

Web site (www.wyeth.com/ClinicalTrialResults?query=Depressive%20Disorder). Since venlafaxine was the 12th most prescribed brand-name drug in 2007, with 17.2 million prescriptions (www.drugtopics.com/drugtopics/article/articleDetail.jsp?id=491207), aren't these results relevant to the public health?

We believe that the publication exposure a clinical trial receives should not hinge on how it turned out. There should be no shame in acknowledging that not every clinical trial is a "success."

If transparency is applied selectively, then it's not transparency — it's translucency.

Erick H. Turner, M.D.

Oregon Health and Science University
Portland, OR 97239
turnere@ohsu.edu

Robert A. Tell, L.C.S.W.

Portland Veterans Affairs Medical Center
Portland, OR 97239

1. Otto MW, Nierenberg AA. Assay sensitivity, failed clinical trials, and the conduct of science. *Psychother Psychosom* 2002; 71:241-3.

Physicians and Execution

TO THE EDITOR: In their editorial about physicians and executions, Curfman et al. (Jan. 24 issue)¹ are correct that our profession has no place in the process of legal execution in this country. I would point out that growing public sentiment against executions has also been fueled by the introduction of DNA evidence into criminal trials and the subsequent realization that we are sometimes executing innocent people as well as the criminally guilty. Those of us in the medical profession have a long, inglorious history of contributing to the death of our fellow human beings through errors of omission and commission. Certainly, physicians, who should adhere to the dictum, "first, do no harm," should reject participation in legal or any other type of execution.

Lawrence S. Bizer, M.D.

Albert Einstein College of Medicine
Bronx, NY 10461

1. Curfman GD, Morrissey S, Drazen JM. Physicians and execution. *N Engl J Med* 2008;358:403-4.

TO THE EDITOR: Curfman et al. state that as healers of the sick, physicians should not be involved in capital punishment and should remember the Hippocratic Oath. But a physician's job is not only to heal the sick — it is also to relieve suffering. When a patient is acknowledged to be terminally ill, the physician's role changes from an emphasis on cure to an emphasis on alleviation of the patient's pain and discomfort. A person whose life society has decided to terminate for the general good can likewise be regarded as terminally ill. Rather than end the person's life in a painful

manner, it would be in line with a physician's role to offer advice on minimizing pain.

The original Hippocratic Oath also spoke out against facilitating any abortion, a dictum that our society no longer wholly observes. As long as society deems capital punishment a directive that is for the greater good, there should be no problem with a physician voluntarily offering to play a role in devising a more humane end.

Mark Weinblatt, M.D.

Winthrop University Hospital
Mineola, NY 11501
mweinbl@yahoo.com

TO THE EDITOR: I am very pleased and encouraged to read the recommendation that physicians should not participate in executions. This is a moral stance with many positive implications, including avoiding a dual-loyalty conflict. Dual-loyalty conflict is a significant struggle in routine daily practice when the obligation to the patient is being balanced against loyalty to a third party, such as an insurer or employer. This conflict is all the greater when a physician enters a professional relationship with a person who is to be executed. Participation in executions, with its obvious harms, violates that obligation. By refraining from participation in executions, physicians also avoid a loyalty conflict with the state, which is paying for the physician's services. Thank you for this article and the discussions it will stimulate.

Robert M. Parke, M.H.Sc.

Humber River Regional Hospital
Toronto, ON M3N 1N1, Canada
bparke@hrrh.on.ca

TO THE EDITOR: The *Journal's* editors add their voices to the chorus opposing physician involvement in the lethal injection of condemned criminals, arguing not that society should reject the execution of even abhorrent criminals but only that a “profession dedicated to healing the sick” should not be involved. They would exclude doctors from even voluntary assistance with a legal state function. To buttress their position, they ask us to “remember the Hippocratic Oath and refuse to participate.” Just which part of the oath do they wish us to remember? Swearing by Apollo and Asclepius, Hygeia and Panacea? Refusing to induce abor-

tion in any woman? Refusing to “use the knife”? Or only the command never to give “a deadly drug” to anybody? Let us doctors put our cards on the table: either execution is a bad thing for society in general, and we, as health professionals and members of society, should stand wholly in opposition to it, or it is not bad, and doctors should be encouraged to use their expertise to reduce the suffering associated with what remains a legal action.

Francis A. Neelon, M.D.

3543 Rose of Sharon Rd.
Durham, NC 27712
drneelon@ricediet.com

Perspective Roundtable: Lethal Injection

TO THE EDITOR: I was deeply disturbed by the discussion, led by Gawande, on physicians and executions (Jan. 31 issue).¹ Except for Truog's principled objection to capital punishment on moral grounds, it seems as if the participants were missing the point of the argument over the question of physician involvement in the legalized killing of human beings. As Denno notes, the adoption of the lethal-injection protocol 31 years ago as the preferred method for execution has led to the medicalization of a procedure that has been abandoned by all but a few modern industrialized nations.

An examination of the history of the death penalty in this country shows a gradual departure from a public and often bloody spectacle to one that is hidden behind closed doors, sanitizing what has become an uncommon form of retributive justice.² It is ironic that removing the procedure from the prying eyes of the public has correlated with a continuing decrease in its application.

The ultimate cleansing of human executions was to have been accomplished by making the process akin to the painless “putting to sleep” of our beloved pets, except under the guidance of enlightened and compassionate physicians rath-

er than veterinarians. Unfortunately for this approach, and as clearly pointed out in the editorial accompanying this article,³ the involvement of physicians in the methodical and intentional killing of a person — who becomes a “patient” the minute a doctor accepts a participatory role, no matter how reprehensible the person's conduct may have been (and irrespective of how far removed from the actual physical procedure the doctor's role may be) — is a grave violation of professional medical ethics. Physicians acting as physicians (i.e., in their professional capacity) may not kill patients on purpose. Even physicians who, in their private lives, might condone capital punishment may not play an enabling role in this process in their professional lives. To do so would be a breach of everything we hold to be important in the practice of medicine.

Philip M. Rosoff, M.D.

Duke University Medical Center
Durham, NC 27710

1. Gawande A, Denno DW, Truog RD, Waisel D. Physicians and execution — highlights from a discussion of lethal injection. *N Engl J Med* 2008;358:448-51.
2. Banner S. *The death penalty: an American history*. Cambridge, MA: Harvard University Press, 2002.
3. Curfman GD, Morrissey S, Drazen JM. Physicians and execution. *N Engl J Med* 2008;358:403-4.