

## LETHAL INJECTION: STATES MEDICALIZE EXECUTION

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### INTRODUCTION

In *Baze v. Rees*, the Supreme Court of the United States upheld the constitutionality of a method of lethal injection used for capital punishment.<sup>1</sup> The three-drug protocol referenced in *Baze* consisted of three chemicals injected into the condemned inmate via an intravenous drip.<sup>2</sup> The three-drug protocol began with sodium thiopental, followed by pancuronium bromide, and lastly, potassium chloride.<sup>3</sup> The claim that this lethal injection method would violate the Eighth Amendment's ban on cruel and unusual punishment was made on behalf of two individuals, Ralph Baze and Thomas Bowling, both sentenced to death in Kentucky.<sup>4</sup>

The findings of *Baze* had a national impact, as the Kentucky method was the same method used in most states practicing lethal injection.<sup>5</sup> Further, at the time of *Baze*, a moratorium on all lethal injection was effectively in place because the Supreme

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1. 553 U.S. 35, 47 (2008).
2. *Id.* at 44.
3. *Id.*
4. *Id.* at 46–47.
5. *Id.* at 41, 44; Robert Schwartz, *The Effect of Baze v. Rees on Death Penalty Reform*, LEADERSHIP CONFERENCE (Apr. 18, 2008), <http://www.civilrights.org/criminal-justice/death-penalty/baze-v-rees.html>.

Court granted the case certiorari.<sup>6</sup> In a 7-2 decision,<sup>7</sup> the Court held that the three-drug protocol was constitutional.<sup>8</sup> However, the Court stressed that the first drug in the three-drug protocol must render the inmate unconscious to avoid an unacceptable risk that the inmate would be aware as he died by suffocation.<sup>9</sup>

*Baze* is noteworthy because the Court claimed that since the death penalty is constitutional, a method of execution must be available that does not violate the Eighth Amendment.<sup>10</sup> The *Baze* Court therefore claimed that the three-drug protocol for lethal injection is that constitutional method.<sup>11</sup> From a medical perspective, it is not apparent that the *Baze* Court understood how the drugs involved in the three-drug protocol worked in the body. It also appears that the *Baze* Court may have underestimated the full implications of this decision to the practice of medicine and the ethical dilemma that *Baze* now places on physicians.

## I. LETHAL INJECTION THROUGH THE FILTER OF SCIENCE

### A. *The Efficacy of Lethal Injection Drugs*

In order to satisfy *Baze*, states have struggled to verify that inmates are unconscious prior to pancuronium bromide and potassium chloride injection.<sup>12</sup>

To achieve that state of unconsciousness, the traditional three-drug protocol used sodium thiopental, a standard general anesthetic.<sup>13</sup> A general anesthetic renders an individual insensate to

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6. *Baze v. Rees: Lethal Injection, Cruel and Unusual Punishment, Eighth Amendment, Death Penalty*, CORNELL UNIV. L. SCH. LEGAL INFO. INST., <http://www.law.cornell.edu/supct/cert/07-5439> (last visited Feb. 27, 2015).

7. Schwartz, *supra* note 5.

8. *Baze*, 553 U.S. at 63.

9. *See id.* at 59.

10. *Id.* at 47.

11. *Id.* at 62.

12. *See id.* at 53 (“It is uncontested that, failing a proper dose of sodium thiopental that would render the prisoner unconscious, there is a substantial, constitutionally unacceptable risk of suffocation from the administration of pancuronium bromide and pain from the injection of potassium chloride.”); *see, e.g.*, Deborah W. Denno, *Lethal Injection Chaos Post-Baze*, 102 GEO. L.J. 1331, 1354–60 (2014) (explaining how states have shifted away from a three-drug protocol to a one- or two-drug protocol to avoid running afoul of the standard set in *Baze* regarding an inmate’s consciousness).

13. *Thiopental Sodium*, DRUGS.COM, <http://www.drugs.com/ppa/thiopental-sodium.ht>

pain, blunts certain adverse physiologic reflexes, and blocks awareness and recall during and after the conduct of the anesthetic.<sup>14</sup> Sodium thiopental, once standard in the practice of anesthesiology, is no longer available in the United States due to concerns by the manufacturer over use in the death penalty via lethal injection.<sup>15</sup> Hospira, the last company to manufacture sodium thiopental for the American market, ceased production to avoid sanctions from the European Union, which forbids any member from manufacturing or distributing any drug for use in an execution.<sup>16</sup>

Pancuronium bromide is the second drug in the three-drug protocol.<sup>17</sup> Pancuronium bromide is a paralytic that, when administered, reversibly blocks the capacity of movement in a particular group of muscles in the body known as skeletal muscles.<sup>18</sup> Paralytics act only on skeletal muscles and have no effect on smooth or cardiac muscle.<sup>19</sup> In the setting of lethal injection, paralyzing

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ml?rintable=1 (last visited Feb. 27, 2015).

14. See *What Is General Anesthesia?*, MED. NEWS TODAY, <http://www.medicalnewstoday.com/articles/265592.php> (last updated Sept. 5, 2013, 7:00 AM).

15. See Erik Eckholm & Katie Zezima, *Drug Used in Executions Dropped by U.S. Supplier*, N.Y. TIMES, Jan. 22, 2011, at A11.

16. See Council Regulation 1236/2005, 2005 O.J. (L 200) 1 (EC); Matt Ford, *Can Europe End the Death Penalty in America?*, ATLANTIC (Feb. 18, 2014, 7:06 PM), <http://www.theatlantic.com/international/archive/2014/02/can-europe-end-the-death-penalty-in-america/283790/>. Hospira, a United States company, was manufacturing sodium thiopental in Italy, a member of the EU, so the Italian government requested a guarantee from Hospira that Italian-produced sodium thiopental would not be used in executions. The company claimed it could not comply and ceased manufacturing sodium thiopental. See Chris McGreal, *Lethal Injection Drug Production Ends in the US*, GUARDIAN (Jan. 23, 2011, 1:17 PM), <http://www.theguardian.com/world/2011/jan/23/lethal-injection-sodium-thiopental-hospira>.

17. Peter Sergo, *How Does Lethal Injection Work?*, SCIENCELINE (Nov. 12, 2007), <http://scienceline.org/2007/11/ask-sergo-deathpenalty/>. Pancuronium bromide is not widely available, as newer paralyzing agents have replaced it. See Larry O'Dell, *Rocuronium Bromide: Lethal Injection Drug Replaces One in Short Supply in Virginia*, HUFFINGTON POST (July 27, 2012, 11:38 AM), [http://www.huffingtonpost.com/2012/07/27/rocuronium-bromide\\_n\\_1710223.html](http://www.huffingtonpost.com/2012/07/27/rocuronium-bromide_n_1710223.html); *Virginia Adds New Lethal Injection Drug: Rocuronium Bromide*, CBS LOCAL (July 27, 2012, 7:24 PM), <http://washington.cbslocal.com/2012/07/27/virginia-adds-new-lethal-injection-drug-rocuronium-bromide/>. These new agents work similarly to pancuronium bromide, but even if substituting drugs by class or intent may be permitted in a medical setting, *Baze* includes no provision for such substitutions. See *Baze v. Rees*, 553 U.S. 47, 56–57 (2008); WORLD MED. ASS'N, WMA STATEMENT ON DRUG SUBSTITUTION (Oct. 2005), available at <http://www.wma.net/en/30publications/10policies/d13/>.

18. Adam Liptak, *Critics Say Execution Drug May Hide Suffering*, N.Y. TIMES, Oct. 7, 2003, at A1.

19. NANCY L. CAROLINE ET AL., NANCY CAROLINE'S EMERGENCY CARE IN THE STREETS

drugs have been extraordinarily effective in convincing the observer that death occurs without cruelty.<sup>20</sup> Since the dead can never tell us if they experienced cruelty in their own death, the responsibility to guard against cruelty is entirely in the hands of the observers.<sup>21</sup>

Potassium, available as potassium chloride, is a naturally occurring element necessary for normal bodily functions in a number of human physiological systems.<sup>22</sup> Of importance here is the effect of potassium chloride on the heart. As potassium rises outside of the heart cell, depolarization is increasingly blocked until a point at which the heart cell is essentially held in place and cannot contract.<sup>23</sup> At this point, the heart ceases to function in any capacity.<sup>24</sup> The lack of heart muscle contraction causes the blood pressure to drop.<sup>25</sup> The lack of blood flow, which carries oxygen to each cell in the body, ceases and progressive and rapid multi-organ failure ensues.<sup>26</sup> An additional concern is that potassium chloride, when injected into the body, produces an intense burning sensation in the veins.<sup>27</sup>

Expertise in the subject of unconsciousness in the setting of chemical injections is recognized as a skill possessed by physicians.<sup>28</sup> Further, lethal injection has the look and feel of a medical

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811 (Andrew N. Pollak ed., 7th ed. 2012).

20. See Deborah W. Denno, *When Legislatures Delegate Death: The Troubling Paradox Behind State Uses of Electrocution and Lethal Injection and What It Says About Us*, 63 OHIO ST. L.J. 63, 66 (2002).

21. See Emma Schwartz, *A Challenge to Lethal Injections*, U.S. NEWS (Nov. 3, 2007, 2:57 PM), <http://www.usnews.com/news/articles/2007/11/03/challenge-to-lethal-injections>.

22. See *What Is Potassium Chloride*, EVERYDAY HEALTH, <http://www.everydayhealth.com/drugs/potassium-chloride> (last visited Feb. 27, 2015).

23. See generally Brief of Kevin Concannon et al. as Amici Curiae Supporting Petitioners at 9, *Baze v. Rees*, 553 U.S. 35 (2008) (No. 07-5439), 2007 WL 3440946 at \*9 (explaining that increased levels of potassium in the body affects the heart's impulse generation).

24. See Mark Heath, *The Medicalization of Execution: Lethal Injection in the United States*, in PUBLIC HEALTH FROM BEHIND BARS: FROM PRISONS TO COMMUNITIES 88, 93 (Robert Greifinger ed., 2007).

25. Walter A. Brezezski, *Blood Pressure*, in CLINICAL METHODS: THE HISTORY, PHYSICAL, AND LABORATORY EXAMINATIONS 95, 97 (H. Kenneth Walker et al. eds., 3d ed. 1990).

26. *Id.*

27. See Heath, *supra* note 24, at 93.

28. Paul Litton, *Physician Participation in Executions, the Morality of Capital Punishment, and the Practical Implications of Their Relationship*, 41 J.L. MED. & ETHICS 333, 334–35 (2013).

act.<sup>29</sup> The intention here is to convey a message of seriousness and safety. However, employing the trappings of science and medicine do not create the safety and circumspection of the scientific method. Lethal injection simply occurs as a protocol, involves personnel, and is recorded by the state.<sup>30</sup>

### B. *Pseudoscience*

Occasionally, an execution does not proceed according to plan and might be referred to as “botched.”<sup>31</sup> These alarming public failures increase pressure on the states to “get it right” and to seek physician involvement.<sup>32</sup> If science were brought to bear on lethal injection, it would proceed by first generating a hypothesis and then designing a method of investigation free of bias to determine if the hypothesis is proven or disproven.<sup>33</sup> Science begins with the null hypothesis; the assumption is that the claim is false and must be proven to be true.<sup>34</sup>

Consider an experiment that requires subjects to participate. Can a prisoner be a subject in an experiment? Past examples of

29. *See id.* (describing a typical lethal injection protocol, which includes use of IVs, saline solution, various drugs and medical devices, and the presence of physicians).

30. *Id.*; *see, e.g.*, ARIZ. DEP’T OF CORRS., DEP’T ORDER 710, EXECUTION PROCEDURES 5 (Sept. 21, 2012), *available at* [https://corrections.az.gov/sites/default/files/policies/700/0710\\_u.pdf](https://corrections.az.gov/sites/default/files/policies/700/0710_u.pdf) (providing an example of a state execution protocol that requires the state to record the event).

31. AUSTIN SARAT, GRUESOME SPECTACLES: BOTCHED EXECUTIONS AND AMERICA’S DEATH PENALTY 5 (2014).

32. *See, e.g.*, Radley Balko, *In Praise of the Firing Squad*, WASH. POST (Feb. 6, 2015), <http://www.washingtonpost.com/news/the-watch/wp/2015/02/06/in-praise-of-the-firing-squad/> (examining opposition to lethal injections in light of a possible return to the firing squad as a more humane method of execution); The Editors, *Don’t Botch Executions. End Them.*, BLOOMBERG VIEW (Aug. 5, 2014, 11:53 AM), <http://www.bloombergvew.com/articles/2014-08-05/don-t-botch-executions-end-them> (arguing that lethal injection has not resulted in a humane manner of execution and the state should not resort to old methods, such as the electric chair or the gas chamber, to remedy the problem); Matt McCarthy, *What’s the Best Way to Execute Someone? Doctors Say Lethal Injection Is Often Botched and Horrific*, SLATE (Mar. 27, 2014, 11:44 PM), [http://www.slate.com/articles/health\\_and-science/medical\\_examiner/2014/03/death\\_penalty\\_drugs\\_lethal\\_injection\\_executions\\_are\\_so\\_bad\\_that\\_it\\_s\\_time.html](http://www.slate.com/articles/health_and-science/medical_examiner/2014/03/death_penalty_drugs_lethal_injection_executions_are_so_bad_that_it_s_time.html) (presenting the opinions of numerous doctors and anesthesiologists that current lethal injection drugs and protocols are medically incompetent, and thus more likely to result in botched executions).

33. *See* E. BRIGHT WILSON, JR., AN INTRODUCTION TO SCIENTIFIC RESEARCH 25–28, 44 (1952).

34. *See* MICHAEL HARRIS & GORDON TAYLOR, MEDICAL STATISTICS MADE EASY 27 (2003).

performing experiments on prisoners have resulted in documents and directives from the Nuremberg Trials<sup>35</sup> and the Declaration of Helsinki<sup>36</sup> in order to protect against involuntary and harmful subject participation. In the Code of Federal Regulations, any experiment protocol that uses prisoners as research subjects and is generated under the Department of Health and Human Services must, at a minimum, personally benefit the prisoner.<sup>37</sup> It would be a dangerous claim to suggest that, as a rule, prisoners would benefit from their own death.

With the loss of sodium thiopental, states have sought alternatives allowed by *Baze*.<sup>38</sup> The question remains: On what scientific principle can substitutions occur? Substitution would not only require an understanding of the drugs, but also a test of the change. If a drug substitution in lethal injection was evaluated according to science, the trial would ideally involve a prospective analysis,<sup>39</sup> employ the blinding of all the participants including impartial observers,<sup>40</sup> be subject to a power analysis,<sup>41</sup> establish a p-value, and be subject to statistical review to eliminate a result attributed to chance alone.<sup>42</sup> An institutional review board, or some body capa-

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35. 2 TRIALS OF WAR CRIMINALS BEFORE THE NUERNBERG MILITARY TRIBUNALS 181 (1949).

36. WORLD MED. ASS'N, DECLARATION OF HELSINKI—ETHICAL PRINCIPLES FOR MEDICAL RESEARCH INVOLVING HUMAN SUBJECTS 5 (2013), available at [http://www.wma.net/en/30publications/10policies/b3/index.html.pdf?print-media-type&footer-right=\[page\]/\[toPage\]](http://www.wma.net/en/30publications/10policies/b3/index.html.pdf?print-media-type&footer-right=[page]/[toPage]).

37. Permitted Research Involving Prisoners, 45 C.F.R. § 46.306(a)(iv) (2014).

38. See Emma Marris, *Death-Row Drug Dilemma*, NATURE (Jan. 27, 2011), <http://www.nature.com/news/2011/110121/full/news.2011.53.html>.

39. A prospective analysis is one in which none of the subjects of the study have developed the outcomes of interest before the study begins. Wayne W. LaMorte, *Prospective and Retrospective Cohort Studies*, OVERVIEW OF ANALYTIC STUDIES, [http://sphweb.bumc.bu.edu/otlt/MPH-Modules/EP/EP713\\_AnalyticOverview/EP713\\_AnalyticOverview3.html](http://sphweb.bumc.bu.edu/otlt/MPH-Modules/EP/EP713_AnalyticOverview/EP713_AnalyticOverview3.html) (last updated Jan. 22, 2015). In that way, the study can be designed to answer a specific question. *Id.*

40. Charles Warlow, *Comparing Like With Like and the Development of Randomisation—Goodbye Anecdotes*, in CLINICAL TRIALS 1, 4 (Lelia Duley & Barbara Farrell eds., 2002). Blinding prevents those involved in the study from being influenced by any conscious or unconscious bias. *Id.*

41. *Statistical Computing Seminars: Introduction to Power Analysis*, INST. DIGITAL RES. & EDUC., [http://www.ats.ucla.edu/stat/seminars/Intro\\_power/](http://www.ats.ucla.edu/stat/seminars/Intro_power/) (last visited Feb. 27, 2015) (“A power analysis is a good way of making sure that you have thought through every aspect of the study and the statistical analysis before you start collecting data.”). The “power” of a study is the probability of rejecting a null hypothesis that is actually false. *Id.*

42. P-value is the probability that an observed difference in a study happened by chance and is used to show the likelihood that a hypothesis is true. HARRIS & TAYLOR, *supra* note 34, at 24. “The lower the P value, the less likely it is that the difference happened

ble of ethical and methodological evaluation, must first approve any experiment.<sup>43</sup>

In reality, chemicals are changed up until the last minute before an execution, based on availability more than efficacy.<sup>44</sup> Personnel are inconsistently screened, facilities are poorly designed, and record keeping is inconsistent and unreliable.<sup>45</sup> Attempts to gain information about the details of lethal injection in order to critically evaluate methodology are met with resistance, or worse, the passing of secrecy laws that constrain medical board oversight.<sup>46</sup> The charge of a medical board is to regulate the practice of medicine, including the scientific practice, while acting in the public interest.<sup>47</sup>

Secrecy laws exclude medical practitioners that participate in lethal injection from medical board oversight.<sup>48</sup> In effect, secrecy laws empower the state as the authority on the science of medicine as applied to capital punishment. This cannot stand.

The real problem with lethal injection is that it can never pass through the filter of science as it is impossible to conduct ethical experiments involving lethal injection.<sup>49</sup> During World War II, Nazi scientists carried out hypothermia experiments on concen-

by chance and so the higher the significance of the finding.” *Id.* at 25.

43. Barbara Farrell & Patsy Spark, *Building Resources for Randomised Trials*, in CLINICAL TRIALS 81, 86 (Lelia Duley & Barbara Farrell eds., 2002).

44. See Press Release, Arizona Death Row Prisoners Sue State Officials Alleging Human Experimentation in Executions (June 26, 2014), available at <http://www.deathpenaltyinfo.org/documents/az627.pdf>.

45. K.W. PRUNTY, JR. ET AL., STATE OF CAL. DEPT’ OF CORR. & REHAB., LETHAL INJECTION PROTOCOL REV. 1 (2007).

46. See *Glance: Execution Drug Secrecy in 5 States*, ASSOC. PRESS (Apr. 5, 2014, 10:56 AM), <http://bigstory.ap.org/article/glance-execution-drug-secrecy-5-states-1>.

47. See, e.g., MED. BD. OF CALIF., <http://www.mbc.ca.gov/> (last visited Feb. 27, 2015) (stating that the mission of the Medical Board of California “is to protect health care consumers through the proper licensing and regulation of physicians and surgeons and certain allied health care professions”); STATE MED. BD. OF OHIO, <http://www.med.ohio.gov/> (last visited Feb. 27, 2015) (stating its mission “[t]o protect and enhance the health and safety of the public through effective medical regulation”).

48. See Maurice Chammah, *Ohio’s New Frontier in Secrecy*, MARSHALL PROJECT (Dec. 1, 2014, 7:41 AM), <https://www.themarshallproject.org/2014/12/01/ohio-s-new-frontier-in-secrecy>; Andrew Cohen, *New ‘Injection Secrecy’ Law Threatens First Amendment Rights in Georgia*, COLUM. JOURNALISM REV. (July 17, 2013, 2:55 PM), [http://www.cjr.org/behind\\_the\\_news/georgia\\_lethal\\_injections\\_shie.php](http://www.cjr.org/behind_the_news/georgia_lethal_injections_shie.php).

49. Cf. Leonidas G. Koniaris et al., *Ethical Implications of Modifying Lethal Injection Protocols*, 5 PLoS MED. 845, 848 (2008), available at <http://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.0050126>.

tration camp prisoners.<sup>50</sup> After the war, much was made regarding whether such research could be cited in the scholarly literature.<sup>51</sup> Because the Nazis forced participation on prisoners—rather than utilizing volunteers—ethics should preclude the use of the data they produced. Separate from any ethical failing, these experiments were also determined to be methodologically flawed.<sup>52</sup> Lethal injection clearly lacks voluntary participation and is also bad science. No amount of adjusting will make it any better. It should be relegated to the scrap heap of dangerous pseudoscience.

## II. THE ROLE OF PHYSICIANS

### A. *Inmates Have a Constitutional Right to Health Care*

Inmates have a constitutional right to health care.<sup>53</sup> Prison officials are legally obligated to provide inmates health care until the prisoner is released, dies a natural death, or is executed.<sup>54</sup> Prison officials may not withhold health care out of neglect or in order to bring about a de facto execution.<sup>55</sup> Analytically, a nearly instantaneous death would protect the prisoner from unnecessary cruelty. An inmate who survives an execution but suffers injuries must receive medical treatment.<sup>56</sup> The failure by prison officials to provide adequate medical care in these circumstances may also violate the state law of some jurisdictions, Eighth Amendment concerns aside.<sup>57</sup>

### B. *The Moral Obligation of Physicians*

As the stewards of the practice of medicine, physicians have a moral obligation to object to lethal injection. The physicians con-

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50. Robert L. Berger, *Nazi Science—The Dachau Hypothermia Experiments*, 322 NEW ENG. J. MED. 1435, 1435 (1990).

51. *See id.*

52. *See id.* at 1439–40.

53. *See Estelle v. Gamble*, 429 U.S. 97, 103–04 (1976) (citing *Gregg v. Georgia*, 428 U.S. 153, 173 (1976)).

54. *See id.* at 103.

55. *See id.* at 104–05 (citing *Gregg*, 428 U.S. at 173).

56. *See id.* at 103.

57. *See, e.g.*, CAL. PENAL CODE § 673 (West 2009).



trol the tools of the medical trade and protect the public interest. Lethal injection is a method of execution that repurposes chemicals developed to treat diseases and uses them for killing.

The process of lethal injection intentionally mimics a medical procedure, thereby deceiving physicians who imagine a medically necessary role, and the public which imagines safe oversight. In the hands of the state, lethal injection disguises killing as healing. The practice of medicine is fundamentally about the ethical treatment of illness.<sup>58</sup> Every medical act must first be filtered through an ethical model to be certain that the harm done does not exceed the benefit received.<sup>59</sup> For the physician in the execution chamber, a traditional defense claims that a doctor's knowledge and practice will reduce the suffering of the condemned.<sup>60</sup> This claim will be false.

Suffering is not the same as pain and not all pain is malevolent.<sup>61</sup> Doctors have a duty to act against maleficence and in the interest of beneficence but this directive is bounded within the doctor-patient relationship.<sup>62</sup> Fundamentally, lethal injection blurs the lines between the doctor as a citizen and the doctor as a doctor. Does the act of lethal injection turn an inmate into a patient? If the inmate is a patient, the doctor's duty is to save his life, not take it.<sup>63</sup> If the inmate is not a patient then the doctor has no role beyond that of a citizen.<sup>64</sup> Can a doctor use what he knows

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58. See *Principles of Medical Ethics*, AM. MED. ASS'N (revised June 2001), <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/principles-medical-ethics.page>? (“The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient.”).

59. See *id.*; Bryan A. Liang & Arthur M. Boudreaux, *Special Doctor's Docket. Lethal Injection: Policy Considerations for Medicine*, 18 J. CLINICAL ANESTHESIA 466, 467, 469 (2006).

60. See Liang & Boudreaux, *supra* note 59, at 468, 469.

61. See Wilbert E. Fordyce, *Pain and Suffering: A Reappraisal*, 43 AM. PSYCHOLOGIST 276, 278 (1988) (noting that pain arises from the stimulation of perceived nociception, and suffering is “an affective or emotional response in the central nervous system, triggered by nociception or other aversive events. . .”). Nociception is “mechanical, thermal, or chemical energy impinging on specialized nerved endings . . . thus initiating a signal to the central nervous system that aversive events are occurring.” *Id.*

62. See *Opinion 10.01—Fundamental Elements of the Patient-Physician Relationship*, AM. MED. ASS'N (last updated 1993), available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion1001.page>; Lee Black & Robert M. Sade, *Lethal Injection and Physicians: State Law vs. Medical Ethics*, 298 J. AM. MED. ASS'N 2779, 2780 (2007).

63. See *Principles of Medical Ethics*, *supra* note 58.

64. See *id.* (“A physician shall, in the provision of appropriate patient care, except in

and what he does in his capacity as a medical practitioner to claim an exemption that permits him to use his skill and yet is not the practice of medicine? The state softly declares that lethal injection is not the practice of medicine yet demands the presence of the physician.<sup>65</sup>

### III. STATES MEDICALIZE LETHAL INJECTION

The state medicalizes lethal injection in two distinct ways, yet claims that lethal injection is not a medical act. First, it demands the presence of physicians in the execution chamber and compels them to perform tasks that have the look and feel of medical acts.<sup>66</sup> Doctors wear white coats and carry stethoscopes in the execution chamber. The use of the white coat is specious and egregious here. Second, the state attempts to turn the inmate into a patient, which serves the dual purpose of drawing the doctor in, but also employing ethical notions of the doctor-patient relationship in a manner that turns the concept of consent upside down.<sup>67</sup>

#### A. *Consent and Do Not Resuscitate Orders*

Central to the doctor-patient relationship is the concept of consent.<sup>68</sup> Can an inmate facing his execution be said to have consented? Is execution a treatment to cure a wrongful act? In Missouri, death-row inmate Russell Bucklew was asked to sign a do not resuscitate (“DNR”) order.<sup>69</sup> For a DNR to be valid, a moral agent must request it.<sup>70</sup> A prisoner is a person and apart from

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emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care.”)

65. See, e.g., Black & Sade, *supra* note 62, at 2779 (“Georgia law stipulates that physicians who participate in executions are not practicing medicine. . .”).

66. See *id.*; see also *supra* Part II.B.

67. See Dennis Curry, *Lethal Injection and Medical Ethics: Physicians in the Execution Chamber*, 2 HARV. MED. STUDENT REV. 39, 39 (2015).

68. See Lawrence Nelson & Brandon Ashby, *Rethinking the Ethics of Physician Participation in Lethal Injection Execution*, 41 HASTINGS CTR. REP. 28, 32 (2011).

69. Personal communication with Russell Bucklew (May 2014) (on file with author).

70. See *Opinion 2.2—Do-Not-Resuscitate Orders*, AM. MED. ASS’N (last updated Nov. 2005), available at [www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion222.page](http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion222.page); Carol Ann Mooney, *Deciding Not to Resuscitate Hospital Patients: Medical and Legal Perspectives*, 1986 U. ILL. L. REV. 1025, 1034. A physician ignoring a person’s right to bodily self-determination implies the patient’s “moral and ethical beliefs are secondary to his objectively-determined physical well-being.” See *id.* at

physical constraint imposed as a consequence of incarceration, inmate moral agency should be assumed. However, this assumption requires further analysis. The mental health toll on incarceration cannot be understated.<sup>71</sup> In the circumstance of depression, doctors routinely weigh requests about treatment choices against that backdrop of the patient/inmate affect.<sup>72</sup> If a patient/inmate refuses treatment, leading to his death, how can the validity of his agency be considered?

If prisoners choose to sign a DNR, and that request is not contained within an advance directive document, it has the appearance of suicide. Advance directives are generated by a moral agent with the purpose of affirming autonomy in anticipation of a circumstance when further decisionmaking capacity is lost.<sup>73</sup> Advance directives are put forward as a legal right, recognized by all fifty states and the District of Columbia and, if so, impose a corollary duty of action on the part of others, including friends, families, and health care providers.<sup>74</sup> Advance directives include the designation of a person or persons to be the substitute decision-maker (“SDM”) in the place of the person when they are unable.<sup>75</sup> The person or persons, designated as the SDM provides a critical element to the advance directive by turning the advance-directive document into something fluid and adaptable to the circumstance at hand.<sup>76</sup> The SDM named by the patient may be a spouse, adult child, sibling, close friend, or religious advisor, but not a treating physician.<sup>77</sup> A corrections officer or prison warden would be under the same clear conflict as a treating physician and cannot be the SDM.<sup>78</sup> Ultimately, a DNR order, as an autonomous request made

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1080–81.

71. See, e.g., Seena Fazel & John Danesh, *Serious Mental Disorder in 23,000 Prisoners: A Systematic Review of 62 Surveys*, 359 LANCET 545, 545, 548 (2002).

72. FED. BUREAU OF PRISONS, MANAGEMENT OF MAJOR DEPRESSIVE DISORDER 7 (2014).

73. ANNE WILKINSON ET AL., LITERATURE REVIEW ON ADVANCE DIRECTIVES 1 (2007).

74. *Id.*; see also Charles P. Sabatino, *10 Legal Myths About Advance Medical Directives*, in ABA COMM’N ON LEGAL PROBLEMS OF THE ELDERLY 2, available at <http://www.ruralinstitute.umt.edu/transition/Handouts/10LegalMyths.pdf> (last visited Feb. 27, 2015).

75. WILKINSON ET AL., *supra* note 73, at 1.

76. *Id.* at 3, 11.

77. See, e.g., 12 VA. ADMIN. CODE § 35-115-146 (2010); N.H. CODE ADMIN. R. ANN. 137-J:8 (2014).

78. See M. Scott Smith et al., *Healthcare Decision-Making for Mentally Incapacitated Incarcerated Individuals*, 22 ELDER L.J. 175, 197–99 (2014) [hereinafter Smith et al.,

by a moral agent, can only be understood in the circumstance of the timing of death when death otherwise occurs naturally.<sup>79</sup>

### B. *DNRs and Inmates' Right to Healthcare While Incarcerated*

Execution is not a natural death and DNR in this context nefariously serves the interests of prison officials for a very specific reason. Inmates have a constitutional right to healthcare and the warden is under a legal duty to provide it up until the moment the prisoner dies a natural death or is executed.<sup>80</sup> A prisoner condemned to death cannot be executed by stealth or neglect.<sup>81</sup> Capital punishment cannot be brought about in consequence of withholding necessary health care.<sup>82</sup> Nor can it occur by the infliction of sub-lethal injuries that, in the course of time, are expected to worsen and cause death.

Analytically, a death brought about nearly instantaneously eliminates subjective unnecessary cruelty. An inmate who survives an execution but suffers sub-lethal injuries that without treatment will or may lead to death or disability is again entitled to healthcare and the warden is under a duty to provide it.<sup>83</sup> Therefore, an execution must cause nearly instant death and if the execution fails, the inmate must be substantially free of risk of disabling injuries or pain due to the failed execution, or medical intervention must be immediately available to reduce that risk.<sup>84</sup> If an inmate survives an execution attempt, the constitutional duty requiring the delivery of necessary health care is re-

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*Healthcare Decision-Making*] (“[J]ust as fear of malpractice litigation can often influence a physician’s treatment decisions, a prison administrator’s decisions regarding treatment may be influenced by the fear of litigation.”).

79. See *infra* Part III.B.

80. See *Estelle v. Gamble*, 429 U.S. 97, 104–05 (1976); Smith et al., *Healthcare Decision-Making*, *supra* note 78, at 197.

81. See *Estelle*, 429 U.S. at 104–05 (concluding that “deliberate indifference to serious medical needs of prisoners” is prohibited by the Eighth Amendment); see also *Baze v. Rees*, 553 U.S. 35, 48–49 (2008) (noting that forbidden methods of execution are those that add “pain to the death sentence through torture or the like”).

82. See *Estelle*, 429 U.S. at 104–05.

83. *Id.* (“[D]eliberate indifference to serious medical needs of prisoners . . . [is] proscribed by the Eighth Amendment. This is true whether the indifference is manifested by prison doctors in their response to the prisoner’s needs or by prison guards in intentionally denying or delaying access to medical care. . . .”).

84. *Id.*

vived.<sup>85</sup> Execution is a form of killing; however, in the setting of an execution, if an inmate is killed or dies, it is not necessarily a result of execution.<sup>86</sup>

Execution, as a method of killing is a bounded concept not defined by death alone.<sup>87</sup> The definition of killing by execution warrants analysis. To be lawful, an execution should be timely, that is, the execution itself cannot be expected to require a protracted amount of time.<sup>88</sup> In 1996, the United States Court of Appeals for the Ninth Circuit declared the gas chamber to be an unconstitutional method of execution and sited the length of time necessary to complete the execution as a cause of unnecessary cruelty.<sup>89</sup>

Recently, a few executions in the United States have not gone as predicted.<sup>90</sup> If an execution is “botched,” the suggestion is made that it can be improved. However, if an inmate is DNR, a botched execution only occurs if the inmate fails to die.<sup>91</sup> If the inmate is

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85. See Smith et al., *Healthcare Decision-Making*, *supra* note 78, at 197 (“Prison administrators are obligated to provide adequate medical treatment to prisoners in their custody.”).

86. See e.g., Cary Aspinwall, *Inmate Clayton Lockett Dies of Heart Attack After Botched Execution; Second Execution Postponed*, TULSA WORLD (Apr. 30, 2014, 12:00 AM), [http://www.tulsaworld.com/news/state/inmate-clayton-lockett-dies-of-heart-attack-after-botched-execution/article\\_80cc060a-cff2-11e3-967c-0017a43b2370.html](http://www.tulsaworld.com/news/state/inmate-clayton-lockett-dies-of-heart-attack-after-botched-execution/article_80cc060a-cff2-11e3-967c-0017a43b2370.html) (indicating Clayton Lockett died during execution as a result of a massive heart attack).

87. See Austin Sarat, *What Botched Executions Tell Us About the Death Penalty*, BOS. GLOBE (Apr. 5, 2014) (suggesting that executions are partly about technology making a final punishment less painful); see also *Execution Definition*, WEBSTER’S NEW WORLD DICTIONARY 490 (2d ed. 1980) (demonstrating that execution by definition includes death and a legal sentence).

88. See *Fierro v. Gomez*, 77 F.3d 301, 308 (9th Cir. 1996) (stating that the risk an execution will last for several minutes is enough to violate the Eighth Amendment); see also *People v. Stewart*, 520 N.E.2d 348, 358 (Ill. 1988) (indicating that unnecessary pain is unlawful if protracted for an extended period).

89. *Fierro*, 77 F.3d at 309.

90. See Mark Berman, *Inmate Dies Following Botched Oklahoma Execution, Second Execution Delayed*, WASH. POST (Apr. 29, 2014), <http://www.washingtonpost.com/news/post-nation/wp/2014/04/29/oklahoma-execution-botched-inmate-still-dies-second-execution-delayed/> (stating that inmate Clayton Lockett’s execution was botched); see also Mark Berman, *Execution Takes Nearly Two Hours*, WASH. POST, July 24, 2014, at A3 (stating that inmate Joseph Wood gasped and snorted for air while taking nearly two hours to die); Mark Berman, *The Recent History of States Scrambling to Keep Using Lethal Injections*, WASH. POST (Feb. 19, 2014), <http://www.washingtonpost.com/news/post-nation/wp/2014/02/19/the-recent-history-of-states-scrambling-to-keep-using-lethal-injections/> (stating that inmate Dennis McGuire took nearly twenty-five minutes to die and choked several minutes before dying).

91. Cf. *So Long as They Die: Lethal Injections in the United States*, 18 HUM. RTS. WATCH, 1, 46, 53 (2006) [hereinafter *So Long as They Die*] (suggesting that Clarence Ray Allen’s execution was botched even though he eventually died); see also Don Thompson,

not dead but merely dying, a DNR order may constrain resuscitation.<sup>92</sup>

The execution of Clayton Lockett in Oklahoma illustrates this point.<sup>93</sup> Oklahoma execution protocol requires the placing of intravenous catheters for the purpose of delivering the chemicals.<sup>94</sup> Technically, this action can be challenging and in Lockett's case the catheters were inserted improperly.<sup>95</sup> As the chemicals were infused, the inmate began to complain of distress.<sup>96</sup> An exchange took place between prison officials and those on the execution team when it became clear that Lockett had not died as anticipated.<sup>97</sup> A question was asked if more medication was available to deliver an additional dose.<sup>98</sup>

Forty-three minutes after the execution began, it was announced that Lockett died of a "massive heart attack."<sup>99</sup> Two points are worth noting: (1) the diagnosis of a "massive heart attack" is not a term of art, and (2) a diagnosis of a heart attack of any degree cannot be made without a laboratory to evaluate spe-

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*Death Row's Oldest Executed*, DAILYNEWS (Jan. 17, 2006, 12:01 AM), <http://www.dailynews.com/general-news/20060117/death-rows-oldest-executed> (stating that executed inmate Clarence Ray Allen had a DNR order).

92. See e.g., *Op-140138, Offender Living Will/Advance Directive for Health Care and Do Not Resuscitate (DNR) Consent*, OKLA. DEP'T. OF CORR. (2014) (indicating that a DNR order provides that an inmate cannot receive CPR if the heart stops beating).

93. See Erik Eckholm, *IV Misplaced in Oklahoma Execution, Report Says*, N.Y. TIMES, Sept. 5, 2014, at A14 (stating that after Clayton Lockett's execution was called off, no steps were taken to provide emergency resuscitation as the inmate's heart failed).

94. See *Oklahoma Execution Protocol Calls for Specific Procedure*, NEWSOK (May 1, 2014), <http://newsok.com/oklahoma-execution-protocol-calls-for-specific-procedure/article/4744678> (indicating Oklahoma execution protocol calls for IV catheter to administer the drugs).

95. See Jessica Glenza, *Autopsy on Oklahoma Death Row Inmate Shows IV Not Inserted Correctly*, GUARDIAN (June 13, 2014, 12:48 PM), <http://www.theguardian.com/world/2014/jun/13/autopsy-oklahoma-death-row-inmate-clayton-lockett> (stating that the intravenous needles were not inserted correctly); see also *So Long as They Die*, *supra* note 91, at 3 (stating that inserting an intravenous catheter can be difficult if veins have been compromised).

96. See Katie Fretland, *Clayton Lockett Writhed and Groaned. After 43 Minutes, He Was Declared Dead*, GUARDIAN (Apr. 30, 2014, 11:19 AM), <http://www.theguardian.com/world/2014/apr/30/clayton-lockett-oklahoma-execution-witness> (reporting that Lockett lunged forward and mumbled, "Man").

97. See Erick Eckholm & John Schwartz, *Timeline Describes Frantic Scene at Execution*, N.Y. TIMES, May 2, 2014, at A1 (describing the conversation between the warden and the doctor).

98. See *id.*

99. Fretland, *supra* note 96.

cific blood work and without appropriate electrocardiogram monitoring at a minimum.<sup>100</sup> An autopsy was performed and a report was issued, “though the report does not settle the question of how Lockett died, concluding only that the cause of death was ‘judicial execution by lethal injection.’”<sup>101</sup> This execution was widely regarded as botched; that is, Lockett did not die by execution, rather he died by another method.<sup>102</sup> No evidence has been brought forward to suggest that the state attempted to resuscitate him when it was clear that the execution attempt had failed to kill him.<sup>103</sup>

If Lockett was DNR, the state could claim that no resuscitation obligation exists.<sup>104</sup> No such claim has been made. A physician was present at Lockett’s execution and made no attempt to resuscitate him.<sup>105</sup> As Lockett lay dying, not as a consequence of execution, he became a patient. The warden placed a physician in the chamber who could have acted. In that moment, the physician present was ethically obliged to attempt resuscitation.<sup>106</sup> In a hospital setting, physicians recognize a potential problem of ethical double agency when they act as both resuscitator and paliator.<sup>107</sup> The warden may have never told the physician in the execution chamber to consider that he may be required to switch roles. The

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100. See *About Heart Attacks*, AM. HEART ASS’N, [http://www.heart.org/HEARTORG/Conditions/HeartAttack/AboutHeartAttacks/About-Heart-Attacks\\_UCM\\_002038\\_Article.jsp](http://www.heart.org/HEARTORG/Conditions/HeartAttack/AboutHeartAttacks/About-Heart-Attacks_UCM_002038_Article.jsp) (last visited Feb. 27, 2015) (stating a heart attack is referred to as a myocardial infarction); *How is a Heart Attack Diagnosed?*, NAT’L HEART, LUNG, & BLOOD INST., <http://www.nhlbi.nih.gov/health/health-topics/topics/heartattack/diagnosis> (last visited Feb. 27, 2015).

101. See THE EXECUTION OF CLAYTON D. LOCKETT, OKLA. DEP’T OF PUB. SAFETY 13, available at <http://www.dps.state.ok.us/investigation/14-0189SI%20Summary.pdf> (last visited Feb. 27, 2015); Ed Pilkington, *Clayton Lockett Didn’t Die of Heart Attack, Oklahoma Official Autopsy Shows*, GUARDIAN (Aug. 28, 2014, 5:02 PM), <http://www.theguardian.com/world/2014/aug/28/clayton-lockett-official-autopsy-released>.

102. See Fretland, *supra* note 96 (explaining Lockett died from a “massive heart attack” after the execution was halted).

103. See Katie Fretland & Jessica Glenza, *Oklahoma State Report on Botched Lethal Injection Cites Medical Failures*, GUARDIAN (Sep. 4, 2014, 4:47 PM), <http://www.theguardian.com/world/2014/sep/04/oklahoma-inquiry-botched-lethal-injection-clayton-lockett>.

104. See *Do-Not-Resuscitate Order*, U.S. NAT’L LIBRARY MED., <http://www.nlm.nih.gov/medlineplus/ency/patientinstructions/000473.htm> (last visited Feb. 27, 2015).

105. See Fretland & Glenza, *supra* note 103.

106. See *Ethical Issues of Resuscitation*, AM. C. EMERGENCY PHYSICIANS, <http://www.acep.org/Clinical---Practice-Management/Ethical-Issues-of-Resuscitation/> (last visited Feb. 27, 2015).

107. See, e.g., Tony Back, *Ethics in Medicine*, U. WASH. SCH. MED., <https://depts.washington.edu/bioethx/topics/eol.html> (last visited Feb. 27, 2015) (discussing the ethical dilemma between preservation of life and a patient’s plan for care).

execution chamber is so far removed from a therapeutic environment that a physician's normal bioethical inclinations are subverted.

Ethical conduct is benefited by context. Physicians need the support of colleagues and a setting conducive to healing to promote proper bioethical values. This created setting leads and misleads. Lethal injection employs terminology and equipment that falsely suggests a medical setting and encourages the physician to participate.<sup>108</sup> In Lockett's case, the therapeutic façade quickly evaporated and the result was a cruel death witnessed by a doctor.

The Lockett case demonstrates a further ethical dilemma. On the day of the execution, the inmate refused to be removed from his cell.<sup>109</sup> In response, the corrections officers used a Taser—an electronic shock device—to disable him so that he could be extracted.<sup>110</sup> Upon examination, medical staff discovered a laceration on Lockett's arm.<sup>111</sup> An evaluation determined that the laceration did not require sutures.<sup>112</sup> One may ask why officials would consider suturing a laceration hours before an execution. In so doing, the state acknowledges its duty to deliver healthcare to the inmate up until the execution.<sup>113</sup> In the case of Lockett's injury, a doctor-patient relationship could be imagined. In that moment, a doctor's ethical duty to deliver treatment existed, but an additional conflict could be imagined.

In a deontological construct, a doctor's duty consists of following rules that, to a degree, internally conflict with one another.<sup>114</sup>

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108. See Joel B. Zivot, *The Absence of Cruelty Is Not the Presence of Humanness: Physicians and the Death Penalty in the United States*, 7 PHIL., ETHICS, & HUMAN MED. 13 (2012), available at <http://www.peh-med.com/content/7/1/13>.

109. Michael McLaughlin, *Clayton Lockett Was Tasered on the Day of His Execution*, HUFFINGTON POST (May 1, 2014, 6:54 PM), [http://www.huffingtonpost.com/2014/05/01/clayton-lockett-taser-execution\\_n\\_5249690.html](http://www.huffingtonpost.com/2014/05/01/clayton-lockett-taser-execution_n_5249690.html).

110. *Id.*

111. Letter from Robert Patton, Dir., Okla. Dep't of Corr., to Mary Fallin, Governor, State of Okla. (May 1, 2014), available at <https://www.documentcloud.org/documents/1151378-5-1-14-doc-letter-re-clayton-lockett.html>.

112. *Id.*

113. See *Estelle v. Gamble*, 429 U.S. 97, 103 (1976) (discussing the government's duty to provide medical services to the incarcerated).

114. Compare Cedric M. Smith, *Origin and Uses of Primum Non Nocere—Above All, Do No Harm!*, 45 J. CLINICAL PHARMACOLOGY 371, 375 (2005) (discussing the origin of “do no harm” as a “general maxim for medical practice”) (citations omitted), with B.P. White et



The directive to first avoid malevolence might conflict with beneficence. It is necessary, on occasion, to first cause harm to produce a greater good. The physician draws right conduct from the combination of these rules filtered through a “greatest good” standard. In the hand of the physician, conduct is aspirational and practical. At the apex of right conduct is the directive to do no harm.<sup>115</sup> It is the first rule from which all other rules and decisions follow.

### C. *Physicians Caring for Inmates Headed for Execution*

In the case of a physician who cares for an injured inmate destined for execution, what is the endpoint and whose interests are served? As a model, consider the rule of double effect.<sup>116</sup> This rule distinguishes between intended effects and foreseen effects.<sup>117</sup> In a circumstance where an action brings about two results—one good and one harmful—the rule suggests that such an arrangement is not always morally wrong.<sup>118</sup> A physician may claim that the care rendered to an injured or ill inmate who will soon be executed satisfies the directive to restore health and act with beneficence.

The traditional application of the rule of double effect involves providing pain relief at the end of life. A physician never intends to shorten that life.<sup>119</sup> Death occurs naturally. A physician called to care for an inmate does not intend to cause death as a result of treatment, but in effect, the primary purpose for treatment is to make the inmate medically fit for execution. As an extreme example, if an inmate attempts suicide prior to his execution, the physician is under an obligation to resuscitate him.<sup>120</sup>

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al., *Palliative Care, Double Effect, and the Law in Australia*, 41 INTERNAL MED. J. 485, 486 (2011) (discussing the palliative care industry’s acceptance of the doctrine of double effect, in which “an act performed with good intent can still be moral despite negative side-effects”).

115. Cf. Smith, *supra* note 114, at 374–75 (examining the use and meaning of the phrase “above all, do no harm” but disputing its sufficiency as a guideline for medical ethics).

116. Joseph T. Mangan, *An Historical Analysis of the Principle of Double Effect*, 10 THEOLOGICAL STUD. 41, 43 (1949).

117. *Id.* at 42–44, 57.

118. *Id.* at 60.

119. White et al., *supra* note 114, at 486.

120. See *Estelle v. Gamble*, 429 U.S. 97, 103 (1976) (discussing the government’s duty to provide medical services to the incarcerated).

Capital punishment does not provide the inmate with an option of suicide. In the case of Russell Bucklew, the Supreme Court temporarily stayed his execution at the last moment over concerns that a health-related issue would render lethal injection needlessly cruel.<sup>121</sup> Bucklew suffers from congenital cavernous hemangiomas of the face and airways.<sup>122</sup> His vascular tumors continue to expand and could cause choking or hemorrhaging during his execution.<sup>123</sup> The Supreme Court ruled that the lower court erred when it set aside unchallenged physician testimony that first raised these concerns.<sup>124</sup> In effect, the Court determined Bucklew was too sick to execute.<sup>125</sup> The question now remains on how Bucklew will be treated presently in order to be executed later.<sup>126</sup>

In Bucklew's case, his facial tumors cannot be removed and the only recourse to maintain a patent airway would be to perform a tracheostomy on him.<sup>127</sup> If Bucklew is compelled to undergo such a medical procedure and he refuses to consent, can the procedure be forced upon him? If a doctor performs the procedure without consent and a complication, as a result of negligence, arises, does Bucklew now have a claim against the doctor? A perfect outcome would now make Bucklew fit for his own death by execution. Under the normal ethical practice of medicine, no such treatment could take place. A physician still may be identified who would be willing to perform a tracheostomy. To lay the blame exclusively at the feet of physicians for wayward ethical conduct would be incorrect. Governments obfuscate on matters of medical ethics and seem to send mixed messages to the physician and the public they

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121. *Bucklew v. Lombardi*, \_\_\_ U.S. \_\_\_, \_\_\_, 134 S. Ct. 2333, 2333 (2014); Lyle Denniston, *Execution Delayed in Unusual Case*, SCOTUSBLOG (May 21, 2014, 10:58 PM), <http://www.scotusblog.com/2014/05/execution-delayed-in-unusual-case/>.

122. See Denniston, *supra* note 121. See generally T.N. Sas & N. Boutsiadis, *Facial Hemangiomas Diagnosis*, 36 CURRENT HEALTH & SCI. J. 166 (2010) (describing facial hemangiomas).

123. Declaration of Joel B. Zivot (May 8, 2014) (on file with author).

124. See *Bucklew v. Lombardi*, 565 F. App'x 562, 566, 571 (8th Cir. 2014) (en banc) (including testimony by Dr. Zivot stating "it is my opinion that a substantial risk exists that, during the execution, Mr. Bucklew will suffer from extreme or excruciating pain as a result of hemorrhaging or abnormal circulation of the lethal drug, leading to a prolonged execution").

125. *Id.* at 564.

126. *Id.* at 568.

127. *Id.* at 565.

serve. State governments have overridden medical board ethical directives and have successfully prevented the disciplining of physicians who participate in the death penalty.<sup>128</sup>

### CONCLUSION

Botched executions disturb the public and the state, leading to calls for change. Lethal injection as a form of execution now sits at the crossroads. Some argue that the way forward is further lethal injection refinement. That is, lethal injection will benefit from an increased physician presence, charged anew, with making it right. A group of legal professionals known as the Death Penalty Committee of the Constitution Project (the “Death Penalty Committee”) was recently convened.<sup>129</sup> The Death Penalty Committee generated a list of thirty-nine recommendations intended to resolve problems with lethal injection as the method of execution for capital punishment.<sup>130</sup>

The Death Penalty Committee’s final recommendation calls for the presence of qualified medical personnel at every lethal injection execution to ensure that the medically related elements are properly conducted.<sup>131</sup> This astonishing conclusion needs careful analysis. It remains entirely unresolved as to what constitutes successful lethal injection beyond the presence of the killing of the inmate. We cannot improve what we cannot define. Further, the Death Penalty Committee lacks the credentials to direct medical practitioners under the normal practice of medicine.<sup>132</sup> It suggests that physicians should be responsible for all future lethal injection executions.<sup>133</sup> By setting the physician as the responsible party here, it is conceivable that an inmate or his estate might have a claim of negligence against a physician if the execution

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128. Zivot, *supra* note 108, at 13.

129. Robert D. Truog et al., *Physician, Medical Ethics, and Execution by Lethal Injection*, 311 JAMA 2375 (2014).

130. *Id.*

131. IRREVERSIBLE ERROR: RECOMMENDED REFORMS FOR PREVENTING AND CORRECTING ERRORS IN THE ADMINISTRATION OF CAPITAL PUNISHMENT, CONST. PROJECT 143 (2014), available at [http://www.constitutionproject.org/wp-content/uploads/2014/06/Irreversible-Error\\_FINAL.pdf](http://www.constitutionproject.org/wp-content/uploads/2014/06/Irreversible-Error_FINAL.pdf).

132. See *About Us*, CONST. PROJECT, <http://www.constitutionproject.org/about-us/> (last visited Feb. 27, 2015) (indicating that they are essentially a lobby group and not experts in the medical field).

133. IRREVERSIBLE ERROR, *supra* note 131, at 143.

should occur outside of some sort of standard. The practice of medicine is self-regulated and it rests with medical boards empowered to set the standards and protect the public.<sup>134</sup> The Death Penalty Committee lacks a mandate here and demonstrates a lack of understanding of ethical medical practice by tasking physicians in this way.<sup>135</sup>

The ethical practice of medicine means to hold oneself out to the public as being engaged in the diagnosis or treatment of diseases, defects, or injuries of human beings.<sup>136</sup> Life is not a disease cured by death and killing is not a medical act. Lethal injection cannot be further refined by the presence of medicine, in fact, the opposite is true. When lethal injection failed to kill Lockett, did he not become entitled to medical care in order to resuscitate him? Why has there been no public investigation of this homicide? Was a crime committed by the failure to resuscitate? Lethal injection, as the method to carry out execution, creates an unresolvable dilemma for the ethical practice of medicine and perhaps for the legal regime on which it rests. If physicians and medicine have any role here, it is in the role of the ethical practice of medicine, that is, as a resuscitator, not an executioner.

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134. See Drew Carlson & James N. Thompson, *The Role of State Medical Boards*, 7 *AMA J. ETHICS* (Apr. 2005), <http://journalofethics.ama-assn.org/2005/04/pfor1-0504.html>.

135. See *generally id.* (identifying the related duties of physicians and medical boards, thereby clarifying the lack of understanding demonstrated by the Death Penalty Committee of the Constitution Project).

136. See *Rodriguez v. Krancer*, 984 F. Supp. 2d 356, 358–59 (M.D. Pa. 2013).