EDITORIAL

# Medicalisation of 'legal' killing: doctors' participation in the death penalty

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Societal support to the death penalty in India was high during the public debate preceding the hanging of Dhananjoy Chatterjee in Kolkata. Community hysteria was such that some youngsters died in mock re-enactments of the hanging, and the hangman acquired the status of a celebrity. The support base for the death penalty has only expanded over the years, with increasing violence—sponsored by both civil society and the state. This cuts across political parties and ideologies, emboldening the judiciary, law-makers and constitutional heads to use it more often.

In 1980, in Bachan Singh v. State of Punjab, the Supreme Court, by a four-to-one majority ruled that the death penalty was constitutionally valid and did not constitute an 'unreasonable, cruel or unusual punishment'. It should be kept in mind that the terms 'unreasonable, cruel or unusual punishment' and 'rarest of rare case' are defined not by objective criteria but subjectively by judges who are influenced by public opinion. This is also true in the USA (1).

## Medical involvement in the death penalty

In the past decade, the law and judiciary have made systematic efforts to promote doctors' participation in the death penalty. In 1995, a two-judge bench of the Supreme Court decided on a petition opposing the stipulation in the *Punjab Jail Manual* that, after execution, the body of an executed person be kept hanging for half an hour. The petitioner also demanded that instead of hanging, potassium cyanide should be used for execution. The Court did not accept the second demand, but agreed that keeping the body hanging for half an hour was barbarous and ruled that 'A convict shall remain hanging only till he is declared dead by the medical officer.' As a result of this little-known judgment, a doctor must periodically examine the person after the hanging, to look for signs of life. If the person is found alive, the doctor is to ask the hangman to continue—to order hanging to kill instead of resuscitating (2).

Further medicalisation of execution was suggested in 2003, when the Law Commission of India in its 187th report recommended the use of a lethal injection (3). It is a matter of time before the Supreme Court decides—or Parliament enacts a law—that hanging is barbarous, cruel and unusual, and should be replaced by a lethal injection. The use of a lethal injection is unique because it simulates the medical procedure; the setting of the execution looks medical, and due to the condition of the prisoner it often needs a doctor's assistance to carry out.

Historically, medical professionals have played an active role in designing execution methods and in helping make existing methods more efficient. In the eighteenth century, Dr Antoine Louis designed and Dr Joseph-Ignac Guillotine advocated the decapitating machine as a humane method of execution that became infamous as the guillotine. Dr Alfred Southwick, a dentist, helped design the electric chair that was considered 'more humane' for many years. Medical expertise played an important role in the use of the gas chamber and even in hanging. Dr Stanley Deutsch, an anaesthesiologist, conceived of a lethal injection along the lines of intravenous induction of general anaesthesia. The first 'clinical trial' of the lethal injection was carried out in Texas in 1982 on a 40-year-old African–American man who was injected with anaesthetic agents as two doctors watched. He was dead within minutes (4).

In the process of an execution, doctors are involved in the care of prisoners awaiting execution, in preparations such as certifying fitness, procuring chemicals for lethal injection, sedating the prisoner on the day of execution, advising on or participating in the execution itself, pronouncing death, certifying death, removing organs for transplantation, and carrying out an autopsy. Psychiatrists carry out evaluations of the prisoner's mental state, provide testimony in capital cases (including 'fitness for execution' determinations) and give or recommend treatment. Other health professionals may be asked to carry out doctors' roles when doctors refuse to participate.

## Doctors oppose medical participation

In 1980, the American Medical Association (AMA) and in 1981, the World Medical Association strongly opposed medical participation in the death penalty. Most other national and international associations of medical and other health professionals also forbid participation of their members. In 1992, the AMA came out with detailed guidelines on medical acts in the process of execution that do or do not violate medical ethics (5). Accordingly, testifying on competence to stand trial, testifying on relevant medical issues during a trial, testifying during the penalty phase of the trial, witnessing an execution in a non-professional capacity, relieving acute suffering of the condemned and certifying death after someone else has already verified the death, are considered within the framework of ethical conduct. On the other hand, prescribing or administering tranquillisers or other drugs that are part of the execution procedure, monitoring vital signs, attending or observing the execution as a physician, selecting sites for injecting, starting intravenous lines to administer lethal chemicals, prescribing or administering the drugs, supervising lethal injection devices or personnel and pronouncing death (examining the executed person to ascertain life) are considered unethical.

The AMA guidelines, however, do not deal with issues such as providing evidence bearing on competence to be executed, treating incompetent prisoners to restore competence to allow execution, and issues relating to transplantation of organs following execution. Ethical problems in these areas are acute and fiercely debated. Interestingly, though the AMA adopted an anti-death penalty resolution in 1969, it subsequently remained silent on issues other than regulating doctors' participation. Medical associations from Europe, with the lead provided by the British Medical Association, consistently opposed the death penalty and played a key role in ensuring that it was taken off the law books of most European countries.

## Ethical challenges for health professionals in India

The 1995 Supreme Court judgment and the Law Commission's report (2003) pose major ethical challenges for health professionals in India. The 1995 court ruling demanding that a medical officer monitor vital signs while the person is hanging severely compromises medical ethics and must be opposed by the profession. Involving medical professionals in the death penalty, or demanding that psychiatrists should treat mentally ill persons to make them fit for execution, puts law and medical ethics on a head-on collision. The ethics movement must educate the judiciary and law-makers on the subject. Finally, the Law Commission's recommendation on lethal injection should be firmly opposed as it tries to give a medical face to an inhuman punishment. Doctors, who occupy a more powerful position in the medical hierarchy, must support other health professionals, such as nurses and technicians, forced by administrative orders to participate in executions.

### References

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