The North Carolina Medical Board's Stand Against Physician Participation in Judicial Executions: Implications for Physician Ethics and Professionalism

by David K. Gittelman, DO*

Setting: On November 18, 2008, Attorney Todd Brosius stood before the North Carolina Supreme Court (NCSC) arguing that the North Carolina Medical Board (NCMB) has a right to discipline physicians who participate in a judicial execution, according to North Carolina Gen. Stat. § 90-14(a), "to protect the public from unethical and unprofessional conduct by physicians."[1] Assistant Attorney General Joseph Finarelli representing the North Carolina Department of Corrections (NCDOC) told the court a doctor's presence is needed to monitor the inmate's vital signs and pronounce death. "Our position is the term 'present' does not preclude participation," he said, "The Medical Board can not discipline physicians for doing something the Legislature has told them to do."[2]

Background: In 2006, prisoners in Eastern North Carolina challenged the legality of the NCDOC execution protocol, contending that it violated the Eighth Amendment of the United States Constitution banning "cruel and unusual punishment." This challenge was denied because the NCDOC satisfied the Eighth Amendment by including a registered nurse and licensed physician's presence "to monitor the plaintiff's consciousness," (a way to prevent awareness of pain). Shortly thereafter, the NCMB received inquiries from concerned citizens regarding the appropriateness of a physician's participation in an upcoming execution. These inquiries led, after discussions with the NCDOC, the public, and physicians, to the NCMB's adoption in January 2007 of its first position statement on Capital Punishment.[3]

The NCMB Position Statement on Capital Punishment "attempted to harmonize the Medical Board's obligation to enforce the ethics of the medical profession with the statutory requirements of sections §15-190 and –192 of the North Carolina General Statutes that a physician be present (italics added) at a judicial execution and certify the execution of the condemned inmate…"[4] The NCMB Position Statement expressly forbid a physician from *participation* ("any verbal or physical activity, beyond the requirements of North Carolina Gen. Stat. § 15-190, that facilitates the execution"[5]) in an execution, adopting language directly from the American Medical Association's Council on Ethical and Judicial Affairs Opinion 2.06 on Capital Punishment.[6]

One month after the NCMB adopted the Position Statement on Capital Punishment the NCDOC revised their Execution Protocol explicitly to *include* a physician to "monitor the essential bodily functions of the condemned" and "to notify the Warden (if) the inmate shows signs of undue pain and suffering."[7] This revision, according to the NCMB, constituted physician participation in execution, a violation of medical ethics worthy of disciplinary action. The NCMB Position Statement effectively halted judicial executions in North Carolina. Thus, conflict arose between two state agencies resulting in this case that were appealed to the North Carolina Supreme Court.

Issues for physicians and the medical profession: Physicians in the United States may support or oppose the death penalty in their personal or political opinions, as recognized by American Medical Association Opinion 2.06. However, the American Medical Association has opposed physician *participation* in judicial executions since issuing Opinion 2.06 in 1980. The reasons for the American Medical Association's opposition to capital punishment have little to do with the typical concerns of a death penalty opponent. In fact, the American Medical Associaiton does not take a stand on the death penalty itself. Instead, the American Medical Association views a physician's involvement in executions as a contradiction to the professional conduct of a physician. The American Medical Association bases its standard of professional conduct in Opinion 2.06 on the idea that "A physician, as a member of a *profession dedicated to preserving life* (italics added) when there is hope of doing so, should not be a participant in a legally authorized execution," which is grounded in the Hippocratic dictum of "Primum non nocere" or "First do no harm."[6]

The public ideally, respects the medical profession for the expertise, dedication, and high moral conduct of its members and *allows* the profession exclusive rights to the practice of medicine and self-regulation of its profession. The public entrusts our profession with its health and confidences, without fear of being taken advantage of, believing the physician will follow the professional principle of putting the patient's interests before self-interest.[8] It is public trust in the beneficence of the medical profession that is threatened when physicians participate in capital punishment.

Outcome: Ultimately on May 1, 2009, a divided North Carolina Supreme Court upheld the lower court's ruling in favor of the NCDOC. The NCMB likely has no further legal recourse to challenge the North Carolina Supreme Court's decision, according to attorneys Brosius and Noah H. Huffstetler, III. In July 2009, the NCMB amended the Position Statement on Capital [Continued on page 40]

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Punishment to reflect the loss of legal right to discipline physicians participating in judicial executions, but reiterated the view that it continued to regard such activity as a *"departure from the ethics of the medical profession."*[3] Physicians are left to decide whether to follow ancient moral precepts of their profession and the bylaws of their professional organizations or to participate in lethal executions for which they have never been trained or intended to do. However a physician participating in judicial executions may risk expulsion from one's specialty organization as many (ex: North Carolina Medical Society, Society of Correctional Physicians, American Association of Anesthesiologists[9]) have bylaws that forbid participation in judicial execution and this is reportable to the National Practitioner Data Base. Of course, physicians participating in executions are often afforded anonymity,[10] but is that not enough to inform any moral person that what they are doing is wrong? ꟿ

** David K Gittelman has practiced at WakeMed for 21 years. This article is based on his final research paper for his most recent course on Medical Professionalism. Dr. Gittelman welcomes any inquiries regarding this paper, the AMA-MCW Medical Ethics Program, or medical ethics in general.*

1 *www.ncga.state.nc.us/EnactedLegislation/Statutes/HTML/BySection/Chapter_90/GS_90-14.html*, accessed Dec 2008
2 N.C. Supreme Court Hears Case on Execution Doctors Raleigh, N.C., 11.18.2008 AP *wbt.com/news/details.cfm?article_id=44419* accessed Dec 2008
3 *www.ncmedboard.org/Clients/NCBOM/Public/PublicMedia/capitalpunishment.htm*, accessed Dec 2008, Oct 2009
4 Ibid
5 Ibid
6 Code of Medical Ethics of the American Medical Association, Council on Ethical and Judicial Affairs, Current Opinions with Annotations, 2006-2007 ed. Pages 19-25
7 Woolverton, P. "Execution Protocol Approved." *The Fayetteville Observer* (NC) 7 March 2007
8 Latham, SR. Medical Professionalism: A Parsonian View. *The Mount Sinai Journal of Medicine*. 2002: 69(6);363-369
9 *www.ama-assn.org/ama1/pub/upload/mm/395/nc_captialpunishment.pdf*, accessed December 13, 2008
10 Gawande, A. *When Law and Ethics Collide – Why Physicians Participate in Executions,* 354 *New England Journal of Medicine.* 1221, 1227-28 (2006)

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newborns.

We need incentives for wider application of hospice care for terminal situations. Reality tells us that life will end for each of us no matter how elaborate our healthcare might be. In many clinical situations the hospice approach helps a patient end life with grace and dignity, with far less cost.

It is not unusual for tens of thousands of dollars to be spent on chemotherapy applied in some conditions when there is only marginal hope for clinical benefit. An alternative method could be to require that such desperate therapy be utilized only through a clinical trial protocol. Such an approach would be more humane, save expenses, and would help us to move forward with developing improvements in chemotherapy.

Data and experience show clearly that healthcare is more effective and more efficient if patients have a medical home. To make that possible, we need a system that encourages healthcare professionals to pursue careers in primary care. To accomplish that is economically challenging, but is essential for effective healthcare.

Another step that should be taken to help with this cost burden is administrative simplification of the often aggravating methodology for insurance claims. Large numbers of people work to submit claims while others process, adjudicate, and eventually pay some of the claims for work that has been done.

We need to collectively recognize the negative impact of lifestyles in this nation that contribute to chronic disease and greater healthcare costs. Can incentives be effective to change behavior regarding obesity, smoking and lack of exercise?

Finally, to come back to some change in the incentives on the provider side with its fee-for-service payment system, let me briefly describe one possibility. This change might begin with Medicare, whereby it would make payments on a per capita basis to large networks of physicians, clinics, hospitals and other medical providers. The network would in turn work out its particular plan to pay for services. Such an approach could be used to help with the medical home shortcomings and could be used to diminish the major variability in costs among different regions of the country. It would provoke better focus on and assessment of outcomes with less encouragement for more units of service.

If our democratic process would get beyond smears and exaggerations to strive toward the greater good with more constructive problem solving, we could make needed improvements. We need to minimize the people with no health insurance, and we need to have economic considerations more involved in decisions for elaborate healthcare. With strategic improvements in our system we could enhance our collective health, live longer, and save on healthcare expenses. ꟿ