

“TO COMFORT ALWAYS”:[†] PHYSICIAN PARTICIPATION IN EXECUTIONS

*Kenneth Baum, M.D.**

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[†] From the quote, widely attributed to sixteenth-century French surgeon Ambroise Pare, “The task of medicine is to cure sometimes, to relieve often, and to comfort always.”

* Lecturer in Political Science, Yale University; Associate, Wiggin & Dana, L.L.P.; M.D., Yale School of Medicine; J.D., Yale Law School; B.A., University of California at Berkeley. I would like to thank Dean Barbara Safriet and Professor Eugene Volokh for their generous guidance and thoughtful comments. I would also like to thank the *Legislation* staff generally, and Matthew Marcotte personally, for insightful comments, painstaking bluebooking, and for all of the other invaluable contributions that they made to this Article. Finally, this Article, like many other things in my life, would not have been possible without the continued love and support of my family.

INTRODUCTION

Physician participation in the implementation of the death penalty is a highly contentious issue, spawning voluminous professional and academic debate.¹ Society has long provided a role for physicians in the execution process,² but as the death penalty has become more and more medicalized, the appropriate contours of such participation have come under increasing scrutiny. Should physicians be present at executions? Should they oversee the execution process? Should they deliver lethal injections or pronounce death? Social consensus on these pressing issues is imperative in order to guide legislation and remove current roadblocks to appropriate physician involvement.

Resolution is particularly crucial at a time when debate concerning the institution of capital punishment is experiencing renewed intensity.³ Recently, politicians, physicians, and the media have pulled the death penalty back into the national spotlight. Governor Ryan's moratorium on executions in Illinois⁴ (the result of numerous DNA-confirmed wrongful convictions), the start of George W. Bush's presidential administration,⁵ and the recent federal executions of Timothy

1. See, e.g., THE AM. COLL. OF PHYSICIANS ET AL., BREACH OF TRUST: PHYSICIAN PARTICIPATION IN EXECUTIONS IN THE UNITED STATES (1994) [hereinafter BREACH OF TRUST]; Council on Ethical and Judicial Affairs, Am. Med. Ass'n, *Council Report: Physician Participation in Capital Punishment*, 270 JAMA 365 (1993) [hereinafter *Council Report*]; William J. Curran & Ward Casscells, *Sounding Board: The Ethics of Medical Participation in Capital Punishment by Intravenous Drug Injection*, 302 NEW ENG. J. MED. 226 (1980); Alfred M. Freedman & Abraham L. Halpern, *The Erosion of Ethics and Morality in Medicine: Physician Participation in Legal Executions in the United States*, 41 N.Y.L. SCH. L. REV. 169 (1996); David J. Rothman, *Physicians and the Death Penalty*, 4 J.L. & POL'Y 151 (1995); Andrew A. Skolnick, *Health Professionals Oppose Rules Mandating Participation in Executions*, 269 JAMA 721 (1993); Robert D. Truog & Troyen A. Brennan, *Sounding Board: Participation of Physicians in Capital Punishment*, 329 NEW ENG. J. MED. 1346 (1993); Stacy A. Ragon, Comment, *A Doctor's Dilemma: Resolving the Conflict Between Physician Participation in Executions and the AMA's Code of Medical Ethics*, 20 U. DAYTON L. REV. 975 (1995).

2. See *infra* Part I.B.

3. See *infra* notes 4–10 and accompanying text.

4. Ken Armstrong & Steve Mills, *Ryan: 'Until I Can Be Sure': Illinois Is First State to Suspend Death Penalty*, CHI. TRIB., Feb. 1, 2000, at 1; John Bacon et al., *Illinois Governor Orders Execution Moratorium*, USA TODAY, Feb. 1, 2000, at 3A; William Claiborne, *Illinois Order on Executions Lauded: Governor Backs Moratorium After 13 Death Row Inmates Are Exonerated*, WASH. POST, Feb. 1, 2000, at A2; Dirk Johnson, *Illinois, Citing Faulty Verdicts, Bars Executions*, N.Y. TIMES, Feb. 1, 2000, at A1.

5. Having presided over some 150 executions during his six-year tenure as the governor of Texas, President George W. Bush's support for the death penalty is widely acknowledged. See, e.g., *Annan Supports Halt to Death Penalty: U.N. Official Received World Petition Signed by 3.2 Million*, WASH. POST, Dec. 19, 2000, at A20 ("As governor of Texas, President-elect Bush presided over nearly 150 executions. In

McVeigh⁶ and Juan Raul Garza⁷ after a thirty-eight-year hiatus on federal executions have focused the public's attention on many aspects of our capital punishment system.

At both its 2000 and 2001 annual meetings, the American Medical Association (AMA) considered, but ultimately rejected, a resolution calling upon the entire medical profession to support a moratorium on all executions until questions regarding the availability of DNA evidence and the quality of legal representation are resolved.⁸ Arguably more important are the results of a recent survey of American physicians finding that, despite the norms adopted by the AMA and other professional societies, the majority of physicians approve of physician participation in executions.⁹

Further, the media, seizing this opportunity, has flooded the public with articles and television shows questioning the accuracy, fairness, and morality of capital punishment in America.¹⁰ The nation

2000 alone, 40 people were put to death in Texas, the most of any state in U.S. history.”).

6. Executed on June 11, 2001, by lethal injection, Timothy McVeigh was the first federal prisoner to be put to death in thirty-eight years. Rick Bragg, *McVeigh Dies for Oklahoma City Blast: No Final Words Before He Is Executed*, N.Y. TIMES, June 12, 2001, at A1; Lois Romano, *McVeigh Is Executed: Bomber Is 1st Federal Prisoner Put to Death since 1963*, WASH. POST, June 12, 2001, at A1.

7. Juan Raul Garza was executed by lethal injection on June 19, 2001, eight days after the execution of Timothy McVeigh. Raymond Bonner, *U.S. Executes a Second Killer in a Week*, N.Y. TIMES, June 20, 2001, at A12; Peter Slevin, *Garza Executed 8 Days After McVeigh: His Long Legal Battle Over, Killer Apologizes for 'All the Pain and Grief'*, WASH. POST, June 20, 2001, at A2.

8. AM. MED. ASS'N HOUSE OF DELEGATES, REPORT OF REFERENCE COMMITTEE ON AMENDMENTS TO CONSTITUTION AND BYLAWS 13 (2000), available at <http://www.ama-assn.org/meetings/public/annual00/reports/hodactions/cbannot.rtf> (last visited Nov. 8, 2001) (requesting that the AMA “recommend to The National Governors’ Association that all executions be stopped until questions concerning the availability of DNA evidence, the quality of legal representation, and the harmful impact to the judicial system when innocent defendants are executed are answered”). However, at the 2000 annual meeting, the AMA’s House of Delegates rejected the resolution, and instead approved an amended resolution directing the AMA to “support the availability and use of all appropriate medical forensic techniques in the criminal justice system.” *AMA Declines to Endorse Death Penalty Moratorium*, MED. INDUSTRY TODAY, June 14, 2000, LEXIS, Medtdy File. At the 2001 annual meeting, the AMA again declined to endorse a nationwide moratorium on executions. See Jim Ritter, *AMA Opposes Scouts’ Gay Ban*, CHI. SUN-TIMES, June 21, 2001, at 14 (“For the second year in a row, the AMA declined to oppose the death penalty.”).

9. Neil Farber et al., *Physicians’ Attitudes about Involvement in Lethal Injection for Capital Punishment*, 160 ARCHIVES INTERNAL MED. 2912 (2000).

10. See, e.g., Jonathan Alter, *The Death Penalty on Trial*, NEWSWEEK, June 12, 2000, at 24; Jonathan Alter, *Why the Mess Really Matters*, NEWSWEEK, May 21, 2001, at 29; *America’s Death-Penalty Lottery*, ECONOMIST, June 10, 2000, at 15; Raymond Bonner, *Charges of Bias Challenge U.S. Death Penalty*, N.Y. TIMES, June 24, 2000, at A1; Raymond Bonner, *Justice Dept. Set to Study Death Penalty in More Depth*,

appears to be reassessing the institution of capital punishment, and central to that evaluation is the appropriate role for the scientific community, and particularly the medical profession, in the accurate and ethical implementation of that punishment.

Unique circumstances and compelling arguments exist both for and against continued physician participation in executions, making any choice about participation a difficult one. This Article critically examines the relevant ethical, legal, and policy arguments that bear on this decision. By doing so, it comes to the conclusion that, taken as a whole, all perspectives speak in favor of an active role for physicians in the lethal injection process, conditioned, in every case, on the wishes of the condemned. However, current legal tensions between state death penalty statutes and medical practice acts stand in the way, creating an unnecessary and unwarranted ethical bind for physicians. Although most death penalty statutes provide for or even require physician participation in executions,¹¹ many current medical practice acts allow physicians to be subjected to professional discipline for such actions.¹² Although the negative effect of this threat of sanction and delicensure is difficult to quantify, it increases as our system of capital punishment becomes more and more medicalized.

If physicians are to continue to participate in executions, states must remedy these statutory ambiguities. Although some states have adopted various legislative measures to this end,¹³ such approaches fail to adequately address the problem. Both permissive death penalty

N.Y. TIMES, June 14, 2001, at A28; William Claiborne & Paul Duggan, *Spotlight on Death Penalty*, WASH. POST, June 18, 2000, at A1; Dan Eggen, *U.S. Death Penalty System Not Biased, Ashcroft Declares*, WASH. POST, June 7, 2001, at A29; John Aloysius Farrell, *DNA Technology Puts Death Penalty to Test*, BOSTON GLOBE, June 2, 2000, at A1; David Gergen, *Death by Incompetence*, U.S. NEWS & WORLD REP., June 26, 2000, at 76; Steve Mills et al., *Flawed Trials Lead to Death Chamber*, CHI. TRIB., June 11, 2000, at 1; *More Death-Penalty Doubts*, USA TODAY, July 6, 2001, at 11A; *New Evidence of Errors Fuels Death-Penalty Doubts*, USA TODAY, June 12, 2000, at 18A; William Schneider, *Growing Doubts about the Death Penalty*, 32 NAT'L J. 1874 (2000); Michael Tackett, *National Consensus Has Yet to Emerge on Death Penalty*, CHI. TRIB., June 13, 2000, § 1, at 6; Stuart Taylor Jr., *Does the Death Penalty Save Innocent Lives?*, 33 NAT'L J. 1551 (2001); *CNN Live at Daybreak: Experts Discuss Recommendations on Death Penalty to Be Publicized Today* (CNN television broadcast, June 27, 2001); *Talk of the Nation: Federal Death Penalty* (NPR radio broadcast, June 19, 2001); *The O'Reilly Factor: Is Capital Punishment in U.S. Getting Out of Hand?* (Fox News television broadcast, July 10, 2000); *Larry King Live Weekend: Is the United States Criminal Justice System Broken?* (CNN television broadcast, July 8, 2000); *CNN International World News: Graham Execution Makes Death Penalty an Issue in U.S. Presidential Election* (CNN television broadcast, June 23, 2000).

11. See *infra* note 81.

12. See *infra* notes 78–79.

13. See *infra* Part III.A–B.

statutes, which allow for physician participation, and the addition of safe harbor provisions to medical practice acts, which protect physicians from professional discipline for such participation, are necessary to resolve the conflict. Such legislation will also best serve the needs of the condemned, the profession as a whole, and the public.

In Part I, this Article clarifies exactly what types of participation in executions are contemplated for physicians. It then provides a brief history of the medical establishment's involvement in the evolution and implementation of capital punishment. From the guillotine to the electric chair to the lethal injection, physicians have played a consistent and integral role in shaping the face and character of executions. Perhaps as a result of this professional involvement, capital punishment has increasingly moved away from more barbaric forms and taken on the appearance of more humane, even medical, procedures. It is against this backdrop that we must frame the current debate regarding the appropriate role of the physician in the death penalty.

Part II then surveys the major ethical, policy, and legal considerations surrounding physician participation in executions. Arguments for and against such participation are analyzed along dimensions of rationality, consistency, and empirical support. This Part concludes that, despite compelling arguments otherwise, all considerations support a continued and active role for physicians in the execution process, guided by the wishes of their condemned patients. Preserving this role will further the fundamental ethical ideals of the practice of medicine, safeguard the interests of the condemned, and best serve the public interest.

Part III highlights and analyzes the current tension that exists between state death penalty statutes and medical practice acts, as well as the threat that tension poses for physician participation in capital punishment. Death penalty statutes establish the procedural guidelines to which states must adhere when administering capital punishment. Medical practice acts, on the other hand, establish the legal guidelines for the practice of medicine within a state. While most death penalty statutes allow for, or even require, physician participation in executions, many medical practice acts expose physicians to professional disciplinary action for such participation. Physicians thus confront a dilemma: either forego participation in capital punishment or risk professional discipline. Legislative resolution is therefore necessary to release physicians from this no-win situation. The Article then analyzes the various legislative approaches that some states have employed to resolve the conflict between death penalty statutes and medical practice acts. Although well intentioned, the Article finds all

such approaches problematic and insufficient to appropriately remedy the dilemma. It then proposes a more appropriate alternative legislative response.¹⁴

I

BACKGROUND

This Part clarifies exactly what is meant by “physician participation in executions,” and provides a brief history of the medical establishment’s involvement in capital punishment.

A. *What is “Participation”?*

Before discussing whether or not physicians should participate in lethal injections and other forms of capital punishment, we must first define what “participation” means in this context. For the purposes of this Article, physician participation refers only to actions taken as part of the actual execution process, as opposed to physician involvement in earlier stages of the criminal justice system, such as trials and sentencing hearings. The following actions are illustrative of the sort of physician participation in capital punishment envisioned by this Article, but are not inflexible or exhaustive—details will necessarily depend on context. First are preparatory actions taken prior to the scheduled date of the execution, such as examining the condemned to determine whether any medical condition might interfere with the execution process, examining the condemned’s medical records to determine and prescribe an appropriate lethal pharmacological regimen, or supervising the arrangement of medical supplies needed for the execution. Second are preparatory actions taken immediately prior to the execution, like preparing syringes with lethal solution, supervising attachment of a heart monitor to the condemned, locating appropriate veins for insertion of catheters that will deliver the lethal solution, or inserting the catheters. Next are supervisory or direct actions during the execution itself, including beginning the flow of the lethal solu-

14. This Article does not address the ethics of capital punishment itself. The death penalty is a democratic reality in the majority of the United States, and the focus of this Article is accordingly narrowed to the optimal implementation of this policy. It leaves the debate of the moral appropriateness of capital punishment to others. In addition, the Article focuses primarily on the physician’s role in the actual execution, noting the myriad other stages of the criminal law process at which physicians so regularly participate for purposes of comparison and context only. For example, this Article does not address the appropriateness of physicians drawing blood in order to obtain evidence; testifying as to competency to stand trial, competency for execution, or aggravating or mitigating circumstances at sentencing hearings; or treating a defendant to restore their competency to stand trial or for execution.

tion, monitoring the flow of lethal solution, and monitoring the vital signs of the condemned. Finally, there are conclusory actions taken after the execution, most notably pronouncing death.¹⁵

B. *History of Physician Participation in Executions*

Physician participation in the death penalty is not novel. To the contrary, the medical establishment has had a long and storied history of involvement in both the evolution and implementation of capital punishment.¹⁶ While that participation may initially seem macabre, the impetus for physicians who have chosen to participate in the execution process has always been to ease the suffering of the condemned.

At the end of the eighteenth century, during the French Revolution, Dr. Joseph Ignace Guillotine developed the machine of the same name in an attempt to civilize the practice of capital punishment.¹⁷ Dr. Guillotine, a respected and dedicated physician, and a notable opponent of the death penalty, felt that his invention was a more humane alternative to contemporary approaches such as hanging because it was quick, relatively painless, and highly effective.¹⁸ The French surgeon Dr. Antoine Louis, who was likewise concerned with making capital punishment more humane and egalitarian, improved upon the guillotine's design by changing the blade's shape from crescent to diagonal, resulting in a cleaner incision.¹⁹

Similarly, in 1887, a commission of American physicians lobbied for electrocution as a more humane alternative to hanging, claiming that hanging was imprecise, undignified, and unnecessarily unpleasant for criminals.²⁰ In fact, two American physicians, Dr. Carlos MacDonald and Dr. E.C. Spitzka, supervised the first use of the electric

15. Alternatively, the AMA's Council on Ethical and Judicial Affairs has defined physician participation in executions to include three categories of actions: (1) actions that "directly cause the death of the condemned," such as administering the lethal injection itself; (2) actions that "assist, supervise, or contribute to the ability of another individual to directly cause the death of the condemned," such as prescribing the necessary drugs; and (3) actions that "could automatically cause an execution to be carried out on a condemned prisoner," including determinations of death during an execution. *Council Report, supra* note 1, at 368.

16. See, e.g., BREACH OF TRUST, *supra* note 1, at 9–12; Christina Michalos, *Medical Ethics and the Executing Process in the United States of America*, 16 MED. & L. 125, 126–28 (1997).

17. Dora B. Weiner, *The Real Dr. Guillotin*, 220 JAMA 85, 88–89 (1972).

18. *Id.*

19. Michalos, *supra* note 16, at 126.

20. See Curran & Casscells, *supra* note 1, at 227 (citing J. Mount Bleyer, *Best Method of Executing Criminals*, 5 MEDICO-LEGAL J. 425 (1887)).

chair as a method of execution.²¹ More recently, physicians played integral roles in the adoption and acceptance of lethal injections as the new standard of practice in capital punishment.²² Again, physicians were on hand to play prominent roles in the first executions by lethal injection.²³

It is perhaps because of the medical profession's extensive and intimate relationship with capital punishment policies that the death penalty has generally taken increasingly controlled, precise, and medicalized forms. This influence is most striking today, now that lethal injection is the mandatory or optional method of execution in the majority of states with capital punishment.²⁴ This new method not only furthers the march towards more precise and painless forms of execution, but it incorporates what is otherwise a standard medical procedure as its foundation.²⁵

Whether this employment of the medical profession's tools in the realm of capital punishment is beneficial—and to whom—is debatable and is further addressed in Part II. For now, it is enough to acknowledge that the medicalization of capital punishment has taken place, and has done so in large part because of the active role that physicians have historically played in the implementation of the death penalty. It is from this perspective that we must approach the question of the appropriate role for physicians in future executions.

II

ARGUMENTS FOR AND AGAINST PHYSICIAN PARTICIPATION IN EXECUTIONS

Physician participation in executions raises unique and substantial ethical, policy, and legal conflicts. This Part explores and ana-

21. See BREACH OF TRUST, *supra* note 1, at 9–10 (citing Arnold Beichman, *The First Electrocutation*, 35 COMMENT. 410 (1963)).

22. For a discussion of the various methods of execution currently used in the United States, see sources cited *infra* note 23.

23. BREACH OF TRUST, *supra* note 1, at 10 (noting that Dr. Ralph Gray, Medical Director of the Texas Department of Corrections, supervised the lethal injection of Charles Brooks in 1982, the first execution by that method).

24. Michalos, *supra* note 16, at 126; Death Penalty Information Center, *Authorized Methods of Execution by State*, at <http://www.deathpenaltyinfo.org/methods.html> (last visited Nov. 8, 2001).

25. Technically speaking, lethal injections are indistinguishable from the intravenous infusion of any therapeutic solution, be it antibiotics, electrolytes, or re-hydrating fluids. Intravenous catheters, or IVs for short, are large-bore needles inserted into a person's veins to facilitate the infusion of liquids into the bloodstream. Doctors insert IVs constantly in the regular course of health care provision. The only difference present in a lethal injection is the identity and desired effect of the fluids actually infused. The process of inserting the catheter, however, is identical.

lyzes those arguments, seeking clarity through rationality, consistency, and empirical support. In doing so, it concludes that ethical, policy, and legal perspectives all unite to endorse continued, active physician participation in executions, conditioned on the wishes of the condemned. Such an outcome best harmonizes the ethical ideals of the practice of medicine, the public interest, and statutory and Eighth Amendment jurisprudence.

A. *Ethical Arguments Against Physician Participation*

Opponents of physician participation in the death penalty argue that doctors are healers, and as such, active participation by physicians in executions would be irreconcilable with their basic ethical code.²⁶ The medical profession has an implicit understanding with the public that it will employ its tools and skills only for the betterment of individual and public health. Therefore, using their healing skills to serve as the harbingers of death appears to be contrary to medicine's most cherished ideals, and seems to violate the physician's fiduciary role to act in the best interests of the patient.²⁷

Such a position finds substantial support in both ancient and modern medical ethics. The Hippocratic Oath, while over 2000 years old, remains one of the most well-known and frequently cited sources of professional ideals for practicing physicians.²⁸ Popularly attributed to physicians of the Hippocratic tradition who dominated Greek medicine near 400 B.C.,²⁹ the Oath's language broadly condemns any physician action taken with the intent of causing harm or death: "I will prescribe regimen for the good of my patients according to my ability and my judgment and never do harm to anyone. To please no one will I prescribe a deadly drug, nor give advice which may cause his death."³⁰

26. *E.g.*, Jack C. Schoenholtz et al., *The "Legal" Abuse of Physicians in Deaths in the United States: The Erosion of Ethics and Morality in Medicine*, 42 WAYNE L. REV. 1505, 1507 (1996) (arguing that "a corollary to the physician's function as a healer is the proposition that it is unethical for a physician to assist in delivering death to any person").

27. *See, e.g.*, BREACH OF TRUST, *supra* note 1; Curran & Casscells, *supra* note 1; Truog & Brennan, *supra* note 1.

28. ROBERT M. VEATCH, *A THEORY OF MEDICAL ETHICS* 18–19 (1981) (stating that the Hippocratic Oath is "the central document, the single most often-cited summary of the physician's own understanding of what is morally required to be a good medical doctor").

29. *See generally* LUDWIG EDELSTEIN, *THE HIPPOCRATIC OATH: TEXT, TRANSLATION AND INTERPRETATION* (1943).

30. STEDMAN'S MEDICAL DICTIONARY 822 (27th ed. 2000).

Modern ethical treatments of medical practice stress similar disdain for actions that knowingly present harm to patients or contribute to death. That sentiment, embodied by the ideal of nonmaleficence, remains a cornerstone of current bioethical ideology.³¹ The American Medical Association, the most powerful political faction within the profession, continues to oppose an active role for physicians in the execution process.³² In its statement on the ethics of physician participation in executions, the AMA's Council on Ethical and Judicial Affairs (CEJA) pronounced: "A physician, as a member of a profession dedicated to preserving life when there is hope of doing so, should not be a participant in a legally authorized execution."³³

31. See generally TOM L. BEAUCHAMP & JAMES F. CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* (5th ed. 2001) (discussing autonomy, nonmaleficence, beneficence, and justice as four basic principles of bioethics).

32. The fact that the AMA has weighed in against physician participation is of great importance, due to its recognized role, both inside and outside the profession, as the voice of organized medicine. Despite recently declining numbers, the AMA continues to represent nearly 300,000 of the nation's 800,000 physicians and medical students. See *AMA Members Consider Joining Death Penalty Debate*, MED. INDUSTRY TODAY, June 13, 2000, LEXIS, Medtdy file (citing current membership of 293,695). The AMA's Code of Medical Ethics serves as the guide for both individual practitioners and state medical societies. See David Orentlicher, *The Influence of a Professional Organization on Physician Behavior*, 57 ALB. L. REV. 583, 591 (1994) (noting that number of specialty societies and medical licensing statutes have adopted AMA's Code of Medical Ethics, and concluding that "professional regulation can have a substantial impact on physician behavior"); *Doctors Can't Assist Execution, Says Group Citing AMA Ethic Code*, COMMERCIAL APPEAL (Memphis, Tenn.), Oct. 26, 1999, at B2 (reporting that Tennessee Medical Association refused to participate in execution of Robert Glen Coe because of ethical dictates included in AMA's Code of Medical Ethics that it had adopted); Joel Stashenko, *Death Penalty Stirs Ethical Debate by Doctors*, RECORD (Hackensack, N.J.), Sept. 10, 1995, at A4 (quoting Dr. Abraham Halpern, psychiatrist from Mamaroneck, New York, as stating, "New York law states that a physician will be required to pronounce the inmate dead. This is absolutely in contravention of . . . the American Medical Association's code of ethics."). Even the judicial system looks to the AMA for guidance on issues of medical ethics. For examples of Supreme Court cases that cite AMA positions, see *Stenberg v. Carhart*, 530 U.S. 914, 924–25 (2000); *Vacco v. Quill*, 521 U.S. 793, 800–01 n.6 (1997); *Washington v. Glucksberg*, 521 U.S. 702, 731 (1997); *Cruzan v. Dir.*, *Missouri Dep't of Health*, 497 U.S. 261, 288 (1990) (O'Connor, J., concurring); *Roe v. Wade*, 410 U.S. 113, 141–44 (1973). The profession and the rest of the world listens when the AMA speaks, making its position on physician participation in executions of primary importance.

33. COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, AM. MED. ASS'N, *CODE OF MEDICAL ETHICS: CURRENT OPINIONS WITH ANNOTATIONS*, Op. 2.06 (2000) [hereinafter *AMA CODE*]. The opinion goes on to clarify the type of participation contemplated, stating:

Physician participation in an execution includes, but is not limited to, the following actions: prescribing or administering tranquilizers and other psychotropic agents and medications that are part of the execution procedure; monitoring vital signs on site or remotely (including monitor-

In 1994, physician and human rights organizations published an in-depth review and ethical analysis of physician participation in executions which concluded that, beyond the Hippocratic Oath's and the AMA's general prohibitions, proscription of physician participation is justified on more specific grounds that outweigh its potential beneficial effects:

Although physician participation in some instances may arguably reduce pain, there are many countervailing arguments. First, the purpose of medical involvement may not be to reduce harm or suffering, but to give the surface appearance of humanity. Second, the physician presence also serves to give an aura of medical legitimacy to the procedure. Third, in the larger picture, the physician is taking over some of the responsibility for carrying out the punishment and in this context, becomes the handmaiden of the state as executioner. In return for possible reduction of pain, the physician, in effect, acts under the control of the state, doing harm.³⁴

Acknowledging that someone must oversee the technical aspects of executions, those opposed to physician participation assert that other non-physician personnel could serve as able substitutes.³⁵ Lethal injections are not technically difficult. They merely consist of inserting intravenous lines,³⁶ administering a drug through those lines,

ing electrocardiograms); attending or observing an execution as a physician; and rendering of technical advice regarding execution.

In the case where the method of execution is lethal injection, the following actions by the physician would also constitute physician participation in execution: selecting injection sites; starting intravenous lines as a port for a lethal injection device; prescribing, preparing, administering, or supervising injection drugs or their doses or types; inspecting, testing, or maintaining lethal injection devices; and consulting with or supervising lethal injection personnel.

Id. Regarding the impropriety of physician participation in executions, the AMA's Council on Judicial and Ethical Affairs has further stated that, "Physician participation in executions contradicts the dictates of the medical profession by causing harm rather than alleviating pain and suffering." *Council Report, supra* note 1, at 365; *see also* Editorial, *Doctors and Death Row*, 341 LANCET 209 (1993) (urging professional guidelines and medical organizations to unequivocally oppose physician participation in capital punishment); Andrew Sikora & Alan R. Fleischman, M.D., *Physician Participation in Capital Punishment: A Question of Professional Integrity*, 76 J. URB. HEALTH 400 (1999) (challenging professional medical organizations to impose sanctions on members who participate in executions); Howard Zonana, *Releasing Serial Killers: We're Doctors—Not Judges, Juries or Jailers*, WASH. POST, Dec. 5, 1999, at B3 (stating, as matter of fact, that "physicians should not participate in legally authorized executions").

34. BREACH OF TRUST, *supra* note 1, at 38.

35. *See, e.g., Council Report, supra* note 1, at 366 ("Even when the method of execution is lethal injection, the specific procedures can be performed by nonphysicians with no more pain or discomfort for the prisoner.").

36. For a brief description of intravenous lines, *see supra* note 25.

monitoring vital signs, and pronouncing death. It requires little more than training in basic blood-drawing and monitoring. Therefore, other allied health professionals, such as nurses or physician assistants (PAs), or a new class of medical technicians trained specifically for such situations, could fill this role, leaving physicians to fulfill their ethical obligations.³⁷

B. Ethical Arguments for Physician Participation

“The task of medicine is to cure sometimes, to relieve often, to comfort always.”³⁸ That is the ethical ideal to which physicians should aspire. Physicians’ deepest obligation is to their patients’ interests and wishes. While it is true that the preservation of life is an important maxim for medical practitioners, it is neither always the paramount ethical value nor always in the best interests of the patient. The preservation of life must, therefore, yield at times to other objectives, such as the treatment of extreme suffering.³⁹ Such is the logic of the ethical acceptance of withholding and withdrawing life-sustaining treatment to relieve pain and suffering.⁴⁰ Doing so hastens, and arguably even causes, death. But for some patients, death is a welcome alternative to a slowly deteriorating life of agony. More generally, contemporary legal theory and medical ethics both sanction

37. It is ironic that organized medicine would put forth such an argument, as it historically has and continues to zealously fight to retain its exclusive dominion over most facets of the practice of medicine. Physicians are currently involved in territorial battles with non-physician practitioners for the treatment of common illnesses such as diabetes and hypertension, the delivery of anesthesia, and the exclusive right to prescribe medications. See, e.g., James L.J. Nuzzo, M.D., *Independent Prescribing Authority of Advanced Practice Nurses: A Threat to the Public Health?*, 53 FOOD & DRUG L.J. 35 (1998) (arguing against independent prescribing authority for advanced practice nurses); Marilyn W. Edmunds, *Nursing Leaders Consider Reactions to AMA Policy*, NURSE PRAC., Sept. 1999, at 73 (chronicling AMA’s historic opposition to expansion of nurse practitioner’s scope of practice); Molly Tschida, *Liberty Quest*, MODERN PHYSICIAN, Apr. 1, 2000, available at <http://www.modernphysician.com> (“Allied health professionals seeking greater independence and authority are setting off skirmishes with physicians over scope-of-practice bills in state legislatures across the country.”); *Turf Wars: Are Consumers Caught in the Middle?*, PEOPLE’S MED. SOCIETY NEWSL., Feb. 1999, at 1 (“There’s a war going on in the medical community. And if you’re not careful, you may get caught in the middle. The war is over the ‘turf,’ or responsibilities, of nonphysician clinicians, namely nurse practitioners (N.P.’s) and physician assistants (P.A.’s).”).

38. *Supra* note †; see also Curran & Casscells, *supra* note 1, at 229 (“To be sure, medicine has for centuries realized that one of its important functions is to comfort and relieve, when unable to cure.”).

39. See, e.g., BEAUCHAMP & CHILDRESS, *supra* note 31, at 139–52 (discussing ethical appropriateness of withholding or withdrawing life-sustaining treatment to promote comfort).

40. *Id.*

the Double Effect Doctrine, which holds that actions undertaken for beneficent purposes, such as the amelioration of suffering, may be morally permissible even if they foreseeably contribute to death.⁴¹ Ethical ideologies such as the Hippocratic tradition that categorically preclude physician actions that contribute to death fail to appreciate this distinction, and thus miss the mark.

For many other reasons, it seems unreasonable to rely on the Hippocratic Oath as a rigid and ultimate source of ethical guidance. For one, the foremost historian on the Oath has concluded that it has never been representative of prevailing thought in medical ethics, and was never intended to be an absolute standard for medical conduct.⁴² In fact, the Oath was likely the product of a small, nontraditional Greek sect of Pythagorean physicians.⁴³ Further, regardless of its role in ancient medical practice, the Oath's broad mandates make it anachronistic and antithetical to modern medical practice and ethics. For instance, it explicitly forbids abortion,⁴⁴ restricts the practice of medicine to men,⁴⁵ and prohibits physicians from ever breaching patient confidentiality,⁴⁶ despite the well-established obligation of modern day physicians to do so in various situations.⁴⁷ Blindly clinging to its "Do no harm" ideology in the face of so many other clearly inapplicable edicts without critically examining its justification disservices both the profession and the public.⁴⁸

41. *Id.* at 129 (defining the rule of double effect: "[T]hat a single act having two foreseen effects, one good and one harmful (such as death), is not always morally prohibited" if the harmful effect is not intended); *see also* *Washington v. Glucksberg*, 521 U.S. 702, 737–38 (1997) (O'Connor, J., concurring) ("There is no dispute that dying patients in Washington and New York can obtain palliative care, even when doing so would hasten their deaths.").

42. *See* EDELSTEIN, *supra* note 29, at 64.

43. *Id.*; *see also* Ben A. Rich, *Postmodern Medicine: Deconstructing the Hippocratic Oath*, 65 U. COLO. L. REV. 77, 91 (1993) ("[I]t is ludicrous to assert that twentieth century American physicians should be ethically bound by principles which were rejected by both the majority of physicians practicing when they were promulgated and physicians practicing in the Hippocratic tradition.").

44. *STEDMAN'S MED. DICTIONARY* 822 (27th ed. 2000) ("Nor will I give a woman a pessary to procure abortion.").

45. *Id.* (using only male pronouns and references throughout).

46. *Id.* ("All that may come to my knowledge in the exercise of my profession or outside of my profession or in daily commerce with men, which ought not to be spread abroad, I will keep secret and will never reveal.").

47. *See* BEAUCHAMP & CHILDRESS, *supra* note 31, at 303–12 (discussing circumstances surrounding ethically appropriate breaches of patient confidentiality).

48. Additionally, even if the Oath symbolizes some sense of ethical authority, one must not overlook the impact of the Oath's preamble. It clearly delegates individual ethical determinations to the individual practitioner. As it specifically states, "[T]o keep according to my ability and my judgment the following Oath." *STEDMAN'S MED. DICTIONARY* 822 (27th ed. 2000). It was not intended to be a list of absolute

More fundamentally, it is inaccurate to conceive of medical ethics as being driven by a single imperative, such as “Preserve life” or “Do no harm.” Instead, it requires balancing a number of independent interests and objectives. Sometimes the totality of the circumstances

ethical mandates, but rather a collection of idealistic duties tempered by the ability and judgment of the individual who takes it. Therefore, it misses the mark to conceive of the Oath as dictating the only ethically appropriate course of action in a given clinical situation.

Perhaps most importantly, the Oath is not a medical school graduation or licensing requirement. In fact, the majority of graduating medical students do not even take this Oath. Robert D. Orr et al., *Use of the Hippocratic Oath: A Review of Twentieth Century Practice and a Content Analysis of Oaths Administered in Medical Schools in the U.S. and Canada in 1993*, 8 J. CLINICAL ETHICS 377, 380 (1997) (finding that only one American medical school still administered classical version of Hippocratic Oath in 1993, and only forty-seven percent of schools were using any form of Oath at that time).

In light of these realities, it seems unreasonable to defer to this anachronistic, seldom-used and voluntary Oath as the ultimate ethical authority. Yet much of the profession and others continue to do exactly that. See, e.g., Keith Alan Byers, *Incompetency, Execution, and the Use of Antipsychotic Drugs*, 47 ARK. L. REV. 361, 382 (1994) (“The Hippocratic Oath is the foundation of medical ethics . . .”); Howard Isestein, *One More Time*, MODERN PHYSICIAN, July 1, 2000, available at <http://www.modernphysician.com> (reporting that Senator Christopher Dodd based his argument for need to reduce deadly medical errors on Hippocratic Oath’s proclamation of “First, Do No Harm”); Neve Gordon, *The White Coat Passes Like a Shadow in the Execution Chambers*, HUMANIST, Nov./Dec. 1995, at 35, 36 (“Unlike many ethical questions, the answer to this one is simple: doctor participation in executions contradicts the first dictum of the Hippocratic Oath—‘Do no harm.’”); Ragon, *supra* note 1, at 998 (“The Oath of Hippocrates reaches back over 2,000 years and represents a cornerstone upon which the medical profession has been built. Physicians swear upon the Oath upon entrance into the medical profession.”); Rochelle Graff Salguero, Note, *Medical Ethics and Competency to Be Executed*, 96 YALE L. J. 167, 174 (“The significant point is that both physicians and the society in which they work view the [Hippocratic] Oath as a distillation of medical ethics, as well as a legitimate standard of evaluation for medical performance.”); Darryl Van Duch, *Is There a Doctor in the Death House?*, NAT’L L. J., Sept. 4, 1995, at A6 (noting that “[t]he Illinois State Medical Society has officially criticized any physician involvement in state executions as anathema to the Hippocratic Oath”). Even the AMA highlights the Hippocratic Oath as the centerpiece of its Code of Medical Ethics. See AMA CODE, *supra* note 33, at x. (“The Oath of Hippocrates, a brief statement of principles, has come down through history as a living statement of ideals to be cherished by the physician. . . . Other civilizations subsequently developed written principles, but the Oath of Hippocrates . . . has remained in Western Civilization as an expression of ideal conduct for the physician.”); Skolnick, *supra* note 1, at 723 (quoting Dr. James Todd, then executive vice president of the AMA, in response to proposed federal regulations requiring physician participation in executions: “For 2400 years, [the Hippocratic Oath] has been our contract with society. And I pray that doctors may never again violate that oath.”). And finally, our courts—including our highest Court—often look to the Hippocratic Oath for guidance when faced with questions of medical ethics. As examples of court opinions that rely on the Hippocratic Oath for ethical guidance, see *Washington v. Harper*, 494 U.S. 210, 222–23 n.8 (1990); *Roe v. Wade*, 410 U.S. 113, 130–33 (1973); *Andrews v. United States*, 732 F.2d 366, 368 n.2 (4th Cir. 1984).

will call for the preservation of life, sometimes it will not. In many situations, hastening death is harmful and contrary to the patient's best interests, but in other instances it is the only compassionate thing that can be done.⁴⁹ What is important is not that physicians stave off death, but that they tailor their actions, as much as possible, to the interests of their patients and the realities and necessities of the circumstances.⁵⁰ The practice of medicine is a therapeutic *and* compassionate enterprise, dedicated to furthering human dignity and well-being beyond the myopic goal of simply preserving life. The relevant question then changes: What should the caring physician do to best comfort an individual being executed?

Operating within this reality, it is not clear that physician participation in executions is contrary to either the patient's interests or the doctor's ethical obligations. As the AMA states, "A physician, as a member of a profession dedicated to preserving life *when there is hope of doing so*, should not be a participant in a legally authorized execution."⁵¹ But here, there is no such hope. This is a patient who is going to die. By the time physicians become involved in the actual execution process, prisoners have exhausted all appeals and the state has assigned an execution date. Barring intervention by the governor or the Supreme Court, the death of the condemned is a forgone conclusion. Condemned death row inmates are, for all practical purposes, terminally ill patients, albeit under a nontraditional definition of the term, and deserve to be treated as such.⁵² Therefore, physicians should do what any compassionate physician would do for a dying patient—preside over the condemned's final moments to minimize complications and suffering, and maximize the patient's comfort until the end of his life. Physicians are expected to provide these services to all others facing imminent death. Why should they deny comfort-care to the condemned? It is the physician who abandons his or

49. Consider, for example, the terminally ill patient who wishes to be disconnected from life-support, or who requests increasing doses of morphine to dull the intractable pain of disseminated cancer despite the knowledge that such medication will inevitably cause a cessation in the respiratory drive, resulting in death.

50. Sherwin Nuland, a surgeon and writer, has explained the need to acknowledge the complexities of modern medical decision-making rather than resorting to traditional codes of physician ethics: "To seek refuge in ancient aphorisms is to turn away from the unique needs of each of our patients who have entrusted themselves to our care." Sherwin B. Nuland, *Physician-Assisted Suicide and Euthanasia in Practice*, 342 NEW ENG. J. MED. 583, 584 (2000).

51. AMA CODE, *supra* note 33, Op. 2.06 (emphasis added).

52. See, e.g., Truog & Brennan, *supra* note 1, at 1348 ("The death-row inmate may be seen as a terminally ill 'patient' whose death is unavoidable and imminent.").

her patient by failing to provide such comforting care who truly violates the ethical code of the profession.

By contrast, physicians who care for condemned prisoners at their executions are models for other doctors and medical students. They poignantly illustrate the physician's obligation not to abandon the dying.⁵³ To desert these individuals in their most vulnerable hour would be antithetical to the beneficent ideals of medical practice. Physicians are ethically obligated to help their patients, and considering the circumstances, all that can be done here is to ensure the condemned's comfort and minimize their suffering. The caring physician can prescribe and prepare a lethal pharmacological regimen compatible with the condemned's unique medical condition, and assure that the drugs are given in the correct order, thereby minimizing the chance that the condemned will regain consciousness during the lethal injection and suffer the unimaginable horror of conscious asphyxiation.⁵⁴ The physician can locate appropriate veins and insert the catheters so that the condemned will not suffer the pain and humiliation of multiple needle punctures by inept technicians.⁵⁵ The physician can monitor vital signs during the injection to guarantee that death, and not some irreversible condition of brain damage, is achieved. That is the ethical role for the compassionate physician—to help a patient in need and provide the only source of comforting care still available.

Even the narrower proposition that physicians should not participate in the *involuntary* death of a patient (i.e., a death against the patient's wishes) lacks reason and rationality. Quite commonly, and necessarily, physicians are actively involved in involuntary deaths. How often does the terminal cancer patient or gun shot victim really "want" to die? Granted, for some, acceptance of impending death is achieved, but this is quite different from what we think of as "voluntary." Yet we acknowledge the ethical propriety of physician involvement, even palliative actions that hasten death, in such cases. It is not the mere participation in involuntary deaths by physicians that bothers us, but participation motivated by any desire other than to maximize

53. The physician's obligation not to abandon dying patients derives from the well-established ethical principles of beneficence and nonmaleficence. See generally BEAUCHAMP & CHILDRESS, *supra* note 31 (discussing autonomy, nonmaleficence, beneficence, and justice as four basic principles of bioethics).

54. See, e.g., Barb Albert, *Moving Death Row Under Consideration*, INDIANAPOLIS STAR, July 30, 1995, at B1 (reporting that Steven Hawkins, executive director of the National Coalition Against the Death Penalty, spoke of executions in which lethal drugs were given in wrong order, resulting in conscious paralysis and suffocation).

55. For examples of such mishaps, see *infra* note 58.

comfort and minimize suffering for the individual, such as a desire to force an involuntary death upon an individual.

There is no rational distinction between the dying patient and the condemned criminal, *if* one accepts the patient-centered conception of medical ethics espoused above. In neither the hospital nor the execution chamber does the physician kill the patient—in one, it is the disease or trauma, in the other, it is the state. Put differently, in neither case is the physician a “but for” cause of death—death would take place regardless of whether the physician was involved or not. And if the physician is ultimately ethically obligated to the patient, why should it matter what the underlying cause of death is? In all end-of-life situations, where there is no hope of survival, the physician’s role is to minimize suffering and maximize comfort for the patient. Therefore, it is the condemned patient who suffers when the medical establishment arbitrarily chooses to turn its back on, and withhold its experience and wisdom from, this subset of the patient population. The only relevant achievement of such categorical abandonment is increased suffering for the condemned patient, and, ethically, this cannot be tolerated.

The only rule that one can derive from the classic ethical prohibition of physician participation in executions that is consistent with a patient-centered theory of medical ethics is the following: A physician should not participate in the death of a patient, whether voluntary or involuntary, if such participation is against the wishes of that patient. Any other rule necessarily fosters irrationality, discrimination, and a departure from the core tenets of medical ethics. The condemned should be free to request or refuse physician oversight,⁵⁶ and the indi-

56. There are two basic ways to structure this decision-making process, depending on the appropriate default position. One could argue for an “opt-in” system in which physicians should participate only if requested by the condemned. Alternatively, one could argue for an “opt-out” system in which physicians should participate unless the condemned requests otherwise. Which system is superior should depend ultimately on whether or not we believe that the reasonable person would want such physician oversight. If so, then it makes more sense to use the “opt-out” system, with its presumption in favor of physician involvement. If not, we should use the “opt-in” system with its default position that disfavors physician involvement. Believing, as I do, that the reasonable person would want physician oversight of a medicalized death, I would argue for the “opt-out” system. Affording the condemned this decisional power would be analogous to the “choice of method” statutes that exist in many states, which allow the condemned to choose between several legislatively endorsed methods of execution. *See, e.g.,* ARIZ. REV. STAT. ANN. § 13-704(B) (West 2001) (“A defendant who is sentenced to death for an offense committed before November 23, 1992, shall choose either lethal injection or lethal gas at least twenty days before the execution date.”); CAL. PENAL CODE § 3604 (West 2000) (“Persons sentenced to death prior to or after the operative date of this subdivision shall have the opportunity to elect to

vidual physician should be free to choose to participate in executions or not to do so. But the medical profession should not, based on political beliefs and flawed conceptions of ethical practice, deprive condemned patients of this last choice and physicians of the leeway to carry out that wish. Paternalism practiced for the benefit of patients is problematic, but paternalism practiced to the detriment of patients is unacceptable.

True, physician participation may have the consequence of providing a surface appearance of humanity or adding an aura of medical legitimacy to the execution process. This is undoubtedly a troubling proposition, and one worthy of significant consideration. But this is a concern with the death penalty itself, not physician participation. The unease that underlies this potential whitewashing of the core identity of the death penalty concerns the morality of any state-sanctioned taking of life, not the involvement of physicians in carrying out that penalty. The physician's obligation is to the patient, not to the political agenda of special interest groups—not even to the American Medical Association. And although it is sometimes difficult to distinguish intent (when is participation intended to ameliorate suffering and when does it aim to aid in execution?), the AMA has stated in the execution context that, “[T]here is no alternative at this time than to rely upon the treating physician to exercise judgment in deciding when and to what extent treatment is necessary to reduce suffering.”⁵⁷

Further, although less trained personnel could oversee the execution process, experience proves that without the benefit of compassionate physician oversight, condemned patients sometimes endure unnecessary pain and suffering. Media accounts have detailed numerous instances in which poorly trained execution technicians botched seemingly basic medical procedures, leading to excruciating pain and

have the punishment imposed by lethal gas or lethal injection.”); VA. CODE ANN. § 53.1-234 (Michie 1998) (“The method of execution [electrocution or lethal injection] shall be chosen by the prisoner.”); WASH. REV. CODE ANN. § 10.95.180 (West Supp. 2001) (“[D]eath . . . shall be inflicted by intravenous injection . . . or, at the election of the defendant, by hanging by the neck until the defendant is dead.”). Such choice of method statutes have routinely been upheld against Eighth Amendment challenges. *See, e.g.*, *Hunt v. Nuth*, 57 F.3d 1327 (4th Cir. 1995) (upholding constitutionality of Maryland's former choice of method statute); *Campbell v. Wood*, 18 F.3d 662 (9th Cir. 1994) (en banc) (upholding constitutionality of Washington's choice of method statute).

57. AMA COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, *PHYSICIAN PARTICIPATION IN CAPITAL PUNISHMENT: EVALUATIONS OF PRISONER COMPETENCE TO BE EXECUTED: TREATMENT TO RESTORE COMPETENCE TO BE EXECUTED* (1995) (on file with the *New York University Journal of Legislation and Public Policy*).

prolonged suffering for the condemned.⁵⁸ Maybe these procedures are more difficult than they appear. Or maybe the stress of the situation leads to errors in the procedures. Regardless, physicians have more extensive training and experience acting under the pressure of imminent death than any other class of health practitioners. Participation by skilled physicians could likely protect many of the condemned from unnecessary mishaps.⁵⁹ Further, there is a lack of logic underlying

58. For a comprehensive list of botched lethal injections since 1982, see Michael L. Radelet, *Post-Furman Botched Executions*, at <http://www.deathpenaltyinfo.org/botched.html> (last visited Nov. 8, 2001) (including: Stephen Peter Morin, Mar. 13, 1985, Texas (execution technicians, unable to find a suitable vein, stuck both arms and one leg with needles for forty-five minutes); Randy Woolls, Aug. 20, 1986, Texas (execution technicians needed Woolls's help to find a suitable vein); Raymond Landry, Dec. 13, 1988, Texas (due to inappropriate technique, syringe carrying lethal solution popped out of Landry's vein during execution, spraying deadly chemicals towards the witnesses and necessitating a prolonged delay to reinsert catheter); Stephen McCoy, May 24, 1989, Texas (possibly due to excessive drug dosage or infusion speed, McCoy had a violent physical reaction to injection, including heaving chest, gasping, choking, and arching back, causing one witness to faint on top of another witness); Charles Walker, Sept. 12, 1990, Illinois (kink in plastic tubing and inappropriate positioning of IV caused great delay in infusion rate of lethal injection, resulting in prolonged and excessively painful execution); Rickey Ray Rector, Jan. 24, 1992, Arkansas (execution technicians took more than fifty minutes sticking Rector with needles, ultimately resorting to a surgical cut-down in order to find a suitable vein, resulting in much pain and numerous loud moans from Rector); Robyn Lee Parks, Mar. 10, 1992, Oklahoma (Parks's physical reaction to lethal injection, including sustained muscle spasms, gasping, and violent gagging, was described by witnesses as "painful," "ugly," and "scary"); Billy Wayne White, Apr. 23, 1992, Texas (execution technicians took nearly forty minutes to find suitable vein); Justin Lee May, May 7, 1992, Texas (May had unusually violent reaction to lethal injection, including prolonged gasping, coughing, and muscle spasms); John Wayne Gacy, May 10, 1994, Illinois (due to inexperience and technical incompetence of execution technicians, lethal chemicals solidified and clogged IV tube, requiring lengthy delay while tube was removed and replaced); Emmitt Foster, May 3, 1995, Missouri (execution technicians pulled straps binding Foster to gurney so tight that they blocked flow of lethal chemicals into Foster's vein, resulting in prolonged execution during which Foster gasped and convulsed); Tommie J. Smith, July 18, 1996, Indiana (execution technicians, unable to locate adequate vein, had to call physician in to insert catheter); Michael Eugene Elkins, June 13, 1997, South Carolina (execution technicians took nearly hour to find suitable vein); Joseph Cannon, Apr. 23, 1998, Texas (poorly placed IV popped out of Cannon's arm in middle of execution, requiring fifteen-minute delay while second IV was started); Bennie Demps, June 8, 2000, Florida (execution technicians took thirty-three minutes to locate adequate vein, leading Demps to say, "They butchered me back there. I was in a lot of pain. They cut me in the groin; they cut me in the leg. I was bleeding profusely. This is not an execution, it is murder."); Bert Leroy Hunter, June 28, 2000, Missouri (Hunter suffered unusually violent convulsions in response to injection)); see also Deborah W. Denno, *Getting to Death: Are Executions Constitutional?*, 82 IOWA L. REV. 319, 428-38 (1997) (listing botched lethal injections since 1982).

59. For example, experienced physicians are probably less likely to encounter prolonged difficulties in inserting catheters, the most common source of botched lethal

ing the assertion that, although it is inappropriate for physicians to play this role, nurses or PAs could alternatively do so. Why are other health professionals any less dedicated to the ethical ideals of medical practice, whatever those might be, than physicians? Why shouldn't the same ethical arguments and constraints apply to them?⁶⁰

Logic and consistency also argue for physician participation. Doctors routinely use their medical skills to contribute to the capital punishment process. Physicians facilitate the gathering of evidence when they pump victims' stomachs or draw blood from detained suspects for DNA or other testing. They regularly testify in criminal trials and capital sentencing hearings. They restore the mentally ill to competence in the process leveling the last barrier to execution.

Some may argue that participation at these earlier stages is somehow ethically distinct from participation in the final process, but such arbitrary and emotionally-based distinctions have little merit. Participation in any stage of a capital case is ethically equivalent, as it may always be a "but for" cause of execution. To argue otherwise blurs the line between emotion and logic. Were it not for a DNA test based on a physician's blood-draw or the psychiatrist's testimony that the accused is competent to stand trial, there would be no conviction, and thus no execution. Likewise, were it not for the pharmacological restoration of competency, there would be no execution. Such conduct differs temporally from direct participation in executions, but not ethically.⁶¹ In all cases, there is at least the possibility that the physician's

injections, than other medical personnel. *See supra* note 58. Their familiarity with both the procedure and the underlying anatomy would facilitate the process. Further, trained medical professionals could provide educated medical oversight in cases of mishaps.

60. Indeed, the current professional oaths and position statements of both the American Nursing Association and the American Academy of Physician Assistants prohibit member participation in executions on ethical grounds. *See* AM. ACAD. OF PHYSICIAN ASSISTANTS, GUIDELINES FOR ETHICAL CONDUCT FOR THE PHYSICIAN ASSISTANT PROFESSION 8 (adopted May 2000), available at <http://www.aapa.org/images/GECIN-SERTATION.pdf> ("Physician assistants, as health care professionals, should not participate in executions because to do so would violate the ethical principle of beneficence."); AM. NURSES ASS'N, POSITION STATEMENTS: NURSES' PARTICIPATION IN CAPITAL PUNISHMENT, available at <http://www.nursingworld.org/readroom/position/ethics/etcptl.htm> ("The American Nurses Association (ANA) is strongly opposed to nurse participation in capital punishment. Participation in executions is viewed as contrary to the fundamental goals and ethical traditions of the profession.").

61. For example, it would be illogical to argue that there is a difference between the dying patient who refuses to be put on a respirator and the dying patient who demands that a respirator be withdrawn, even though those scenarios *seem* distinct. They may even *feel* distinct, especially for the physician who removes life-sustaining treatment. However, withholding and withdrawing medical care are ethically and logically identical; the difference is in the timing. *See Cruzan v. Director, Mo. Dept. of Health*, 497

conduct will facilitate an execution. Prohibiting physicians from fulfilling their ethical obligations of care and compassion at the end of the criminal process—when their patients need them the most—while ignoring that physicians play integral roles throughout that process is arbitrary and irrational.⁶² There is no reasoned way to draw this bright line across time.

C. Policy Arguments Against Physician Participation

Opponents of physician participation in executions argue that such involvement will erode the public's trust in the medical profession.⁶³ According to this argument, the credibility of the profession is undermined when its members take actions that directly conflict with its central mission. As former AMA Executive Vice President James Todd, M.D., put it, "When the healing hand becomes the hand inflicting the wound, the world is turned inside out."⁶⁴ Blurring the line between healer and executioner, then, will allegedly compromise future interactions between the medical profession and the public, as patients will question their physicians' motives and loyalties.

Opponents of physician participation also note that in the recent physician-assisted suicide case of *Washington v. Glucksberg*, the United States Supreme Court asserted that states "ha[ve] an interest in protecting the integrity and ethics of the medical profession."⁶⁵ This interest presumably arises from states' obligation to promote the safety and well-being of their citizens. Some might argue that in furtherance of this interest, legislatures should explicitly prohibit physicians from taking actions, such as participating in executions, which have the potential to jeopardize the public-physician relationship.

U.S. 261 (1990) (equating withdrawal of nutrition and hydration with refusal of medical care). Here too, the only difference is in the timing.

62. The AMA draws this distinction between direct and indirect physician participation by narrowly defining "[p]hysician participation in execution" as "actions which would fall into one or more of the following categories: (1) an action which would directly cause the death of the condemned; (2) an action which would assist, supervise, or contribute to the ability of another individual to directly cause the death of the condemned; (3) an action which could automatically cause an execution to be carried out on a condemned prisoner." AMA CODE, *supra* note 33, Op. 2.06. That it draws this distinction is relevant only if it has a principled reason for doing so. But, in fact, the Code fails to offer any, let alone a convincing, ethical rationale.

63. See, e.g., BREACH OF TRUST, *supra* note 1, at 37–38; Council Report, *supra* note 1, at 365; Ragon, *supra* note 1, at 999–1001.

64. James Todd, Address at Opening of *The Worth of the Human Being: Medicine in Germany 1918-1945* (Nov. 5, 1992), quoted in BREACH OF TRUST, *supra* note 1, at 38.

65. 521 U.S. 702, 731 (1997).

In addition, some have argued that physicians should not be “prostituting medical knowledge and skills” to legitimize “the nonbeneficent goals of the state.”⁶⁶ They argue that by turning to medicalized forms of execution like lethal injection, and by having the medical profession lend its credibility to the execution process, pro-capital punishment groups are distorting public perception of the death penalty. The process becomes more palatable, but no less inhumane. Some go so far as to argue that this subversion of medicine’s caring ethic for the furtherance of the state’s criminal justice system is highly reminiscent of, and equally inappropriate as, the role that Nazi physicians played in covering up and rationalizing the atrocities of the Holocaust.⁶⁷

D. Policy Arguments for Physician Participation

Despite the initial appeal of the preceding policy arguments, further reflection casts serious doubts on their merits. While there is a trust between the public and the medical profession, physician participation in executions will not undermine that trust. First, such actions are not incompatible with the physician’s role when properly conceived of as that of a compassionate healer, as opposed to a zealous advocate of the preservation of life under all circumstances. Second, there is no empirical evidence to support the conclusion that physician participation in executions is detrimental to the best interests of the public.

Although the *Glucksberg* Court did indeed assert that states have an interest in protecting the integrity and ethics of the medical profession, it stopped there. The Court merely acknowledged the existence of the opinion *by others* that certain behaviors, like physician-assisted suicide, *could* adversely affect the medical community’s image and *perhaps* harm the public.⁶⁸ But it did not take that view as its own, and with good reason.

The argument that physician involvement in execution harms the public by eroding its trust in the medical establishment is unsupported and overstated. Does the presence of a priest at a parishioner’s execution erode the public’s trust in the church? Certainly not. The mere involvement of a priest in an execution says nothing about either the

66. Truog & Brennan, *supra* note 1, at 1348.

67. *See, e.g., id.* at 1349 (“Although the Nazi analogy is often overused and inappropriately applied, we believe that it is on the mark in this case.”).

68. *Glucksberg*, 521 U.S. at 731 (noting that “physician-assisted suicide *could, it is argued*, undermine the trust that is essential to the doctor-patient relationship,” but failing to analyze or endorse that contention) (emphasis added).

priest's or the church's feelings about the death penalty. The clergy's involvement is intended to minimize the suffering of the condemned, not contribute to the punishment. The public recognizes that distinction, and its trust in religious institutions has not wavered as a result of clergy participation in executions. The same should hold true for physicians, even if they play a more direct role in the execution process than the clergy.

Like the clergy, physicians who participate in executions do not make political statements about the death penalty, and they do not blur the line between healing and harming. Rather, such participation reinforces the medical profession's compassion for all human beings—even those sentenced to death. By overseeing the execution process, physicians fulfill their ethical obligation to ensure that society carries out its medicalized executions as humanely and painlessly as possible.

In fact, one could credibly argue that physicians are more likely to erode public trust by *refusing* to participate in executions than by participating. The public could view a blanket refusal by physicians to assist a dying prisoner as medical abandonment in the patients' greatest hour of need. This is particularly so for penitentiary staff physicians who have already established doctor-patient relationships with the condemned. The refusal to care for certain patients—those who are sentenced to death—undergoing medically related procedures (i.e., lethal injections) could taint the public's view of the medical profession. Prisoners, too, are deserving of compassionate and competent medical care.

The public's trust in physicians is built on the profession's unswerving commitment to the medical interests of its patients, regardless of the circumstances. It is worth repeating: "The task of medicine is to cure sometimes, to relieve often, to comfort always."⁶⁹ This is the ultimate expression of the medical establishment's altruistic ideal, and it underscores the point that the doctor-patient relationship does not end on death row. Without question, states have an interest in maintaining the ethics of the medical profession. But allowing medical ethics boards to professionally sanction physicians for providing comfort care to condemned prisoners contradicts this interest.⁷⁰

The lack of evidence of any such detrimental effect on public trust is also highly instructive. As noted previously, the medical establishment has consulted for and participated in state ordered execu-

69. See *supra* note †.

70. For a discussion of statutory provisions permitting the sanction of physicians for participating in executions, see *infra* note 78.

tions for centuries.⁷¹ But in the face of all this intermingling of medicine and capital punishment, we have yet to see erosion in the doctor-patient or doctor-public relationship as a consequence. There is no reason to believe that continued active participation in lethal injections, in the name of compassion and comfort, will be any different. In fact, the one court that has directly addressed this issue, a California court of appeals, concluded that there is no evidence that such conduct “has in any way affected the trusting quality of the doctor-patient relationship for the population at large.”⁷²

Further, analogies between physician participation in American executions and the role of Nazi doctors in the Holocaust fail to appreciate crucial differences between the two contexts. First and foremost, the democratic nature of our system of government and our treatment of capital punishment undercuts analogies to the dictatorial political environment of Nazi Germany. The citizens of the United States democratically chose the death penalty, and the majority of citizens continue to support its use.⁷³ Here, the state’s objective is to carry out the will of the people, not usurp it. Second, our legal system and the rights guaranteed to citizens by our Constitution, such as the Four-

71. See *supra* Part I.B.

72. *Thorburn v. Dep’t of Corr.*, 78 Cal. Rptr. 2d 584, 590 (Cal. Ct. App. 1998). In *Thorburn*, thirteen licensed physicians in California brought suit claiming that physician participation in executions constituted “unprofessional conduct” within the meaning of Business and Professions Code section 2234, and therefore sought an injunction against such conduct in the future. Of note, the conduct involved was precisely the same as the participation contemplated in this Article:

[E]xamining the condemned inmate to determine whether any medical condition might interfere with the process; examining the inmate’s medical records to determine and prescribe an appropriate sedative; identifying primary and secondary injection sites; making a list and supervising the arrangement of medical supplies needed for execution; preparing syringes with the lethal solution; supervising the attachment of a heart monitor to the inmate and verifying that the inmate’s heartbeat can be detected on the instrument; locating appropriate veins for insertion of catheters that will carry the lethal solution; inserting the catheters; monitoring the flow of the lethal substances to ensure that there will be no interruption and death will occur; monitoring the inmate to notify the warden when death has occurred; and pronouncing death.

Id. at 586.

73. See, e.g., THE GALLUP ORG., GALLUP POLL TOPICS: A-Z: DEATH PENALTY, available at http://www.gallup.com/poll/indicators/inddeath_pen.asp (October 11–14, 2001) (reporting 68% for, 26% against, and 6% no opinion as the results of its survey in which it asked following question to randomly selected national sample: “Are you in favor of the death penalty for a person convicted of murder?”). It is worth noting that this figure of 68% represents a significant decline from the zenith of public support for the death penalty, which Gallup recorded as 80% in September of 1994. *Id.* Regardless, it is still true that the overwhelming majority of Americans support capital punishment.

teenth Amendment's due process guarantees⁷⁴ and the Sixth Amendment's right to a trial by an impartial jury,⁷⁵ provide protections that were not available to Holocaust victims. We do not arbitrarily choose whom to execute.⁷⁶ Third, as this Article suggests, physicians should willingly participate in executions only if their participation is consistent with the wishes of the condemned. They should not force their way into the execution chamber. Because the decision on physician participation lies with the condemned patient, any analogies to Nazi physicians are fundamentally flawed. This emotional appeal to a terrible tragedy in world history may be powerful, but it is unfounded and exaggerated.

Our democratic governance structure has further implications for arguments against physician participation, particularly those that are based on philosophical or moral disapproval of capital punishment itself. If an individual opposes the death penalty, he or she can and should support legislation and candidates that are similarly opposed. The same is true for physicians. But what physicians should not do is refuse, on professional grounds, to participate in executions in order to subvert the democratic will of the people.⁷⁷ Doctors are healers, not politicians, and the medical establishment should not exert its political power to the detriment of its patients. To be sure, physicians may lobby against the death penalty. But if the death penalty is to be undetermined, it should be done democratically or constitutionally, not

74. U.S. CONST. amend. XIV, § 1 ("No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law . . .").

75. U.S. CONST. amend. VI ("In all criminal prosecutions, the accused shall enjoy the right to a speedy and public trial, by an impartial jury of the State and district wherein the crime shall have been committed . . .").

76. This is not meant to imply that our system of capital punishment is entirely devoid of bias. Quite to the contrary, numerous empirical studies of capital sentencing have revealed a highly significant effect of race—both of the convicted and the victim—on the imposition of the death penalty. See, e.g., David C. Baldus et al., *Comparative Review of Death Sentences: An Empirical Study of the Georgia Experience*, 74 J. CRIM. L. & CRIMINOLOGY 661 (1983) (finding that individuals convicted for murder in Georgia were significantly more likely to receive death penalty if victim was Caucasian than if victim was African-American). Regardless, the analogy to the Holocaust is still irreparably flawed, as our society at least maintains the threshold requirement of a murder conviction to even be eligible for a death sentence. Again, this is not to imply that a biased imposition of the death penalty upon and amongst convicted murderers is acceptable. But it is not at all analogous to the systematic execution of millions of innocent people.

77. I qualify this statement with the words "on professional grounds" because I do believe that it is acceptable for physicians to refuse to participate in executions on personal grounds. No physician should be forced to participate in an execution if doing so is against their personal ethics or morals.

through the strong-arm politics of physicians or other professional groups. And as long as state ordered executions persist, physicians' primary ethical obligation is to make them as painless and humane as possible for the condemned.

E. Legal Arguments Against Physician Participation

The primary legal argument against physician participation in executions is that such actions may violate medical practice acts in certain states. Medical practice acts commonly establish the grounds for physicians to be disciplined or de-licensed. Often, these acts list "unprofessional" or "dishonorable" conduct as a ground for professional sanction.⁷⁸ Many medical practice acts further incorporate into their definitions of "unprofessional" or "dishonorable" conduct actions that are contrary to prevailing ethical norms within the profession.⁷⁹ As the majority of physician lobbying groups, including the AMA, have taken a stance against physician participation in executions, it is conceivable that state medical boards could discipline physicians for such participation. While no state board has yet disciplined a physician for violating this ethical norm,⁸⁰ the possibility remains.

78. See, e.g., ALA. CODE § 34-24-360 (1997) (citing "unprofessional or dishonorable conduct" as one of the grounds for the suspension or revocation of a physician's license); KAN. STAT. ANN. § 65-2836 (Supp. 2000) (stating that "unprofessional or dishonorable conduct" is grounds for public or private censure and license suspension or revocation); N.C. GEN. STAT. ANN. § 90-14 (West Supp. 2000) (authorizing denial, annulment, suspension, or revocation of physician's license for "unprofessional conduct"); OR. REV. STAT. § 677.190 (1999) (listing "unprofessional or dishonorable conduct" as ground for suspension or revocation of license to practice medicine); S.D. CODIFIED LAWS § 36-4-29 (Lexis 1999) (listing "unprofessional or dishonorable conduct" as grounds for license cancellation, suspension, revocation, or cancellation); TENN. CODE ANN. § 63-6-214 (Supp. 2000) (citing "unprofessional, dishonorable or unethical conduct" as basis for license suspension or revocation); WYO. STAT. ANN. § 33-26-402 (Lexis 2001) (listing "unprofessional or dishonorable conduct" among grounds for physician discipline, including license revocation).

79. See, e.g., N.C. GEN. STAT. ANN. § 90-14 (West Supp. 2000) (including within its definition of unprofessional conduct "departure from, or the failure to conform to, the standards of acceptable and prevailing medical practice, or the ethics of the medical profession"); OR. REV. STAT. § 677.188 (1999) (defining "unprofessional or dishonorable conduct" to include "[a]ny conduct or practice contrary to recognized standards of ethics of the medical or podiatric profession"); WYO. STAT. ANN. § 33-26-402 (Lexis 2001) (including "[a]ny conduct or practice [c]ontrary to recognized standards of ethics of the medical profession" within definition of "unprofessional or dishonorable conduct").

80. Ragon, *supra* note 1, at 998 ("[N]o state licensing board has disciplined a physician for violating the AMA policy against physician participation in death penalty executions.").

F. Legal Arguments for Physician Participation

While some medical practice acts arguably prohibit physician participation in executions, most state death penalty statutes either allow for or require physician participation of some sort.⁸¹ Of note, the federal execution protocol also permits, but does not require, physi-

81. See ALA. CODE § 15-18-83(a)(3) (Supp. 2000) (allowing two physicians, including prison physician, to be present at execution); CAL. PENAL CODE § 3605(a) (West 2000) (requiring that prison warden invite two physicians to execution); COLO. REV. STAT. § 16-11-402 (2000) (requiring that a licensed physician or a coroner pronounce the death of an executed inmate); COLO. REV. STAT. § 16-11-404 (2000) (requiring presence of physician at each execution); CONN. GEN. STAT. ANN. § 54-100(b) (Supp. 2001) (permitting presence of physician at each execution); FLA. STAT. ANN. § 922-11(2) (West 2001) (requiring that qualified physician be present and announce death); GA. CODE ANN. § 17-10-41 (Supp. 2001) (requiring presence of two physicians at each execution to determine when death intervenes); IDAHO CODE § 19-2716 (Michie 1997) (requiring that licensed physician pronounce death); 725 ILL. COMP. STAT. ANN. 5/119-5(a)(1) (West Supp. 2001) (requiring that licensed physician pronounce death); IND. CODE ANN. § 35-38-6-6 (West 1998) (allowing for presence of prison physician and one other physician at execution); KY. REV. STAT. ANN. § 431.250 (Michie 1999) (stating that penitentiary physician may attend executions); LA. REV. STAT. ANN. § 15:570(A)(3) (West Supp. 2001) (stating that every execution shall take place in presence of physician); MISS. CODE ANN. § 99-19-51 (West 1999) (requiring death to be pronounced by county coroner or by licensed physician); MISS. CODE ANN. § 99-19-55(2) (West 1999) (requiring presence of at least one, but not more than two, physicians or county coroner at each execution); NEV. REV. STAT. 176.355(2)(e) (1999) (instructing director of department of corrections to invite competent physician, county coroner, and psychiatrist to each execution); N.H. REV. STAT. ANN. § 630:6 (Supp. 2000) (mandating that county sheriff request presence of surgeon at each execution); N.J. STAT. ANN. § 2C:49-7 (West Supp. 2001) (requiring presence of one licensed physician at each execution); N.M. STAT. ANN. § 31-14-15 (Michie 1978) (requiring prison warden to invite presence of physician at every execution); N.C. GEN. STAT. ANN. § 15-190 (West 2000) (requiring presence of either surgeon or physician of penitentiary at every execution); OHIO REV. CODE ANN. § 2949.25(a)(4) (West 1997) (permitting presence of penitentiary physicians at executions); OKLA. STAT. ANN. tit. 22, § 1014(a) (West 1986) (requiring that licensed physician pronounce death); OKLA. STAT. ANN. tit. 22, § 1015(B) (West Supp. 2001) (requiring prison warden to invite presence of physician at every execution); OR. REV. STAT. § 137.473(1) (1999) (requiring invitation of one or more physicians to every execution); S.D. CODIFIED LAWS § 23A-27A-32 (Michie 1998) (requiring that licensed physician pronounce death of executed inmate); S.D. CODIFIED LAWS § 23A-27A-34 (Michie 1998) (requiring prison warden to arrange for attendance of prison physician and two other licensed physicians at every execution); TENN. CODE ANN. § 40-23-116(a)(4) (Supp. 2000) (entitling prison physician to be present at executions); TEX. CODE CRIM. PROC. ANN. art. 43.20 (Vernon 1979) (permitting the presence of two physicians, including the prison physician, at each execution); VA. CODE ANN. § 53.1-234 (Michie 1998) (requiring presence of physician employed by Department of Corrections, or his assistant, at every execution); WASH. REV. CODE ANN. § 10.95.180(1) (West 1990) (providing that death of executed inmate shall be pronounced by licensed physician); WYO. STAT. ANN. § 7-13-904(a) (Lexis 2001) (providing that licensed physician must pronounce death of executed inmate); WYO. STAT. ANN. § 7-13-908(a)(ii) (Lexis 2001) (allowing presence of two physicians, including prison physician, at each execution).

cian participation.⁸² It appears, then, that a potential legislative conflict exists between medical practice acts and death penalty statutes. Accepted norms of statutory construction dictate that the death penalty statutes should trump the medical practice acts for two reasons.

First, when confronted with conflicting statutes, courts typically follow the rule of “last in time.”⁸³ In the event of a perceived or actual conflict between two statutes, deference is commonly afforded to the last statute to be enacted because that statute is a more accurate description of the current will of the legislature, and hence the people.⁸⁴ In effect, the later act, to the extent of the conflict, constitutes an implied repeal of the earlier one. Because most death penalty statutes are of more recent vintage than their corresponding medical practice acts, resolution should be in their favor.

Second, norms of statutory construction dictate that courts should consider which statute speaks more directly to the subject matter in question when resolving legislative conflicts. The more specific statute should prevail since it provides individuals with more specific guidance as to the appropriate and legal course of action.⁸⁵ Because death penalty statutes speak directly to the issue of physician partici-

82. See Implementation of Death Sentences in Federal Cases, 28 C.F.R. § 26 (2000) (providing for “qualified personnel” to administer lethal injection without explicitly requiring or forbidding that such personnel be physicians). Interestingly, the Department of Justice’s original proposed rule required the presence of at least one physician at all federal executions, and also provided that a physician could be called upon to pronounce death. Implementation of Death Sentences in Federal Cases, 57 Fed. Reg. 56,536 (Nov. 30, 1992) (to be codified at 28 C.F.R. pt. 26). However, in response to numerous comments and objections by medical associations, such as the AMA, and individual physicians, the final rule eliminated both requirements for physician participation and expressly provided that individual physicians could decline to participate in executions on medical ethical grounds. See Implementation of Death Sentences in Federal Cases, 58 Fed. Reg. 4,898 (Jan. 19, 1993) (to be codified at 28 C.F.R. pt. 26) (noting AMA and American College of Physicians objections to the original proposed rule).

83. See, e.g., NORMAN J. SINGER, 2B SUTHERLAND STATUTORY CONSTRUCTION § 51.02 (5th ed. 1992) (“Where two statutes are involved each of which by its terms applies to the facts before the court, the statute which is the more recent of the two irreconcilably conflicting statutes prevails.”); see also *Watt v. Alaska*, 451 U.S. 259, 266 (1981); *Thompson v. Calderon*, 151 F.3d 918, 929 (9th Cir. 1998); *Rhode Island v. Narragansett Indian Tribe*, 19 F.3d 685, 704 (1st Cir. 1994); *Boudette v. Barnette*, 923 F.2d 754, 757 (9th Cir. 1991); *United States v. Smith*, 831 F. Supp. 549, 551 (E.D. Va. 1993).

84. *Boudette*, 923 F.2d at 757 (“When two statutes conflict the general rule is that the statute last in time prevails as the most recent expression of the legislature’s will.”).

85. See, e.g., SINGER, *supra* note 83, § 51.02 (“Where a conflict exists the more specific statute controls over the more general one.”); see also *Thompson*, 151 F.3d at 929; *Suburban Trust & Sav. Bank v. Univ. of Del.*, 910 F. Supp. 1009, 1017 (D. Del. 1995); *Smith*, 831 F. Supp. at 551; *N. Border Pipeline Co. v. Jackson County*, 512 F.

pation in executions and the medical practice acts fail to explicitly address that topic, the death penalty statutes should prevail.

In addition, constitutional law arguably requires that physicians participate in executions. According to the Eighth Amendment, “Excessive bail shall not be required, nor excessive fines imposed, *nor cruel and unusual punishments inflicted.*”⁸⁶ In 1972, the Supreme Court held that executions in the State of Georgia were unconstitutional because the processes and procedures used constituted cruel and unusual punishment.⁸⁷ But in a series of cases in 1976, the Court upheld the constitutionality of the death penalty as imposed in Florida, Georgia, and Texas, because those states had changed their procedures to incorporate methods that were not cruel and unusual.⁸⁸ The question is, what defines cruel and unusual punishment, and does the lack of physician participation make executions “cruel and unusual”?

In *Trop v. Dulles*, the Court noted that the definition of what constitutes “cruel and unusual punishment” for purposes of the Eighth Amendment is context specific, and depends on “the evolving standards of decency that mark the progress of a maturing society.”⁸⁹ In addition, the Court has stated that punishments are excessive and unacceptable if they are “nothing more than the purposeless and needless imposition of pain and suffering”⁹⁰ or go beyond “the mere extinguishment of life” and cause torture or a lingering death.⁹¹

Considering the nationwide move towards lethal injection as the preferred method of execution, as well as the fact that the majority of death penalty statutes either obligate or permit physician attendance, such “evolving standards of decency” may now require the presence of physicians at executions.⁹² These trends in the evolution of the death penalty provide evidence that, as a society, we have concluded that physician-supervised lethal injection is the most humane and ac-

Supp. 1261, 1264 (D. Minn. 1981); *Turnbull v. Fink*, 668 A.2d 1370, 1377 (Del. 1995).

86. U.S. CONST. amend. VIII (emphasis added).

87. *Furman v. Georgia*, 408 U.S. 238 (1972).

88. *Gregg v. Georgia*, 428 U.S. 153 (1976); *Jurek v. Texas*, 428 U.S. 262 (1976); *Proffitt v. Florida*, 428 U.S. 242 (1976).

89. 356 U.S. 86, 101 (1958).

90. *Coker v. Georgia*, 433 U.S. 584, 592 (1977).

91. *In re Kemmler*, 136 U.S. 436, 447 (1890).

92. *See, e.g., McCleskey v. Kemp*, 481 U.S. 279, 300 (1987) (“In assessing contemporary values, we have eschewed subjective judgment, and instead have sought to ascertain ‘objective indicia that reflect the public attitude toward a given sanction.’ First among these indicia are the decisions of state legislatures, ‘because the . . . legislative judgment weighs heavily in ascertaining’ contemporary standards.” (quoting *Gregg*, 428 U.S. at 173, 175)).

ceptable form of capital punishment. It has become our standard of decency. To forbid physician participation would deviate from that standard and arguably constitute cruel and unusual punishment as defined in *Trop*. In addition, as noted previously, experience proves that the absence of trained physicians at lethal injections can and does lead to needless pain and suffering, and occasionally to lingering death.⁹³ Until the Supreme Court hears a case on point, the parameters of these Eighth Amendment considerations will remain unclear.

Surveying and analyzing the major ethical, policy, and legal arguments for and against physician participation in executions leads to the conclusion that, taken as a whole, considerations in favor of participation strongly outweigh those against it. The ethical and policy arguments against participation are founded on misconceptions of the physician's ethical role and the nature of the trust between the public and the medical profession. Indeed, physicians neglect their ethical obligations to maximize patient comfort and minimize suffering when they collectively and categorically refuse to care for condemned prisoners during executions. Additionally, norms of statutory construction and potential Eighth Amendment considerations sufficiently rebut the legal argument raised by the medical practice acts. This being the case, the Article now turns to examining the current tension between the medical practice acts and death penalty statutes in more detail, and considers alternatives for legislative resolution of that tension.

III

CURRENT LEGISLATIVE CONFLICT AND ALTERNATIVES FOR LEGISLATIVE RESOLUTION

Physicians currently find themselves in an undesirable, no-win situation. As mentioned above, most state death penalty statutes permit or require some form of physician participation at executions.⁹⁴ However, at the same time, many state medical practice acts expose physicians to professional discipline, including de-licensure, for these same actions.⁹⁵ Physicians are thus forced to choose between fulfilling their ethical obligations as committed and compassionate healers, thereby jeopardizing their professional standing, or neglecting their ethical obligations to minimize patient suffering and maximize comfort at the end of life. It is an unfortunate dilemma, one that promises to exert a chilling effect on appropriate physician behavior to the detri-

93. See *supra* note 58.

94. See *supra* note 81.

95. See *supra* notes 78–79.

ment of the condemned, the public, and the profession. It is therefore imperative that states take appropriate action to remove this legislative conflict. Indeed, several states have already attempted to remedy this apparent conflict in order to facilitate physician participation in lethal injections. However, the means chosen to achieve this end are conceptually flawed and serve to undermine, not reinforce, the ethics of the profession.

A. *Redefining the Practice of Medicine*

The most common approach has been the enactment of legislation explicitly declaring that participation in state-ordered lethal injections does not constitute the practice of medicine.⁹⁶ By pronouncing that such actions do not qualify as the practice of medicine, these statutes have preempted many of the ethical and policy arguments against physician participation. However, such an approach is premised upon arbitrary legal fictions that fail to promote the ethical and policy justifications for physician participation noted in Part II.

Other than these legislative decrees, what is it about such actions that remove them from the practice of medicine? Under any other circumstance, we view these same behaviors as the practice of medicine: selecting drugs, inserting catheters, monitoring vital signs, and pronouncing death. If this is not the practice of medicine, then much of what physicians do, such as prescribing medications and providing immunizations, is likewise not the practice of medicine. But we know that this is an untenable position, so it cannot be the nature

96. See FLA. STAT. ANN. § 922.105(6) (West 2001) (“[F]or purposes of this section, prescription, preparation, compounding, dispensing, and administration of a lethal injection does not constitute the practice of medicine, nursing, or pharmacy.”); IDAHO CODE ANN. § 19-2716 (Michie 1997) (“[A]ny infliction of the punishment of death by administration of the required lethal substance or substances in the manner required by this section shall not be construed to be the practice of medicine”); 725 ILL. COMP. STAT. ANN. 5/119-5(g) (West Supp. 2001) (“Notwithstanding any other provision of law, assistance, participation in, or the performance of ancillary or other functions pursuant to this Section, including but not limited to the administration of the lethal substance or substances required by this Section, shall not be construed to constitute the practice of medicine.”); N.J. STAT. ANN. § 2C:49-3(a) (West 1995) (“Any imposition of the punishment of death by administration of the required lethal substances in the manner required by section 2 of this act shall not be construed to be the practice of medicine”); OR. REV. STAT. § 137.473(2) (1999) (“The person who administers the lethal injection under subsection (1) of this section shall not thereby be considered to be engaged in the practice of medicine.”); S.D. CODIFIED LAWS § 23A-27A-32 (Michie 1998) (“Any infliction of the punishment of death by administration of the required lethal substance or substances in the manner required by this section may not be construed to be the practice of medicine”); WYO. STAT. ANN. § 7-13-904(a) (Lexis 2001) (“Administration of the injection does not constitute the practice of medicine.”).

of the actions that remove them from the practice of medicine. Where else could the distinction lie?

Some have argued that physicians who participate in executions are not practicing medicine because no physician-patient relationship exists within the execution context.⁹⁷ The theory is that the doctor who participates in an execution acts not in a medical capacity, but as an agent of the state. The condemned serves merely as a subject—the container into which the lethal injection is inserted—not a patient in the traditional sense. According to one commentator, this particular physician-subject relationship “does not carry the implication or promise of primacy for the patient’s welfare that defines the traditional medical relationship.”⁹⁸ Thus, because there is no doctor-patient relationship to be damaged, the participating physician does not violate any ethical obligations.

Such a position is unwise and untenable. To begin with, if anything is reminiscent of the Nazi doctors, it is the idea that those under the care of physicians are not patients, but merely “subjects” upon whom physicians perform procedures. In addition, despite the lack of a traditional doctor-patient relationship between Nazi doctors and those in the concentration camps, many would still claim that these physicians’ actions violated professional ethical standards. Clearly, then, the absence of a traditional doctor-patient relationship does not preclude the occurrence of ethical transgressions.

Next, the physician who participates in a given prisoner’s execution is often a member of the penitentiary medical staff. As such, it is likely that the physician has previously interacted with and cared for the prisoner in a medical capacity. Therefore, regardless of the events of the day, a doctor-patient relationship sometimes already exists. But more importantly, this portrayal misconstrues the role of the participating physician. As argued at length in this Article, the reason physicians *should* play an active role in executions is that their ethical obligations to patients require it. It is their status as compassionate healers that obliges physicians to minimize pain and suffering in this context, as they would in any other. If we assert that no professional duties exist, then the justification for physician participation evaporates. Physicians should participate because of the very fact that they

97. See Skolnick, *supra* note 1, at 722 (recording statement by advocate of physician participation arguing that no such relationship is involved in physician participation).

98. Edmund D. Pellegrino, *Societal Duty and Moral Complicity: The Physician’s Dilemma Of Divided Loyalty*, 16 INT’L J.L. & PSYCHIATRY 371, 376 n.2.

are physicians, not in spite of that identity. In effect, then, such legislative approaches prove too much.

Lastly, legislation that exempts physician participation from the practice of medicine also removes these behaviors from the jurisdiction of state medical disciplinary boards. Although precluding medical disciplinary boards from sanctioning physicians solely for their participation in executions may be appropriate, the wisdom in removing all oversight of such activities is questionable. Doing so would foreclose all intra-professional forms of quality control. Therefore, if a physician did a substandard job in carrying out an execution, causing unnecessary pain, suffering, and delay, professional sanction would not be available, as such actions would not constitute the practice of medicine and would therefore fall outside of the medical disciplinary board's jurisdiction.

B. Anonymous Participation

A second approach, advocated and employed by the state of Illinois,⁹⁹ is the use of anonymity and confidential cash payments. According to Illinois criminal procedure:

The identity of executioners and other persons who participate or perform ancillary functions in an execution and information contained in records that would identify those persons shall remain confidential In order to protect the confidentiality of persons participating in an execution, the Director of Corrections may direct that the Department make payments in cash for such services.¹⁰⁰

Again, this approach does more harm than good. Cloaking physician participation in executions in secrecy and under-the-table cash payments sends the message that something inappropriate is going on. But projecting this image is exactly what our society should avoid. The goal should be to promote ethical behavior on the part of physicians, not to taint the caring ethic. Our society should be as open and honest as possible, so as to avoid misunderstandings and distrust. If anything is sure to erode the public's trust in the medical profession, it is portraying physicians as rogues for hire.

99. It is somewhat ironic that Illinois, the home state of the American Medical Association, is the state that has enacted the most legislation enabling physician participation in executions.

100. 725 ILL. COMP. STAT. ANN. 5/119-5(e) (West Supp. 2001).

C. A Novel Approach

So, where does that leave us? How should we resolve the conflict between death penalty statutes and medical practice acts without drawing arbitrary distinctions or promoting public distrust? Appropriate legislative resolution should address the issue head-on, rather than attempt to sweep it under the rug. It should reinforce the notion that physicians are ethically obligated to provide comforting care for their condemned patients, not undermine the profession's image with injudicious, albeit creative, end runs.

First, every state that endorses capital punishment should draft its death penalty statute so as to *explicitly* sanction physician participation in the execution process. However, because participation in executions is a personal choice, no individual physician should be forced to act against his or her own conscience. Therefore, death penalty statutes should also include conscientious objector exemptions for participating physicians.¹⁰¹

Second, to remedy the current legislative conflict and its consequent chilling effect, states should amend their medical practice acts to include safe harbor, or hold harmless, provisions for physician participation in executions. By doing so, states could eliminate the possibility that medical disciplinary boards would hold such actions to fall within the grounds for professional sanction, whether those grounds are defined by the language of "unprofessional or dishonorable conduct" or by some other language.¹⁰² Such provisions would also pre-

101. This is analogous to the treatment of therapeutic abortion. Although legally authorized in many situations, no individual physician is obligated to participate in such a procedure if doing so is inconsistent with personal moral or religious beliefs. Such conscientious objector clauses are found in many state statutes concerning the performance of abortions. *See, e.g.*, ARIZ. REV. STAT. ANN. § 36-2151 (West 1993) ("A physician . . . who shall state in writing an objection to such abortion on moral or religious grounds shall not be required to participate in the medical or surgical procedures which will result in the abortion."); MASS. GEN. LAWS ANN. ch. 112, § 12I (West 1996) ("A physician . . . who shall state in writing an objection to such abortion or sterilization procedure on moral or religious grounds, shall not be required to participate in the medical procedures which result in such abortion or sterilization . . ."); N.C. GEN. STAT. ANN. § 14-45.1(e) (West 2000) ("Nothing in this section shall require a physician . . . who shall state an objection to abortion on moral, ethical, or religious grounds, to perform or participate in medical procedures which result in an abortion.").

102. This was the method that Oregon employed in the context of its physician-assisted suicide statute, entitled the Oregon Death with Dignity Act. OR. REV. STAT. §§ 127.800–.897 (1999). To preclude the possibility that state medical disciplinary boards might sanction physicians for actions that are arguably contrary to prevailing professional ethical norms, the legislature included a hold harmless clause, expressly absolving physicians from liability for actions contemplated by the statute. The Act states in relevant part: "No professional organization or association, or health care

clude individual lawsuits brought by physicians or others seeking to have these actions declared as unprofessional or dishonorable conduct, as in the *Thorburn* case.¹⁰³

This approach will provide physicians with a continued, active role in executions for the right reasons, without relying on irrational distinctions or shrouds of secrecy and their attendant air of impropriety. At the same time, it will remove the threat of professional sanction or de-licensure for those physicians who choose to participate in executions.

In addition to the proposed legislative resolution, it is imperative that the medical establishment, especially the AMA, reconsider its position on the ethics of physician participation in lethal injections. With the loudest voice among health care practitioners, the AMA speaks for the profession, and the rest of the world tends to listen.¹⁰⁴ Their current categorical opposition to any sort of participation by physicians in the execution process fails to appreciate the nuanced ethical, political, and legal considerations inherent in this debate. Of course, individual practitioners and professional medical organizations may continue to lobby against the death penalty itself. However, the medical establishment must separate its political agenda from its ethical obligation to meet the unique needs of all patients—even condemned criminals. Physicians should not use their professional status to make political statements at the expense of their patients' welfare. As long as the death penalty exists, physicians must recognize and acknowledge that patient needs are paramount.

CONCLUSION

Few social conventions evoke more visceral and polemical reactions than capital punishment. The involuntary termination of an individual life is permanent and final. Reflexive opposition to healers' participation, of any kind, is to be expected because of the grave, con-

provider, may subject a person to censure, discipline, suspension, loss of license, loss of privileges, loss of membership or other penalty for participating or refusing to participate in good faith compliance with ORS 127.800 to 127.897." OR. REV. STAT. § 127.885(2) (1999). The model language for the hold harmless clauses in medical practice acts could follow that used in the Oregon Death With Dignity Act, reading: "No professional organization or association, or health care provider, may subject a person to censure, discipline, suspension, loss of license, loss of privileges, loss of membership or other penalty for participating or refusing to participate in good faith compliance with this state's death penalty statute."

103. For a more detailed discussion of the *Thorburn* case, see *supra* note 72.

104. See *supra* note 32.

tentious, and irreversible nature of an execution. But a patient-centered theory of medical ethics demands a more probing analysis.

The current trend towards lethal injection as the preferred method of execution presents an opportunity for physicians to participate in the evolution and implementation of capital punishment in this country while still maintaining their role as comforting caregivers. Despite reasonable and legitimate concerns, ethical, legal, and public policy considerations all suggest that physicians should embrace this opportunity to extend their comforting capabilities to the condemned. Physicians should not, as urged by the dominant professional societies, abandon these patients for the sake of political posturing. External influences have already fractured the modern doctor-patient relationship; professional politics should not compromise patient care in the execution chamber.

Further, legislatures should remove the ambiguity that currently plagues statutes concerning physician participation in capital punishment in a way that explicitly permits physician involvement in the execution process. This resolution will benefit the condemned, the profession, and society at large. It is clear that preventable mishaps occur during executions, particularly lethal injections.¹⁰⁵ Competent medical oversight by physicians can ensure that these mishaps are minimized as much as they possibly can be. Prisoners killed by the state are entitled to such competent oversight—no one should be sentenced to a botched execution.

105. *See supra* note 58.