

Years Later the Question Remains: “Physician Participation in Executions: Care Giver or Executioner?”

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Abstract

The “medicalization” of the death penalty has ignited a debate, by those within the medical profession and by others outside it, about the appropriateness of physicians participating in executions. Physicians participating as “agents” of the State in state-sponsored executions argue that their presence ensures a more humane execution. Opponents argue physician participation violates the Hippocratic Oath, which states clearly that physicians should never do harm to anyone. How any physician, who is dedicated to “preserving life when there is hope,” can argue that taking the life of a healthy person because the state commands it is in the patient’s best interest and does not conflict with the goals of medicine is beyond comprehension. Physician participation in executions is unethical because it violates the four basic principles that govern medical ethics: respect for persons, beneficence, nonmaleficence, and justice.

In a June 8, 2015 front-page article in Time Magazine, David von Drehle writes convincingly that the “era of capital punishment” is coming to an end. A look into the shortage of drugs used for lethal injection protocols, the constitutional questions of “cruel and unusual punishment” in light of botched and drawn-out executions in 2014, and the unquestionable financial burdens on states with inmates on death row versus those employing lifetime sentences reveals why von Drehle and others see an end to capital punishment on the horizon. Including a recent May vote by Nebraska’s legislature to abolish capital punishment in the state, there have been seven states since 2007 that have ended the practice. *With all of these factors, however, the question of ethical physician participation in state executions remains and must be addressed by the medical community and society itself.*

To circumvent objections that the death penalty was “cruel and unusual punishment” and therefore a violation of the 8th Amendment to the Constitution, advocates proposed lethal injection and the involvement of physicians to overcome the negative perceptions associated with the death penalty and to increase public acceptability of the practice. Initiated in 1982, lethal injection is now the main method of execution in all 31 states with the death penalty. The Death Penalty Information Center reports that 1234 of the 1409 executions

carried out by states since 1976 and the reinstitution of capital punishment by the Supreme Court have been by lethal injection.[ii] More recently, of the 726 executions performed in the United States since 2001, 723 have been by lethal injection.[iii] This “medicalization” of the death penalty has ignited a debate both by those within the medical profession and by others outside it regarding the appropriateness of physicians participating in executions: “This image of a white-coated symbol of care working with or as the black-hooded executioner is in striking contrast to established physician ethics, which bar physicians from involvement with executions.”[iv]

Physicians participating as “agents” of the State in state-sponsored executions argue that their presence ensures a more humane execution. They are being compassionate and caring by not abandoning their patient at his or her time of need and by ensuring the prisoner does not experience unnecessary pain or suffering. Some proponents even argue that this whole debate is nothing more than a ruse by death penalty abolitionists to end capital punishment in the United States. Opponents argue that physician participation violates the Hippocratic Oath, professed by many physicians upon graduation, to which the dictum “first, do no harm” is attributed. The goal may appear to be to reduce pain and suffering, but in reality the physician’s participation only

maximizes efficiency.[v] Opponents further argue that there is a profound conflict of purpose, role or interest. A study of physician’s attitudes about participation in executions by Neil Farber et al., found that the majority of physicians surveyed approved of most disallowed actions involving capital punishment, indicating that a majority of physicians believed it is acceptable in some circumstances for physicians to kill individuals against their wishes despite the continued objections by the American Medical Association (AMA) and other medical societies.[vi] This debate pits one ethical principle against another, beneficence against nonmaleficence. Despite changing state execution policies and practices, pending Supreme Court rulings, and calls for older forms of capital punishment, the basic question remaining is whether medicine has a role in addressing more competent and compassionate ways of executing people.

The purpose of this article, therefore, is twofold: first, to examine the role of physicians who are involved in executions; and second, to give an ethical analysis of the arguments for and against physician participation in executions, with special attention to the use of pharmaceutical agents in lethal injection.

Endnotes

Editor, “States With and Without the Death Penalty,” *Death Penalty Information Center* (2015): 1.
<http://www.deathpenaltyinfo.org/states-and-without-death-penalty>.

[ii] Editor, “Methods of Execution,” *Death Penalty Information Center* (2015): 1.
<http://www.deathpenaltyinfo.org/methods-execution>.

[iii] Editor, “Searchable Execution Database,” *Death Penalty Information Center* (2015): 1.
<http://www.deathpenaltyinfo.org/views-executions>.

[iv] L. Emanuel & L. Bienen, “Physician Participation in Executions: Time To Eliminate Anonymity Provisions and Protest the Practice,” *Annals of Internal Medicine* 135 (2001): 922-924.

[v] Editor, “Breach of Trust: Physician Participation in Executions in the United States,” *Human Rights Watch* (2004): 1. <http://www.hrw.org/reports/1994/usdp/8.htm>.

[vi] N. Farber, E. Davis, J. Weiner, J. et al. “Physicians’ Attitudes About Involvement in Lethal Injection for Capital Punishment,” *Annals of Internal Medicine* 160 (2000):

2912-2916.

PHYSICIAN’S PARTICIPATION IN EXECUTIONS

The death penalty is as old as recorded history, but what most people are unaware of is that physician’s participation in it also has a long history. The earliest recorded history of physicians’ involvement in the death penalty probably dates back to 1789 when French physicians, and notable opponents of the death penalty, Antoine Louis and Joseph-Ignace Guillotin developed a device to behead the condemned which they believed was far more humane and civilized than methods of that day. The “guillotine” or “louisette” was used in France between 1792 to 1977 before capital punishment was abolished in 1881. *It should be noted that Dr. Guillotin became shocked and disillusioned by the impact of his efforts, which facilitated capital punishment, and made his name a symbol of killing.*[ii] “For nearly two centuries the medical role in executions was driven by a desire to lessen the suffering of the condemned (and thus of the witnesses) or by a more mundane willingness to play the part insisted on by the state—to assist in bureaucratic aspects of transforming a prisoner to a corpse and to certify death.”[iii] However, medical expertise is not a requirement to find or use a method of killing that minimizes suffering. Humane methods of killing animals have been utilized before the times of modern medicine. While Dr. Guillotin may have based his method on medical knowledge, a similar method of using a razor-sharp knife to sever the soft tissue of the neck had existed for thousands of years.[iv]

In 1887, a commission of American physicians lobbied for the method of electrocution as a more humane alternative to hanging, claiming that hanging was imprecise, undignified, and necessarily unpleasant for criminals.[v] New York State established a committee, chaired by a dentist, to investigate alternative methods of execution. Following the recommendations of the committee, New York constructed an electric chair which, as Thomas Edison testified, would lead to instantaneous death and was therefore considered more humane.[vi] It is documented that two American physicians, Dr. Carlos MacDonald and Dr. E. C. Spitzka, supervised the first use of the electric chair as a method of execution.[vii] A more recent attempt to make executions more humane and less painful occurred in the mid-1970s when a professor of anesthesiology in Oklahoma responded to a request from the state to develop a cheap and effective chemical form of execution. Oklahoma’s electric chair needed to be replaced, which was likely to be

expensive. A three drug “cocktail” was created that included a fast-acting anesthetic, a muscle-paralyzing agent, and a cardio-toxin. Typically the condemned person is strapped to a chair or a trolley. Two intravenous lines are inserted, one as a back up. The lines are kept open with saline solution. Then at the warden’s signal, the injection team administers the three drug “cocktail.”[viii] The first person to be executed by this method was Charlie Brooks in Texas in 1982. He died under the combined effect of sodium thiopental, pancuronium bromide, and potassium chloride. Two physicians were present for the execution and were heard to advise the executioner during the procedure.[ix] Lethal injection became the method of choice by States not only because of the cost factor but more so because it was viewed as more humane. Even though the electric chair was introduced as a more humane method of execution, due to a number of cases that involved torturous suffering, there was a move to make electrocution unconstitutional under the cruel and unusual punishment clause of the 8th Amendment.[x] The use of lethal injection not only overcame the objections of cruel and unusual punishment but incorporated a standard medical procedure as its foundation.[xi] Lethal injection by intravenous catheter[xii] can be indistinguishable from the intravenous infusion of any therapeutic solution commonly used in hospitals for antibiotics, electrolytes or re-hydrating fluids. The only difference in a lethal injection is the identity and desired effect of the fluids actually infused. The process of inserting the catheter medically is the same.[xiii]

The “medicalization” of lethal injection and thus the increased public acceptability of it have been further advanced by at least 28 states requiring the presence of a physician at the execution to determine death and with nine of those states not indicating what role the physician presence is supposed to play in the proceedings.[xiv] According to Human Rights Watch “since these laws do not indicate the purpose of the physician’s presence, one can only surmise that medical expertise is desired by the state to ensure that the procedure runs smoothly, in case something goes awry, or to pronounce death. Mere physician ‘presence’ in the execution chamber risks conveying the message that the execution is countenanced by the medical profession.”[xv] In a study of executions in the state of Illinois in the 1990s by Howard Wolinsky, physician involvement in lethal injections included setting up of intravenous portals for delivery of the execution drugs, monitoring vital signs, and pronouncing death. During a double execution the doctors are reported to have even

administered the intravenous drugs. However, no one knows for certain because a state law passed in 1991 allows for anonymity of the physicians and orders that they be paid in untraceable cash.[xvi] Physician involvement not only violates a basic tenet of the Hippocratic Tradition that is over 2000 years old but violates the more recent Code of Medical Ethics by the American Medical Association.

Opposition to physician involvement in executions can be traced back to the Hippocratic Oath which states: “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.”[xvii] The Oath broadly condemns any physician whose action has the intent of causing harm or death. In more recent time, even though the AMA does not take a stand on the issue of capital punishment itself, it is quite clear that physicians should not be part of the process. In 1980, the Council of Ethical and Judicial Affairs of the AMA stated that, “Physician participation in executions contradicts the dictates of the medical profession by causing harm rather than alleviating pain and suffering.”[xviii] This position was expanded and reaffirmed in 1992, 1997 and 2000. The Council’s report was used as the basis for Current Opinion 2.06 of the AMA’s Code of Medical Ethics. It states:

An individual’s opinion on capital punishment is the personal moral decision of the individual. 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. Physician participation in an execution is defined generally 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 the condemned prisoner.[xix]

The AMA’s Code of Medical Ethics spells out what physician participation in an execution includes. The following actions are included:

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 monitoring electrocardiograms); attending or observing an execution as a physician; and rendering technical advice regarding execution.[xx]

In particular cases when the method of execution is lethal injection the AMA stipulates the following actions as constituting 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.[xxi]

The AMA recognizes that someone should oversee the technical aspects of the execution so to reduce pain and suffering but argues that “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.”[xxii]

In March of 1994, the AMA and other groups called for licensing boards to consider physician complicity in capital sentences to be grounds for disciplinary proceedings, including revocation of licensure. However, according to Dr. Jonathan Groner, surgery professor at Ohio State University, in an interview in 2002 “The AMA has never sanctioned anybody who participates in executions.”[xxiii] It is estimated that about 28 states allow or require physicians to be present at executions. But obtaining accurate information about the number of physicians who participate in executions is difficult to obtain because states generally refuse to name anyone who does so, citing security and privacy concerns. At least 8 states, including Georgia, also seek to shield physicians from professional discipline through laws saying that aiding in executions is not the practice of medicine.[xxiv] The issue hinges on whether this is a medical procedure or not. Baum argues that

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.[xxv]

This issue came to the public’s attention with the case of Dr. Sanjeeva Rao, who is the attending physician at the state prison in Jackson, Georgia. When the state of Georgia started lethal injections in 2000, Dr. Rao took an active role in the executions. He does not administer the injection but does monitor the process. However, in 2001 Dr. Rao inserted a catheter into a prisoner’s right subclavian vein after a nurse had tried unsuccessfully for 39 minutes to find a suitable vein in the prisoner’s right arm, hand, leg and foot. This action led Dr. Arthur Zitrin, retired professor of Psychiatry at New York University and self-described death penalty abolitionist, to attempt to have Dr. Rao expelled from the American College of Physicians for violating the AMA’s Code of Medical Ethics. The effort failed when the American College of Physicians, an internists’ organization, determined that Dr. Rao was behind in his dues and thus no longer a member.[xxvi] Dr. Zitrin subsequently filed a complaint against Dr. Rao with the Georgia Composite State Board of Medical Examiners seeking an investigation and appropriate sanctions against Dr. Rao for his participation in executions. He has also filed similar complaints against physicians in Illinois and Virginia. The problem is that the states appear to have contradictory laws. On the one hand, a physician can be disciplined by state medical boards for violating codes of medical ethics. On the other hand, numerous states allow and require physicians to be present at executions and protect their identity because the law states that aiding in executions is not the practice of medicine. This tension manifested itself in 2009, when the North Carolina Department of Correction brought suit against the North Carolina Medical Board (NCMB) for attempting to discipline physician members that participated in executions ordered by the state. The NCMB provided the following public statement following the ruling against their enforcement of the policy:

In North Carolina Dept. Correction v. North Carolina Medical Board, the North Carolina

Supreme Court ruled that while the North Carolina Medical Board does “retain disciplinary power over a licensed medical doctor who participates in an execution,” the Board “may not discipline or threaten discipline against its licensees solely for participating in the execution alone.” Consistent with the Supreme Court’s ruling, the Board will not take any disciplinary action against a physician for participation in an execution. The North Carolina Medical Board does, however, continue to take the position that physician participation in capital punishment is a departure from the ethics of the medical profession.[xxvii]

The stance taken by the Supreme Court of North Carolina highlights the struggle between medical licensing boards attempting to hold their members to a professional standard against physician participation in executions and the individual statutes that demand a physician present for the execution on death row inmates.

The American College of Physicians, Human Rights Watch, the National Coalition to Abolish the Death Penalty and Physicians for Human Rights have joined forces to influence the position of the State Medical Societies on the question of physician participation in executions. They are insisting that each medical society have a written policy opposing medical participation in executions, support physicians who refuse to participate, and impose sanctions on those who do. Their hope is that with a concerted effort by physicians to protest medical participation in executions that capital punishment would grind to a halt in those states that require the presence of a physician, at least until the legislatures reformulate the existing laws and regulations.[xxviii] In February 2010, the American Board of Anesthesiology (ABA), the licensing board for anesthesiologists that issue certificates to practice, published a commentary indicating that the ABA would be adopting the AMA’s position on capital punishment and prohibited members from participating in states executions. In May 2014, the ABA reaffirmed their position stating that “ABA certificates may be revoked if the ABA determines that a diplomat participates in an execution by lethal injection.”[xxix] There have been no reported instances where the ABA has enforced this violation of the professional standing criterion of the certification process resulting in the revocation of a participating physician’s

certification.

The instances above highlight the extrinsic difficulties that exist for the medical community to enforce professional standards that include participation of physicians in executions. These obstacles, however, may be overshadowed by the internal resistance to such efforts. In a survey published by Dr. Neil Farber and colleagues in the Archives of Internal Medicine in 2000, an overwhelming majority of physicians (74%) said it is acceptable for physicians to pronounce an executed inmate dead. Almost half the respondents, 43%, said there was nothing wrong with physicians actually injecting condemned inmates with lethal drugs. Only 3% of the respondents were even aware that the AMA had published any ethical guidelines on this issue.[xxx] Given these findings, it is not surprising that physicians willingly participate in executions and many of them believe it is even ethical to do so because of a sense of citizen obligation. The ethical confusion centers on the role of a physician to minimize pain and suffering, which is consistent with the principle beneficence versus the direct causing of harm rather than the alleviation of pain and suffering, which is consistent with the principle of nonmaleficence.

J. Welsh, “The Death Penalty,” *The Lancet* 362 [supplement 1] (December 2003): s24-s25. See also D.B. Weiner, “The Real Dr. Guillotin,” *Journal of the American Medical Association* 220 (1972): 85-89.

[ii] Emanuel & Bienen, supra note 3, at 923.

[iii] Welsh, supra note 6, at s.24.

[iv] Emanuel & Bienen, supra note 3, at 923. “Using a razor-sharp knife to sever the soft tissues of the neck is an ancient method that is, in the era of anatomy and physiology, thought to cause immediate loss of intracerebral pressure and irreversible unconsciousness.” Id.

[v] W. Curran, & W.Casscells, “Sounding Board: The Ethics of Medical Participation In Capital Punishment by Intravenous Drug Use,” *New England Journal of Medicine* 302 (1980): 226-230.

[vi] N. Gordon, “The White Coat Passes Like A Shadow In The Execution Chambers,” *Humanist* 55 (November-December 1995): 35-36.

[vii] K. Baum, “To Comfort Always: Physician Participation

In Executions,” *New York University Journal of Legislation & Public Policy* 5 (2001): 1-82.

[viii] Editorial. “Medical Collusion in the Death Penalty: An American Atrocity,” *The Lancet* 365 (April 16, 2005): 1361.

[ix] Welsh, *supra* note 6, at s. 24.

[x] D. W. Denno, “Getting To Death: Are Executions Constitutional?” *Iowa Law Review* 82 (1997): 319-464. For a more detailed analysis of “botched” executions, see M. Radelet, “Post-Furman Botched Executions,” *Death Penalty Information Center* (June 30, 2005): 1-8.
<http://www.deathpenaltyinfo.org/article.php?scid=8&did=478>.

[xi] Baum, *supra* note 12, at 54.

[xii] An Intravenous (IV) catheter is a large-bore needle inserted into a person’s veins to facilitate the infusion of liquid into the bloodstream.

[xiii] Baum, *supra* note 12, at 54, note 25.

[xiv] Editor, “So Long As They Die,” *Human Rights Watch* (2006): 7. <http://www.hrw.org/node/11414/section/7>.

[xv] Editor, *supra* note 4, at 2.

[xvi] H. Wolinsky, “U.S. Physicians Debate Capital Punishment,” *The Lancet* 346 (July 1, 1995): 42-45.

[xvii] *Dorland’s Illustrated Medical Dictionary*, 27th Edition, ed. Elizabeth J. Taylor (Philadelphia, Pa.: W.B. Saunders Company, 1988): 768.

[xviii] Council of Ethical and Judicial Affairs (CEJA), American Medical Association, “Council Report: Physician Participation in Capital Punishment,” *Journal of the American Medical Association* 270 (1993): 365. It should be noted that at the same time or subsequent to the Council’s original report, several other medical associations, including the World Medical Association, the American College of Physicians, the American Public Health Association, the medical societies of Nordic countries (Norway, Finland, Denmark, Iceland and Sweden), the American Psychiatric Association, and the Committee on Bioethical Issues of the Medical Society of the State of New York, also adopted policies which prohibited physician participation in executions.

[xix] Council of Ethical and Judicial Affairs, American

Medical Association, “Code of Medical Ethics: Current Opinions with Annotations, 2004-2005 Edition (Chicago, IL: AMA Press, 2004): 2.06, p.18-19.

[xx] *Id.* at 19.

[xxi] *Id.* “The following actions do not constitute physician participation in an execution: (1) testifying as to medical history and diagnoses or mental state as they relate to competence to stand trial, testifying as to relevant medical evidence during trial, testifying as to medical aspects of aggravating or mitigating circumstances during the penalty phase of a capital case, or testifying as to medical diagnoses as they relate to the legal assessment of competence for execution; (2) certifying death, provided that the condemned has been declared dead by another person; (3) witnessing an execution in a totally non-professional capacity; (4) witnessing an execution at the specific voluntary request of the condemned person, provided that the physician observes the execution in a non-professional capacity; (5) relieving the acute suffering of a condemned person while awaiting execution, including providing tranquilizers at the specific voluntary request of the condemned person to help relieve pain or anxiety in anticipation of the execution.” *Id.*

[xxii] CEJA Report, *supra* note 23, at 366.

[xxiii] L. Barclay, “First, Do No Harm: A Newsmaker Interview with Jonathan I. Groner, M.D.” *Medscape Medical News* (2002): 1-3.
http://www.medscape.com/viewarticle/445047_print.

[xxiv] A. Liptak, “Should Doctors Help With Executions? No Easy Ethical Answer,” *The New York Times* (January 10, 2004).
<http://www.nytimes.com/2004/06/10/national/10death.html?th=&...>

[xxv] Baum, *supra* note 12, at 77.

[xxvi] Liptak, *supra* note 29, at 2.

[xxvii] North Carolina Medical Board, “Position Statements: Capital Punishment,” (July 2013): 1.
http://www.ncmedboard.org/position_statements/detail/capital_punishment.

[xxviii] Gordon, *supra* note 11, at 36.

[xxix] Andrews, Jeffrey. “Commentary: Anesthesiologists and Capital Punishment,” *The American Board of Anesthesiology* (May 2014).

<http://www.theaba.org/PDFs/BOI/CapitalPunishmentCommentary>.

[xxx] Farber et al., supra note 5, at 2912-2916.

ETHICAL ANALYSIS

The ethical controversy surrounding the debate about the participation of physicians in executions has taken on a sense of urgency because authorities both in the penal system and in state legislatures are increasingly incorporating physician’s evaluative skills and therapeutic techniques to not only prepare prisoners for execution but to help legitimate the act of killing. Penal authorities are asking physicians to use their evaluative skills in three ways: clinical assessment of condemned inmates’ mental competence for execution, physician examination in preparation for the execution, and clinical monitoring of critical skills during the execution. The ethical debate centers on whether the presence of the physician at executions is to ensure a more humane execution that is reducing pain and suffering, or is it to maximize efficiency. *These authors will argue that under the ethical principles of respect for persons, beneficence, nonmaleficence and justice, the participation of physicians at executions is unethical and should be stopped immediately. Failure to do so should entail the revoking of their medical license.*

“Respect for persons” refers to the right of a person to exercise self-determination and to be treated with dignity and respect. Proponents of physician participation in executions argue that the physician’s obligation to his/her patient is never to abandon a patient. For a physician to abandon his or her patient at their most vulnerable hour—as the person faces death—would be a direct violation of the principle of respect for persons. The preservation of life is a basic maxim of the medical profession but it is neither always the paramount ethical value nor always in the best interest of the patient.[ii] “To be sure, medicine has for centuries realized that one of its important functions is to comfort and relieve, when unable to cure.”[iii] The preservation of life can yield to other objectives such as relief of pain and suffering. This is the logic behind the ethical acceptance of withholding or withdrawing life-sustaining treatment for those in a terminal condition or to relieve pain and suffering. Performing this action may hasten and even cause death but this is an unintended consequence. This action has always been morally justified by the principle of double effect. The principle refers to one action with two effects. One effect is intended and morally good;

the other is unintended and morally evil. It is not an inflexible rule or mathematical formula, but rather an efficient guide to prudent moral judgment in solving difficult ethical dilemmas.[iv] In some instances, allowing for the hastening of death in a way that relieves pain and suffering is the only compassionate action. “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. 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.”[v] In this situation the patient is going to die and all hope of legal appeals has been exhausted. Therefore, the physician should help make the patient’s death as free of pain and suffering as possible to protect the dignity and respect of the patient. The AMA’s Council for Ethical and Judicial Affairs negates this argument in two ways:

First, although death may ensue from the physician’s actions, the individual patient is voluntarily choosing to risk death upon withdrawal or withholding of care. With capital punishment, the physician is causing death against the will of the individual. Second, when life-sustaining treatment is discontinued, the patient’s death is caused primarily by the underlying disease; with capital punishment, the lethal injection causes the prisoner’s death.[vi]

Participation in an action that deliberately causes the death of the patient violates the basic dignity and respect of the person.

Further, opponents of physician participation argue that the physician-patient relationship is the primary focus of ethics in medicine. Trust is the bridge to the physician-patient relationship, and the burden is on the physician not only to expect the patient’s trust but also to build a solid foundation upon which the patient can place his or her trust.[vii] If this relationship becomes fractured, a loss of confidence will result, and the effect on the patient could be devastating. For prisoners to see their primary care physician also in the role of assisting in the execution undermines the credibility of the medical profession and is irreconcilable with the physician’s role as healer. There also seems to be a conflict of interest present between preserving the primary fiduciary relationship between physician and patient and the

responsibility of an employee to an institution with different interests or when remuneration does not fit with activities that benefit the patient. Physicians employed or paid by the prison system may have a compromised relationship to the prisoner-patient if the prison acts against the prisoner’s health. When a prison physician participates in, trains technicians or nurses to perform, or provides lethal substances for executions, the conflict is profound.[viii] It is true that the preservation of life is not always a moral absolute, especially in instances when the patient is terminally ill.

However, in many of these execution situations, prisoners know that if the physician is not present the execution cannot happen legally. There is a definite conflict between the physician’s duty to his/her patient and the physician’s duty to his/her employer. Participation in the execution of your patient not only violates the fiduciary relationship between physician and patient but shows a clear conflict between a physician who serves the interests of the state and not those of his/her patient. Serving the state by direct participation in an execution also undermines the credibility of medicine as a therapeutic endeavor.[ix] The World Medical Association’s International Code of Medical Ethics states “physicians are clearly out of place in the execution chamber, and their participation subverts the core of their professional ethics, which require them to maintain the utmost respect for human life from its beginning even under threat and to provide competent medical service in full technical and moral independence, with compassion and respect for human dignity.[x] Physician participation in an execution violates the principle of respect for persons by denying individuals, who at this stage are the most vulnerable, of their basic dignity and respect.

“Beneficence” is the obligation to prevent and remove harms and to promote the good of the person by minimizing the risks incurred to the patient and maximizing the benefits to them and others. Beneficence includes nonmaleficence, which prohibits the infliction of harm, injury, or death upon others.

Proponents of physician participation in executions argue that it is in the prisoner’s best interest that physicians are involved with starting intravenous lines, setting up intravenous infusion sites, and measuring out and administering the appropriate drugs so that the execution proceeds as painlessly as possible.[xi] Participation by physicians is done for compassionate and caring reasons, not to intentionally harm the patient. If the role of the physician

is to prevent and remove harms and to promote the good, then considering the circumstances, that the patient has been legally condemned to death and there are no viable options, then it is the duty of the physician not to abandon his/her patient and to ensure the person’s comfort by minimizing the pain and suffering. To promote the good of the patient and remove harms, 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. The physician can locate appropriate veins and insert catheters so that the condemned will not suffer pain and humiliation of multiple needle punctures by inept technicians. The physician can monitor vital signs during the injection to guarantee that death, and not some irreversible condition of brain damage, is achieved.[xii]

Proponents argue that this is the ethical duty of every physician—to maximize comfort and minimize pain and suffering. Few question physicians who do this when the patient is terminal and there is no hope for survival. How is this situation any different? There are no legal appeals left and death is imminent.

Opponents argue that physician participation in executions violates the basic Hippocratic dictum, “first do no harm.” Many argue that the physician’s role is not in reality to reduce harm but to legitimize the practice. The reason lethal injection was proposed was to overcome the growing concern that the other methods of execution—electrocution, hanging, gas chamber, etc. violated the Eighth Amendment to the Constitution concerning cruel and unusual punishment. Having a physician participate in the lethal injection makes the execution have the appearance of a “medicalized” procedure and may even add some degree of humanness to the execution, but it does not outweigh the greater harm of causing death to the individual. A death that while on the surface may seem painless but in reality may be just the opposite.

The three drug “cocktail” of lethal injection initially

used appears to bring about a peaceful, painless death, but this may be only an illusion. Initiated in 1977 by state medical examiner of Oklahoma, Dr. Jay Chapman,[xiii] the three drug regimen consists of sodium thiopental, followed by pancuronium bromide followed by a final infusion of potassium chloride. Beginning in the 1980’s this regimen was intended as a more humane form of execution however in 1985 inmates on death row filed a claim, which was the start of several claims throughout the years, stating the courts were obligated to review the three drug protocol efficacy in human execution.[xiv]

The first drug that is given is sodium thiopental which renders the prisoner unconscious. Sodium thiopental is currently registered as the name Pentothal® and is a short-acting barbiturate used as an anesthetic to place surgical patients in an unconscious state. It was introduced as an anesthetic in 1932 and depressant effects to the cardiovascular system were discovered in 1941 when it was used for patients subsequent to the Pearl Harbor bombing. However, during this time unexpected deaths occurred with its use forcing scientists to look for an alternative[xv],[xvi]. Sodium thiopental is currently available in 500mg and 1g vials for reconstitution to be diluted and administered as an intravenous solution based upon weight. Current clinical dosages range from 3-5mg/kg of body weight followed by a maintenance dose of 1-1.5 mg/kg per minute. For lethal injection, large quantities of sodium thiopental are used. In the state of Kentucky lethal injection of sodium thiopental is dosed at 3g, increased from 2g in 2004, with unconscious results expected within 1 minute.

This is equivalent to approximately 7 times the initial clinical dose for a 6ft / 180lb male. If loss of consciousness has not been achieved, a second dose of sodium thiopental is administered via a separate intravenous line.[xvii] The 2g dose has been criticized in regards to efficacy, arguing technical difficulties and errors in procedure can promote ineffective administration of the full dose of sodium thiopental. Reports argue 2g sodium thiopental as a suboptimal dose for lethal injection and its use in inmates with history of chronic substance abuse requires altered dosing. Autopsy reports show varied concentration of sodium thiopental in the blood ranging from trace amounts to 370mg/L lending to the assumption some inmates would have been conscious when the pancuronium bromide and potassium chloride were infused.[xviii] Sodium thiopental potency degrades over 7 days if reconstituted and not used immediately.⁵¹ Lack of supplies, in the prison system, may

promote storing a reconstituted vial without knowledge of the degradation effects. In 2005, imports of the drug were restricted with import occurring to the US only upon licensure by the Export Control Organization stating purpose of use and delivery destination. Alternatives on the market were considered due to decreased supply with sodium thiopental being replaced in many states by Propofol.[xix]

The second drug is pancuronium bromide, which is used to relax the muscles to prevent involuntary movement and makes the execution look esthetically pleasing to those who view it. Pancuronium bromide is registered as Pavulon® and was first created in 1964 and developed by Dr. David Savage, medicinal chemist Scotland Oregon. An aminosteroid compound and non-depolarizing agent, it is a highly potent muscle relaxant based upon its bulky steroid nucleus.[xx],[xxi] Pancuronium bromide is a neuromuscular blocking agent (NMBA) with inhibitory effects on cholinesterase[xxii]. Used for its neuromuscular blocking properties, pancuronium bromide stimulates muscle relaxation and induces paralysis with long term potency based upon such factors as age, concomitant drug interactions, body temperature, dehydration, electrolyte imbalance and renal/liver impairment. Additional effects include decreased visual muscle movement and decreased respiration.[xxiii] Current clinical dosage ranges from an initial dose of 0.04 to 0.1 mg/kg based upon body weight followed by a maintenance dose of 0.01 mg/kg with incremental increases. Dosed in high quantity, pancuronium bromide can create significant tachycardia and hypertension.⁵⁶ From a historical multi-state perspective, pancuronium bromide was introduced into Oklahoma’s three drug lethal execution regimen in 1977. In the state of Kentucky, lethal injection of pancuronium bromide was disclosed to be 50mg,⁵³ which would be equivalent to approximately 6 times the initial clinical dose for an a 6ft / 180lb male. Fifteen years ago, the state of Tennessee was required to defend the use of sodium thiopental administration prior to pancuronium bromide. The claim stated if sodium thiopental was ineffective after infusion, and pancuronium bromide was administered, the prisoner would be paralyzed but not unconscious. This would result in suffocation followed by significant pain with the administration of potassium chloride. The prisoner claimed they could be awake but unable to speak but knowingly feel the effects of painful cardiac arrest upon infusion of the third drug potassium chloride. The courts upheld that the current dose of sodium thiopental used in the state of Tennessee, was adequate to induce complete unconsciousness[xxiv].

Pancuronium bromide is used in several states for animal euthanasia, however was banned in Tennessee for this use[xxv].

The third drug is potassium chloride, a cardiac depolarizing agent, which causes the death of the prisoner. Potassium chloride maintains heart rhythm and if raised to high levels, can cause suppression of the heart’s normal activity. Even mild increase in potassium levels can be visual on an electrocardiogram (ECG) and if significant can result in ventricular fibrillation and cardiac arrest.[xxvi] In the clinical setting potassium chloride is used to treat hypokalemia and its dosing is based upon the clinical presentation, age and weight of the patient. In the clinical setting potassium chloride is mixed as an intravenous solution since direct administration may include cardiac arrest[xxvii]. Seen in suicide attempts, causing chemical burns where injected, local necrosis of the tissues can result due to extravascular leaking.[xxviii] Clinically, the daily dose of potassium chloride should not exceed 200mEq, in the state of Kentucky, it was disclosed that the lethal injection of Potassium Chloride was 240mEq.⁵³ Potassium chloride is the final infusion for lethal injection and is accountable for cardiac ceasing.

Due to the restricted access to drugs on the three drug regimen list, states have sought out alternatives to include: Phenobarbital sodium (replacement for sodium thiopental), midazolam (anxiolytic), tubocurarine (replacement for pancuronium bromide) and propofol (replacement for sodium thiopental). Phenobarbital sodium (long-acting barbituate) and pentobarbital sodium (short-acting barbiturate) are considered for lethal injection in replacement for sodium thiopental. Currently used in clinical practice as sedative-hypnotics if used in large quantities can cause depression of the central nervous system and respiratory failure.[xxix] Midazolam hydrochloride (Versed®), a benzodiazepine, frequently given prior to surgery causing muscle relaxation and sedation, has been considered in Florida for single drug execution.⁴⁹ Tubocurarine, considered as a replacement for pancuronium bromide, is a purified alkaloid of curare used by South American Indians to coat their hunting arrows causing paralysis for those animals struck. Tubocurarine is a competitive antagonist blocking the effects of acetylcholine from activating receptors and is currently the “gold standard” in tracheal intubation with the use of a depolarizing muscle relaxant.[xxx],[xxxi],[xxxii] However, tubocurarine can in some cases provide unpredictable

muscle response person to person and is affected by multiple drug interactions including Propofol.[xxxiii] Propofol (Diprivan®) is used in the clinical setting as a short-acting anesthetic and considered a replacement for sodium thiopental for lethal injection. Propofol was introduced in 1977 and was considered by Missouri in the lethal injection regimen (October 2013) based upon its ability to cause “propofol infusion syndrome” causing significant metabolic acidosis, cardiac suppression, and failure of multiple organ systems.[xxxiv]

Koniaris et al. obtained information from Virginia and Texas, where since 1976 nearly half the executions in the United States have been done. Neither state had a record of how they developed the execution protocol. In addition, the injection teams were made up of technicians or individuals from medical corps with no training in administering anesthesia, and that there was no assessment of the depth of anesthesia before the paralyzing agent and potassium chloride were injected. Toxicological reports from four other states (Arizona, Georgia, North Carolina, and South Carolina) indicate that the post-mortem thiopental concentrations in the blood of 43 of 49 executed prisoners (88%) were lower than those needed for surgical anesthesia, and 21 prisoners (43%) had drug levels consistent with awareness. That means it is possible that some of these prisoners were fully aware during their executions. Because they were paralyzed, any suffering would be undetectable. This would be a very cruel way to die: awake, paralyzed, unable to move, to breathe, while potassium chloride burned through your veins.[xxxv] In fact, the authors point out that the American Veterinary Medical Association (AVMA) and 19 states, including Texas, prohibit the use of neuromuscular blocking agents to kill animals, because of the risk of unrecognized consciousness.[xxxvi] It appears that the current practice of lethal injection for prisoners in the United States fails to meet veterinary standards.[xxxvii] This clearly violates the principle of nonmaleficence.

Recent cases of “botched” executions bring this violation of the principle of nonmaleficence to light for the public and should do the same for the participating physician. In January 2014, Dennis McGuire was scheduled for execution in Ohio by lethal injection that included midazolam and hydromorphone. After the drugs were administered, reports indicate that Mr. McGuire gasped for air over the course of 25 minutes as the drugs took a prolonged time to take effect. Mr. McGuire’s family brought a lawsuit against the state over the manner in which Mr.

McGuire was executed.[xxxviii] Joseph Wood was executed in Arizona by lethal injection in July 2014 where a reporter present for the proceedings “counted 640 gasps” during the one hour and forty minute period that it took for Mr. Wood to die.[xxxix] Lastly, in April 2014, Clayton Lockett was executed by lethal injection in Oklahoma amidst numerous attempts to stall the proceedings due to objections to the use of an experimental injection drug protocol. Prior to the execution, the state would not release details concerning the drugs to be used, their source and the efficacy of the drugs. The state pushed forward with the execution. After hours of working to find venous access, a sedative was administered, but did not work as anticipated despite the declaration by the participating physician that the patient was unconscious. The next two drugs were injected, but Mr. Lockett was not unconscious and, therefore, clenched his teeth while straining to breathe and lift his head off the table. After 43 minutes, Mr. Lockett died of a heart attack, but not before the blinds were closed and the witnesses asked to leave the observation room.[xl] The events surrounding Mr. Lockett’s execution precipitated a challenge by three current death row inmates in Oklahoma that now sits before the Supreme Court. The justices are expected to rule in June 2015 on whether the use of midazolam in the lethal injection method of execution is a violation of the prohibition on cruel and unusual punishment in the Eighth Amendment to the Constitution.[xli]

Traditionally, the three drug “cocktail” used for lethal injections included sodium thiopental, pancuronium, and potassium chloride. Recent drug shortages, however, have forced states to experiment with other combinations of drugs as the availability dictates. The use of midazolam in Clayton Lockett’s execution in Oklahoma of this past year is an example of this. Another example is the adoption of a one-drug, pentobarbital, protocol by Texas in 2012 when the state ran into a problem securing the necessary amount of drugs for executions with the three drug combination it had used since the 1980’s.[xlii] Many of the drug shortages that are causing states to revisit execution methods in recent years are a result of foreign and domestic pharmaceutical manufacturing companies refusing to ship products to the different states knowing full well the reason for their purchase. On March 24, 2015, the International Academy of Compounding Pharmacists released a statement discouraging its members from participating in the manufacturing and distribution of drugs for use in state executions, a portion of which is below:

IACP discourages its members from participating in the preparation, dispensing, or distribution of compounded medications for use in legally authorized executions. The issue of compounded preparations being used in the execution of prisoners sentenced to capital punishment continues to be a topic of significant interest. It is important to first understand the origin of this issue: states are turning to compounded preparations for this purpose because the companies that manufacture the products traditionally used have unilaterally decided to stop selling them for use in executions.[xlili]

With both foreign and domestic drug manufacturers, as well as compounding manufacturers, actively working to prevent their products from being used in state executions, the states are scrambling to find lethal injection agents to substitute. This activity not only calls into question the constitutionality of these methods, but places an even greater burden on the participating physicians to recall the principles of beneficence and nonmaleficence inherent in the Hippocratic Oath and the physician-patient relationship.

Communitarians view the notion of harm not necessarily related to the participation of the physician in the execution, but instead in the context of the act. In the communitarian viewpoint, medicine defines a moral sphere within which medical activities have special meaning. The execution of a prisoner lies far outside the medical sphere. A physician’s participation in the execution does nothing to promote the moral community of medicine. Instead, it offends the sense of community by prostituting medical knowledge and skills to serve the purpose of the state and its criminal justice system. Participation by a physician subverts the profession for the nonbeneficent goals of the state. Medicine is at heart a profession of care, compassion, and healing. Physician-assisted capital punishment fails to encompass these virtues.[xliv] Participation in the taking of the life of a healthy person at the command of the state not only fails the test of beneficence but also fails the test of nonmaleficence.

Finally, the principle of “justice” recognizes that each person should be treated fairly and equitably, and be given his or her due. The principle of justice can be applied to physician participation in two ways. First, Farber et al. found that the most common rationale for physicians’ willingness to participate in execution was their sense of

citizen obligation.[xlvi] When physicians decline to participate in executions they believe they are breaching their obligations as both physicians and citizens.[xlvi] The argument is that physicians have a moral duty to ensure that the execution is carried out in the most humane and painless way possible. Physician participation would not signal approval of the taking of life, but compassion for the person to be executed. Further, the physician’s duty as a citizen requires him or her to participate because the executions take place with the authorization of the state.[xlvii] Opponents of physician participation argue that the procedures used in lethal injection executions do not necessarily require the skills of a physician. These procedures can be performed by non-medical personnel with no more pain or discomfort for the prisoner. It may be true that physician participation adds some degree of humanness to the execution, but this does not outweigh the greater harm of causing death to the prisoner. Finally, while physicians do have certain civic duties, medical ethics do not require physicians to carry out civic duties which contradict fundamental medical and ethical principles, such as the duty to avoid doing harm. Further, state approval or authorization of an act does not constitute a requirement on the part of any citizen to take action.[xlviii]

To argue that physicians have a duty as citizens to participate in executions is an exaggerated sense of civic duty, the type that has been attributed to physicians in Nazi Germany who performed medicalized killings. Dr. Joel Geiderman, in an article published in the March 2000 issue of *Academic Emergency Medicine*, examines the moral temper of the medical establishment in Nazi Germany and analyzes it in relationship to current issues in medicine. Geiderman highlights several present-day practices, such as physician participation in executions, and suggests that the medical profession is still not entirely independent of the state’s coercion. His hope is that in promoting awareness and discussion of these practices he can stop the medical profession from proceeding down the slippery slope to unacceptable behaviors that are clearly unjust.[xlix]

Second, in the study done by Farber et al. 46% of physicians who responded believed that the death penalty significantly lowers or somewhat lowers the murder rate.[i] According to most criminologists, there is no conclusive evidence that capital punishment brings about either deterrence or brutalization (i.e., that the death penalty somewhat raises or significantly raises the murder rate).[ii] According to Dr. Jeffrey Fagan of Columbia Law School,

the new studies that claim the death penalty is a form of deterrence are “fraught with technical and conceptual errors: inappropriate methods of statistical analysis, failures to consider all the relevant factors that drive murder rates, missing data on key variables in key states, the tyranny of a few outlier states and years, and the absence of any direct test of deterrence.”[iii] One has to wonder if physicians understood that capital punishment is not a more effective deterrent to murder than long-term imprisonment and does not protect public health by decreasing societal violence, would they have less of an appetite for participating in executions or otherwise supporting capital punishment?[liii] However, Wirt et al. also raise the possibility that physicians’ expressed belief in deterrence is a surrogate or rationalization for other motives (for example, vengeance or the desire to make a moral statement regarding the sanctity of life). In this case, physicians’ willingness to participate in capital punishment might be little affected by knowledge of the lack of deterrent effect as compared with long-term imprisonment.[liv] As a matter of justice there is also the issue of errors in the administration of capital punishment in the United States. Since 1973, 153 prisoners have been exonerated and released from death row.[lv] Despite the safeguards in the current system, the threat of executing innocent individuals who are legally or actually innocent is real. A lack of information or misunderstanding by physicians regarding how race bias, class bias, and errors impact on capital convictions may provide a reason why a majority of physicians view their participation in executions as ethically acceptable and morally just.[lvi] The failure of physicians to recognize that civic duty can never trump medical ethical principles and that there is a viable option to capital punishment, which would protect against errors, is clearly an injustice. If the principle of justice mandates that each person should be treated fairly and equitably then physician participation in executions clearly violates the principle of justice since it is not a proven deterrent, allows for errors and is clearly an exaggerated sense of civic duty.

Editor, supra note 4, at 1.

[ii] Baum, *supra* note 12, at 58.

[iii] Curran & Casscells, *supra* note 10, at 229.

[iv] J. Mangan, “An Historical Analysis of the Principle of Double Effect,” *Theological Studies* 10 (March 1949): 41. The principle of double effect specifies four conditions that must be fulfilled for an action with both a good and bad effect to be morally justified. (1) The action, considered by

itself and independently of its effects, must not be morally evil. The object of the action must be good or indifferent; (2) the evil effect must not be the means of producing the good effect; (3) the evil effect is sincerely not intended, but merely tolerated; (4) there must be a proportionate reason for performing the action, in spite of the evil consequences. See G. Kelly, *Medico-Moral Problems* (St. Louis, Mo.: The Catholic Hospital Association of the United States and Canada, 1958): 13-14.

[v] Baum, *supra* note 12, at 61.

[vi] CEJA Report, *supra* note 23, at 366.

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[viii] Emanuel & Bienen, *supra* note 3, at 1.

[ix] Editor, *supra* note 4, at 3.

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[xii] Baum, *supra* note 12, at 62.

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CONCLUSION

A physician’s opinion on capital punishment is a personal opinion of that individual. However, as a physician he or she has the ethical responsibility to abide by the Code of Medical Ethics that governs the actions of those in the medical profession. The AMA’s position on physician participation in executions, which embodies the spirit of the Hippocratic Oath, is quite clear that “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.” *The AMA sees its role in protecting values and services that may otherwise be vulnerable in society because of overshadowing by government, as is the case for executions, or by the private sector.*[ii] *Despite the fact that physician participation at executions violates the basic tenet of the Hippocratic Oath and the position of the AMA, not to mention similar positions of other medical societies, physicians continue to participate and it is expected that their involvement will only increase in the future. Their rationale has been spelled out in this article that ranges from it is a legal procedure approved by a democratic government, to participation minimizes pain and suffering and therefore is in the best interest of the prisoner. Personal and societal values seem to trump their professional values. However, these arguments fall apart when examined and scrutinized from an ethical perspective.*

Some have argued that the way to circumvent the dilemma of physician participation is to train other medical personnel, such as physician assistants, nurses, etc., to perform the same task as the physician. This argument is clearly illogical. It assumes that other health care professionals are less dedicated to the ethical ideals of the medical profession. One might assume that all health care professionals are bound by the same basic ethical standards such as “first, do no harm.” In fact, 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.[iii] Logic and consistency would dictate that all medical professionals are bound by the same ethical arguments and constraints. Other physicians have tried to argue that their participation in executions is beneficent because it minimizes the risk of a botched procedure and thus

minimizes pain and suffering. However, it has been shown that lethal injection, while on the surface may appear to be a painless way to die, in reality may be far more cruel and painful than anyone even imagined. It has also been demonstrated in recent years that botched executions occur despite the presence of physicians in the execution chamber, dismantling the argument that the patient is assured a painless death when the state co-opts the service of the physician. How any physician, who is dedicated to “preserving life when there is hope,” can argue that taking the life of a healthy person because the state commands it is in the patient’s best interest and does not conflict with the goals of medicine is beyond comprehension. Physician participation in executions is unethical because it violates the four basic principles that govern medical ethics: respect for persons, beneficence, nonmaleficence, and justice.

The fear of many is that some physicians have been co-opted by the penal authorities and state legislatures in this country to believe that physician participation is a civic duty and one that is in the prisoner’s best interest. In reality, these physicians are being used as a means to an end. They are being used by certain states to medicalize executions in order to make them more palatable to the American public and to prevent capital punishment from being declared unconstitutional because it is “cruel and unusual punishment.” A basic tenet of the principle of respect for persons is that one may never use another person as a means to an end. Legislating that physicians must be present at executions uses these physicians as pawns or means in order to legitimize capital punishment. This not only violates the rights of these physicians but violates the basic ethical principles of the medical profession and distorts the physicians’ role in society. The AMA and other medical societies should take a strong position that participation of physicians in executions is grounds for revoking a physician’s license. “Even though state legislatures may attempt to subvert this position by guaranteeing anonymity to physicians who serve as executioners, the risk of losing one’s license should serve as a deterrent.”[iv] Until the AMA and other medical societies back up their positions with concrete actions, the image of a “white-coated healer” will continue to be confused with that of the “black-hooded executioner.” This does not bode well for the medical profession or society as a whole, “because when the healing hand becomes the hand inflicting the wound, the world is turned inside out.”[v]

Council of Ethical and Judicial Affairs, American Medical

Association,” Code of Medical Ethics, supra note 24, at 2.06, p.18.

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