



Nurse participation in legal executions: An ethics round-table discussion

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Abstract

A paper was published in 2003 discussing the ethics of nurses participating in executions by inserting the intravenous line for lethal injections and providing care until death. This paper was circulated on an international email list of senior nurses and academics to engender discussion. From that discussion,

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several people agreed to contribute to a paper expressing their own thoughts and feelings about the ethics of nurses participating in executions in countries where capital punishment is legal. While a range of opinions were presented, these opinions fell into two main themes. The first of these included reflections on the philosophical obligations of nurses as caregivers who support those in times of great need, including condemned prisoners at the end of life. The second theme encompassed the notion that no nurse ever should participate in the active taking of life, in line with the codes of ethics of various nursing organisations. This range of opinions suggests the complexity of this issue and the need for further public discussion.

Keywords

Capital punishment, codes of ethics, end-of-life issues, palliative care, professional ethics, topic areas

Introduction: Linda Shields, Charles Sturt University, Australia

I maintain an international email list. Most of the members are nurses and I send out news, events, conferences and so on, and, when I find a paper or news report of interest to nursing, I send that around too. Recently, I listed a paper by Hooten and Shipman¹ about nurses who participate in executions in the United States. One of our members (who has contributed to this paper) found a news interview² with ‘Nurse Karen’ who was such a nurse, who explained how and why she felt she could participate in executions. Both these articles engendered considerable discussion on the email list and we believe that some of the central and often troubling ethical issues raised deserved to be explored in a more open ‘round table’ discussion with which *Nursing Ethics* readers may wish to engage further. Hence, the aim of this paper is to collate the writing of 12 senior nurses who work on both the academy and clinical positions, and thereby summarise their responses to the ethics of nurses being part of a process of executing a person condemned to die. A wide range of opinions were articulated – some believe that ‘Nurse Karen’s’ actions were appropriate and supported the argument postulated by Hooten and Shipman.¹ Others felt very strongly that any involvement by nurses in executions is morally wrong.

In this paper, we present each contributor’s position gleaned from the online discussion, then expanded to catalyse further consideration and discussion of the ethics of nurses’ involvement in executions. We do not intend to analyse any ethical stances, nor do we provide a consideration of the existing literature. Our intention is, first, to highlight to the nursing world that this is occurring; second, to show a range of opinions and stances; and third, to initiate discussion, argument and analysis of the topic.

It is inarguable that the execution of a person deemed to have done something that warrants death remains part of the legal system in many countries, including the United States; other nations, however, uphold the principle that capital punishment is wrong. Codes of ethics for nurses in many countries state that nurses should not be part of any process that assists with or implements executions. Participation in such processes could be defined in a myriad of ways; so for the purposes of this discussion, we take it to mean being part of any process which leads to the intended death of a person. We use the term ‘legal executions’ to mean where the execution of a person is sanctioned by the state.

Roger Watson, University of Hull, United Kingdom

Nurses are no strangers to ethical dilemmas. These range from decisions about resource allocation when resources are scarce (who gets the last blanket in the linen cupboard?) to major decisions about whether or not they will participate in abortions. Other dilemmas such as caring for enemies in times of war or covertly

‘patching up’ wounded terrorists who will only kill again also arise. However, the above situations are usually covered by codes of practice. It is usual for nurses who object to abortion to be excused participation, and nursing – and medical – care in times of war are covered by the Geneva Conventions³ and, regardless of the intentions of a wounded terrorist, no nurse would be justified in withholding care; whether he or she should take further action regarding the terrorist is another matter.

However, with the possible exception of abortion where a life is ended (arguments about humanity aside), there can be no greater contrast to the ‘normal’ work of the nurse – where preserving life is the usual basis for care – than participating in judicial executions as they do in the United States where the use of lethal injections has been a preferred method since the execution by lethal injection of Charles Brook Jr in 1982.⁴ The American Nurses Association⁵ takes the stance that nurse participation in executions is contrary to our ethos of doing no harm; nevertheless, they do participate. One of the arguments for the participation of nurses – and doctors (also discouraged from participation by the American Medical Association) – is that technicians often make a ‘botched job’ leading to unnecessary suffering by the prisoner.⁶

In the history of judicial execution, the current situation is unique for nurses. Doctors have, at least, to attend executions to verify death, and other professionals such as chaplains often attend to comfort the prisoner. However, these roles are not directly associated with inducing death. The situation arises, of course, due to the method of execution. Other methods of execution – variably effective or unpleasant – mainly require death by some rapid and fairly detached method such as hanging, firing squad, beheading and electrocution. No expert medical skills are needed as these methods do not require any invasion of the body prior to the act of killing. Indeed, the very method of execution – whether one agrees with capital punishment or not – could be viewed as a perversion of medical practice and procedures. Ironically, the principles and practice of lethal injections were refined in Nazi Germany⁷ where many doctors and nurses were encouraged, or volunteered, to participate in programmes of involuntary euthanasia.

Judith Anderson, Charles Sturt University, Australia

Issues exist in recruiting health professionals to participate in executions.⁸ Professional bodies, for example, the American Medical Association,⁹ indicate that medical practitioners ‘should not be a participant in a legally authorized execution’ and the American Nurses Association⁵ similarly states that ‘it is a breach of the ethical traditions of nursing and the Code of Ethics’. Hooten and Shipman¹ identify stigmatisation as reducing the willingness of health professionals to participate, and more recently Alper¹⁰ has identified a reduced willingness of drug companies to supply medications for the purpose in an attempt to comply with European laws which prohibit trade of good used for capital punishment. Nelson and Ashby⁸ cite several cases where executions have been poorly managed, including several which have been needlessly painful. They state that chemical execution ‘risks pain and suffering being inflicted on prisoners’ (p. 31), so the support of health professionals with sufficient knowledge and understanding of pain assessment and medication administration is essential to provide supportive care at this time of their lives.¹ However, some authors^{1,11,12} have indicated that due to difficulty in recruiting health professionals to undertake these tasks, untrained or undertrained personnel working in the prison are sometimes delegated this work.

The fear of disciplinary action, stigmatisation and lack of desire expressed by health professionals to participate in executions has led to some institutions dividing the process of execution into parts. Some ask health professionals to cannulate but have untrained workers administer the lethal injection.¹¹ This is based on the argument that it is not unethical to secure intravenous (IV) access, but a lethal injection is not a medical procedure. Such ethical ‘hair splitting’ acknowledges the difficulties health professionals have with their role in these types of procedures and the difficulty institutions have in recruiting staff to work in these roles, but is it a solution or does it merely cover up and hide the real issue?

David Stanley, University of New England, Australia

Hooten and Shipman¹ make an interesting appeal for readers to consider the ethical issues nurses face when they participate in executions. Nurses, they argue, participate because they may be the difference between a prisoner's (patient's) humane death and a death that involves cruel and unusual punishment. The International Council of Nurses (ICN)¹³ guidelines make it clear that deliberate infliction of physical or mental suffering should be avoided and nurses should avoid and not participate in acts that result in the deliberate infliction of physical or mental suffering. As such, Hooten and Shipman¹ suggest that nurses who participate in executions may be doing so to uphold the ICN guidelines. In terms of a definition of nursing, both the ICN¹⁴ and the World Health Organization¹⁴ define nursing as

... encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings. It includes the promotion of health, the prevention of illness, and the care of ill, disabled and dying people.

Nothing in this definition indicates that nursing should not involve the care of condemned prisoners. Although as abhorrent as the death penalty is and with arguments about the moral place of executions in the modern justice system to one side, Hooten and Shipman¹ suggest that nurses' (and physicians') involvement in executions brings a degree of compassion, care and humanity to the execution process by including medical personal.

In 2006, Atul Gawande from Harvard University gave a lecture exploring the issue of why physicians (and nurses) participated in lethal injection executions.¹⁵ In his lecture, Gawande explained that he had spoken with four doctors and one nurse about the reasons for their participation in lethal injection executions. The nurse's reason for participating was to ensure that the executions were performed properly (with the least amount of suffering). Interestingly, while three of the doctors discussed various reasons to participate, including being obligated, only one doctor described their participation as being about alleviation of the patient's suffering at the end of their life.¹⁵

Having worked as a nurse in a criminal justice system, I am aware that the patients were commonly from marginalised pockets of society – vulnerable, voiceless and powerless. My role as a nurse was to offer excellent non-discriminatory healthcare and to advocate for their health or social concerns. Thankfully, I was not in a system that practiced executions, but I cannot see how I could have abandoned patients had they been condemned to die and I am sure I would offer the best of my care and skill to them, to their end. In my work in the prison, I offered health promotion information, distributed medications and supported the prevention of illness. I cared for prisoners when they were ill or if they became disabled. Why would I abandon them if they were about to die, even if by execution? Indeed, the very definition of nursing states that it is my responsibility as a nurse, to stay. I agree with the ICN,¹³ the death penalty is cruel, inhumane and unacceptable. However, I also consider that I agree with them when I see it as the nurse's responsibility to stay with a prisoner sentenced to death until the conclusion of the execution.

I see no ethical or moral ambiguity other than the one created by professional bodies that make contradictory and unrealistic statements, either by combining different issues (e.g. torture and execution are not the same things) or by offering contradictory statements when they should be offering guidance and support for health professionals obliged (by the nature of their employment) to stay alongside their dying patients to the end, even if the end is one stipulated by a court of law.

Ged Williams, Abu Dhabi Health Service, United Arab Emirates

In 2012, the National Health Service (NHS) in the United Kingdom published *Compassion in Practice*.¹⁶ In the foreword, Jane Cummings and Viv Bennett wrote that 'To be a nurse... We support hundreds of

thousands of people in living with illness. We provide care and comfort when people's lives are coming to an end' (p. 5). When applying this sentiment to the needs of a person sentenced to death by execution, challenging moral issues confront the nurse who is asked to provide nursing care during such a process.

Nurses often do many things they would prefer not to do, sometimes risking our lives or violating our personal moral preferences in order to give others the nursing care they need. Care of the prisoner/patient undergoing execution is but one of many such scenarios. The ICN Code of Ethics¹⁷ is a widely accepted guide and forms a useful framework to explore the ethical and practical issues that arise should a nurse be approached to or agree to participate in the care of a prisoner/patient about to be executed.

Section 1 of the ICN Code of Ethics, 'Nurses and People',¹⁷ can be used to inform the debate regarding the appropriateness or otherwise of a registered nurse's role, if any, in providing nursing care before, during and after execution of an imprisoned felon legally sentenced to execution under the authority of a government-sanctioned court or other authorised agent of government. The following provides such argument:

Nurses and People

The nurse's primary professional responsibility is to people requiring nursing care. In providing care, the nurse promotes an environment in which the human rights, values, customs and spiritual beliefs of the individual, family and community are respected.¹⁷ (p. 2)

The assumption in this debate is that execution has been determined after a legally authorised judicial system has considered all aspects of the prisoner's case and the expectations of the people as determined through their elected/appointed public officials. We are not here to judge the legal system and governance system but to consider whether such a condemned prisoner should be able to receive care and support from a registered nurse:

The nurse shares with society the responsibility for initiating and supporting action to meet the health and social needs of the public, in particular those of vulnerable populations.¹⁷

A prisoner/patient has been formally denied many rights and privileges afforded to other human beings in society. The prisoner/patient is, by definition, a member of an extremely vulnerable population:

The nurse advocates for equity and social justice in resource allocation, access to health care and other social and economic services.¹⁷ (p. 2)

Due to the nature of the condemned prisoner's/patient's vulnerability, correctional nurses are in a privileged position to see and know when such patients are most vulnerable and therefore when they may most require a health professional's support:

The nurse demonstrates professional values such as respectfulness, responsiveness, compassion, trustworthiness and integrity.¹⁷

This statement is critical to this debate and requires further distillation:

Respectfulness essentially means we must respect the person (in this case the prisoner/patient) as a vulnerable human being who needs care. This right must be respected in both life and at the time of death; there are no known exceptions.

Responsiveness suggests there are no excuses for delaying or limiting the treatment and care needs of the vulnerable person despite their 'prisoner facing execution' status.

Trustworthiness and integrity – the prisoner/patient can expect that the nurse will do whatever is legally possible to achieve the best possible outcome for the patient.

Other caring professionals will also be required from time to time to participate in such activities. Doctors and priests in particular face the same moral dilemma as the nurse. Nurses may also feel similarly about participation in abortion for many of the same moral and legal reasons.

A ‘practical ethics’ approach to such situations requires a *genuine intent on a nurse’s part* to provide for the medical, physical, emotional and spiritual needs of a person facing execution. Nurses may well ask themselves:

‘What would have happened to the person if I didn’t do what I did?’

‘Did I do the best in my power to advocate in the best interests of my patient, despite the horrible outcome?’

‘Where can I seek help and guidance to make this situation, or the next one, better?’

Catherine Hungerford, Charles Sturt University, Australia

Debates about the participation of health professionals in the execution of prisoners are not new.^{1,18,19} What is new is the consideration of the issues involved in light of contemporary approaches to healthcare, where the expressed needs of consumers are positioned as central.²⁰ For example, inmates on death row are now advocating for the participation of health professionals in the administration of lethal injections, to reduce the risk of unnecessary suffering due to mal-administration.¹⁸ In view of the current move towards responsive, consumer-centred healthcare, the questions must be asked, where is the voice of the inmate on death row in this discussion? Do they have the right to voice their preferences? Are nurses obliged to listen to the voice of the individual inmate? Or are there much larger considerations at play?

Hooten and Shipman¹ noted that some jurisdictions in the United States, where the death penalty is still legal, excuse nurses from participating in executions – while other jurisdictions do not. This leads to further ethical considerations for nurses with regard to law versus professional codes of conduct. Which framework – legal or professional – holds more sway?

Of course, when considering the notion of participating in the execution of prisoners by lethal injection, such questions have no clear answers – which is perhaps why some commentators continue to refer to the three-drug protocol developed by Chapman in 1977.⁴ This protocol has enabled health professionals to participate in the preliminary steps of the execution, and thereby ensure the comfort of the inmate, while at the same time protecting the health professionals from the moral dilemma of administering the lethal injection.¹⁸ However, this approach likewise has its critics,²¹ who argue that it will only be when health professionals as a group refuse to take part, at any point, in the execution of prisoners, that capital punishment will be finally outlawed.

It is relatively easy for the ‘arm chair critics’ located in countries where there is no capital punishment to suggest that there are ‘black and white’ answers to this dilemma, expressed as ‘health professionals, including nurses, should never participate in executions’. Those who take this position, however, may find it useful to consider related debates. For example, in the context of palliative care, McCammon and Piemonte²² provide a strong ethical argument against the option of continuous sedation as an option of first resort; Li Puma and DeMarco²³ challenge this view with an equally strong argument. Others in palliative care refer more generally to the consumer voice and suggest the need for health services and health professionals alike to consider how best they can meet the needs and preferences of the consumer, including autonomy and choice.^{24,25} While some would argue that the context of justice health is much different to the palliative care setting, and that inmates on death row have lost their right to choose or express

preferences, there are definite parallels. Take, for instance, the example of ‘Nurse Karen’.² What are the moral responsibilities of nurses who have cared for the inmates for a long time and, presumably, developed a therapeutic relationship with the inmate, in alleviating the suffering of the inmate facing death?

Benny Goodman, Plymouth University, United Kingdom

Haidt²⁶ explores moral reasoning and human behaviour in his book *The righteous mind*. He argues there are three principles of moral psychology:

1. Intuitions come first, strategic reasoning comes second.
2. There is more to morality than harm and fairness.
3. Morality binds and blinds.

The main argument in the book is that rationality is driven by the passions and intuitions, not the other way around. We have moral foundations which guide our beliefs and actions, and when confronted with social and political situations, it is our moral intuitions that lead us, our reasoning is *post hoc*, after the intuitive decision is made.

He suggests that there are six moral foundations:

1. Care/harm;
2. Fairness/cheating;
3. Loyalty/betrayal;
4. Authority/subversion;
5. Sanctity/degradation;
6. Liberty/oppression.

He also suggests that those of a progressive political persuasion draw on the first two: care/harm and fairness/cheating while those of conservative frame of mind use all six to decide what is right. That is the second principle above. His main point, however, is that moral reasoning as to why something is right or wrong happens after we have already decided, Principle 1 above, so we look for facts and reasoning to support what we already think. That is why the use of facts and reasoning is often useless in changing minds in political and ethical debates, because our chosen morality binds us together as a group and blinds us to the reasoning and morality of the other side (Principle 3).

If this applies to nurses’ moral reasoning, it suggests we make decisions about what is right and wrong based on deep-seated and long-held moral intuitions and then we will reason afterwards to support our viewpoints. It also supports the view that decision-making is not always based on clear, rational and analytical thinking but on emotion, intuitions and past experiences. Other factors may also come into play such as the ‘affect heuristic’.²⁷ The ‘affect heuristic’, which suggests emotion is important in guiding judgements and decisions, acts as a mental short cut to aid decision-making. Fox²⁸ argues that ‘alongside reasoned choices and decisions, what humans feel has a part to play in producing the world’. Conscious reasoning, including conscious moral reasoning, is in this view mediated by heuristics and emotions. The rational actor (*homo-economicus*) who is consciously weighing up cost/benefits and analysing ethical and moral positions is therefore more myth than reality.

However, it might be the case that nurses’ reasoning is bound in any case by the context where they work taking no regard of their personal moral reasoning. Nurses faced with the moral choice of being involved in executions may be able to put those intuitions on hold if asked to consider the issues without a time frame, consequences to themselves or implicit coercion by dint of an employment contract in the prison service. However, those already working in that setting might more readily fall back on *post hoc* rationalisations.

Nurse Karen's² admission that she believes in the death penalty may well provide the platform for *post hoc* rationalisation for her involvement. There seems to be a referral to a higher moral order of the state, the state's law, to override principles of autonomy to transgress the care/harm principle.

Philip Darbyshire, South Australia

Nurses who may be approached to or who actually become involved in helping prisoners facing execution and who look to nursing's authorities for guidance may find more disapproval and confusion than help. The American Nurses Association Position Statement on Nurses' Role in Capital Punishment⁵ is emphatic in its condemnation of any nursing involvement, either directly or indirectly. The specific ICN guidelines on 'Torture, death penalty and participation by nurses in executions'²⁹ seem more ambiguous, advising in one paragraph that nurses

Should play no voluntary role in any deliberate infliction of physical or mental suffering and should not participate, either directly or indirectly, in the preparation for and the implementation of executions. To do otherwise is a clear violation of nursing's ethical code of practice.

Yet only two paragraphs later, the same guidelines state that

clearly the nurse's responsibility to a prisoner sentenced to death continues until execution.²⁹

What this enactment of the nurse's responsibility might look like is left unstated by ICN but described by 'Nurse Karen',² in one of the unsurprisingly few accounts offered by a nurse who has actually participated in an execution. I say 'unsurprising' given the censure and judgementalism that would almost surely come this nurse's way, from fellow nurses and our professional organisations, should her identity be revealed.

This account highlights many of the ethical dilemmas inherent in any nursing involvement in executions. For example, what is the relationship between the nurse and the condemned prisoner? Can this be considered a nurse-patient/client relationship? Does the prisoner's almost total lack of autonomy and decision-making ability in this situation obviate such a relationship or throw an undeniably present one into even sharper relief? If 'medical or nursing' procedures are required at this time, for example, insertion of IV lines for a lethal injection, is it preferable that these are undertaken by a competent health professional rather than by minimally or untrained prison officers, or is the condemned person to be denied this also? If a prison nurse has developed a professional relationship with a prisoner in the build up to their execution, should the nurse end his or her involvement prior to the execution process or should he or she maintain this helping relationship all the way through to the prisoner's death? If other 'helping professionals' such as prison chaplains are able to use their skills and abilities to support prisoners facing execution without being branded as complicit state stooges, could a similar rationale apply to nurses' involvement?

As with so many perplexing ethical issues, how these are framed and who is allowed to do this framing is critical. If we are linguistically, to 'frame' all state or government-sanctioned execution as an aberration, as state sanctioned murder, government approved torture, 'just like Nazi Germany' or similar, then precluding any nursing involvement can be mandated from the most rarified of moral high ground. However, if the very particular human situations faced by a 'Nurse Karen'² are seen as opportunities to provide skilled nursing help to utterly marginalised people facing certain death and, just perhaps, being able to bring some sliver of care and humanity into a hideous situation, perhaps the frame changes. Who gets to define this situation? Is it the 'Nurse Karens'² directly involved, is it even the condemned prisoner or is it the more powerful states or governments where the executions occur or nursing's professional associations? Wherever we stand, we see once again that neither ethics nor nursing is ever easy. If anyone suggests otherwise, they lie.

Hugh McKenna, Ulster University, United Kingdom

Hastening a person's death seems anathema to nurses. However, I have worked in wards where older patients had 'not to be resuscitated' written in their notes. We also know that such decisions had often been taken without either the patient or their family being consulted. For example, if the patient had a cardiac arrest, the nurses, including myself, would not intervene. Were we practising passive euthanasia? By not intervening, we consoled ourselves that we were not causing the patient any further distress – in other words – we were being humane. But today, almost 30 years later, I still remember my view that by being passive we were hastening the death of another human being. I also had feelings of unease when I actively assisted in electro convulsive therapy. The experts were not really sure how it worked and we knew it had some well-documented detrimental effects on some patients. These two examples lead to the question of whether my participation and my moral conflict caused me some psychological trauma.

Zimering and Gulliver³⁰ wrote about secondary traumatisation among mental health professionals. This has also been referred to as vicarious traumatisation.³¹ Essentially, this occurs when health professionals hear tales of, or observe, extreme human suffering or death. Most of the research on this topic has been done with counsellors who have heard traumatic stories or with health professionals who have worked in disaster zones. Regardless of role, their occupational duties may cause psychological symptoms in the practitioners.

Zimering and Gulliver³⁰ argued that, just as most individuals directly exposed to a traumatic stressor exhibit some post-traumatic stress disorder (PTSD) symptoms that abate quickly over time, a small percentage of individuals will develop a full psychiatric disorder. They highlighted that the following factors are potentially predictive of secondary traumatisation – insufficient training, identification with the victims, insufficient support in the workplace and insufficient social and familial support. Symptoms include re-experiencing the trauma or noticing an increase in arousal and avoidance reactions related to the indirect trauma exposure. They may also experience changes in memory and perception, alterations in their sense of self-efficacy, a depletion of personal resources and disruption in their perceptions of safety, trust and independence.³² The following is taken from a participant in an execution by lethal injection:

Just like taking slides in a film projector and having a button and just pushing a button and just watching, over and over: him, him, him. I don't know if it's mental breakdown, I don't know if . . . probably would be classified more as a traumatic stress, similar to what individuals in war had. You know, they'd come back from war, it might be three months, it might be two years, it might be five years, all of a sudden they relive it again, and all that has to come out. You see I can barely even talk because I'm thinking more and more of it. You know, there was just so many of 'em.³³

We would argue that those nurses who are actively involved in the execution of another person are at risk of such secondary trauma. We know that those involved in atrocities during times of war justify their participation by concentrating on the legality of the war and the just defeat of the enemy. It is possible that nurses involved in executions justify their participation by concentrating on the desire to see that the condemned person has a 'humane death'. In fact, to continue to participate in executions, nurses have to focus on the positive aspects of their role and convince themselves that without them being present, the condemned person would have an inhumane death. Otherwise, how could they continue to undertake the role?

Freinkel et al.³⁴ wrote how media eyewitnesses to an execution experienced dissociative symptoms reminiscent of secondary trauma. A total of 18 journalists were invited as media eyewitnesses to an execution in San Quentin. The authors postulated that witnessing this execution was psychologically traumatic and that dissociative and anxiety symptoms would be experienced by the journalists. To investigate the prevalence and specific nature of these symptoms, questionnaires were sent to all the journalists a

month after the execution. The results showed that the experience of being an eyewitness to an execution was associated with the development of dissociative symptoms in several journalists.

However, the journalists were not assisting with the execution, but merely bystanders. They could justify their presence as being part of their job. Does that mean that active participants experience greater secondary trauma? Not necessarily, perhaps nurses who directly assist in an execution have a much better justification than eyewitnesses to the event. After all they are not simply bystanders, rather they are using their skills to relieve suffering and ensure the condemned person has as humane a death as possible in the circumstances. In my 'do not resuscitate' example, nurses were using their judgement to stop further suffering and also to ensure the patient had as humane a death as possible in the circumstances. Are there parallels?

Peter Draper, University of Hull, United Kingdom

Hooten and Shipman¹ (p. 492) state 'The death of the prisoner is more humane if a nurse provides the technical expertise to start the IV line and emotional support for the prisoner as he/she leaves this life'. This statement raises more questions than it answers. Is it actually true that the death of the prisoner is more humane if facilitated by a nurse? What do we mean by 'more humane', and how can the level of humane-ness be determined? Can an action be deemed ethically correct because it produces more of some 'good', in this case humane-ness, than an alternative source of action? And how can a deliberate action that results in the involuntary death of another human being be deemed 'humane' at all?

I want to focus on the last of these questions. I suggest that the writers are able to present nurses' participation in execution as a humane act in line with the traditions and values of nursing, because they use the euphemism 'as he/she leaves this life' to represent the prisoner's being killed. Let us pick that little phrase apart and consider the work it does in this text.

To leave is a voluntary act. Therefore, to speak of a prisoner 'leaving this life' imputes agency – the ability to make decisions and act on them. This is not true of a prisoner strapped to a gurney, and the use of the word 'leave' disguises this fact.

Leaving also implies spatial relocation. I leave work to travel home. If I leave one room I may enter another. This corresponds with a popular view of death expressed in a poem that it sometimes read at funerals, containing the line 'death is nothing at all; I have only slipped away to the next room'. To conceptualise death as relocation implies the possibility that some aspect of the self may continue in some other place.³⁵ The word 'this' – as in leaving this life – also contributes to the sense that the person continues, though in a different location. 'Leaving this life' thus disguises the totality and finality of death.

I have suggested that the phrase 'leaving this life' is a euphemism which disguises the underlying fact of the deliberate killing of a prisoner. As such, the phrase plays an important role as part of a strategy to persuade the reader that a nurse's participation in execution can be deemed a moral act. Tenbrusel and Messick³⁶ argue that in the business world, metaphors and euphemisms are often used to make harmful conduct respectable, turning unacceptable into socially approved behaviours:

What is dangerous is when these metaphors hide the moral or ethical implications of our decision' so that 'we no longer see the questionable behaviour they were designed to disguise'. They continue 'In doing so, unethical behaviour becomes justifiable through a process of deception, in which we transform morally wrong behaviour into socially acceptable actions'³⁶ (pp. 227–228)

Ellen Ben-Sefer, University of Hawaii, and Susan Benedict, Medical University of South Carolina, the United States

As a global community, we have become increasingly exposed to executions through the platform of television and social media. Beheadings and soldiers hacked to death are some examples. However, it is less than 100 years since the Holocaust during which millions of Jews were systematically murdered. Other victims include Gypsies, homosexuals, political prisoners, resistance fighters and many others. Most relevant to this discussion is the murder of thousands of people with mental health problems, ‘mentally deficient’ (the term used then) and other adult and child victims of the infamous ‘euthanasia’ programme instituted in 1939 and primarily carried out by nurses. Perhaps, in a world in which we are increasingly exposed to violent executions and death, we have become de-sensitised and thereby, as nurses, failed to examine the role of contemporary nurses involved in the execution of convicted inmates.

Hannah Arendt notably coined the phrase ‘banality of evil’ in reference to the bureaucrats who implemented government orders to murder.³⁷ In the ‘euthanasia’ programme, this included many nurses.⁷ Additionally, as the ‘euthanasia’ programme served as a rehearsal for the larger genocide, a number of nurses were recruited from the programme to work in concentration and death camps. Most troubling is that the nurses failed to see anything wrong in carrying out these murders during the war years and also during the post-war era. In other words, they served as executioners, believing they had acted and behaved appropriately, both in accordance with the law and their own consciences.

While the murder of a convicted prisoner may not necessarily be completely analogous to the systematic murder of millions by the Nazi regime and specifically by nurses, the actions taken by nurses involved in the state mandated executions are still murders. The American Nurses Association strongly opposes the nursing participation in any aspect of capital punishment.⁵ Yet, a small number of nurses have participated in executions. Common arguments for participation include competence and comfort, in particular, with lethal injections and insertion of IV lines. However, unlike other patients receiving nursing care, the inmate has no choice, just as the victims under the Nazi regime had no choice. In other words, just as the ‘euthanasia’ programme victims could not refuse ‘care’, so too is the convict in a situation in which ‘care’ cannot be refused. Furthermore, in the case of modern day executions, the identity of the nurse is hidden. One conclusion is that the participation of nurses in executions is not only morally and ethically unacceptable but serves neither the ‘patient-inmate’ nor promotes any positive understanding of nursing. Rather, the sole beneficiary is the government’s purpose, strikingly similar to the Nazi murders, with the nurse as the executioner. No hiding behind the notion of a ‘comforting hand’ can mask the action. This is truth that cannot be denied.

Although, as stated above, the comparison of nurses’ actions in the so-called ‘euthanasia’ programme⁷ and the actions of nurses in executions like ‘Nurse Karen’² is not perfect, it is more than sufficient to give us pause. In both cases, nurses are using their skills to kill for the state. That is not what we are educated to do and it goes against most nursing organisations’ imperatives. The notion that only the participation of nurses assures a skilled and painless placement of the IV lines to facilitate death is absurd. Many people can be highly skilled at placing IVs. Consider, for example, military medics who perform under the highest duress. The notion that ‘caring for the patient until the end’ is an obligation likewise is insufficient. If that were to be true, why would the nurse be hidden? She or he should be visible to all, providing comfort to the person until the last heartbeat. As it is, at least in the United States, the nurse is not even in the same room at the time of the execution. If in doubt about whether or not a nurse should participate in executions, ask this: What would my other patients think about my killing for the state? Let us use our skills only as we were educated to do.

Conclusion – Linda Shields

A total of 11 senior nurses from several countries have written their individual responses to the Hooten and Shipman's¹ (2003) paper about the ethics surrounding nurses' participation in executions in countries where the death penalty is law. As the 12th author, it falls to me to sum up and write the conclusion – and I do this with some trepidation. When we first decided to write this article, I knew divergent arguments would arise, but I had not anticipated how polarised they would be. Most fall into one of the two themes – either the nurse has a moral and ethical duty to provide the same care he or she would give to any patient at the end of life, or the second theme, which is demonstrated in all the codes of ethics and practice discussed, is that there is no role for nurses in helping to actively induce death, which occurs when a nurse inserts IV lines for lethal injections.

Some were concerned that the codes of ethics were not taking into account the fact that nurses are bound to provide care to everyone regardless of circumstances, while others argued that an integral part of all the codes of ethics is the need to alleviate suffering – and this is what nurses who insert the IV lines do. The argument goes that if a nurse did not do it, then an unqualified person would be taught the procedure and this may increase the condemned person's suffering.

The philosophers gave reason for thought and frameworks from which to view the topic, while others discussed how language can so powerfully form perspectives in any context, but most importantly in those where dilemmas abound. An interesting perspective is that most of the authors live in countries where capital punishment is not legal; however, most seemed to agree that the nurse must give end-of-life care to the condemned prisoner. Many of those who expressed the opposite, that nurses should never be involved in executions, lived in countries where capital punishment was legal. While this very small sample, and the opinions expressed are certainly not representative research, perhaps it is time to do some research around this question and examine what might influence a nurse to participate or not in executions.

The aim of this article is to generate debate on this most contentious topic. We invite commentary and argument.

I finish with a paraphrase of a quote from one of the nurses who worked in Hadamar Psychiatric Hospital, one of the main killing centres in the Nazi 'euthanasia' programmes.⁷ When asked why she killed her patients, she said 'they were going to die anyway. The patients knew and trusted me, and so I could do it kindly and they wouldn't suffer. If I didn't do it, then someone would kill them roughly'. History is a great teacher.

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References

1. Hooten J and Shipman D. Comment: the ethical dilemmas of nurses' participation in prisoner executions. *Nurs Ethics* 2013; 20(4): 491–492.
2. Hinojosa M. Week of 7.14.06: web-extended interview: 'Nurse Karen', <http://www.pbs.org/now/shows/228/nurse-execution.html> (2006, accessed 16 March 2016).
3. International Committee of the Red Cross 2016. Geneva Conventions, <https://www.icrc.org/en/war-and-law/treaties-customary-law/geneva-conventions> (accessed 11 March 2016).

4. Death Penalty Information Center. Part 1: introduction to the death penalty, <http://www.deathpenaltyinfo.org/part-i-history-death-penalty#reinst> (2016 accessed 11 March 2016).
5. American Nurses Association. Position statement: nurses' role in capital punishment, <http://www.nursingworld.org/MainMenuCategories/EthicsStandards/Ethics-Position-Statements/prtetcptl14447.pdf> (2010, accessed 4 April 2016).
6. Death Penalty Information Center. Lethal injection. 2016 <http://www.deathpenaltyinfo.org/lethal-injection> (accessed 29 October 2016).
7. Benedict S and Shields L. *Nursing in Nazi Germany: the 'euthanasia' programs*. New York: Routledge History, 2014.
8. Nelson L and Ashby B. Rethinking the ethics of physician participation in lethal injection execution. *Hastings Cent Rep* 2011; 41: 28–37.
9. American Medical Association. AMA Code of Ethics, <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.page?> (2016, accessed April 2016).
10. Alper T. The United States execution drug shortage: a consequence of our values. *Brown J World Aff* 2014; 21: 27–39.
11. Johnson K. The medical-legal quandary of healthcare in capital punishment: an ethical dilemma for the anesthesia provider. *AANA J* 2008; 76: 417–419.
12. Holmes D and Federman C. Killing for the state: the darkest side of American nursing. *Nurs Inq* 2003; 10: 2–10.
13. International Council of Nurses. Definition of nursing, <http://www.icn.ch/who-we-are/icn-definition-of-nursing/> (2010, accessed 11 March 2016).
14. World Health Organization. Health topics: nursing, <http://www.who.int/topics/nursing/en/> (2016, accessed 11 March 2016).
15. Cochrane T. The excellent execution: why physicians participate in lethal injection of prisoners, <http://ethics.harvard.edu/event/excellent-execution-why-physicians-participate-lethal-injection-prisoners> (2006, accessed 11 March 2016).
16. Department of Health. Compassion in practice: nursing, midwifery and care staff, our vision and strategy, <https://www.england.nhs.uk/wp-content/uploads/2012/12/compassion-in-practice.pdf> (2012, accessed 4 April 2016).
17. International Council of Nurses. Code of Ethics, http://www.icn.ch/images/stories/documents/about/icncode_english.pdf (2012, accessed 30 January 2016).
18. Litton P. Physician participation in executions, the morality of capital punishment, and the practical implication of their relationship. *J Law Med Ethics* 2013; 41: 333–352.
19. Perezts M and Picard S. Compliance or comfort zone? The work of embedded ethics in performing regulation. *J Bus Ethics* 2015; 131: 833–852.
20. Hungerford C. Recovery as a model of care? Insights from an Australian case study. *Issues Ment Health Nurs* 2014; 35: 1–9.
21. Truog R, Cohen G and Rockoff M. Ethical considerations surround lethal injection: reply. *JAMA* 2014; 312: 1804–1805.
22. McCammon S and Piemonte N. Continuous sedation until death should not be an option of first resort. *J Clin Ethics* 2015; 26: 132–142.
23. Li Puma S and DeMarco J. Clarifying an expanded use of continuous sedation until death: a reply to the commentary by McCammon and Piemonte. *J Clin Ethics* 2015; 26: 266–269.
24. McConigley R, Shelby-James T and Currow D. Promoting the consumer voice in palliative care: exploring the possibility of using consumer impact statements. *Health Expect* 2015; 18: 653–660.
25. Wilson F, Ingleton C, Gott M, et al. Autonomy and choice in palliative care: time for a new model? *J Adv Nurs* 2014; 70: 1020–1029.
26. Haidt J. *The righteous mind: why good people are divided by politics and religion*. London: Penguin, 2012.
27. Slovic P, Finucane M, Peters E, et al. The affect heuristic. *Eur J Oper Res* 2007; 177: 1333–1352.

28. Fox N. Emotions, affects and the production of social life. *Br J Sociol* 2015; 66: 301–318.
29. International Council of Nurses. Position statement: Torture, death penalty and participation by nurses in executions. http://www.icn.ch/images/stories/documents/publications/position_statements/E13_Torture_Death_Penalty_Executions.pdf (2012, accessed 28 October 2016).
30. Zimering R and Gulliver SB. Secondary traumatization in mental health care providers. *Psychiatric Times*, <http://www.psychiatrictimes.com/ptsd/secondary-traumatization-mental-health-care-providers> (2003, accessed 4 April 2016).
31. Pearlman LA and Saakvitne KW. *Trauma and the therapist: countertransference and vicarious traumatization in psychotherapy with incest survivors*. New York: W.W. Norton, 1995.
32. NCTSN Secondary traumatic stress, <http://www.nctsn.org/resources/topics/secondary-traumatic-stress> (accessed 16 March 2016).
33. Soundportraits.org. Witness to an execution, http://soundportraits.org/on-air/witness_to_an_execution/transcript.php (2000, accessed 17 March 2016).
34. Freinkel A, Koopman C and Spiegel D. Dissociative symptoms in media eyewitnesses of an execution. *Am J Psychiatry* 1994; 151: 1335–1339.
35. Draper P, Holloway M and Adamson S. A qualitative study of recently bereaved people's beliefs about death: implications for bereavement care. *J Clin Nurs* 2014; 23: 1300–1308.
36. Tenbrusel A and Messick D. Ethical fading: the role of self-deception in unethical behaviour. *Soc Justice Res* 2004; 17: 223–236.
37. Yar M. *Hannah Arendt (1906–1975)*. The Internet Encyclopedia of Philosophy, <http://www.iep.utm.edu/arendt/> (2016, accessed 16 March 2016).