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Killing for the state: the darkest side of American nursing

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The aim of this article is to bring to the attention of the international nursing community the discrepancy between a pervasive 'caring' nursing discourse and a most unethical nursing practice in the United States. In this article, we present a duality: the conflict in American prisons between nursing ethics and the killing machinery. The US penal system is a setting in which trained healthcare personnel practice the extermination of life. We look upon the sanitization of *deathwork* as an application of healthcare professionals' skills and knowledge and their appropriation by the state to serve its ends. A review of the states' death penalty statutes shows that healthcare workers are involved in the capital punishment process and shielded by American laws (and to a certain extent by professional boards through their inaction). We also argue that the law's language often masks that involvement; and explain how states further that duplicity behind legal formalisms. In considering the important role healthcare providers, namely nurses and physicians, play in administering death to the condemned, we assert that nurses and physicians are part of the states' penal machinery in America. Nurses and physicians (as carriers of scientific knowledge, and also as agents of care) are intrinsic to the American killing enterprise. Healthcare professionals who take part in execution protocols are state functionaries who approach the condemned body as angels of death: they constitute an extension of the state which exercises its sovereign power over captive prisoners.

Key words: capital punishment, caring, ethics, Foucault, governmentality, nursing, power.

The scaffold, indeed, when it is prepared and set up, has the effect of a hallucination ... The scaffold is vision. The scaffold is not a mere frame ... not an inert piece of mechanism made

of wood, of iron, and of ropes. It seems a sort of being which had some somber origin of which we can have no idea; one could say that this frame sees, that this machine understands, that this mechanism comprehends; that this wood, this iron, and these ropes have a will. In the fearful reverie into which its presence casts the soul, the awful apparition of the scaffold confounds itself with its horrid work. The scaffold becomes the accomplice of the executioner; it devours, it eats flesh, and it drinks blood. The scaffold is a sort of monster created by the judge and the workman, a specter which seems to live with a kind of unspeakable life, drawn from all the death which it has wrought. (Victor Hugo 1862)

The American rhetoric regarding human rights is internationally known and witnessed. Though describing itself as the benchmark of freedom and human rights, the United States of America violates several United Nations motions, and thus international conventions and laws, regarding human rights (Amnesty International 2002; Chomsky 1999). The death penalty in the United States of America constitutes one of the most blatant of these many violations. According to Amnesty International (2002), the death penalty is the ultimate denial of human rights because it violates the right to life (Universal Declaration of Human Rights, 10 December 1948).

More than half of the countries in the world now forbid the death penalty. Yet, the United States has accelerated the rate of executing condemned inmates. Six people each month are executed in the US, more than 800 since 1976 (as of 1 December 2002) and 3500 are on deathrow waiting to die, some, for years. The United States, along with other so-called human rights violators, as classified by the US State Department (such as: Afghanistan, Bangladesh, Chad, China, Iran, Iraq, North Korea, Libya, Malaysia, Nigeria, Pakistan, Saudi Arabia, Sudan and Yemen), continues to use capital punishment. While some techniques used by certain states are seen as barbaric (beheading, crucifixion, stoning), some are considered 'more humane' (electrocution, hanging, lethal injection).

Over 85% of executions recorded by Amnesty International occurred in the United States, China and Saudi

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Arabia (Amnesty International 2002). Of juvenile offenders executed, the United States executed half of them; Yemen, Nigeria, Saudi Arabia, Pakistan and Iran the other half (Amnesty International 2002). Having said that, the 'apparatus' of capital punishment in the United States relies on several agents in order to fulfill its deathwork.

The aim of this article is to bring to the attention of the international nursing community the discrepancy between a pervasive 'caring' nursing discourse and a most unethical nursing practice in the United States. In considering the important role healthcare providers, namely nurses and physicians, play in administering death to the condemned (whether through care during the deathrow period, finding veins for lethal injections or checking for vital signs of life after the execution), we assert that nurses and physicians are part of the states' penal machinery in America (Bessler 1998; Federman and Holmes 2000). Healthcare professionals who take part in execution protocols are state functionaries who approach the condemned body as angels of death. As such, they constitute an extension of the state which exercises its sovereign power over captive prisoners (Foucault 1977/1995; Michalos 1997; Rothman 1995).

Our critical reflection is supported by official documents from various healthcare professional statements (ACP 1994; ANA 1995; ICN 1991), and relies on the theoretical literature regarding social control and governmentality (Bergali and Sumner 1997; Dean 1999; Foucault 1977/1995, 1978/1990, 1991; Garland 1990; Ignatieff 1978; Rose and Miller 1992). By treating prisoners as patients, and by participating in the state's search for less disagreeable forms of execution, nurses and physicians (as carriers of scientific knowledge, and as agents of care) are intrinsic to the American killing enterprise.

HISTORICAL CONSIDERATIONS OF THE DEATH PENALTY IN THE UNITED STATES

In this section, we describe the quest for knowledge that drove elites to choose lethal injections over electricity, and to replace hooded executioners with healthcare professionals. But rather than explain lethal injection as an 'unreality' (Zimring and Hawkins 1986, 123) in American political life, we focus on its utility and concrete reality.

By replacing the electric chair with a gurney and a hooded executioner with a nurse or a physician, lethal injections offer the spectacle of calm (Federman and Holmes 2000). As Johnson (1990, 25) has written, 'Executions today are disturbingly, even chillingly, dispassionate'. For some, it constitutes an improvement in the management of capital punishment.

Lethal injections offer the promise of a humanitarian solution to a criminal act, the cure for an ill, rather than the threat of societal retribution or punishment. Their appeal lies not in reducing pain to the prisoner, but in imposing a 'medical veneer' to the act of killing. By minimizing resistance, the procedures of control are more total (Federman and Holmes 2000, 446).

Social knowledge is the attempt by elites to gather information for the purpose of managing social problems. Because state actors possess knowledge and power, those who define, shape, and respond to social problems exercise a degree of autonomy over dominated economic groups. Ever since academics and state elites recognized prisons as essential parts of modern welfare states, prisons and prisoners have been the subjects of scientific research. But too many studies of capital punishment have failed to recognize that the procedures used to execute prisoners are 'scientific' forms of knowledge. Penal studies often fall short of acknowledging how 'the system of capital punishment in the United States today is shaped by its participants' attempts to distance themselves from the infliction of physical violence' (Dubber 1996, 545). Studies of the death penalty repeatedly emphasize the popular, legal, and juridical aspects of punishment, at the expense of analyzing the relationships of power that exist from below, for example, between the prisoner as patient and caregivers as executioners within the prison.

The move toward lethal injections was not motivated solely by humanitarian sentiment, but rather by 'a desire on the part of legislators to neutralize public opposition to the death penalty after *Gregg v. Georgia*' (Abernethy 1996, 408). The development of the 'long drop', for example, made hangings more efficient and less painful, and also helped to insulate Washington state's capital punishment statute from constitutional attack (*Campbell v. Wood* 1994). Economics also plays a role. The state of Texas lists the cost of a lethal injection at \$86.08 (Florida DOC 1999); Florida, by contrast, which uses the electric chair, pays the person who throws the switch \$150.00 (Florida DOC 1999).

Focusing on the general public's reaction directs attention away from the healthcare profession's involvement with the prisoner and his confinement, a relationship that is not only hidden from public view, but is also legally protected. Consequently, we regard the state's interest in the way capital punishment is practiced in more insular terms, as the creation of autonomous state actors searching for economical and scientific ways to kill prisoners, perhaps in part, to reduce pain, but overall to serve particular ends of control and regulation, and to fulfill the state's idea of punishment as civilized (Spierenburg 1991). The autonomy of state actors to make choices based on the amount of knowledge available may be more significant than the public's views of capital

punishment. As both Foucault and Garland point out, the internal discourses of penal institutions become cultural symbols and have an effect on the public's understanding of punishment (Garland 1990; Foucault 1977/1995).

The need for lethal injections is less in the interest of the public than of the state. The invention of the penitentiary and the use of capital punishment in the United States are more than the 'byproducts of the intellectual and humanitarian movements of the eighteenth century that contributed so generously to the founding of the American nation' (McKelvey 1977, 1). Taken together, the penitentiary and capital punishment in the US constitute a unified (but partial) story in the development of the state. Rejecting the prison as a history of good intentions, we regard the emergence of the penitentiary as 'constitutive of liberal democracy' (Dumm 1987, 6). Jails, penitentiaries, and prisons are the creations of autonomous state agents and intellectuals using the available scientific and technological knowledge concerning death, control, and discipline to further dispossess prisoners, isolate them from the public, and transform them. 'The Enlightenment, which discovered the liberties, also invented the disciplines' (Foucault 1977/1995, 222).

In dealing with the role of science (knowledge) in politics, particularly in the execution process, we are less concerned with knowledge 'for what?' than with knowledge 'about what?' (Katznelson 1996). That is, we are not trying to understand the instrumental purpose of using nursing and medical knowledges to hasten death, for its purpose is clear. In liberal democracies such as the United States, 'where knowledge is produced in an ethos of free competition' (Scheingold 1998, 886), state actors need knowledge about more humane methods of putting criminals to death to alleviate any potential public outcry about the degree or excessiveness of punishment (Savelsberg 1994). Thus, although it is quite possible that lethal injections are as painful as electrocutions, and the 'procedure becomes more ... problematic for the untrained executioner' (Denno 1996, 381), support for the procedure is high because of its perceived humanitarianism (Michalos 1997). As Ellsworth and Gross (1994) point out, Americans support the death penalty more out of moral concerns and prejudice than as a method of control.

In the realm of penology, politics needs science and healthcare practitioners to substitute the more repressive methods of punishment and control with more palatable techniques (and persons) because of the finality of punishment and its effect on modern sensibilities. Yet what is missing in most surveys of the execution process is insight into the multiple meanings and applications of the practitioners

of science with the practitioners of politics when they converge around a gurney.

Medicalized penal procedures remove the state from the language, if not the realm, of punishment. After witnessing the first electrical execution in New York in 1890, Dr Alfred Southwick, the inventor of the electric chair, said, 'We live in a higher civilization from this day' (Amnesty International 1998). This kind of language is not uncommon among American penal reformers. Since the Enlightenment, the advance of social knowledge and the strengthening of the state have been linked by 'a compelling vision of progress' (Rueschmeyer and Theda 1996, 299). As the Supreme Court has noted, the replacement of hanging with electrocution 'did not increase the punishment of murder, but only changed its mode' (Denno 1996, 336). Death by lethal injection is an extension of, and not a replacement for, death by electrocution. More than denoting a new fusion of technology and state power, medicalized penal procedures represent a new configuration in the relationship among the state, its agents, and those in custody.

DECENTRALIZATION OF PUNISHMENT: FROM THE STATE TO PROFESSIONAL AGENTS

In the United States, the 37 states (except Nebraska) that still sanction the death penalty use lethal injection as the primary or secondary method of execution (Amnesty International 2002). The United States federal government and military also use lethal injections as the sole method of execution. Interestingly enough, 11 states deny that lethal injection is a medical procedure, indemnify healthcare executioners against legal harm, and shield their names from the public, while other state laws are silent regarding execution protocols. A Pennsylvania Department of Corrections fact sheet on execution protocol, for example, states that:

The Department of Corrections engages the services of individuals technically competent by virtue of training or experience to carry out the lethal injection procedure.... The state does not identify injection team members because of the confidentiality of the execution policy, for security reasons and out of respect of the privacy of those involved (PA DOC 1999).

New Jersey requires the prisoner to be 'sedated by a licensed physician, registered nurse, or other qualified personnel, by either an oral tablet or capsule or an intramuscular injection of a narcotic or barbiturate such as morphine, cocaine or Demerol' (NJ ST, 2C, 49-2). All other death penalty statutes leave the administration of death to the warden or director of corrections. Indeed, wardens or directors of corrections

are free to perform executions themselves, enlist healthcare professionals to help, or use trained personnel to prepare prisoners for death, insert needles, and regulate other medical procedures. Although the healthcare personnel may be nurses or physicians, they can also be physician's assistants (*Campbell v. Wood* 1994).

According to Garland, the focus of the new penology is not just on the state but its agents, who act 'indirectly' in the administration of criminal justice. The central state under the new penology seeks 'to activate action on the part of non-state agencies and organizations' (Garland 1996, 452) by outsourcing 'penological' functions to private citizens and agencies. The state relies on a web of government agencies 'to conduct the conduct' of its citizens. Thus government (which includes punishment techniques) is, according to Rose and Miller (1992), 'an active process which joins political rationalities (more or less coherent conceptions of the end of government, constituting a field of legitimate intervention and expressed in a characteristic axiom) with governmental technologies (practices and techniques for the transformation of activities, conditions and subjects in a field of intervention)' (Curtis 1995, 575). The state and the penal *dispositif* (apparatus), consequently, no longer only punish — they administer, correct, discipline and normalize.

Resentment, outrage, hatred, — as well as mercy, justice, and forgiveness — continue to feature within these rationalized measures [of punishment]. But they do so in an unexpressed, sublimated fashion, overlaid by a utilitarian concern with institutional discipline and individual management, so that even the most transparently punitive actions are often represented in more 'positive', instrumental terms (Garland 1990, 189).

Michel Foucault's description of 'governmentality' helps us to understand how the state governs beyond its official structures. Foucault (1991) never neglected the state, but stressed that other apparatuses or institutions can 'conduct the conduct' of citizens. Foucault stated that 'governmentality' should be understood as a powerful web of power relations that links together three forms of powers: sovereign, disciplinary, and pastoral (McNay 1994). The state as a sovereign power remains an important actor. 'The concept of governmentality implies all those tactics, strategies, techniques, programmes, dreams and aspirations of those authorities that shape the beliefs and the conduct of the population' (Nettleton 1991, 99).

Governing (which punishment is an integral part of) today requires an active process in which the political rationalities bind themselves to the technologies of government. The articulation of these two elements is ensured by a specific form of knowledge (scientific) and the presence of an expert

(professional) who mediates between the political objectives and the object of intervention (citizen/criminal) (Rose and Miller 1992). In penal policy, the state and non-state agents have continuous exchanges, even if these exchanges are not clearly specified. The relationship between the state, its agents and agencies, and non-state actors regarding penalty is interactive rather than unidirectional. In an era of 'governmentality', power functions well beyond the figure of the state as a unified institution. As Hall writes, the state is a 'network of institutions, deeply embedded within a constellation of ancillary institutions associated with society and the economic system' (Hall 1986, 17). Agents and agencies at a local and cellular level make sure that the broad objectives of the state are fulfilled. Power is capillary (Foucault 1977/1995, 1978/1990). The use of professional healthcare agents in the execution protocol insures the optimal functioning of this new art of government.

Nursing and medical sciences are represented in prison by the presence of trained personnel who operate the machines and demonstrate the professional techniques used to carry the lethal solutions to the body of the condemned. South Dakota's capital punishment statute states that:

An execution carried out by lethal injection shall be performed by a person selected by the warden and trained to administer the injection. The person administering the injection need not be a physician, registered nurse or licensed practical nurse or registered under the law of this or any other state. (SD ST, s23A-27A-32)

Various states indemnify the healthcare personnel involved in executing prisoners. The South Dakota statute states that 'Any infliction of the punishment of death by administration of the required lethal substance or substances in the manner required by this section may not be construed to be the practice of medicine'. The South Dakota statute denies that there is an ethical (or legal) problem in procuring healthcare professionals to insert tubes into prisoners or to obtain the medicine (*Heckler v. Chaney* 1985) used to extinguish life. Idaho's capital punishment statute is no different:

any infliction of the punishment of death by administration of the required lethal substance or substances in the manner required by this section shall not be construed to be the practice of medicine and any pharmacist or pharmaceutical supplier is authorized to dispense drugs to the director or his designee, without prescription, for carrying out the provisions of this section, notwithstanding any other provision of law (ID ST, s19-2716).

Kansas's death penalty statute gives the secretary of corrections full power to control the death process (KS ST, s22-4001). The secretary 'shall designate one or more executioners' to carry out the lethal injection in a 'swift and humane manner'. The secretary's discretion, however, is circumscribed

by a legal requirement to 'appoint a panel of three persons to advise the secretary' on the 'type of substance or substances to be administered' to the condemned prisoner. The Kansas penal authority requires scientific knowledge to exercise its power over the condemned.

As an important part of the execution apparatus, health-care professionals constitute a new and critical element of social control in prison. The laws, however, hide their importance, as if to point out that the prisoner, not the doctor, is the subject of inquiry (cf. Foucault 1977/1995, 187: 'Disciplinary power ... is exercised through its invisibility').

Oklahoma's capital punishment statute states that the warden 'must invite' (to the execution) physician, the district attorney of the county in which the crime occurred, the judge who presided over the sentence of death, the chief of police of the municipality in which the crime occurred, as well as the sheriff of the county where the conviction occurred, and the cabinet secretary of public safety (OK ST, T. 22 s1015b). Yet even if a physician were to take part in an execution, his or her actions would not constitute the practice of medicine, nor would the purchase of drugs needed to administer the injection be considered lethal substances. Delaware frankly admits that its law governing lethal injections 'permits correctional officers to obtain controlled substances for the execution in violation of the Federal Drug Abuse Prevention and Control Act ... and the Federal Food, Drug and Cosmetic Act' (DE ST, TI 11 s4209). Oregon's statute allows the director of corrections to purchase 'lethal substances' from 'any wholesale drug outlet ... registered with the State Board of Pharmacy', and then states that the 'lethal substance or substances' purchased 'are not controlled substances when purchased, possessed or used for purposes of this section' (OR ST, s137.473(1) and (3)).

The state appropriates the nurse's and physician's knowledge, using them like prison labor force. Others practice their craft, use their methodologies, evoke the symbols of their trade. But she/he cannot be named and her/his role is unclear. Is she/he or isn't she/he the executioner? It is as if the laws can only recognize one subject — the convicted. Everyone else is a spectator.

Healthcare professionals are necessary for modern-day executions because of their status as scientists and caregivers. Idaho's capital punishment statute denies that administering lethal injections constitutes the practice of medicine, and protects against 'unnecessary suffering' of the condemned by using 'expert technical assistance'. If Idaho's director of the department of corrections cannot obtain expert technical assistance to carry out the lethal injection, the method of execution switches to firing squad (ID ST, s19-2716). Idaho equates less scientific methods of execution with less humane

forms of execution. Utah's death statute separates execution by 'shooting', which is carried out by a 'five-person firing squad of peace officers', and death by lethal injection, which is carried out by 'two or more persons trained in accordance with accepted medical practices'.

'Expert technical assistance' over life and death is so important that law must protect that status, regardless of who is dispensing knowledge and exercising power. Montana's execution statute allows any person trained by the warden to administer death. 'The person administering the injection need not be a physician, registered nurse, or licensed practical nurse licensed or registered under the laws of this or any other state'. Yet the 'identity of the executioner must remain anonymous. Facts pertaining to the selection and training of the executioner must remain confidential' (MT ST, 46-19-103(6)). Healthcare personnel help make lethal executions 'humane', 'faster', and perhaps constitutional (*Gregg v. Georgia* 1976). Death penalty states appropriate healthcare personnel to alleviate the pain of death or to offer the illusion of alleviating pain. If punishment was once harsh, it is now peaceful and painless. Maryland's penitentiary historian states that 'the worst physical pain' from lethal injection is 'the prick of a needle' (MD DOC 1999). Arizona's historical fact sheet on the death penalty similarly dismisses the possibility of pain from a lethal injection, and describes the pain a prisoner feels from lethal gas as akin to a heart attack. 'Death by lethal injection is not painful and the inmate goes to sleep prior to the fatal effects of the Pavulon and Potassium Chloride' (AZ DOC 1999).

The Kansas statute makes clear that healthcare personnel — whether called a 'nurse' or a 'physician' — are important because of the knowledge they have and the image they project. Their execution activities disperse power and responsibility throughout the prison complex, mirroring developments in civil society regarding decentralization. According to Bessler (1996, 709), the multilayered process of social and coercive control regarding the means of punishment has gotten so complex that 'no one in the entire criminal justice system is now fully accountable for death sentences'. Focusing on the rationalization of punishment, Garland (1990, 182) adds that penal agents today 'avoid the bad conscience and cultural infamy that used to attach to the executioner or the jailer by claiming to be more than merely instruments of punishment.

From the standpoint of lethal injections, the 'agent of welfare', in Foucault's words, the nurse or the physician, is less necessary than what she or he represents: the care of the soul in the care of the state. Their purpose is to transform executions from being terrifying to being peaceful and to

render submissive the condemned prisoner. In the process, their work, too, is transformed. They heal by pacifying, not correcting. Their work is legal fiction. Under a mask of care, healthcare professionals (and the nursing and medical technologies that surround an execution) combine part of the state's power and disciplinary knowledge (nursing and medicine) in order to achieve their work. Lethal injections are Bentham's Panopticon. They gain in efficiency what they lose in terror.

It is an important mechanism, for it automatizes and individualizes power. Power has its principle not so much in a person as in a certain concerted distribution of bodies, surfaces, lights, gazes; in an arrangement whose internal mechanisms produce the relation in which individuals are caught up ... Any individual, taken almost at random, can operate the machine: in the absence of the director, his family, his friends, his visitors, even his servants ... The Panopticon is a marvelous machine which, whatever use one may wish to put it to, produces homogeneous effects of power (Foucault 1977/1995, 202).

The problem of healthcare professionals serving the state's end is not only an ethical one, but also a question of the state's use of power in rendering punishment. Foucault's (1977/1995, 129) description of the development of modern prison regimes mirrors contemporary penal policy: 'The agent of punishment must exercise a total power, which no third party can disturb ... it must have its own functioning, its own rules, its own techniques, its own knowledge'.

Traditionally understood, the prison, according to Sim (1990, 9), is a 'laboratory in which the advice and expertise of the medical profession' is 'geared to reintegrating the confined back to normality'. A prison's medical personnel fulfill the state's vision of itself as a welfare state. But this is not the only way medical knowledge is employed in prison. It is also used to exterminate life. By the nineteenth century, as Foucault has noted, 'a whole army of technicians took over' the job of 'the executioner, the immediate anatomist of pain: warders, doctors, chaplains, psychiatrists, psychologists, educationalists', contributing, in their own way, to the body of knowledge known as 'penal practice' (Foucault 1977/1995, 11). Nurses and physicians are part of the new economy of punishment.

THE NEW FACES OF THE 'BOURREAU': HEALTHCARE PROFESSIONALS, TORTURE, AND EXECUTIONS

Over time, the face of the executioner (*bourreau*) has changed. When we think about these persons we might imagine them wearing a hood, 'hiding in the shadow of the gallows' (Farber et al. 2001; Johnson 1990, 125). In Florida,

which uses the electric chair to execute prisoners, the executioner remains hooded throughout the death process. 'You won't be seeing him', a Florida Department of Corrections official told a journalist; 'Not on this side of life' (Johnson 1990, 125).

The image of the executioner as a sinister and often solitary person, is, of course, a holdover from earlier times, when executions were public and executioners were scorned as evil, contaminated by the death work that was their livelihood.... They were often afforded a hood or cloak while at work to protect their identities, which would offer them a token shield against harm. Some of these execution traditions, or at least remnants of them, linger on even today. Thus it is that a few states hire free-lance executioners and engage in macabre theatrics. Executioners may be picked up under cover of darkness at lonely country crossroads; some still wear black hoods to hide their identity. They slip into the prison unnoticed, do their work, then return to their civilian lives (Johnson 1990, 125).

Yet this is not entirely descriptive of the reality of the death process. A review of prison literature informs us that healthcare professionals are part of the 'execution team' (Trevelyan 1988). The sinister figure of the hooded executioner has been replaced by the 'caring' figure of a healthcare professional. Not only do healthcare professionals participate in the administration of the death penalty, they are involved in the torture or corporal punishment of prisoners in other countries (Racine-Welch and Welch 2000; Trevelyan 1988). As violations of human rights have become more pervasive in prisons, scientific discoveries have brought about more sophisticated forms of torture, methods of resuscitation and execution (ICN 1991). For example, Amnesty International (1998, 171) reports that 'lethal injection executions depend on medical drugs and procedures and the potential of this kind of execution to involve medical professionals in unethical behavior, including direct involvement in killing, is clear'. In the United States, healthcare professionals' participation in executions receives the legal protection, which includes shielding their identity from public scrutiny. Arizona's capital punishment statute, which calls for 'an intravenous injection of a substance or substances in a lethal quantity sufficient to cause death', shields healthcare personnel from legal retribution. 'If a person who participates or performs ancillary functions in an execution is licensed by a board the licensing board shall not suspend or revoke the person's license as a result of the person's participation in an execution' (ARS, 13-704; *Lambright v. Lewis* 1996, arguing that lethal injections comport with societal norms). Illinois's statute is more explicit: 'Notwithstanding any other provision of law, assistance, participation in, or the performance of ancillary or other functions pursuant to this Section, including but not limited to the administration of the lethal

substance or substances required by this Section, shall not be construed to constitute the practice of medicine' (ILCS, 725 5/119-5).

The state enlists healthcare professionals, mainly nurses and physicians, to select lethal injection sites, start intravenous lines to serve as ports for lethal injections, inspect, test, or maintain lethal injection devices, consult with or supervise lethal injection personnel and participate directly in the administration of the lethal solution. Healthcare knowledge is crucial for the performance of the new killing technique of lethal injection. This latest discovery in the killing arsenal, which is considered more humane than electrocution because it does less damage to the prisoner's body, is an obvious application of scientific (medical and para-medical) knowledge and professional skills. Trombley (1992, 318-21) describes the process as follows:

The inmate walks from the holding cell to the gurney, accompanied by guards and he is placed in a supine position on the gurney and he is strapped. Legs, abdomen, chest ... The arm that takes the IV [intravenous line] is exposed. The nurse-anesthetist, who acts like a nurse consultant, starts the IV. Using a number 16-gauge needle, and a plastic catheter ... [After a signal to begin] they press the button [of the lethal injection machine].... The first solution, sodium pentothal, goes into the person. He's awake, and then he goes to sleep. [After another minute] the Pavulon ... is injected, and it arrests the respiratory muscles. Paralyze the lungs and depress the respiratory center ... You can see the patient doing an agonal, or terminal, breathing ... Finally the potassium chloride is given and it's three times the lethal dose... [W]hen the prisoner had died and had been certified as such, the nurse-anesthetist removes the IV. Then the mortician comes in and removes him from the gurney to his table, and takes him to the funeral parlor.

The official positions of American nursing academics regarding capital punishment are unknown. But for the International Council of Nurses (ICN) and the American Nurses Association (ANA), it is clear that participation in execution is contrary to the 'ethical traditions of the nursing profession' (ANA 1995; ICN 1991). Moreover, the ANA (1995) states that, regardless of personal opinion, nurses who participate either directly or indirectly in legally authorized execution violate nursing code of ethics.

The ANA is strongly opposed to all forms of participation, by whatever means, whether under civil or military legal authority. Nurses should refrain from participation in capital punishment and not take part in assessment, supervision or monitoring of the procedure or the prisoner; procuring, prescribing or preparing medications or solutions; inserting the intravenous catheter; injecting the lethal solution; and attending or witnessing the execution as a nurse. The fact that capital punishment is currently supported in many segments of society does not override the obligation of nurses to uphold the ethical mandates of the profession (ANA 1995, 2).

According to the International Council of Nurses, nursing educators should address issues related to capital punishment and torture. ICN (1998) advocates that all levels of nursing education curricula include the recognition of human rights issues and violations, such as death penalty and torture and awareness of the use of medical technology for executions.

Jails, prisons, penitentiaries, and asylums are not just places of social exclusion (Foucault 1977/1995; Goffman 1968). Some are places where executions are practiced. The journey of the 'state's victim' starts with the prosecution, followed by incarceration and what Foucault (1977/1995) calls the 'carceral'. The subject is introduced into the *carceral machine* and is later transformed into an object as he or she goes through interventions, and corrective, disciplinary, punitive, and educative processes. Just as the alimentary bolus is attacked by enzymes and acids and is transformed by the mechanical movement of different organs all the way through its voyage into the GI tract, so too is the inmate transformed until his/her final destination before the execution, or in more physiological terms, his/her 'elimination'. The last hours of the inmate's life are referred to as the 'deathwatch', which is meticulously organized by the state's agents.

The deathwatch is, we believe, an example of torture, as in this last stage of the journey, the condemned experiences multiple deaths before the 'real' one occurs. Critical activities during the deathwatch include 'the prisoner's final visit with loved ones; a last meal; a final shower' (Johnson 1990, 142). During these last 24-48 h, the prisoner is transformed, so that by the time he walks to the execution room he is completely dehumanized. 'The execution process today is distinctively mechanical, impersonal, and ultimately dehumanizing' (Johnson 1990, xv). Not only is the deathwatch an example of torture, the deathrow experience is a prelude to this torturous, final stage. For Johnson (1990, 196-7), both stages are torture. According to Amnesty International (2002, 13), torture signifies:

Any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted by or at the instigation of a public official on a person for such purposes as obtaining from him or a third person information or confession, punishing him for an act he has committed, or intimidating him or other persons.

The goal of deathrow is to maintain secure physical custody of those sentenced to death. During the deathwatch, social control is the ultimate objective. Thus, the objectives of deathrow and the deathwatch are different. For the latter, 'the condemned prisoner must be under the social but not physical, control of his keepers; he must submit to the execution routine' (Johnson 1990, 143).

The social control imperatives during the deathwatch have specific objectives. The condemned should be able to enter his last walk in a dignified way without cuffs, physical coercion, or resistance, walking almost hand in hand with his executioners. The execution team is invested with a task that will be attained using different forms of power (sovereign, disciplinary, pastoral). 'Is it not the supreme exercise of power to get another or others to have the desires you want them to have — that is to secure their compliance by controlling their thought and desire' (Lukes 1974, 23). No reason for physical violence, no resistance; the condemned has been made ready to die in the way that his executioners had planned. Through the torturous journey of the deathwatch, within the *carceral machine*, the sentenced one becomes calm, obedient, docile, and disciplined: the objective is achieved.

CONCLUSION

In this article, we have presented a duality: the conflict in American prisons between nursing ethics and the killing machinery. The US penal system is a setting in which trained healthcare personnel practice the extermination of life. Moreover, we looked upon the sanitization of deathwork as an application of healthcare professionals' skills and knowledge and their appropriation by the state to serve its ends. A review of the states' death penalty statutes shows that healthcare workers are involved in the capital punishment process and shielded by American laws (and to a certain extent by nursing boards through their inaction). We have demonstrated how the law's language often masks that involvement; and how the states further that duplicity behind legal formalisms. Legal formalism is only a screen and an obstacle for what Foucault terms 'pouvoir/savoir': 'Every programme ... either articulates or presupposes a knowledge of the field of reality upon which it is to intervene and/or which it is calculated to bring into being' (Foucault 1980, 248). Lethal injection is to the twentieth century what the guillotine was to the Enlightenment. The guillotine was the 'perfect vehicle' for Enlightenment principles. 'Contact between the law, or those who carry it out, and the body of the criminal, is reduced to a split second. There is no physical confrontation; the executioner need be no more than a meticulous watchmaker' (Foucault 1977/1995, 13).

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