Damned if you do and damned if you don’t:
Medical ethics and a second career

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Even when laws have been written down, they ought not always to remain unaltered. Aristotle from “Politics”

November of 2004, Ernie Fletcher, MD, Governor of Kentucky, fulfilled the duties of his office by signing the execution order for a man duly convicted of capital murder. In so doing, Dr. Fletcher appears *en passant* to have violated American Medical Association ethical guidelines prohibiting any manner of physician participation in capital punishment. Nevertheless, Kentucky state law also requires that its physicians conform to all ethical standards of the AMA or face disciplinary action, including possible license revocation, by the state medical board. Dr. Fletcher may forfeit his license to practice medicine in Kentucky if it is determined that he has violated AMA ethics guidelines in fulfilling his responsibilities as governor and authorizing the convicted murderer’s execution. At the time of this writing, execution of the condemned man has been stayed by the court and the signed warrant has expired. Should the stay be subsequently lifted and the governor asked to sign a new death warrant at a later date, what would be his best course of action to insure satisfaction of his responsibilities to both his professions, to insure compliance with all applicable laws, and to demonstrate the high sense of ethical development expected of physicians and elected officials?

A. Sign the death warrant in his capacity as governor and surrender his medical license.
B. Sign the death warrant with the expectation that a collegial state medical board will interpret this act as a non-violation of AMA ethical standards.
C. Don’t sign the warrant. Let the next non-physician governor order the execution.
D. Pressure the state legislature to abolish the death penalty.
E. Pressure the state legislature to abolish the requirement that Kentucky physicians must abide by AMA ethical guidelines to maintain state licensure.

It is not uncommon for physicians to be recruited for positions outside the medical profession which require almost no exercise of their clinical abilities, but which prize the physician’s presumptive intellect, problem-solving skills, capacity for hard work, and integrity. Physicians have distinguished themselves very prominently in all sorts of responsible non-medical second occupations. Within the last few years a surgeon has been elevated to leadership of the majority party in the US Senate and a family practitioner has been a leading candidate for the nation’s presidency. Eight physicians currently serve in Congress, and at least eight have served as state governors in the course of American history. The concept is not unique – virtually everyone in elective politics has come to it from some other livelihood. The physician-in-a-second-role commonly retains identification as a physician, but when medical practice stops so do its obligations. Governor Fletcher of Kentucky maintains a license to practice medicine in the state.

Admired though physicians may be, our professional role and its obligations can be deeply incompatible with new job responsibilities of a government leader. This degree of potential role conflict of physicians-in-a-second-role exceeds that of most other professions. Unlike professional/personal conflicts in which both aspects must and can be satisfied,^1^ social role incompatibilities often require meeting one obligation at the expense of the other. Seemingly well-suited for other lines of work, our ethical obligations are in fact unique to the medical profession and likely will present conflicts with professions outside medicine, as Governor Fletcher and the citizens of Kentucky are in the process of discovering.

As a current medical licensee in Kentucky, Governor Fletcher remains subject to the regulations of the Commonwealth Board of Medical Licensure. KRS 311.97 de-
scribes “[A]cts declared to constitute dishonorable, unethical, or unprofessional conduct” as including “but not limited to the following acts by a licensee: . . . (4) . . . any departure from, or failure to conform to principles of medical ethics of the American Medical Association. . . .”. 2

The American Medical Association’s Code of Medical Ethics (Section E-206) states that

[A]n individual’s opinion on capital punishment is the personal moral decision of the individual. A physician, as a member of a profession dedicated to preserving life when there is hope of doing so, should not be a participant in a legally authorized execution. Physician participation in execution is defined generally as actions which would fall into one or more of the following categories: (1) an action which would directly cause the death of the condemned; (2) an action which would assist, supervise, or contribute to the ability of another individual to directly cause the death of the condemned; (3) an action which could automatically cause an execution to be carried out on a condemned prisoner. 3

A number of other American and international associations of physicians have also addressed the ethics of physician involvement in capital punishment. All have condemned participation by practicing physicians which is not identical with non-practicing participation. Each has appealed to the ethics of medicine and obligations that define the practicing physician’s social role. The American College of Physicians and American Society of Internal Medicine cite the core ethical principle governing the relationship between physicians and our culture: “Society has conferred professional prerogatives on physicians with the expectation that they will use their position for the benefit of patients”. 4 These learned organizations confine their determinations to the activities of the medical profession, avoiding direct confrontation with the wider societal ethics of capital punishment itself.

Not all physicians accept the constraints of professional integrity in assessing their willingness to become involved in capital punishment. In Farber, et al.’s large physician survey, 41% reported that they would perform at least one execution-related action not permitted by AMA ethical standards, and 25% would agree to perform five or more of the proscribed actions. Only 3% were aware that there were professional ethical guidelines on capital punishment. 5

Many respondents reported that their willingness to participate in executions was substantially based on a belief that capital punishment reduces murder rates. Whether the deterrent effect of capital punishment is any more effective than life imprisonment has been intensely disputed by criminologists, and there is even considerable data that judicial execution may actually increase murder rates. 6

If so many doctors would agree to contribute their knowledge and skills to legally sanctioned capital punishment, is the AMA’s argument that execution is incompatible with the physician’s role ethically durable? The core of the position adopted by the AMA and other medical societies is based in the ancient tenet that physicians should never use their specialized knowledge and skills to intentionally harm a person without some modicum of compensating clinical benefit. No such paradigm justifies physician participation in capital punishment.

Dr. Fletcher’s legal counsel’s answer to criticism has been that “By signing a death warrant, in no way is Governor Fletcher participating in the conduct of an execution.” Perhaps the attorney is thinking in terms of whether the governor is actually administering the fatal injection or otherwise exercising a physician’s knowledge and skill in facilitating the condemned man’s death. Clearly Governor Fletcher is not, and that raises the question of whether professional policy-setting bodies like the AMA should be governing the behavior of physicians when they are not performing within the physician’s traditional roles.

The AMA obviously anticipated the question, and a scenario eerily similar to the one involving Governor Fletcher, when it included among its prohibitions “supervision” and contributions “to the ability of another individual to directly cause the death of the condemned,” which is justifiable because medicine can be practiced through a supervisory educational role. The 3rd AMA prohibition, “any action which would automatically cause an execution to be carried out on a condemned prisoner” is likely in response to the dilemma faced by prison psychiatrists when their therapy improves the symptoms of psychotic death row inmates and thereby renders them eligible for execution. In this special circumstance, psychiatrists violate the taboo against use of medical knowledge and skill to harm prisoners without actually participating or supervising participants in an execution. By providing an otherwise indicated therapy the condemned prisoner becomes a patient and the physician’s fiduciary role is conflicted by unfettering the law.

Dutifully signing a death warrant as chief executive of the state, however, neither involves the practice of medicine or its supervision, nor confers the status of patient on the prisoner. On closer scrutiny, Governor Fletcher’s signing the death warrant violates at worst the letter and not the spirit of the prohibition. If the AMA’s third prohibition was intended literally as written, a physician on jury duty adjudicating capital murder would be unable to render a guilty verdict without violating the prohibition, which is permitted. 3 We argue that this prohibition is heavily context dependent and is not automatically universally applicable.

The state board does not demand automatic forfeiture of the medical license with every breach of AMA ethical standards – the system of review and penalty is graduated, with revocation only the most severe among several actions available to the board. Option A is therefore an extreme and unnecessary response, serving no one’s legitimate interest. Option C is a clear violation of the ethical obligations of his role as governor, subverting law, and possibly generating undesired legal and political consequences. Option D, asking the legislature to abolish the death penalty, may or may not represent the governor’s legislative goals, but it is irrelevant to the question at hand here. Petulance and impulsivity are common responses to frustrating situations, but they are seldom fruitful, and certainly cannot be ex-
cused in matters of lasting importance. Option E, asking the legislature to eliminate the requirement for physician compliance with AMA ethical standards, would constitute a statutory response to a personal aggravation, represent an abuse of gubernatorial power, and jettison one of the most carefully considered and comprehensive codices of medical ethics ever compiled, without proposing an equivalent replacement. Choosing Option B, signing the death warrant, provided it is legally and morally just, fulfills his obligation as governor and exemplifies the courage necessary for both his social roles. He can present his case for peer review before the state medical board with the expectation of a successful verdict.

The force of the AMA’s 2nd and 3rd prohibition turns on something else: an implicit but not argued opposition to capital punishment itself, no matter who is involved or the extent of their involvement. The inconsistent AMA ethical position does not actually condemn capital punishment. It does advocate its societal abolition by the extraordinary manner in which it distances its members from using medical knowledge to kill those society has decided are unfit to live. We will not attempt to address the possible inconsistency abortion poses. The AMA notes that individual opinions about the appropriateness and societal value of capital punishment may vary, and makes no effort to influence this ongoing cultural debate, as perhaps it should instead of largely limiting political activities to economic issues affecting medicine.

Addendum: Shortly after the writing of this article, physician Governor Ernie Fletcher courageously fulfilled his gubernatorial duties and petitioned the Kentucky State Medical Board to consider the status of his medical licence. The Board voted unanimously that Dr. Fletcher had not violated the ethical code of the AMA and absolved him of any misconduct.

REFERENCES