Court held that executions of the mentally disordered violate the Eighth Amendment prohibition against cruel and unusual punishment.[1] In that case, Justice Lewis Powell articulated a standard that prisoners should, at minimum, be able to understand that they are about to die and why. What was not resolved in that case was whether the government could medicate condemned prisoners who became mentally disordered after trial but before their execution. Since receiving a death sentence for a 1979 murder, Charles Laverne Singleton has become delusional and paranoid. In early 2003, the U.S. Court of Appeals for the eighth District ruled that Arkansas can try to bring Singleton out of his disordered state by medications given against his will.[2] In October 2003, the Supreme Court declined to hear an appeal of this ruling. The decision opened the way to the forcible medication of Singleton. At state behest, physicians did exactly that, and, after Singleton's mental state was successfully restored, he was executed in the summer of 2004.[3]

The state's expectation of physicians' assistance in readying psychiatrically disordered convicts for execution is at profound odds with the moral standards that physicians have set for themselves. As a matter of professional ethics, major medical organizations have concluded that physicians should not participate in executions, in general, and should not ready prisoners with mental illnesses for execution, in particular. As matters stand, there is an unnerving dissonance between what many states expect from physicians at criminal executions and what professional codes describe as ethically acceptable conduct.

A moral standard that is routinely ignored invites contempt for both the standard and its author. To avoid this effect, there are several options open to the medical profession. Medicine could ignore the conflict as something eclipsed in importance by other pressing goals. It could also work to bring state statutes into line with the moral standards of the profession. Physicians could also simply boycott executions and leave states empty-handed when it comes to carrying out death sentences. Or, in the name of respecting the choice of individual physicians, it could alter its advisories against involvement in criminal executions. Despite the *laissez faire* approach advocated by some commentators, there are morally convincing reasons why physicians should withdraw from executions even if states ask for their help in putting people to death, even if the law continues to define a role for them.

## A QUESTION OF MEDICAL ETHICS

Physicians do not hold uniform views about capital punishment. The influential American Medical Association (AMA) *Code of Medical Ethics* concedes, "An individual's opinion on capital punishment is the personal moral decision of the individual."[4] That said, the AMA *Code of Medical Ethics* then goes on to prohibit direct participation by physicians in criminal execution, namely actions that directly contribute to the death of the prisoner or that otherwise assist, supervise, or enable another person to cause the death, as well as actions that "automatically cause" executions to be carried out. Among other things, the AMA *Code of Medical Ethics* specifically excludes prescribing or administering drugs that are part of the execution procedure, monitoring vital signs, rendering technical advice regarding the execution, or otherwise attending or observing the execution as a physician.

By contrast, the AMA *Code of Medical Ethics* does allow *indirect i*nvolvement in criminal execution, such as medical testimony from a physician regarding competence to stand trial, forensic testimony, testimony regarding medical matters relevant to sentencing, and testimony related to legal assessments of competence to be executed. It also permits physicians to certify death, provided someone else has made a prior declaration of death. Physicians may witness executions so long as they do so in a nonprofessional capacity. Physicians may even administer drugs to relieve suffering so long as they do so at the prisoner's specific request and not, for example, at the request of the state to make the prisoner more pliant for execution. The *Code of Medical Ethics* also specifically forbids readying psychiatrically disordered prisoners for execution.

While the AMA has the most fully developed advisory on these matters, it does not stand alone in its opposition to the direct involvement of physicians in execution or readying psychiatrically disordered prisoners for execution. The American Psychiatric Association takes a very similar stand,[5] as do the American College of Physicians,[6] the World Medical Association,[7] and Physicians for Human Rights.[8] Many state medical societies are of the same opinion. In Texas, which carries out more executions than any other state, the Texas Medical Association advises physicians, "A physician may be present at an execution by lethal injection *for the sole purpose of pronouncing death*."[9] (Emphasis added.) In its formally defined standards, medicine has drawn up a uniform and invariant standard against the direct participation of physicians in execution that is neither unclear nor ambiguous. It does not appear that any professional medical group that has considered the matter has ever come to a different conclusion.

## PHYSICIANS AND CRIMINAL EXECUTIONS

Despite the monolithic counsel of medical organizations, physicians do participate in executions. Indeed, physicians hold a central role in the history of capital punishment. In the eighteenth century, the French physician Joseph Guillotine devised the decapitation device named after him.[10] Another physician, Antoine Louis, contributed the angled blade that made that iconic device more effective. Physicians oversaw the first electrocutions in the U.S. in 1890.[11] It was a U.S. anesthesiologist who in 1977 formulated the method of lethal injection now in wide use.[12] Regardless of the method involved, physicians are ordinarily not far from executions. Jurisdictions that allow capital punishment sometimes require physicians at the execution. In some states, execution guidelines do not appear to preclude physicians from themselves administering lethal injections.[13]

States that allow capital punishment are not unaware that professional ethics condemn physicians' participation in executions. Some states address this discrepancy not by withdrawing physicians from execution, but by protecting physicians who do participate from any legal or licensing repercussions. For example, some states have adopted statutes that define the administration of lethal substances at executions as behavior that falls outside the realm of medicine. What this means is that the administration of lethal substances is specifically excluded from the medical practices that fall under the review of state medical licensing agencies that are entitled to investigate physicians for violations of professional ethics.[14] Under such statutes, physicians do not have to answer to licensing agencies because of their involvement in executions. Legisla-

tures have put other statutory protections in place as well. In the summer of 2003, Illinois withdrew physicians entirely from execution.[15] Prior to that, however, the state used statutes to keep the names of physicians who were involved in execution confidential and allowed cash payments for their services, to protect their identities. In most jurisdictions, therefore, physicians may participate in execution—even to the point of administering lethal substances—without fear of interference from the state agencies that have been charged to oversee physicians' ethics.

Statutory requirements for physicians' involvement in executions have survived legal challenge. In 1998, a group of California physicians sought to enjoin the state from requiring physicians' participation; they pointed to professional licensing standards that forbid unethical conduct. The penal code in California at the time required three "alienists" to examine inmates who were scheduled for execution and to investigate their mental state. The physicians who brought the suit claimed that examinations of this kind were forbidden as a matter of medical ethics. In *Thorburn v. Department of Corrections*, the California Court of Appeal held that the state legislature did not intend this involvement to open physicians to charges of professional misconduct.[16]

The profound conflict between formally stated medical ideals and the reality of criminal execution is not simply a state of affairs imposed by state legislators on unwitting physicians. Although the matter is not well studied, ethical advisories against physicians' involvement run up against the actual beliefs of physicians who believe there is a place for medicine at executions. After an imposed moratorium on executions, the Supreme Court eventually upheld the legitimacy of capital punishment,[17] and most Americans favor the practice, as do many physicians.[18] It appears that most physicians are unaware of professional advisories against participation in executions.[19] Two companion studies of physicians from all fields showed that only 3 percent of the respondents knew that professional organizations offered any ethical guidelines on the matter.[20] Moreover, a majority of those surveyed actively supported physicians' involvement in capital punishment, and substantial numbers of physicians believe it would be appropriate for a physician to carry out some of the procedures that ethics codes specifically describe as morally objectionable, including the administration of lethal injection.[21]

In short, when it comes to capital punishment in the U.S., physicians help design the means of death, evaluate fitness, sometimes inject lethal substances, and otherwise act as agents of the state in putting prisoners to death. They do so against the wishes of their professional bodies, and their actions are protected as a matter of law. This conflict is too important to leave in a state of permanent contradiction. Moving to resolve this conflict will help promote the values that are important to medicine and to throw light on executions themselves. There is a strong case to be made that a resolution will require physicians to withdraw from any direct role in execution as a matter of professional morality.

## THE ETHICS OF PHYSICIANS' INVOLVEMENT IN CRIMINAL EXECUTIONS

Medical ethicist Edmund Pellegrino has said that medical ethics is almost entirely the elaboration of one precept in the Hippocratic Oath: "I will follow that system or regimen which, according to my ability and judgment, I consider for the benefit of my patient and abstain from whatever is deleterious and mischievous."[22] Many of the theological and historical components of the Oath have no place in contemporary moral analysis. No one worships, for example, at the temples of the gods in whose name the oath is sworn, gods such as Apollo, Hygiea, and Panacea. Furthermore, the Oath's categorical prohibition of surgery lacks credibility. Nevertheless, could the Oath be useful in providing guidance about medicine and criminal executions? As philosopher Robert Veatch has observed, there is nothing in the Oath that explicitly rules out physicians' involvement that way.[23] On the one hand, one could say that readying a prisoner for execution and taking part in that execution offer no benefit to the prisoner, insofar as those actions ordain the prisoner to death. On the other hand, it might be plausible to say that physicians' involvement protects prisoners from undue harm and cruelty. As in other matters, the Hippocratic Oath fails as a practical guide on this question, and physicians must look elsewhere when trying to decide the morality of physicians' involvement in execution.

## THE CASE AGAINST PHYSICIANS' INVOLVEMENT

Since 1980, the AMA has justified its opposition to physicians' involvement as a matter of preserving life when there was hope of doing so.[24] Critics have not failed to note that physicians are frequently involved in decisions to limit or forgo treatment when patients or their surrogates conclude that additional treatment is without meaningful benefit. In other words, physicians do not act to prolong life under all circumstances. That being the case, shouldn't physicians be free to participate in execution? One commentator put the matter this way: "What is important is not that physicians stave off death, but that they tailor their actions, as much as possible, to the interests of their patients and the realities and necessities of the circumstances."[25] The AMA justification is rightly open to criticism because it is overbroad and idiosyncratic. It is overbroad because prolongation of life is not the goal of all medical interventions, and it is idiosyncratic because this rationale is not used anywhere else in the AMA *Code of Medical Ethics* as a guide to physicians' conduct. If this is all there were to the matter, it would have to be ceded to the critics that the rationale against physicians' participation in criminal executions is unconvincing.

In fact, there are other moral considerations that make a much more convincing case against physicians' involvement. For example, the AMA expresses its position on the responsibilities of physicians to their individual patients this way: "A physician shall, while caring for a patient, regard responsibility to the patient, as paramount."[26] This kind of moral vision—centered on advocacy within a therapeutic relationship—offers a better rationale against physicians' involvement in execution than prolongation of life. Asking a physician to design, supervise, and carry out executions undercuts the therapeutic goal of caring for the well-being of a person. In other words, an essential component of the relationship is abrogated.

Participation in criminal execution also opens up several important questions about whose interests physicians are serving, and at what cost to their own intellectual and moral independence. The matter can be raised as a case of divided loyalty. To whom does the physician ultimately answer, the prisoner or the state? In some cases, there is also reason to worry that physicians are not participating entirely of their own free will. Many physicians who participate in execution do so as employees of departments of corrections. A 1994 report by Human Rights Watch described the job pressure felt by several physicians who played a role in their state's executions.[27] Concerns along these lines raise worries that both prisoners' and physicians' interests both are directed by the state. It is hard to see that a patient's interests can be protected as paramount under these circumstances.

## THE CASE FOR PHYSICIANS' INVOLVEMENT

Despite medicine's professional advisories, some commentators believe that criminal execution is more humane when physicians are involved; when they use their skills and expertise to ensure that executions go smoothly.[28] For example, physician and attorney Kenneth Baum argues that physicians should be at executions for the psychological good of the prisoner, specifically because of their medical expertise in dealing with terminally ill patients. In fact, Baum goes so far as to say, "Condemned death row inmates are, for all practical purposes, terminally ill patients, albeit under a nontraditional definition of the term, and deserve to be treated as such."[29]

Physicians' involvement could protect against some of the botched executions that have been reported.[30] What remains unsettled, though, is why a physician's presence is necessary, rather than the involvement of other skilled parties. Surely, executions are not botched because there is imperfect knowledge about what it takes to kill a human being by way of lethal injection, hanging, or electrocution, for that matter? Perhaps the solution to botched executions is not the involvement of physicians, but a greater sharing of knowledge and techniques among state agencies that carry out executions? It should also be noted that prisoners are not terminally ill patients in the sense of having underlying pathological processes that will eventuate in their death. Condemned prisoners face death in consequence of intentional actions undertaken for the explicit purpose of killing them. A physician's actions in the execution process do not diagnose, prognosticate, or treat a prisoner for an underlying pathological disorder. The psychological state of condemned prisoners is important to physicians, but these concerns are fully addressed in medical ethics: physicians may aid and

even medicate condemned prisoners so long as they do so at the prisoner's request. Doing so does not require taking on additional roles assigned by the state.

Some critics of existing codes of medical ethics reject the distinction between direct and indirect involvement that defines the boundaries of legitimate medical involvement.[31] These commentators are skeptical that there is a meaningful way to draw this line, and believe it is morally spurious to say that physicians may testify at trials involving the death penalty, but not declare a prisoner dead after a lethal injection. Commentators in this camp note that the participation of physicians at various points in legal proceedings are integral parts of the process that leads to condemnation and execution. Isn't it simply arbitrary to say that physicians may do certain things in this process but not others?

By way of response to this line of criticism, it should be noted that few distinctions fully cleave a subject into wholly separate parts. Nonetheless, it is reasonable to distinguish physicians' involvement in the justice system *prior to* conviction and sentencing from physician involvement *afterward.* During the course of criminal proceedings, physicians aid the state as they diagnose, prognosticate, and testify about medical aspects of a case. However, these activities are part of a process designed to evaluate allegations of wrongdoing, as well as fitness relative to a proposed sentence. The physician's participation with the legal system prior to conviction is not inherently ordained toward conviction or a specific punishment: this participation is part of a *truth-finding process.* Participation in execution has no parallel function: its purpose is enforcement. This difference between truth-finding and enforcement is enough to sustain a meaningful moral distinction between direct and indirect participation in execution. While it is true that some condemned prisoners are spared by unexpected, last-minute reprieves or for other reasons, physicians who take direct roles in criminal execution are no longer acting as advisors to the court.

When it comes to the views of individual physicians, some commentators note that medical organizations allow physicians to support capital punishment as a matter of individual conscience, but then go on to forbid their actual involvement.[32] What justifies, they wonder, closing off freedom to act on that belief? These commentators want the matter left to individual choice, as is done some with other controversial medical practices.[33] Yet, as a matter of logic, there is no contradiction here: it is one thing to say that individuals are free to believe as they choose about whether states ought to use capital punishment. It is another thing altogether to say that physicians' involvement in this practice betrays certain values important to the profession and—for that reason—no physician should play anything but an indirect direct role.

What about physicians' involvement in other socially controversial practices, such as abortion? Isn't that a precedent that opens the door to physicians acting in accordance with their own consciences, without the need for a uniform standard for all physicians? Despite its nineteenth-century history as a prime mover behind the criminalization of abortion in the U.S.,[34] the AMA *Code of Medical Ethics* now advises that its principles of ethics do not prohibit a physician from performing an abortion under appropriate medical and legal circumstances.[35] Why not treat participation in execution the same way? One key difference between abortion and criminal execution is the question of agency. In abortion, physicians act on behalf of a patient whose deliberated choice is the ultimate justification for the procedure. In criminal execution, by contrast, the physician is acting on behalf of the state, whose judgments do not coincide with the interests of the prisoner. In criminal execution, the physician is enlisted by the state for the purpose of killing a party, about whom the physician may otherwise know nothing—except that he or she will be put to death. These prisoners are not free to terminate this relationship or agree to the physician's involvement, something they are free to do in other healthcare relationships. In execution, the physician must perform to the satisfaction of the state, not to the satisfaction of a patient. This difference in agency is enough to distinguish physicians' involvement in abortion as materially different from involvement in criminal execution; it is enough to call the participation of any physician in these circumstances into moral question.

## TREATING PSYCHIATRIC DISORDERS IN ACCUSED AND CONDEMNED PARTIES

The state asks for physicians' help not only at executions proper, but also to ready psychiatrically disordered prisoners for execution. The courts have generally accepted involuntary medical treatment for prison-

ers and accused parties when important legal considerations are at stake. In 1990, the Supreme Court held that prisons could medicate prisoners against their will in order to protect their well-being and that of others; prison guards, for example.[36] What about treating prisoners so that they may stand trial and undergo execution? In 1992, the Supreme Court held in *Riggins v. Nevada* that the state could not medicate a particular prisoner to make him competent to stand trial.[37] That ruling turned on particular facts of the case, and did not mean that states could never medicate to make accused parties competent to stand trial. In the summer of 2003, the Supreme Court decided a case involving a mentally disordered dentist accused of fraud and money laundering; he believed involuntary medication was part of a conspiracy to kill him.[38] The court held that involuntary treatment is acceptable when that treatment is necessary to achieve an important government goal, when there is reasonable likelihood of its success, and when there is little risk of significant side-effects.[39] This ruling affects not only the accused dentist, but all other similarly situated accused parties. It is a reasonable approach, because medical treatment for psychosis is presumably in the dentist's best interest, to the extent it enables him to participate in the truth-finding purposes of the court. The case of the accused dentist is, therefore, materially different from the case of Charles Singleton in Arkansas. The question at stake in Singleton's case is whether he ought to be medicated, brought out of mental disorder if possible, only to be walked down the hall and injected with lethal substances. In this case, it is the state that is the primary beneficiary of Singleton's treatment.

The AMA advisory against readying psychiatrically disordered patients for execution does not mean that physicians should never treat death row prisoners. That approach would orphan people who suffer from medical disorders. The AMA is sensitive to the dilemma that may confront some physicians: if a physician treats a prisoner at the state's request, that treatment may in fact hasten the execution of the prisoner, opening the physician to a charge of violation of fiduciary responsibility toward the prisoner as patient. On the other hand, if all physicians decline to treat condemned prisoners, these prisoners may be left in extreme suffering. An internal AMA report described medical responsibility in these cases this way: "If [death row] prisoners lack competence to provide informed consent to treatment, therapeutic interventions, including the use of psychotropic medications, can be provided in accordance with ethical principles and state law. . . . In such instances in which there is extreme suffering, medical intervention, which is intended to mitigate the level of suffering is ethically permissible."[40] In drawing the distinction between the alleviation of suffering and preparing for execution, the report noted, "it will not always be easy to distinguish between these situations, perhaps even to determine when treatment initiated to reduce extreme suffering should be stopped. While even brief treatment of a severe psychotic disorder may have the unintended effect of restoring the prisoner's competence for execution, there is no alternative at this time than to rely upon the treating physician to exercise judgment in deciding when and to what extent treatment is necessary to reduce suffering."[41]

It will certainly be difficult to negotiate this finely drawn line—between treatment to reduce suffering and treatment to prepare for execution—in all cases. To protect physicians from crossing this line, however, the AMA and other professional groups recommend that states commute the sentences of condemned prisoners who have disabling psychiatric disorders. In this way, physicians would be able to treat prisoners without worrying that they are—through that very treatment—readying their imprisoned patients for execution. Medical organizations have concluded that commutation is desirable because it serves a balancing function between conflicting interests: the government's interest in enforcing the law and medicine's interest in avoiding any direct role in causing death. The State of Maryland has, in fact, chosen this approach: it requires the commutation of capital sentences when prisoners are not competent—despite treatment—to understand that they are to be executed and understand why.[42]

## COMPLICITY IN INJUSTICE AND ERROR

In early 2003, Illinois brought capital punishment in the U.S. under international scrutiny when its former governor, George Ryan, pardoned four inmates on death row and commuted the death sentences of 164 others to life imprisonment. Ryan said the justice system was "broken," both in the way capital sen-

tences were levied and prosecuted. This assessment was not original, but the governor's sweeping actions were without precedent in U.S. history. Whether owing to prosecutorial bias or malfeasance, substandard legal representation, or misjudgments by juries and judges, the justice system is vulnerable to the conviction and execution of innocent parties. According to one prisoner advocacy organization, more than 100 people have been sentenced to death in the U.S. but cleared afterward.[43]

As matters stand, physicians' involvement in executions occurs without any independent evaluation by the medical profession that individual capital sentences are justified. Withdrawing from roles in execution spares medicine from any complicity in misjudgments and malfeasance that take innocent human life. Many Americans—physicians among them—seem to accept the assumption that the state's prosecutions and executions adequately express a consistent and equitably applied standard of justice. Attorney and author Scott Turow, who served on a 2002 Illinois commission charged to review capital punishment, has rightly questioned this assumption. He points out that several factors lead to wrongful convictions: extreme and repellent crimes, social pressure to execute, the jury selection process, expansive standards of eligibility for death, and a general shift of the burden of proof from the state in proving guilt to the defendants to prove their innocence.[44]

A number of variables affect how prosecutions go forward and how sentences are imposed, and this includes the race and gender of the victim (some crimes are punished more vehemently than others) as well as the location of the murder (some jurisdictions are more prone to use capital punishment than others). As Turow notes, these variables call into question the notion that capital punishment expresses a uniform or broadly shared morality, as opposed to a system that is open to prejudices and preconceptions.[45] Even people who are tried for the same crime can meet with different outcomes. In 1999, Illinois freed Anthony Porter after a wrongful conviction for multiple murders; at one point, he was just two days away from execution. The man who was eventually convicted for these murders was sentenced only to 37 years of imprisonment. The troubling lack of uniformity in sentencing outcomes could hardly be starker than this difference between death and life.

All social systems are imperfect, of course, so it is reasonable to wonder whether mistakes in capital punishment are more grievous than those tolerated elsewhere, such as deaths due to plane or automobile travel, for example. Capital punishment is a social judgment that people's lives—not some portion, not some part, but life itself—ought to be forfeited because no other social reaction is commensurate to their crimes. Making a mistake, taking an innocent party's life, is therefore unlike any other kind of error: participation in this kind of error trivializes our deepest moral expressions. Yet physicians' participation in executions at present goes forward without any independent assessment from medicine that execution is merited as a matter of justice or deserved by the individual prisoner in question.

The question of complicity with a flawed system of criminal executions is not, of course, a question for physicians alone. It is a question for every citizen of states that allow capital punishment. But the importance of the question increases in moral gravity for those who play a significant role in criminal execution: prosecutors, judges, defense attorneys, even wardens and prisoner guards. People in these groups have pressing reasons to consider the integrity of their work in relationship to a system's flaws that end in the execution of the innocent and the collapse of the state's integrity. It is especially incumbent upon physicians to consider their involvement with a flawed criminal execution system, because doing otherwise compromises their own deliberated ideals of professional responsibility to patients and the improvement of society.

For many commentators it is an open question whether error, prejudice, and malfeasance can be rooted out of the system of capital punishment. Doubts about equity in capital punishment have been given eloquent expression by the U.S. Supreme Court Chief Justice Harry Blackmun, who famously wrote in his 1994 dissent to the majority opinion of *Callins v. James,* "From this day forward, I will no longer tinker with the machinery of Death," and, "The basic question—does the system accurately and consistently determine which defendants 'deserve' to die—cannot be answered in the affirmative."[46] The question worth raising is, are individual physicians willing to continue their participation in executions as though they did not know whether an individual prisoner was sentenced to death fairly and equitably; as though they did not know

whether their participation amounts to moral complicity with a miscarriage of justice?

In calling for physicians at executions, Baum has argued, "Physicians also participate in executions to assist society in ensuring that individuals are treated fairly and that some degree of humaneness may potentially be added to the process."[47] In his view, the presence of physicians sends a signal to the public that people are not subjected to barbaric treatment as they are put to death. However, this argument fails to note that the presence of physicians also extends to execution some degree of integrity that the public attaches to medicine. The presence of physicians at execution could wrongly signal to the public that all is well with a system that is, in fact, open to mistakes and malfeasance. If the state wants to kill people, the state should take the responsibility for execution and not ask physicians to loan the halo effect of medicine—such as it is—to a process that is not only flawed, but apparently willing to hide its own mistakes.

## TOWARD A MORE CONSISTENT MEDICAL ETHICS

The ethical advisories of major medical organizations present a unified front against physicians' direct involvement in criminal execution. This consensus is undercut by states that require physicians in key roles at execution and offer them cash, confidentiality, and professional immunity in return. Physicians themselves also undercut this consensus when they prepare, assist, monitor, and carry out execution.

Some critics have said that medical organizations should not use their advisories to advance a political agenda against the death penalty.[48] But resistance to the involvement of physicians in execution is primarily an ethical consideration, one rooted in a moral vision of what is important to the ethics of healthcare. Medical organizations have concluded that it is inconsistent to involve physicians in criminal execution, and, at the same time, expect them to act with compassion, respect, and in the best interests of their patients. As it is, some physicians behave as if medical groups had concluded nothing about capital punishment. If professional organizations genuinely believe that physicians' involvement is unethical, it certainly falls to them to communicate that message across their membership. It also falls to them to make the case plainly and persuasively to all physicians, not just to those who object to capital punishment in general.

There is a stark choice at hand for U.S. physicians: whether to participate in executions or whether to work to undo laws that give them a role in the death penalty. Even if changes in the law are not forthcoming, physicians should withdraw from criminal execution to protect their ability to serve as advocates for people under their care, to protect the independence of their judgments, and to avoid complicity with misjudgment and error. There is, otherwise, a glaring contradiction between the lofty ideals of the profession and the gritty reality that physicians are not far from most executions in the U.S. Given misjudgments made in the course of prosecution, trial, and sentencing, it is hard to avoid the conclusion that the community would be better served if medicine threw its critical intellect to questions of equity in the death penalty rather than fine-tuning individual executions. In any case, reinvigorating debates about medicine's role in execution would go a long way toward shoring up professional standards and helping rethink how prisoners are put to death in this country—and with whose help.

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