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My name is Lawrence D. Egbert. I am a physician and a professor of anesthesiology and have taught anesthesiology at the University of Texas Southwestern Medical School in Dallas and practiced at the Parkland Memorial Hospital since 1982. I received my training in Pennsylvania at the U.S.Naval Hospital, Philadelphia and at the Hospital of the University of Pennsylvania in the 1950s. Between the fifties and 1982, I have taught at Harvard Medical School and at The Johns Hopkins University and was chairman of the Department of Anesthesiology at the American University of Beirut in Lebanon. I have been asked to make this report by the American Civil Liberties Union.

In 1982, Charles Brooks, junior, received an anesthetic in the Texas Department of Corrections. The press referred to his anesthetic as a "lethal injection". However, the anesthetic which you will receive in case you need an operation will include the same drugs that Charles Brooks received probably, that is, thiopental, also known as pentothal, and pancuronium marketed as pavulon. The doses administered are not lethal when we take care of patients. They are lethal when prisoners receive them and are NOT taken care of. The key difference I will deal with here is the presence of physicians and technicians who are supervised by physicians for it is physicians and nurses who make the anesthetic safe and it physician involvement in executions which challenges society. Do you want your doctors administering lethal injections? I will demonstrate to you that physicians are inextricably involved. My question to you is, SHOULD we be involved?

How has the state learned how to execute criminals using anesthetics? This was first accomplished in Oklahoma when a state senator asked the then-chairman of the Department of Anesthesiology at the University of Oklahoma, Stanley Deutsch, MD, PhD, how this should be done. He replied with a formal consultation and taught them how. An intravenous injection is started. In Texas, the intravewnous tubing is injected with pentothal 2000 milligrams (mg) followed by pavulon 100mg followed by potasium. The pentothal puts the criminal or the hospital patient to sleep and makes them comfortable. The pavulon relaxes most of the muscles of the body; the muscles of respiration stop. Respiratory arrest is a side-effect which we anesthetists take care of. Respiratory arrest is the effect DESIRED by the state of Texas. Dr. Deutsch's prescription suggested very similar doses. In Illinois, in September, the original plan was to administer only 300 mg. of pentothal which would have left about 20% of criminals awake while they became paralyzed with the pancuronium. This was changed to 900 mg after physicians criticized the dosage. The point is that physicians are involved even in the evaluation of the quality of the execution.

The first execution using an anesthetic, that of Charles Brooks, junior, was supervised directly by Ralph Gray, M.D., then medical director for the Texas Department of Corrections. As medical director, Dr. Gray was responsible for the buying and storing of these anesthetics, their distribution, and their injection, whether for anesthesia for surgical patients or for executions. Dr. Gray supervised the placement of the intravenous tubing. Technicians under his supervision injected the drugs. Finally, he pronounced Charles Brooks, junior, dead. This direct connection of physician with execution was stopped in Texas when the Texas Medical Association followed the opinion of the American Medical Association insisting that physicians should NOT participate except to pronounce the prisoner dead. Keep in mind, however, that, since death is the objective of this anesthetic, when Dr. Gray once ordered more anesthetic to be injected because the prisoner was not dead, even the pronouncement of death is direct involvement in the process of doctors acting as executioners for the state.

Thus, physicians have been involved in every stage of the execution process except one and even that has been recommended by a physician as something society should institute. Dr. Jack Kevorkian, in an article with the title, "The Nobler Execution", published in Ararat in the summer of 1961 recommended that prisoners be allowed to receive their anesthetic under professional direction, then be transferred anesthetized to a research center where a research project would be carried out upon them. Security would be maintained, of course, and, when the research was accomplished, the anesthetic support therapy would be discontinued just as is now done for executions. The advantages that are relevant to our thinking are two: one, the prisoner is voluntarily permitted to make an altruistic decision to aid society and, two, society would gain by that decision from the research accomplished. I include this not only because Dr. Kevorkian is a physician but because he is the same physician who performed the intravenous injection and set up the pentothal and potassium for the euthanasia for Janet Adkins. Physicians may argue for or against active euthanasia but the arguments are made obscene when the voluntary decision of a person suffering from an incurable disease is technically recommended by the same persons as are assisting with the coerced execution using the same technics.

The professional organization for anesthesiologists chose neither to condemn or applaud the use of anesthetics for executions. The president of the American Society of Anesthesiologists in 1984, H. Ketcham Morrell, M.D., merely wrote the Director of the Office of Drug Research & Review of the Food & Drug Administration that "the use of anesthetic drugs for executions creates in patients profound fears of drugs in common clinical use." The crucial question of our responsibility for the use of anesthetic drugs by other people was not addressed. You will address this. Should physicians or other people use medical drugs to kill people at the behest of the

State of Pennsylvania? At the present time, no other people administer narcotics or sedatives without the supervision of a physician except for street people illegally. Illinois has physicians doing this. Texas has people whose skills are unknown to the public under the supervision of the warden perform these anesthetics.

The medical profession is involved thru the pharmaceutical industry. The Abbott pharmaceutical company in North Chicago manufactures pentothal. They know that pentothal is used for executions and that this is NOT on their list of recommended uses for pentothal. They do NOT approve of this. They have not, as far as I know, officially protested such use of their drug, merely pointing out that other companies also manufacture pentothal. The Organon pharmaceutical company manufactures pavulon. They also know that their product is being used for executions, do NOT approve of this use of their drug, and have not officially protested this use.

My comments thus far have been those of an anesthetist. However, a remarkable conflict of interest in the matter of executions has been faced by the psychiatrists. If a criminal is psychotic, executions are not performed in the United States. Thus, the psychiatrist will diagnose the criminal psychotic and thereby prevent an execution, or diagnose sanity and therefore able to understand and suffer the execution. The American Psychiatric Association "strongly opposes any participation by psychiatrists in capital punishment." American Medical Association trustee, Nancy Dickey, M.D. has deplored lethal injection as tying a medical procedure to state organized executions. "The two should in no way be linked." I agree.

As a citizen of Texas, let me remind you that the cities of Houston and Dallas have very high rates of murder and other violent crimes. No one has ever demonstrated that lethal injection or any other type of execution of criminals has deterred other people from committing crimes. As a matter of fact, states which do not execute criminals usually have lower murder rates. States which have stopped executing criminals have not suddenly had higher murder rates or vice versa. Even if there were a deterrant effect (which no one has succeeded in demonstrating), using the more "pleasant" form of killing would certainly not add to any theoretical deterrant effect since it is obviously less agonizing than hanging, firing squad or electrocution. You have not executed anyone since 1962. You will have clear evidence by now that executions do NOT DETER crime and that in other states in the United States, executions historically have been performed on black criminals more often than on white criminals who committed a similar crime. My recommendation is that physicians should not participate which is so blatantly racist. I grew up

during a time when physicians in one of the most advanced civilized nations in the world were actively narcotizing people for a supposed good of the state. German physicians were roundly comdemned for their participation in this work. So also should physicians in the United States be condemned for such participation. Since most civilized nations in the world nowadays condemn executions per se, would it not be better if U.S. physicians recommended that the health of the State of Pennsylvania would be better if the state did NOT execute people at all?