obliged to act, in consonance with the principles of beneficence, compassion and justice. These principles must be applied not only to the individual patient seeking help but also to society at large. The doctor-patient relationship must be complemented by that between the profession and society. The bystander role adopted by medical doctors is unethical, immoral and a dereliction of duty.

Thus far neither has the medical profession at large nor have the Medical Councils uttered a word against those doctors who fled Surat at the early indications of plague. It was left to the citizens to take the law into their own hands and show their outrage against these cowards. Is this what doctors and the Councils desire as the pattern for the future?

The role of the doctor in legal executions

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The presence of a medical doctor, charged with the saving of human life, at the legal execution of a fellow-being has disturbed many within and outside the medical profession. Most countries mandate such attendance and subsequent certification of death of the condemned person. In the event the convict is still alive, the doctor must recommend a more effective measure to kill him.

Such laws place the doctor in a cruel dilemma. The traumatic experience may haunt a sensitive physician for the rest of his life. In America, the problem is complicated by the fact that though the electric chair was created with the goal of making the execution less inhumane (as death was supposed to follow instantaneously upon the administration of a high-voltage current), in fact the convict may be subjected to agony that may be prolonged for thirty minutes.

The Hindu, in a report dated 2 May 1994, reports an important ruling by the American Medical Association (AMA). A doctor’s participation in an execution constitutes a violation of medical ethics. Mr. Arthur Caplan, director, Centre for Bioethics, University of Pennsylvania, explained that doctors "...should not participate in execution or use their medical skills basically to punish people...".

Acting on this ruling, Dr. Balvir Kapil, Chief Physician, Department of Corrections, Richmond, Virginia refused to attend the execution of Timothy Spencer, convicted for rape and murder of four women. This case had already generated publicity as Spencer was the first person to be sentenced for execution in the USA on the basis of genetic finger-printing. Without DNA collected from tissue samples at the scene of the crime, Spencer could not have been prosecuted as there were neither eye-witnesses to the crime nor circumstantial evidence.

Dr. Kapil is the first doctor in the USA to refuse to participate in the execution after the AMA ruling. In his absence, Dr. Alvin Harris, a private practitioner also working at the Correction Centre, filled in the death certificate. Dr. Harris argued that the AMA ruling was in conflict with state law.

Dr. Kapil was transferred to another department because of his refusal. The American Medical Association’s response is awaited.

This development has important ramifications in the Indian context. This is the time to re-examine the medical practitioner’s role with reference to prisoners in general and those sentenced to execution in particular. What should the doctor do when faced with a victim of torture by the police, security forces or other arms of the government? Is it his duty to make public the facts whilst treating his patient? To what extent is a medical professional obliged to accept governmental orders implicitly?

The Indian Medical Association and other bodies such as Forum for Medical Ethics should, at the outset, initiate a national debate, on this vital issue. The outcome of this debate may also have a positive impact on the move to outlaw capital punishment and execution from civilised society.

References