

Editorials

Doctors and the Death Penalty

Proponents of the death penalty have shifted gears. In the past, gruesome public executions were extolled as a deterrent to others, and even in recent times, death has been inflicted on convicted criminals by hanging, firing squads, electrocution and poisonous gas. All of these methods inflict pain on the victim and have the potential for failure and added suffering — both physical and mental. Many have argued that they are all potentially or actually "cruel and unusual" punishment,¹ and a series of United States Supreme Court decisions suggests that this may be so.²

Defenders of the death penalty, however, do not give up easily; and the current search is for a "humane" way to continue executions. Recently, four states³ have passed statutes embodying this "humane" alternative. In the words of the New Mexico statute:

The manner of inflicting the punishment of death shall be by administration of a continuous intravenous injection of a lethal quantity of an ultra-short-acting barbiturate in combination with a chemical paralytic agent.⁴

Even critics of the death penalty have conceded that death would come with "minimal violence, no mutilation, and little more indignity than an ordinary surgical procedure," and that it is "clearly the most humane of the present methods."⁵

To some, however, a new dimension has been added to the death penalty question by making the physician the instrument of death — either by having him order the injection or actually administer it.⁶ The argument is that medical ethics "should be interpreted to unconditionally condemn medical participation in this new form of capital punishment."⁷ The rationale for condemning injections but not the former modes of death dealing is that injection presents "a more obvious application of biomedical knowledge and skills than any other method of execution yet adopted by any other nation in modern history."⁸ While I have much sympathy for the argument, I do not think it is tenable. The fact is that physicians have always participated in an active way in the infliction of the death penalty, and have traditionally brought their medical knowledge and training to bear on the process. The mere fact that the actual instrument of death can now be seen by everyone as "medical" does not change the moral or ethical (or legal for that matter) considerations: it

just makes them easier to appreciate.

Physicians, for example, are always present to pronounce death; and this involves much more than just that act. It is only *after* the physician has pronounced the "patient" dead that he can be cut down if the method is hanging, taken out of the gas chamber if it is poisonous gas, or taken out of the electric chair in the case of electrocution. The death of Gary Gilmore by firing squad provides a scenario of the doctor's active participation in this "traditional" mode. Norman Mailer describes the scene as the doctor pinned a white circle on Gary's black shirt as a target for the firing squad. After the shots penetrated his body and blood began dripping on the floor, "The doctor came along with a stethoscope and shook his head. Gilmore wasn't dead yet . . . They waited about twenty seconds. Then the doctor went up again . . . and nodded."⁹

It does not seem to me that a meaningful distinction can be made between the physician who orders the mixture of drugs that will be injected into a prisoner's body, and the physician who pins the target over the prisoner's heart and uses his skills to declare the prisoner dead. It surely makes no moral difference whether or not the physician uses his stethoscope as an instrument to pronounce death; nor does it make a legal or ethical difference whether he pins a target on the prisoner or pre-

pares a lethal injection. It is the nature of the action and its intent, not the nature of the instrument used, that is the crucial factor.

Capital punishment should be condemned in *all* forms as an act which itself is inhumane no matter what the method of execution is. Worrying about whether or not physicians should get more directly involved misses the central issue in the death penalty debate and drains off energy and thought which should be mobilized toward ending the death penalty once and for all.

George J. Annas, J.D., M.P.H.

References

1. E.g., Gardner, *Assessment of Methods of Capital Punishment*, 39 OHIO STATE LAW JOURNAL 689 (1978).
2. *Id.*
3. Texas, Oklahoma, Idaho, and New Mexico.
4. St. 31-14-11 (1979 Supp.).
5. Gardner, *supra* note 1, at 703.
6. See, e.g., Malone, *Death Row and the Medical Model*, HASTINGS CENTER REPORT 9(5):5 (October 1979); and Curran & Casscells, *The Ethics of Medical Participation in Capital Punishment by Intravenous Drug Injection*, NEW ENGLAND JOURNAL OF MEDICINE 302(4):226 (1980).
7. Curran & Casscells, *supra* note 6, at 227.
8. *Id.* at 228.
9. MAILER, *THE EXECUTIONER'S SONG* (Little, Brown & Co., Boston) (1979) at 985-87.

Patient Access to Medical Records

The latest assault on the patient's right of access to his or her medical record is an attempt to label the patient mentally disturbed. This unusual tactic came to light in a "study" published in early 1980 in the NEW ENGLAND JOURNAL OF MEDICINE in which four psychiatrists from Boston's Peter Bent Brigham Hospital purport to demonstrate that patients who ask to see their medical record while patients in that hospital have a variety of personality defects, usually manifesting themselves in mistrust of and hostility toward the hospital staff.¹ This conclusion was based on interviewing eleven patients who asked to see their medical records during a defined time period. The study is so poorly designed and conducted

that it would not seem to merit comment; but since its results may be uncritically accepted by those who oppose patient access to their records, it merits at least a brief discussion.

It should be noted at the outset that Massachusetts has had an inpatient access law since 1945,² and the fact that only eleven out of 2,500 patients even asked to see their records at the Brigham indicates that this practice is certainly not encouraged.

Indeed, it is doubtful that anything of general importance about patient's reactions to reading their charts can be learned from an uncontrolled, non-blind, clinically impressionistic study

(continued)

of those few individuals who, for whatever reason, buck a system which routinely fails to inform them of their right of access to their hospital records. In a setting where trusting patients are not routinely told of their right to access, it seems reasonable to assume that only the least trusting or most angry will ask to see their records. To locate the source of that mistrust in the patient's personality style or in the stress of illness and hospitalization is to forget, as Dr. Lipsett perceptively suggests, that "the doctor-patient relationship cannot be understood simply in terms of the patient's side of the equation."³ Altman *et al.* thus fall into what Professor Robert Burt of Yale Law School has referred to as "the conceptual trap of attempting to transform two-party relationships, in which mutual self-delineations are inherently confused and intertwined, by conceptually obliterating one party. . . ."⁴ Thus, it would seem that the ten women who asked to read their charts "to confirm the belief that the staff harbored negative personal attitudes toward them. . . ." were correct in that belief; the psychiatrists labelled them as "of the hysterical type with demanding, histrionic behavior and emotional over-involvement with the staff."

Altman *et al.* also seem unaware of the wide variety of settings in which patients have benefited from routine record access; and incorrectly assert that there were no strikingly beneficial effects in the two studies they do cite. In the first study, for example, two patients only expressed their completely unfounded fear that they had cancer after their record was reviewed with them, and one pregnant patient noted an incorrect Rh typing that permitted RhoGam to be administered at the time of delivery.⁵ In the other study they cite, 50 percent of the patients made some factual correction in the record.⁶

Experience under the new record access regulation enacted by the Massachusetts Board of Registration in Medicine indicates that patients want access to their records for a variety of reasons. In the period from October 13, 1978 (when the regulation went into effect), to January 31, 1980, the Medicine Board received more phone calls from consumers asking about the medical records regulation (approximately ten a month) than about any other single issue dealt with by the Board. There were also 33 formal complaints filed concerning record access during this period. Of this number, almost half (16)

needed help from the Board to get their physician to forward a copy of their record directly to another physician. Of the remaining 18, 6 needed information for insurance purposes, 6 wanted to review the record for various reasons, one alleged negligence, one wanted the record sent to a school nurse, one was moving to another state, one wanted a second opinion, and one wanted her contact lens prescription.⁷

Traditionally the medical rationale for withholding information in the chart has been patient psychopathology or medical paternalism. Both rationales fail to address the issue of rights. Patients have rights because they are people. If we believe in individual freedom and the concept of self-determination, we must give all citizens the right to make their own decisions and to have access to information that is widely available to those making decisions about them. It is as irrelevant in this connection that 2,489 patients at the Brigham did not ask to see their records as it is that more than 200 million Americans never have had to exercise their right to remain silent when arrested. Rights serve us all, whether we exercise them or not.

George J. Annas, J.D., M.P.H.
Daryl Matthews, M.D., Ph.D.
Leonard H. Glantz, J.D.

References

1. Altman, J.H., Reich, P., Kelly, M.J., Rogers, M.P., *Patients Who See Their Medical Record*, NEW ENGLAND JOURNAL OF MEDICINE 302(3): 169 (1980).
2. MASS. GEN. LAWS, c. 111, § 70.
3. Editorial, Lipsett, D., NEW ENGLAND JOURNAL OF MEDICINE 302(3): 167 (1980).
4. BURT, R., TAKING CARE OF STRANGERS: THE RULE OF LAW IN DOCTOR-PATIENT RELATIONS (Free Press, N.Y.) (1979) at 43.
5. Stevens, D.P., Staff, R., MacKay, I., *What Happens When Hospitalized Patients See Their Own Records*, ANNALS OF INTERNAL MEDICINE 86: 474, 476 (1977).
6. Golodetz, A., Ruess, J., Milhous, R., *The Right to Know: Giving the Patient His Medical Record*, ARCHIVES OF PHYSICAL MEDICINE AND REHABILITATION 57: 78, 81 (1976).
7. Statistics compiled for MEDICOLEGAL NEWS by Judy Miller, a student at Boston College Law School.

Guest Editorials Welcomed

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Earle Spring

A new and potentially important decision is expected from the Massachusetts Supreme Judicial Court on the issue of withdrawing life-sustaining medical treatment from those unavailable to decide for themselves. The case of Earle Spring is but an example of an increasingly familiar situation: individuals who are not totally "incompetent," and for whom there is a poor, dismal, and certain prognosis. The lives of hundreds of patients may depend upon being hooked up to life-sustaining or life-prolonging examples of medical technology, and some will indicate that they do not want such procedures to continue.

A right to refuse medical treatment is generally accepted and patients are, presumably, able to exercise this right and instruct their physicians to stop rendering medical care even if death is the clear result. But how and who decides for the legally incompetent person, or the elderly patient who lapses in and out of lucidity? The case of Earle Spring has heightened the debate concerning the role of the patient's family, physicians, and the courts in making the decision to terminate life-prolonging or saving medical treatment of allegedly incompetent persons.

Such questions are not easily answered. Although we tend to give credence to the statements of a competent terminally ill patient, what about the patient who desires "death" only because the life that suddenly presents itself is so unfamiliar or uninviting? Or the patient who only seeks the attention and concern that is evidenced by family and health care personnel when a patient with a controllable but incurable disease expresses a desire to have treatment stopped?

In assuring an informed and knowingly-made decision, the courts clearly have a role, but the extent of that role has been heavily debated. In the next issue of MEDICOLEGAL NEWS, two attorneys, both of whom authored separate *amicus curiae* briefs submitted to the Massachusetts Supreme Judicial Court in the Spring case, will outline their positions. Readers are invited to submit letters or editorials on the subject as well.

A. Edward Doudera, J.D.