## *Soundings*

# Death by injection

On the subject of the death penalty, opinions vary as much as on other controversial subjects, such as abortion, gun control, or welfare for the indigent. Over the past few months I have informally polled friends and acquaintances and found the most diverse and often quite passionate opinions. On the whole, however, my findings bear out the earlier national formal polls: the majority of Americans, over 60%, support the death penalty.

Supporters will admit that theoretically mistakes could occur, but point out that the long delays between sentencing and executions make this quite unlikely. They say that the death penalty has been imposed mostly for particularly heinous crimes against children and old ladies, for rape, or for mass murderers, such as the notorious John Gacy, who murdered 33 young men and boys, and more recently Tim McVeigh, who blew up 168 people in Oklahoma. All this came to the fore recently with the execution of Karla Tucker, who killed two people with a pickaxe in 1983 and was put to death in 1998—this despite her religious conversion, a web page on the Internet, and appeals for clemency by demonstrators, the Pope, and the European parliament.

Throughout the years heated arguments have raged over the merits of the death penalty, whether it is immoral, whether it deters crime—it certainly made Singapore drug free—and what the odds are of an innocent person being put to death in error. At present the death penalty is used in over 90 countries, mostly but not exclusively in Asia and Africa. In the United States 435 men and two women have been executed since the Supreme Court reinstated the death penalty in 1976, provided that it was imposed fairly. In 1997, 74 people were executed, 37 in Texas, the rest in the other 38 states that allow the death penalty. Another 3365 convicted criminals are awaiting execution on death rows. As this is now being carried out largely by lethal injection, there arises the issue of what role doctors should play in this process.

The consensus among members of the medical profession has been: none. Doctors' avowed mission (or job description, in labour union terms) is to support life, to prolong it, or to make it more bearable. They are not in the business of causing death, Dr Jack Kevorkian excepted. Yet this became an issue in the early 1990s when Illinois, several other states, and also the federal government, ruled that a doctor needed to be present during executions by lethal injection. Such rulings ran into vigorous opposition from medical groups, which had already declared in 1980 that such medical participation was unethical, and which subsequently reaffirmed their position, as did official nurses' organisations.

Activities defined as participation were starting intravenous lines, preparing or maintaining execution fluids or devices, prescribing pre-execution drugs, monitoring vital signs during executions, providing psychiatric information about fitness to be executed, harvesting organs, or declaring death. Excluded activities were serving as a witness in a criminal trial, advising about competence to stand trial, relieving suffering at a convict's request, certifying death provided that another person has pronounced it, and carrying out an autopsy after execution. This for the present is a reasonable solution, one that would leave the actual process of carrying out executions to special technicians who were trained to cannulate a peripheral or if need be a femoral vein.

The alternative approach, recently suggested by someone who supports the death penalty as well as gun control, is to have executions carried out by a firing squad composed of members of the National Rifle Association.

George Dunea, *attending physician, Cook County Hospital, Chicago, USA*

## *Personal view*

# The politics of alcoholism in India

At a recent meeting in Goa organised by the National Commission for Women, its chairwoman, the vibrant and outspoken Ms Mohini Giri, exhorted the women of Goa to join hands with millions of women in other Indian states to demand that prohibition be implemented to reduce the appalling damage resulting from alcohol misuse by men.

The use of prohibition in India has a long history. Gujarat, the home state of Mahatma Gandhi, declared prohibition soon after the British left and has stuck to this policy ever since. More recently, however, prohibition became a major vote winner in the states of Andhra Pradesh and Haryana. Alcohol misuse has become such an enormous problem that it is now the main issue on which elections are being fought and won.

Alcohol misuse is one of the main killers of young men in India today. But its real impact is on the social and family dynamics that underlie our communities. Domestic violence and an exacerbation of poverty have made alcohol misuse the single most important problem for women in India. A recent study in Goa showed that women attending primary care clinics were more likely to cite a drinking relative as a key problem in their homes. They were also more likely to cite problems with making ends meet and to suffer from a depressive or anxiety disorder.

What has changed over the past 20 years is that these women are now an increasingly potent electoral force. Women's organisations have successfully mobilised millions of women and struck a sensitive chord in identifying alcoholism in their families as being a potentially preventable cause of poverty and abuse. Rather deviously, women have been identified by opportunistic politicians as a vote bank; political parties have thrown all the benefit of hindsight to the wind and made prohibition their prime election promise. The result was that the Telegu Desam party won a famous electoral victory, winning 224 out of 294 seats in Andhra Pradesh. Subsequently, the party which put prohibition at the top of its agenda won the elections in Haryana with a large majority.

But has prohibition made any difference to the real problem—that is, drinking by men? If Gujarat is anything to go by prohibition is a complete failure. Not only is alcohol readily available to the rich, but the poor have to resort to illegal brews, with a consequent rise in criminal activity and deaths from methanol poisoning. Prohibition has introduced massive problems for the government treasuries and caused further hardships for the poor by increasing unemployment. In Andhra Pradesh alcohol breweries were shut with the loss of hundreds of legitimate jobs; the state was virtually bankrupted. The government attempted to counter the budgetary deficit by raising taxes and the cost of subsidised rice, the staple food of millions of Indians. Despite this, the deficit continued to spiral out of control reaching a third of the annual budget outlay. Finally, the Reserve Bank of India threatened to withdraw the overdraft facility to the state. The government then relented and introduced the AP Prohibition Act 1997, which effectively removed prohibition in favour of a more regulated alcohol retailing system.

*"There has been no mention of any public health initiatives"*

An amazing feature of all this grassroots democracy is that there has been no mention of any public health initiatives to tackle alcohol misuse. Primary preventive strategies would enable the reduction of problem drinking in an entire population. Such strategies could include the strict enforcement of laws on licensing and on drinking and driving, and the provision of peer education on drinking behaviour in colleges and schools. Secondary prevention would enable the reduction of the effects of problem drinking once it had been detected in an individual. How often does a woman who has been battered by her alcoholic husband receive counselling or a health worker visit her home to counsel the husband? How often does a man who has been in hospital for a bleeding gastric ulcer or after a drinking and driving accident receive information on the nearest Alcoholics Anonymous meeting place? Counsellors could work with other organisations, such as Alcoholics Anonymous and the Indian Psychiatric Association, in a united campaign to help families affected by problem drinking.

The policy of prohibition is at odds with an essential ingredient of any community health programme—namely, its participatory approach. By identifying drinking in men as the problem, the current approach alienates and excludes them from participating in finding a solution. Bar owners and alcohol manufacturers, usually men, see their livelihood destroyed and, instead of empathising with women on this sensitive issue, they feel threatened.

The current drive by the National Commission for Women is an admirable example of women uniting in an effort to make their lives better by forcing the government to act. But in their vociferous support for prohibition women's groups should remember that it will always be the poor who will suffer the most from prohibition. A community based, participatory public health model to tackle alcohol misuse is the only way to reduce the negative impact of problem drinking while safeguarding the economic benefits of alcohol, avoiding punishing the majority who drink sensibly, and preventing deaths and crime which result from the illegal bootlegging industry.

Vikram Patel, *secretary, Sangath Society for Child Development and Family Guidance,Goa, India*

*A lesson learnt*

## A view from the other side

It was five years ago this month, we were all huddled in a corner of a draughty relatives' room talking in hushed whispers as seemed to befit our presence in the stark clinical surroundings. My grandfather was lying grey and struggling for breath in a bed on the ward outside. It was a weekend and I had rushed down to see him for what we all knew would be the last time. My grandmother was there with my mother and aunt. They knew that he was dying and yet wanted to be given some hope to hang on to. No one seemed to know anything about what was happening to him and their timid attempts at finding out from the nursing staff had got nowhere. With some relief from all concerned (except myself) I was nominated as being the only medical member of the family to go and talk to a doctor.

In fact I would have barely classed myself as medical as at the time I had just started my first medical junior house officer post and was still finding my feet in my new life. I was deeply upset at seeing my grandfather looking so vulnerable and weak and confused as this imagery somehow merged and yet clashed with that of patients I had been seeing on my own medical ward at work all week. When it came to the interview with "the Doctor," a tired looking senior house officer on ward cover, my shaky quasiprofessional stance fast dissolved. All I wanted to know was why my granddad was so sick and whether or rather when he was going to die. I did not want jargon, I did not want details, just a few compassionate words that I could pass on to the rest of my family.

What followed has remained with me as a vivid memory. Having established my credentials as a proper doctor the SHO then seemed to be confused about whether I should be treated as a colleague or a relative. In his confusion he must have decided that the easiest route was to adopt the detached clinical hand over routine. The details are now a haze but I remember clearly feeling my distress mounting as his explanation progressed. Words like "probable infarct," "pulmonary oedema," and "acute renal failure" drifted across to me. These went on to "cardiac enzymes" and "creatinine" and finally an electrocardiograph was fished out and shown to me. By this time inside my head I was screaming, "Stop, this is my granddad you're talking about." I did not want a real person to me reduced to a few squiggley lines on a piece of paper. On the outside I nodded and did not say a thing. The interview ended and not a word had been said about my grandfather dying.

What did I learn from this? If am ever put in this situation again I will try and make it clear at the start exactly how I want to be treated—as a doctor wanting medical details or as a relative wanting a simple explanation. I learnt that relatives in distress may not always be able to make their needs known. As a doctor in a similar situation, I will also try to ensure that their wishes are clear.

Kate Walters, *general practitioner, London*

We welcome articles up to 600 words on topics such as *A memorable patient, A paper that changed my practice, My most unfortunate mistake,* or any other piece conveying instruction, pathos, or humour. If possible the article should be supplied on a disk. Permission is needed from the patient or a relative if an identifiable patient is referred to. We also welcome contributions for "Endpieces," consisting of quotations of up to 80 words (but most are considerably shorter) from any source, ancient or modern, which have appealed to the reader.