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Medical Ethics and Competence for Execution

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Bernice Elger mounts a powerful critique of the ethical standards for delivering healthcare at most U.S. correctional facilities.[1] According to Elger, these standards are rooted in a basic proposition of *accommodation to penological interests*: balancing the rights of incarcerated patients to confidentiality or informed consent against the alleged needs of penal institutions to restrict or altogether eliminate such rights. Elger points up the bland and morally weak pronouncements of many U.S. professional organizations regarding the provision of care to prisoners, and rightly denounces the scandalous policy of "deliberate indifference."

In sharp contrast to the U.S. position is the stance of many European and international professional and judicial bodies, broadly endorsing a particular conception of justice — the *principle of equivalence of care* — as the proper basis for correctional medical ethics. According to equivalence, "no distinction is made between patients who are prisoners and those who are not"; "healthcare services that are provided inside and outside correctional institutions should not differ." In short, the standards of ethical practice of medicine should be blind to the patient's correctional status. Elger summarizes her thesis this way:

> The obligation of a physician is not to balance the interests of a patient against the interests of the correctional system; rather, the principles of beneficence and nonmaleficence require a physician to consider what constitutes a good outcome for a patient, and also the possible outcomes that can be expected in the prison context, compared to the possible outcomes outside prison.

And, I would suggest, where a correctional procedure has no comparable outcome outside the prison, a corollary of the principle of equivalence says that such a procedure should immediately be suspect as a product of accommodation. While I agree with Elger that violations of equivalence are the most salient moral errors committed in correctional medicine, I am somewhat less certain that the way to rectify such mistakes is always clear. I briefly mention here one puzzling area of correctional practice where this is apparent: the treatment of death-row inmates, and more particularly still, the requirement that condemned prisoners be "competent" to die before they can be killed.

As Elger indicates, the World Medical Association, the American Medical Association, and other bodies forbid physicians' involvement in executions. Can such a ban be grounded in the principle of equivalence? This is difficult to say. After all, the obvious medical procedures typically called for in an execution — prescribing or administering medications, selecting injection sites, placing intravenous (IV) lines, monitoring vital signs, pronouncing death — are in some sense the precise equivalent of procedures routinely and appropriately afforded persons outside prison walls. Thus, an argument could be made that physicians' involvement in executions calls in this way for equivalent treatment of the incarcerated and the non-incarcer-

ated alike. Of course, the problem is here disguised by the phrase "in some sense": for in the death-chamber, these actions are in the service of directly causing death, and for most physicians that makes all the difference.

Still, there are some points at least worth considering on the side of the "equivalence" argument. As the briefs submitted to the U.S. Supreme Court in the recent lethal injection case revealed,[2] evidence continues to accumulate that the process of lethal injection in U.S. prisons is intolerably marred by botched procedures and incompetent personnel: repeatedly clumsy and painful efforts to obtain venous access, IV infiltrations, inadequate assessment of sedation levels by untrained personnel, and incompetent monitoring of vital signs. If the principle of beneficence requires an equivalent concern for the physical and mental pain and suffering of a condemned prisoner as for a non-incarcerated patient undergoing treatment, then shouldn't healthcare professionals participate even in executions (albeit reluctantly) precisely in order to ameliorate such suffering?[3] (It is worth noting that the AMA policy E-2.06 "Capitol Punishment" permits physicians to provide the condemned with "tranquilizers" to relieve the anticipatory dread of impending execution.[4])

Equally perplexing questions arise about the determination of "competence" to die. Under the Court's decision in *Ford v. Wainright*,[5] a condemned inmate may not be put to death if he fails to comprehend that he is scheduled to die and the reasons for his execution. The "competence-for-execution" (CFE) requirement generates wrenching dilemmas, both for prisoners and for healthcare professionals.[6] While the AMA enjoins what amount to direct forms of physicians' participation in the death-chamber, its policy on capital punishment reasons that "testifying as to medical diagnoses as they relate to the legal assessment of competence for execution" is not forbidden.[7] In a brief submitted in the *Panetti* case, the American Psychiatric Association saw no problems with such evaluations, confidently asserting that "mental health professionals can reliably identify the nature and extent of an individual's rational understanding of an impending execution," and calling this an "uncontroversial aspect of forensic mental health assessment."[8]

Testimony and assessments about competence to die are suspect forms of involvement in execution, according to the corollary of equivalence: for they cannot be performed in a way that is independent of penological considerations — there is no analogue to such procedures outside the penitentiary. Healthcare professionals routinely assess competence, of course — most commonly, the competence or capacity to consent for treatment. Competence-for-execution has nothing to do with decision-making capacity, however, since there is nothing for the condemned to decide. CFE is about awareness of facts pertaining to one's death. That this is so is clear from the key measures mental health professionals use to assess it. Condemned inmates are asked to relate their "beliefs about what it actually means to receive a sentence of death. . . about what it would mean for him/her to be dead . . . about transformations or changes that will happen to him/her after execution." The prisoner is prompted to explain the "procedure for execution that he/she will undergo: what happens, how it works," and is pressed to say "why s/he should be executed."[9] There is no conceivable medical need to elicit answers to such questions from anyone outside death-row. Therefore, physicians and other health professionals who evaluate an inmate's readiness to die are performing a task inextricably connected with — and in furtherance of — an exclusively penological objective; namely, to kill. This is a violation of nonmaleficence.

Yet what if physicians refuse to participate in such assessments of competence? Will these evaluations then be conducted by unqualified personnel — or worse, by correctional officials themselves, producing a patent conflict of interest? Once more, a satisfying solution is elusive. Short of abandoning CFE altogether,[10] courts, correctional officials, and medical ethicists will continue to grapple with this and the many other issues Elger has so thoroughly canvassed.

NOTES

1. B. Elger, "Medical Ethics in Correctional Healthcare: An International Comparison of Guidelines," in this issue of *JCE*.

2. *Baze, et al. v. Rees* (07-5439) (2007), *http://www.supremecourtus.gov/opinions/07pdf/07-5439.pdf*, accessed 25 August 2008.

3. Some physicians who do participate in capital punishment appear motivated by just these concerns. See A. Gawande, "When Law and Ethics Collide — Why Physicians Participate in Executions," *New England Journal of Medicine* 354, no. 12 (2006): 1221-9.

4. American Medical Association policy E-2.06, "Capital Punishment," *Code of Medical Ethics*, 2008-2009 ed. (Chicago: AMA, 2008), available at *www.ama-assn.org/ama1/pub/upload/mm/369/e206capitalpunish.pdf*, accessed 2 September 2008.

5. *Ford v. Wainwright* 477 U.S. 399 (1986).

6. See J. Spring, "Singleton's Story: Choosing Between Psychosis and Execution," *Hastings Center Report* 35, no. 3 (2005): 30-3.

7. See note 4 above.

8. *Brief for* Amici Curiae *American Psychological Association, American Psychiatric Association, and National Alliance on Mental Illness in Support of Petitioner, Baze, et al., v. Rees* (07-4539) (2007), p. 22, *http://www.psych.org/MainMenu/EducationCareerDevelopment/Library/AmicusCuriae_1.aspx*, accessed 25 August 2008.

9. See P. Zapf et al., "Assessment of Competency for Execution: professional Guidelines and an Evalution Checklist," *Behavioral Sciences and Law* 21 (2003): 103-20.

10. I have argued for just this claim in "*Doxa* and Death: Belief, Capital Punishment, and the Competence-for-Execution Requirement," an unpublished manuscript — interested readers may contact the author for further information.