BETWEEN MEDICINE AND PUNISHMENT: ESSAYS IN CORRECTIONAL HEALTHCARE ETHICS

by

DAVID LANDON BOWLES

(Under the Direction of Melissa Seymour Fahmy)

ABSTRACT

This thesis consists of two separate essays that explore various issues with the ethical treatment of criminal offenders in correctional healthcare. The first essay defends the notion that some physician participation in capital punishment is morally impermissible. It is argued that while appeals to traditional principles of medical ethics and complicity in capital punishment fail to provide a persuasive argument for prohibiting the practice, a better argument can be found in one's duty to practice moral caution whenever possible. I discuss how certain epistemic standards lead to prohibiting physician participation broadly over the medical community. The second essay enters previously unexplored territory in criminal justice ethics by connecting environmental, criminal, and medical ethics. I argue that prisoners in the U.S face environmental injustices and have a right to be protected from associated environmental health issues in prison. I demonstrate how this is the case despite the fact that prisoners are being punished. I then discuss how the establishment of this right is relevant to medical professionals and how this creates a complex moral issue for correctional healthcare.

INDEX WORDS: Medical Ethics, Correctional Healthcare, Capital Punishment, Incarceration, Environmental Justice

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DAVID LANDON BOWLES

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DAVID LANDON BOWLES

Major Professor:	Melissa Seymour Fahmy
Committee:	Piers Stephens
	Sarah Wright

Electronic Version Approved:

Ron Walcott
Interim Dean of the Graduate School
The University of Georgia
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DEDICATION

To my wife Rebekkah, the love of my life who has continually encouraged me to pursue my passions and has been a support through my many years of studying philosophy.

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CHAPTER 1

The Epistemic Argument Against Physician Participation in Capital Punishment

Although physician participation in capital punishment has garnered less attention than other issues in medical ethics, such as physician-assisted suicide or physician participation in torture, its moral permissibility is still a pertinent, and difficult, moral issue worth addressing. Most medical associations, including The American Medical Association (AMA), prohibits all medical professionals from participating in any form of state sponsored executions. The AMA's Code of Medical Ethics (2020) states this prohibition in the following way:

> Debate over capital punishment has occurred for centuries and remains a volatile social, political, and legal issue. An individual's opinion on capital punishment is the personal moral decision of the individual. However, as a member of a profession dedicated to preserving life when there is hope of doing so, a physician must not participate in a legally authorized execution. Physician participation in execution is defined as actions that fall into one or more of the following categories: (a) Would directly cause the death of the condemned, (b) Would assist, supervise, or contribute to the ability of another individual to directly cause the death of the condemned, (c) Could automatically cause an execution to be carried out on a condemned prisoner.[1]

[1] The American Medical Association is not alone in its denunciation of physician participation in capital punishment. The American Pharmacists Association, The American Psychiatric Association (APA), The American Nurses Association (ANA), The American Board of Anesthesiologists (ABA), The American Correctional Health Services (ACHSA), National Association of Emergency Medical Technicians (NAEMT), American Academy of Physician Assistants (AAPA), and other medical associations or boards, both domestically and abroad, have all made similar claims or follow the AMA's lead on this debate. See Lethal Injection Information Center. (2019). "Professional Association Policies". https://lethalinjectioninfo.org/professional-associations-policies/#i-pap.

This means that all medical professionals are categorically and unconditionally barred from providing commonly practiced medical care during an inmate's execution whether it is merely giving technical advice or providing medical supervision during the execution, monitoring vital signs, providing tranquilizers or psychotropic medications during the procedure, or even pronouncing death (AMA, 2020). When it comes to execution through lethal injection, currently the most common method of execution in the U.S., the AMA prohibits additional actions such as selecting injection sites, starting intravenous lines as a port for a lethal injection device, and inspecting, testing, or maintaining lethal injection devices (AMA, 2020).

However, there is some difficulty in determining the ethical propriety of physician participation. The medical community's prohibition seems to be in tension with both the beliefs of practicing physicians and other morally relevant factors. First, there is wide-spread disagreement among practicing physicians regarding the moral permissibility of physician participation in state sponsored executions. Many physicians are willing to be involved in lethal injections and have no ethical qualms with some of the procedures prohibited by the AMA. In an influential and widely cited survey colloquially known as the 'Farber study', out of 413 physicians who received and responded to a survey, 41% indicated a willingness to perform at least one of the actions prohibited by the AMA and 25% were willing to perform five. Only 59% percent surveyed were not willing to take part in any of the AMA's prohibited practices during an execution (Farber, 2001). Despite the prohibition by medical organizations, the medical community is not homogenous in their stance regarding physician participation.

Second, the prohibition seems to be in conflict with the overall well-being of the condemned during their execution. The most common type of lethal injection execution is a tripartite lethal injection solution, composed of three separate agents: a barbiturate that serves as a

sedative, pancuronium bromide (a paralytic), and potassium chloride (a cardiac arrest agent). This is in spite of the fact that such a procedure was given no chance of being medically or scientifically studied on human beings before its adoption into the legislation of more than 38 states and has fewer training requirements and procedural protocols than the American Veterinary Medical Association's (AVMA) guidelines on the euthanasia of animals (Denno, 2007). This lack of medical and scientific oversight has translated into a risky execution method whose inhumanness can rival that of its predecessors. If the lethal injection is administered without complications, the inmate should not feel any pain during their execution. But there is always a substantial risk that the procedure will not go according to plan. The procedure itself is complicated and requires a great deal of medical skill in order to ensure that the inmate does not suffer before death. The individuals responsible for the lethal injection must correctly mix the sedative into appropriate concentrations, otherwise they risk the inmate retaining consciousness during the execution and suffocating without the ability to signal their duress due to the paralytic agent (Zimmers, 2007). They must also have adequate technical training on how to insert intravenous catheters for the lethal injection and competency in assessing anesthetic depth in order to determine whether or not the inmate has been fully induced before the paralytic and cardiac arrest agent can be sent through the catheter. Without the above medical capabilities – capabilities that a variety of medical professionals such as nurses, clinical physicians, or anesthesiologists possess – the condemned are at substantial risk of suffering unnecessary pain during their execution.

Lastly, the prohibition seems to be in conflict with the well-being of terminally-ill patients in need of organ transplants outside of the criminal justice system. As of 2019, there are over 113,000 men, women, and children on the national transplant waiting list, with 20 people on average dying each day waiting for a transplant and one individual being added to the waitlist

every ten minutes (HRSA, 2020). One healthy individual can donate up to twenty-five transplantable organs and tissues upon their death (Scott, 1981). The problem is that in order for posthumous donation to be possible for death-row inmates, the traditional method of lethal injection must be replaced with an alternative medical procedure. Not only does the tripartite lethal injection have a high risk of a painful death, it also precludes the possibility of posthumous organ donation for the condemned. The latter two agents, pancuronium bromide and potassium chloride are designed to stop the functioning of the heart completely, but this cardiopulmonary cessation makes valuable organs such as the heart and lungs immediately unusable for transplantation and other organs such as the kidney and liver to lose their viability shortly thereafter (Kellam, 2012).[2] This has caused some to propose alternative methods of executions in order to make their cadaveric organs viable for donation. These proposals range from anesthesia-induced executions, where the inmate would receive an overdose of anesthetic and their organs would be removed immediately after they were pronounced brain-dead (Palmer Jr. 2014)[3], to more radical proposals where death is caused after the inmate is given an unconscious state-inducing sedative before the organs are removed (Wood, 2008). These proposals, however, require substantial medical competency given that their execution would become a surgical procedure to harvest their organs. Without the active involvement of medical professionals, a relatively accessible and untapped supply of transplantable, life-saving organs is left at the wayside.

Despite the above considerations, I believe an argument can be made for the moral impermissibility of physician participation in executions; one that differs substantially from those

[2] See Shu S. Lin's argument that donations could take place in a hospital setting to mitigate some losses of transplantable organs. Lin. S. & et. al (2012). "Prisoners on Death Row Should be Accepted as Organ Donors". Annals of Thoracic Surgery. 93, 1773-1774.

[3] For a similar proposal, see Patton, L.H. (1996). "A Call for Common Sense: Organ Donation and the Executed Prisoner." Virginia Journal of Social Policy & the Law, 3 (2): 387-434.

found in the literature. Most arguments against physician participation in executions argue that their participation is an impermissible act regardless of how much medical good is promoted. Those who appeal to principles of medical ethics, such as the AMA Council of Ethical and Judicial Affairs, argue that physician participation in executions violates their professional obligations to respect human life and dignity of their patients. Others, such as Robert Veatch, rely exclusively on the normative significance of the death penalty to establish the moral permissibility of physician participation in executions. These arguments, as I will demonstrate, turn out to be unpersuasive. Instead, I propose that opponents can find adequate grounds for the impermissibility of physician participation by appealing to the wide-spread moral disagreement in the medical community regarding participation. This means that we should focus on what physicians ought to believe, given their disagreement with one another to determine the moral impermissibility of physician participation rather than determining the moral impermissibility of their participation in order to determine what physicians should believe. By applying Jonathan Matheson's Moral Caution Principle to the ethical propriety of physician participation in executions, I will argue that the epistemic significance of the disagreement between practicing physicians on this issue can establish a prohibition for some physician participation in executions based on moral risk depending on their epistemic situation. This may have far-reaching effects in the medical community depending on how informed practicing physicians are on the debate and presents a significant new challenge for proponents of physician participation or for those who are sympathetic to their cause. The most prominent voices for allowing physician participation such as Kenneth Baum argues that physicians should be permitted to participate if a physician-patient relationship is established, but this will no longer be enough in light of the epistemic argument presented here.

This essay is divided into three sections: Section I presents what I consider to be the most compelling arguments in the current literature against physician participation based on the physician's obligations as a medical professional. I will argue that they all fail to be persuasive. Section II addresses the lack of compelling evidence for the argument that physicians should not participate in lethal injection executions because they should not be complicit with unjust penal practices. Section III introduces Jonathan Matheson's Moral Caution Principle and will demonstrate how it can be used to make an epistemic argument against physician participation based on the moral risk of participating. I will also respond to a possible objection and show how it ends up supporting the epistemic argument and gives us insight into how it may apply broadly in the medical community. Finally, I will conclude with some remarks on the tension between a prohibition on physician participation and the medical needs of the condemned.

Traditional Medical Ethics: The Physician-Patient Relationship

Out of all the possible scenarios we will end up in, we can all be sure that at some point in our lives we will become sick. Illness is a fundamental vulnerability of human existence. Illness affects our ability to be autonomous agents by putting us in a debilitating state often accompanied by pain and anxiety where our time and energy are preemptively diverted towards treatment (Pellegrino, 2004). There is a need to seek medical professionals help because more often than not, illness requires expertise beyond the scope of most individual's knowledge and skills. This is the phenomenon of the physician-patient relationship where traditional medical ethics focuses its attention. Physicians, as professionals, offer effective expert assistance for the treatment of illness (Kelly, 14). But because there is a fundamental power asymmetry between the physician and patient due to the physician's expertise and the patient's reliance on their expertise to be made whole, there must be limiting conditions for physician's actions (Kelly, 14). These conditions are

centered around the formation of a relationship based on fiduciary duties between the physician and patient. By inviting those who are sick to trust them in treating their illness, physicians have obligations toward their patients because they have accepted the discretionary power to responsibly care for health or medical good (Kelly, 22). This can be interpreted as a physician having an obligation to abide by a principle of beneficence in their profession. According to this principle, physicians ought to promote the welfare of their patients (Beauchamp & Childress, 197). In the context of physician participation in capital punishment, Kenneth Baum (2002), a proponent of physician participation, invokes this principle when he compares the treatment of terminally-ill patients to those condemned to a state sponsored execution:

> Condemned death row inmates are, for all practical purposes, terminally-ill patients, albeit under a nontraditional definition of the term, and deserve to be treated as such. Therefore, physicians should do what any compassionate physician would do for a dying patient- preside over the condemned's final moments to minimize complications and suffering, and maximize the patient's comfort until the end of his life. Physicians are expected to provide these services to all others facing imminent death. Why should they deny comforting care to the condemned? (61)[4]

In many cases, physicians ought to preserve life and promote their patients' health, but this is not always possible. In many end-of-life situations the medical good of preserving life and health of terminally-ill patients is not only futile but intolerably painful and the only thing left for a physician to do is make sure their patient is not in excruciating pain upon their death. This latter aspect is especially important because death-row inmates face the risk of a "botched execution" which would result in an excruciatingly painful death. When circumstances of suffering preside, the withdrawal of life support along with the provisions of palliative care by the physician are typically

[4] See also Waisel, D. (2007). "Physician Participation in Capital Punishment". Mayo Clinic Proceedings, 82: 9, 1073-80.

seen as morally permissible despite such actions leading to, and even hastening, the patient's death. For proponents of physician participation in capital punishment, the same treatment standards apply to those in the execution chamber. According to this argument from beneficence, physician participation should be allowed by medical associations in order to provide the end-of-life care that all patients who risk suffering a painful death deserve.

Respecting Patient Autonomy and Posthumous Harm

Appealing to the relief of extreme pain and suffering upon an inmate's death has ultimately failed to persuade the opponents of physician participation. While it may be true that physician participation is compatible with their duties to alleviate suffering, physician participation in capital punishment fails other professional obligations. The AMA's Council for Ethical and Judicial Affairs (1993) makes this claim when they compare the normative significance of physician participation in withdrawing life-sustaining treatments for terminally-ill patients and their participation in a death-row inmate's execution:

> First, although death may ensue from the physician's actions, the individual patient is voluntarily choosing to risk death upon withdrawal or withhold of care. With capital punishment, the physician is causing the 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 (366).[5]

The AMA's assessment seems to draw from two well-known principles of biomedical ethics: The principle of respect for autonomy and the principle of non-maleficence. According to the principle of autonomy, individuals have the right to make their own choices and make their own life plans as self-determining agents. In a medical context, this means that patients have the right to make

[5] See also Clark, P. (2006). "Physician Participation in Executions: Care Giver or Executioner?" Journal of Law, Medicine, and Ethics.

medical decisions for themselves and physicians overseeing their treatment are thus obligated to make any recommendations intelligible to the patient and that their decision be free from coercive influences in order to ensure valid consent (Beauchamp & Childress, 99). Without the informed consent from the patient regarding a certain medical procedure, performing the medical procedure would be morally impermissible even if the procedure would be in the best interest of the patient in promoting their well-being. Although we may consider death-row inmates analogous to terminally-ill patients in the sense that they both face imminent death and the preservation of life is ultimately futile, the analogy does not hold in other morally relevant aspects. Unlike some cases of medical withdrawal, it is not possible for the condemned to consent to their execution, and thus their autonomy is violated. Thus, whenever physicians participate in executions where the inmate has not given their informed consent, their actions are morally impermissible.[6]

According to the principle of non-maleficence, physicians have duties to avoid inflicting harm on their patients. Such a principle is closely associated with the Hippocratic tradition in medical ethics and the maxim "above all (or first) do no harm" (Beauchamp & Childress, 149). While this maxim is overly-simplistic given the inherent risk of harm in practicing medicine, I do not intend to give a complete account of the principle here and there are many important questions that must be answered for a full explanation of the principle: when does the expected justify inflicting harm? Must the expected good be expected to accrue to the one who is harmed? Instead I wish to focus on comparing the principle of non-maleficence and the obligation of beneficence in the context of physician participation in capital punishment. The obligation of do no harm is distinct from an obligation of beneficence in that the principle of non-maleficence sometimes has priority over promoting the welfare of someone else. Even if a surgeon can save ten lives by taking

[6] Gerald Dworkin makes similar remarks in his comparison between capital punishment and torture. See Dworkin, G. (2002). "Patients and Prisoners: The Ethics of Lethal Injection". Analysis, 62: 2, 181-89.

the transplantable organs of one death row-inmate without pain and with their informed consent, we may still consider the actions of the surgeon morally impermissible despite the good it produces or the fact that it is in accordance with the patient's will (Beauchamp & Childress, 150). Many paradigmatic instances of harm are physical in nature, such as instances of pain or death, and by taking the organs of the condemned and causing their death. To harm another is to have an adverse effect on their significant interest (Feinberg, 1984). The surgeon in this case has harmed their patient by having an adverse effect on their patient's significant interest of being alive. This helps explain the AMA's complaint that the physician is causing the death of the condemned while the disease itself causes the death of the terminally-ill patient. What is morally problematic about the physician's actions in the execution chamber, according to this argument, is that they are harming the condemned by causing their death even if they are doing good by alleviating the suffering during their death.

The Problem with Appeals to Patient Autonomy & Posthumous Harm

These arguments, however persuasive they may appear at face value, ultimately fail to pass critical scrutiny. First, the autonomy of the terminally-ill patient and the death-row inmate are more analogous then the argument itself admits. Although the death-row inmate cannot consent to their execution due to the coercive nature of punishment, they may still consent the presence of a medical professional in the same way a terminally-ill patient wills the withdrawal of medical assistance for their illness. When discussing the analogy of an underlying disease and the execution procedure, both serve as background conditions outside the control of either the terminally-ill patient or the death-row inmate (Litton, 337-8). In the same way that some patients facing a terminal illness cannot choose to cure their sickness and could never have consented to their illness in the first place, many death-row inmates lack the control to determine whether or not they will

be executed by the state. Yet, it seems that if we are willing to grant that physicians should be permitted to help terminally-ill patients end their suffering, then we should be consistent and grant that physicians should be permitted to assist the condemned in ending their suffering. When it comes to whether or not the inmate consents to the physician's participation in their execution it cannot be disassociated from how we think about terminally-ill patients in other medical contexts. Physician participation can still respect the autonomy of the condemned if they give their informed consent to a physician's presence during their execution, even if they themselves cannot consent to their execution.

One possible response is to shift the focus from *when* death-row inmates have given their informed consent to medical assistance from physicians during their executions to *if* they have the capacity for informed consent at all. In order for one to give their informed consent, it is necessary that they satisfy preconditions such as having an adequate level of competency to act and the ability to comprehend the information provided to them (Beauchamp & Childress, 120). But the conditions of captivity on death-row are notorious for creating dysfunctional psychologies that undermine one's ability to be an autonomous agent due to the mainstream use of solitary confinement (Haney, 2018). This in turn undercuts one's ability to properly judge whether any death-row inmate is in fact consenting to a physician's help.[7] Although a troubling predicament, this will not work to block the objection. There are many common instances where the ability to judge whether an individual does consent to a medical procedure is obfuscated. It is doubtful

[7] Due to how the courts have defined mental incompetence in the context of capital punishment, it is not reasonable to believe that mental incompetence of the condemned itself will disqualify them from the death penalty. Physicians who participate are no strangers to taking part in the execution of the mentally incompetent. Dr. Carl Musso, an emergency physician turned correctional healthcare professional in and well-known participant in Georgia's lethal injection executions, has been criticized for his assistance in executing a mentally disabled man who was convicted of two murders in 2012. See Mello, M. (2007). "Executing the Mentally Ill: When is Someone Sane Enough to Die?" Criminal Justice, 22: 3 and Vox. F. (2012). "Georgia's Doctors and The Ethics of Execution. The Atlantic. https://www.theatlantic.com/health/archive/2012/07/georgias-doctors-and-the-ethics-of-execution/260083/

whether patients who have suffered a stroke, chronic depression, or other persistent cognitive defects lack the preconditions of competence and comprehension to volunteer to any medical procedure, but it is also common in these contexts to rely on surrogate decision makers for medical treatment; someone who knows the patient's preferences or prior autonomous judgments and acts on these interests or is able to determine what is in their best interest on the patient's behalf (Beauchamp & Childress, 135-40). Surrogacy could be used as a standard for death-row inmates who have shown signs of cognitive decline during their imprisonment to determine physician participation.

Second, the AMA's argument presumes that physician participation is contrary to the inmate's interests by causing their death, but this judgment is dependent upon the possibility of posthumous harm, or whether or not one's interests can be significantly interfered with by and after their death. If posthumous harm is impossible, then the moral relevance does not lie within whether or not the physician caused their death, but rather whether or not the condemned was either wronged or harmed prior to their death (Taylor, 2012). The permissibility of physician's participation will depend on factors such as whether or not the condemned will experience a painful death, if the physician will be able to manage that pain during their death, and if the condemned (or their surrogate) is aware of these risks and consent to the physician's assistance in these matters. On the other hand, if posthumous harm is possible (Wilkinson, 2011), then this still doesn't preclude physician participation by itself. Some death-row inmates seek opportunities for

reconciliation for their wrongdoings by becoming posthumous organ donors and so physician participation would not be harmful in these instances.[8,9]

One way to respond to this objection is to shift who is actually being harmed when physicians participate in capital punishment. Robert Truog and Troyen Brennon (1993), for instance, accept that physicians do not harm the condemned by participating in capital punishment, but rather they harm the physician-patient relationship as a whole by weakening the trust between the medical profession and the public (1348). Physicians have a duty to maintain the integrity of the profession in the eyes of the community because without strong signaling of trustworthiness, those who face illness will not engage in the physician-patient relationship; effectively putting the medically vulnerable at substantial and preventable risk while simultaneously dissolving the

[8] Christian Longo, a death row inmate who was sentenced to death in 2003 for killing his wife and three children, has been a long-time advocate of the condemned being allowed to become organ donors after their execution. Although relatively infamous for his position on posthumous donation, he is not alone in this endeavor. There are at least fourteen other death row inmates who have pursued the possibility of becoming posthumous donors in recent years and recent legislative measures have provided the legal groundwork for this to become a reality. In 2013, Utah passed a law that allows the general prisoner population and death-row inmates to become posthumous donors upon their death. Within the first few weeks of the law passing, around 250 signed up to become donors upon their death, demonstrating that there is interest among those incarcerated to become organ donors upon their death. See Longo, C. (2011). "Giving Life After Death Row". New York Times. https://www.nytimes.com/2011/03/06/opinion/06longo.html?auth=link-dismiss-google1tap and Palmerson, J.M. (2015). "Inmate Organ Donation: Utah's Unique Approach to Increasing the Pool of Organ Donors and Allowing Prisoners to Give Back." Rutgers University Law Review, 68: 479-516.

[9] There also seems to be a further claim of morally relevant causation in the AMA's argument beyond appeals to respecting autonomy and harming patients. Although merely pointing out that physicians are the cause of death is not sufficient for wrongdoing, a sympathetic reading of their assessment may see that they are invoking a traditional medical ethical distinction between killing versus letting die where the former has the necessary condition of intentionally causing death and is always wrong while the latter is morally neutral. This distinction seems to represented in Lee Black's and Hillary Fairbrother's, members of the AMA Council of Ethical and Judicial Affairs, moral reasoning when they write, "Actions that directly and intentionally lead to the death of a patient, even one who is required by the state to die, contravene [physicians' obligation to promote the health of their patient]" (italicizing added by me). But even if this traditional distinction is real, there are cases where physicians participate but do not intend the patient's death. This is most evident in minimal roles where the physician merely supervises the execution, but there may also be a lack of intentional causing of death in more robust roles such as preparing the lethal injection dose. Their death will be intended if and only if they have that end or believe that it is a state of affairs in the causal sequence that will lead to that end. If the physician's end is to lessen the risk of a miserable death for their patient, the actual death of the condemned may not be relevant in their plan. See Black, L., & Fairbrother. (2008). "The Ethics of the Elephant. Why Physician Participation in Executions Remains Unethical." American Journal of Bioethics, 8: 10, 59-61. For a defense of the moral distinction between killing versus letting die, see Sulmasy, D.P. (1998). "Killing and Allowing to Die: Another Look". Journal of Law, Medicine and Ethics, 26, 55-64. For a defense of the strict definition of intentionality, see Masek. L. (2010). "Intentions Motives, and The Doctrine of Double Effect". Philosophical Quarterly, 60: 240, 567-85.

medical profession. According to this argument, when physicians participate in capital punishment they act in a way that makes the medical community as a whole less trustworthy and so should refrain from having a presence in the execution chamber.[10] Usually support for this slippery slope argument is accompanied by comparisons between physician participation in capital punishment, and physicians participating in Nazi T4 programs during World War II (Wikler & Barondess, 1993)[11], but this comparison has been criticized either as non-starter due to the major political differences between the U.S and Nazi Germany (Baum, 70-2) or inflammatory because there is a long history of physician participation in capital punishment without a degradation of the physician's moral character or the communities trust in the profession (Nelson & Ashby, 32-3).[12]

Appealing to the principle of autonomy in traditional medical ethics fails to effectively prohibit physician participation in capital punishment. There is no morally relevant difference in the informed consent of the condemned and the terminally-ill patient. While both do not get a choice in whether or not they live or die, they should get a choice in how they wish to die. Execution and terminal-illness serves merely as a background conditions in which the patient is

[10] For similar reasoning against physician participation in capital punishment, see Groner, J.L. (2002). "Lethal Injection". A Stain on the Face of Medicine". British Medical Journal. 3325, 1026-28 and Guidry, O.F. (2006). "Message from the President: Observations Regarding Lethal Injection". ASA Monitor, 70, 6-8.

[11] See also Freedman A.M., & Halpern. (1996). "The Erosion of Ethics and Morality in Medicine: Physician Participation in Legal Executions in the United States," New York Law School Law Review, 41: 1, 169-188.

[12] A possible issue that has yet to be discussed in the literature is the connection between physician participation in capital punishment and medical racism. There is longstanding distrust between African-Americans and the medical profession in the U.S. due to known medical experimentation during the antebellum period on black slaves in Alabama and Georgia and more recently egregious mistreatment during the Tuskegee Syphilis Study from 1932-1972. This distrust has manifested in different ways, such as low donation numbers of transplantable organs from African Americans. One might wonder whether or not physician participation in capital punishment may further erode the trust between the medical community and African-Americans due to racial discrimination in the capital punishment cases putting a disproportionately high number of African-Americans in the execution chamber, but further empirical research would be needed to make this claim. See Gamble, V. (1997). "Under the Shadow of Tuskegee: African Americans and Health Care". American Journal of Public Health, 87: 11, 1773-78 for an overview of the distrust between African-American's and the medical profession and Minniefield, W.J., & et. al. (2001). "Differences in attitudes toward organ donation among African Americans and whites in the United States". Journal of the National Medical Association. 93: 10, 372-79 for a discussion comparing who African American's view of organ donation. For an overview of the current evidence regarding racial discrimination in our criminal justice system, see Eldridge, K.R. (2002). "Racial Disparities in the capital system: Invidious or accidental?" Washington and Lee School of Law Capital Defense Journal, 305-25.

able to exercise their autonomy. If the condemned gives their informed consent to the physician's presence, either themselves or through a surrogate, then the physician's participation is morally permissible. The principle of non-maleficence fares no better. Physicians do not harm the condemned nor the medical profession's relationship with the community by participating. In cases of posthumous organ donation, the physician may be helping the patient pursue their interests after their death and the empirical data for damaging the reputation of the profession is non-existent.

Unjust Forms of Legal Punishment: Complicity in Capital Punishment

Rather than appealing to the physician-patient relationship to argue against physician participation in executions, one may try to appeal exclusively to the moral impermissibility of capital punishment and the support physicians provide in these executions to make their case. Robert Veatch (2001), advocates for this way of reasoning about participation in the following way:

> The question of whether a physician's behavior is morally appropriate when he or she participates in an execution is surely not settled by the balancing of two competing goals of medicine. It is surely settled by resolving the more fundamental societal moral question- the morality of capital punishment itself. If the society is correct in executing its criminals, surely it is within its rights to construct the role of physician professional in such a way that some of its members (that is, some persons in some of its sub-roles) can participate in executions. On the other hand, if the society should not be executing any criminals, then it should not formulate any of its medical professional roles in a way that they include physician participation in executions (634-35).

According to Veatch the question that must be asked is not whether or not physicians are violating a professional duty, but whether they are violating a duty shared by anyone participating in executions, medical professional or not: a duty to avoid aiding in unjust treatment. While physicians may have professional obligations based on their roles as *medical professionals*, this is

not their only role. Physicians also have a role as *citizens* and part of this responsibility as a citizen is to avoid being complicit in morally impermissible acts. If capital punishment is a morally impermissible form of legal punishment, then physicians do something morally impermissible.[13]

We can evaluate whether or not any contributing actor is complicit in an act by three minimal conditions: (1) they contribute in a way that is not involuntary or accidental, (2) they know or are culpably ignorant of how they contribute to the act, and (3) they know or are culpably ignorant that the act to which they are contributing to is morally impermissible. (Lepora & Goodin, 83).[14] Imagine a friend, who you have prior evidence is mentally unstable, asks to borrow your gun. Despite having good reason to believe that your friend is not trustworthy to be responsible with that weapon, you give it to him anyway. You find out later that your friend killed someone using your gun. Although you were not the main perpetrator of the crime, intuitively you were

[13] There are number of substantive reasons to believe that capital punishment is an unjust form of punishment. Retributivists have appealed to the inability of the criminal justice system to determine guilt or innocence of capital punishment victims or the present unjust authority due to racial discrimination while consequentialists appeal to the inconclusive or even brutalizing effect of capital punishment has on crime. Communicative theorists point out the death penalty unjustifiably removes the possibility of reconciliation and repentance for the inmate. Procedural objections usually make the case that a just criminal justice system cannot tolerate irrevocable punishments and incremental improvements such as crime reduction, better forensic science, or the removal of racism are insufficient or impossible. Although it is impossible to defend all these arguments here, it is enough to point out the supporter of capital punishment has the high burden of needing to reject both the substantive and procedural arguments against capital punishment. See McDermott, D. (2001). "A Retributivist Argument Against Capital Punishment". Journal of Social Philosophy. 32: 3, 317-33 and Brooks, T. (2004). "Retributivist Arguments against Capital Punishment". Journal of Social Philosophy, 35: 2, 188-97 for retributivist arguments against capital punishment. For evidence regarding whether or not capital punishment has deterring effects or actually increases crime see, Shepherd, J.M. (2005). "Deterence Versus Brutalization: Capital Punishment's Differing Impacts Among States". Michigan Law Review, 104, 203-55 and Chalfin A., Haviland & Raphael. (2013). "What Do Panel Studies Tell Us About a Deterrent Effect of Capital Punishment? A Critique of the Literature". Journal of Quantitative Criminology, 29, 5-43. For a communicative argument against capital punishment, see Duff, R. (2001). "Communicative Sentencing." Punishment, Communication, and Community. Cambridge, UK: Cambridge University Press, 152-9. For a procedural objections to capital punishment, see Yost, B. (2011). "The Irrevocability of Capital Punishment". Journal of Social Philosophy. 42: 3, 321-40. For a discussion of the more general structure of objections to capital punishment and the burden the supporter of capital punishment faces, see Stitcher, M. (2014). "The Structure of Death Penalty Arguments". Res Publica. 20, 129-43.

[14] The use of knowledge as the mental state relevant for complicity is different from other analyses who appeal to intentionality as the relevant mental state for establishing complicity. One reason to appeal to knowledge as the necessary criteria is that it establishes a stronger standard for any physician's complicity in capital punishment, because they do not have to share the purposes of the state in the matter. For a similar argument that appeals to intentionality, see Litton, P. (2013). "Physician Participation in Executions, the Morality of Capital Punishment, and the Practical Implications of their Relationship". Journal of Law, Medicine, and Ethics. 41: 4, 344-45.

complicit in the wrongdoing and are blameworthy in some capacity. The minimal conditions of complicity help explain why you were complicit and why you deserve some degree of moral blame. You voluntarily choose to give them your gun. They did not steal it from you without your knowledge or coerce you into giving it to them. You also know that they lack the mental stability to handle such a weapon appropriately. Although you are not aware of how they will use the gun, you are aware that because of their lack of mental stability they could harm themselves or others with the firearm. Giving them the gun is acting negligently. You also know, or at least should know, that death could have been avoided if you hadn't given them your gun.

How blameworthy you are in your complicity depends on a number of considered judgments regarding how responsible you are for the principal wrongdoing of your friend, how much you contributed, and the degree of impermissibility regarding the principal act (Lepora & Goodin, 102-112). Even if your culpability was high given that you gave the firearm to your friend voluntarily with full knowledge of their mental condition, other factors will change the degree of blameworthiness. If for instance your friend hinted at robbing a bank a week prior to being given the firearm or has a known history of violent acts, then your blameworthiness in your complicity may be quite high. On the other hand, if all these conditions are true, but it turns out that the friend's actions are not particularly morally egregious, then your blameworthiness may be lower overall. We can evaluate the complicity and its blameworthiness of physician participation in capital punishment in the same way. Many of the most common methods of contributions by physicians during lethal injection executions, such as starting intravenous lines as a port for a lethal injection device, and inspecting, testing, or maintaining lethal injection devices are voluntary, competent contributions. A morally diligent physician cannot be culpably ignorant on how they are causally efficacious to the inmate's unjust fate. The moral wrongness of such complicity is

dependent upon how we are to evaluate capital punishment. If capital punishment turns out to not just be morally wrong, but morally egregious, then the physician involved is highly blameworthy. If not, then they are either not culpable or their culpability is less severe. An evaluation of the wrongdoing is context-sensitive and can only be evaluated on a case by case basis. But, even if the moral evaluation of complicity is context-sensitive, being complicit is still a moral wrong regardless of its degree. This means that physicians who participate, although they may only be providing mere medical supervision, are still committing a moral wrong because their presence is legally necessary even if their culpability is lower than other possible contributions in the execution chamber. So, even the most minimal contributions of physicians in capital punishment still face moral scrutiny and physicians are obligated to refrain from participating according to this argument.

The Problems with Appeals to Complicity in Capital Punishment

There are two issues with this argument providing a prohibition on physician participation in capital punishment. First, although complicity in wrongdoing is itself a moral wrong, it is not unconditionally wrong. Imagine a intelligent and well-known medical researcher named Tami has been offered a medical research coordinating position at Ethicorp; a company that is well-known and condemned by her and others in the medical community for creating and distributing a cheap and dangerous alternative painkiller to those who struggle with opioid addiction. Tami is aware that the risk of medical complications can be mitigated through proper research coordination and that she has the expertise to make this happen. But she also knows that taking the job would be contributing to the creation and distribution of the painkiller. Tami takes the position.[15] Has Tami done anything wrong? Intuitively, it seems like she hasn't because she will be complicit in

[15] Inspiration for this thought experiment comes from Masek. L. (2000). "The Doctrine of Double Effect, Deadly Drugs, and Business Ethics". Business Ethics Quarterly, 10: 2, 483-95.

Ethicorp's morally problematic business practice. Tami was neither coerced by anyone to take this research role and is not culpably ignorant in how her role will aid in causing medical complications in vulnerable patients despite mitigating that risk. Whether or not she merely supervises the research or takes a more active role in the research, her actions seem to be morally permissible and complicity in wrongdoing by medical professionals is not unconditionally wrong.

Second, although the moral permissibility of capital punishment is normatively significant for physicians considering participating, it is not the only normatively significant aspect. Traditional medical ethics is equally as important in our moral reasoning on the matter. These professional duties are in part what makes the case of Tami and Ethicorp so interesting. Tami, as a medical researcher, must abide by a principle of justice in medicine; she has a responsibility to fairly allocate medical resources and respond to morally problematic distributions of medical burdens (Beauchamp & Childress, 248). Yet, part of what Ethicorp is doing wrong is offering something irresistible to a vulnerable population for their substance abuse treatment. Tami seems to have a conflict of moral reasons: She has good moral reasons to avoid contributing to Ethicorp's business model, but she also has good moral reasons as a medical professional to respond to these unfair medical pathologies perpetrated by the company. These is a symmetrical conflict in a physician's moral reasoning when it comes to their participation in capital punishment. A physician may know that the death of the condemned is unjust and that any contribution to it, however small that contribution may be, is wrong. But they may also know that the unjust execution itself leads to unfairly discriminatory medical pathologies such as physical pain and psychological duress. Thus, it seems that physicians have conflicting moral reasons for participating or not participating in capital punishment.

I suggest that we resolve this moral dilemma by looking at how physicians resolve conflicts in moral reasoning in other contexts. In the moral evaluation of a physician's participation in torture, Chiara Leopara and Joseph Millum propose three factors to determine the permissibility of complicity: (1) the consequences on the physician, the patient, and how it effects the practice of the principal wrong, (2) the preferences and requests of their patients involved in the principal act, and (3) the degree of complicity in the principal act (Lepora & Goodin, 151). Whether or not a physician is acting permissibly or not by participating in capital punishment depends on how one should weigh certain factors such as whether or not the physician's participation perpetuates the penal practice, whether their presence in the execution chamber is preferred by the patient, how the physician chooses to use their medical expertise to contribute, and whether or not they taken actions to minimize their contribution.[16] Although weighing these factors and actually determining the moral permissibility of a physician's participation would be a complicated process of evaluating the possible empirical data and the reasonable disagreement of putting different weight on some factors over others, the point is that appealing to the normative significance of capital punishment and a physician's complicity in the practice is not enough to ensure prohibiting their participation. It is at least possible that a physician's participation in capital punishment and their complicity is morally permissible given certain circumstances.

The Conceptual Difference Between Torture and Capital Punishment

One possible objection to this proposal is that it may be difficult for the physician to determine the preferences of the condemned. In paradigmatic cases of routine torture such as the

[16] One reason to think that resolving the moral dilemma constitutes a claim that physician participation is morally permissible rather than morally obligatory is that it would be a violation of a physician's autonomy to be required to participate in capital punishment. Some physicians might have personal moral beliefs against capital punishment, and there should be limitations to forcing physicians to provide medical care in cases where their personal moral or psychological integrity would be put at risk. See Wicclair M.R. (2011). Conscientious Objection in Health Care: An Ethical Analysis. Cambridge, UK: Cambridge University Press.

CIA's use of psychological torture on inmates in Guantanamo Bay, it would be impossible for the physician to determine whether or not the preferences and requests of the inmate were authentic due to their psychological disorientation and instability of the physician-patient relationship (Shue, 2017). According to this argument, there may be a similar incentive for the state to preclude aspects of transparent communication between the condemned and the physician in order to stifle possible coordination that will delay their execution. Without a reasonable determination of the preferences of the condemned, it is hard to see how a physician's complicity could be permissible, especially if one is inclined to put greater weight on the autonomy of the condemned over other factors. Although there may be a legitimate concern that the state may be wary of such coordination between the condemned and the physician, there are conceptual differences between the function of torture and punishment that incentivizes transparent physician-patient relationships for one and not the other.

The function of torture is to break the will of the victim in order to extract information or for some other purpose (Miller, 2005) and the role of the physician in this scheme is to aid in the total compliance of the victim to the will of the torturers. A physician-patient relationship beyond this function is risky because it leaves opportunities to make the victims total compliance to be less effective. Capital punishment's function is not merely causing the death of the convicted, but also has the purpose of expressing the moral censure of the convict's actions (Feinberg, 1965). When this expression is directed toward the moral community at large, the state has to make sure that the moral emotions the community feels, such as resentment and indignation, are directed towards the actions of the condemned and not the state's actions towards the condemned in punishing. The physician's ability to properly assess the inmate's medical preferences and meet their requests is what helps differentiate capital punishment as a form of punishment from a mere

act of cruelty by the state in the eyes of the community. While the ability of physicians to determine the preferences of their patients in paradigmatic cases of psychological torture is undercut and as such the permissibility of their complicity is in question, we cannot say the same thing about their complicity in capital punishment because the state has a strong incentive to make their relationship stable in order to properly direct moral condemnation.

A New Way Forward: Moral Disagreement and Moral Risk

The purpose of this essay is to not only show how appealing to traditional medical ethics and the immorality of capital punishment fail to provide a prohibition on physician participation in capital punishment, but to also provide a different way to think about a physician's obligations in the matter. Rather than appealing to the obligations of a physician as a medical professional or as a citizen, I propose we appeal to their obligations that follow from knowing the moral risks of participating. This way of looking at a physician's obligations turns the discussion on its head. Appeals to traditional medical ethics or immoral complicity attempt to demonstrate the moral impermissibility of their participation first in order to determine what physicians ought to believe, while my suggestion is to focus on what physicians ought to believe to determine the moral impermissibility. In other words, we should prioritize normative epistemology over normative ethics in this debate. Although this will not amount to prohibiting physician participation in capital punishment because the epistemic situations of physicians may differ in different contexts, we will see that the obligation to refrain from participating may be so widespread that in practice all members of the medical profession are morally barred from the execution chamber.

I argue that we can determine the moral permissibility of a physician's participation in capital punishment by appealing to Jonathan Matheson's Moral Caution Principle (MC) (2016). The principle can be stated as follows:

> MORAL CAUTION (MC): Having considered the moral status of doing action A in context C, if (i) subject S (epistemically) should believe or suspend judgment that doing A in C is a serious moral wrong, while (ii) S knows that refraining from doing A in C is not morally wrong, then S (morally) should not do A in C (120).

MC is an objective moral principle that connects epistemology to morality (Matheson, 120). While the arguments from traditional principles of medical ethics and complicity above appeal to morally relevant empirical conditions such as the psychological state of the patient, their preferences, or the strengthening of the penal practice in the law, MC appeals to one's normative ignorance; the body of evidence one has regarding the moral permissibility of the action amidst the morally relevant empirical conditions is crucial for determining what one is allowed to do (Matheson, 123). It prohibits actions when one ought to believe or suspend judgment that doing an action is morally impermissible while at the same time knowing that refraining from acting is not morally wrong. On a more basic level, MC claims that one's doxastic attitude places certain limiting conditions on what one is allowed to do. One has a duty to mitigate moral risk by playing it safe whenever possible (Matheson, 122)

Epistemic Disagreement & Exercising Moral Caution

There are two aspects about MC that require further clarification and set the boundaries of MC's applicability before we continue. First, for MC to apply one must be in a particular epistemic situation. MC is context-sensitive because not everyone has the same evidence available to them and so are not in a position to adopt particular beliefs about an action. MC strictly applies to situations where one has contemplated the morality of an action. They either have some positive reason to believe that the action in question is morally impermissible or they have a positive reason to believe that the action is morally impermissible and they have some equally strong positive reason to believe that the action is not morally impermissible. If the individual is in a situation

where the latter is the case, then the rational doxastic attitude to adopt is a suspension of judgment regarding the action. (Matheson, 121). One way someone may acquire such a skeptical attitude toward an action is through disagreement with an epistemic peer. Epistemic peers are epistemic equals; they are equally well positioned to determine the truth of a proposition because they share the same cognitive aptitude, epistemic virtues, body of evidence, etc. as yourself (Matheson, 124). Matheson demonstrates the epistemic significance of peer disagreement through the following scenario:

> RESTAURANT CHECK: A group of colleagues goes out for dinner. Upon getting the check, they decide to add 20% gratuity and divide the check evenly, regardless of who ordered what. Having agreed to this, each of the colleagues looks at the bill and independently calculates the shares. Suppose that this is a common practice among the members of the group. Each colleague is quite reliable at performing such calculations. While errors have been made in the past, each individual is about as likely to be correct as any other. When they each reveal their findings, they discover a disagreement—5 individuals believe the shares are $33 a piece, 4 believe that they are $27 a piece, and 2 believe that the shares are $31 (Matheson, 124).

While every individual should double-check their calculations to end the discrepancy between their calculations, the more important aspect is that prior to doing so, intuitively no individual is epistemically justified in holding firm to their first answer even if they in fact have done the math correctly. It seems that the rational response for every member in the group is to doubt their answer and shift the confidence of their belief toward the other members such that they all should suspend judgment about their correct share of the bill. The disagreement with their peers gives each member higher-order evidence that undercuts their belief that they are correct about their evidence in

relation to the bill (Matheson, 125).[17] How we should handle disagreement about moral claims between epistemic peers is analogous to the results of RESTAURANT CHECK. We are all fallible epistemic agents and without a consensus on the matter or additional evidence that acts as a defeater-defeater for one's higher-order evidence, peer disagreement about the moral status of particular actions rationally require a skeptical attitude on the matter at the moment one is aware of the lack of consensus.[18] We cannot ignore the possibility of insufficient evidence or insufficient epistemic dispositions among peers and what that entails in our moral evaluations (Matheson, 125-26). MC takes into account actual peer disagreement in whether or not we should exercise moral caution.

Second, MC is only applicable in situations where moral caution is exercisable and thus does not apply to all possible actions. Some actions are always wrong given the available evidence. Matheson points to the moral permissibility of conducting cancer research on animals as an example where the disagreement about conducting such research fails to satisfy conditions (ii) of MC (Matheson, 128). Even if the disagreement rationally compels us to be skeptical of its moral permissibility, there is also disagreement about whether or not refraining from conducting such research is morally permissible. While some believe that putting sentient creatures through such

[17] This is a version of conciliationism called the Equal Weight View in the epistemology of disagreement. For some more detailed explanation and defenses of the theory, see Bogardus, T. (2009). "A Vindication of the Equal Weight View". Episteme. 6: 3, 324–335, Christensen, D. (2007). "Epistemology of Disagreement: The Good News". Philosophical Review. 116: 187–218, and Matheson, J. (2009). "Conciliatory Views of Disagreement and Higher-Order Evidence." Episteme. 6: 3, 269–279.

[18] Another reason peer disagreement leads to a lack of justification in one's original doxastic attitude toward a proposition that doesn't rely on conciliationist presuppositions may be due to the type of disagreement one is having and the lack of evidence present to determine who is epistemically inferior in the debate. Moral disagreements, unlike disagreements about calculating tips, are non-localized, widespread, and entrenched. They are debates about other philosophical issues, both sides are endorsed by substantial following, and they have persisted for some time. But in these cases of systematic disagreement among peers, the defeater for the belief in the proposition or its denial comes from the good chance that one or more lacks peerhood, yet there is no reason to believe that either party is immune to the charge of epistemic inferiority. See Goldberg, S. (2013). "Disagreement, Defeat, and Assertion". The Epistemology of Disagreement: New Essays. eds. J. Lackey & D. Christenson. Oxford, UK, Oxford University Press. 168-189.

trials for our own gain is morally wrong, others believe that it would be wrong not to do such research given the benefits it provides for human lives. We do not know given the circumstances whether or not we ought to refrain from conducting research on animals and so MC fails to prescribe any course of action. Given the current debate on the issue, there is no way to mitigate the moral risk of conducting such research because no matter which choice we make we may be doing something morally wrong. MC is an objective moral principle with limitations. It is limited to particular epistemic situations where one ought to believe that the action in question is morally wrong or must suspend judgment on the matter and particular debates where it is possible to exercise moral caution because it remains uncontroversial that not doing that action is not morally impermissible.

The Epistemic Argument Against Physician Participation in Capital Punishment

So, how does MC apply to physician participation in capital punishment? Or more specifically, how does MC amount to a new way to evaluate the moral permissibility of physician participation in capital punishment? To answer these questions, we can take additional inspiration from Matheson's use of MC to provide an argument against eating animals for pleasure (Matheson, 127-28). Imagine two groups of well-informed epistemic peers that have reasons for believing either that eating animals for pleasure is morally permissible or impermissible. One group, 'The Vegans/Vegetarians', believe that eating meat for pleasure is morally impermissible. The other group, 'The Omnivores', believe that eating animals for pleasure is morally permissible. Both groups are aware of the opposing evidence for their position, and yet actual moral disagreement persists between them. Given the fact that they disagree on what is the appropriate moral action when it comes to eating animals for pleasure and that they are equal in their epistemic aptitude, epistemic virtues, in access to the body of evidence, etc. they should all suspend judgment on the

issue. They satisfy condition (i) of MC. But it is also the case that there is no significant moral disagreement on whether or not it is morally permissible to refrain from eating animals for pleasure. 'The Omnivores' only claim that it is morally permissible to eat animals for pleasure, not obligatory. On the other hand, 'The Vegans/Vegetarians' only claim that it is morally wrong to eat animals for pleasure and consequently that it is morally obligatory to refrain from doing so. Both groups agree that refraining from eating animals for pleasure is not morally wrong; satisfying condition (ii) of MC. Therefore, all members in both groups have a duty not to eat animals for pleasure. The moral reason for doing so relies on a duty to exercise moral caution rather than on a debate between more traditional arguments such as implications of the moral status of sentient beings or relevance of humane killings and fulfilling lives.

By this point, it should be clear how MC provides a new way to evaluate the moral permissibility of physician participation in capital punishment. We can imagine an analogous situation to the 'The Vegans/Vegetarians' and 'The Omnivores'. Two groups of physicians have been given the opportunity to participate in capital punishment. One group believes that doing so would be a serious moral wrong, while the other group believes that doing so would be morally permissible. Both groups of physicians are aware of the other's reasons for the position and consider each other to be epistemic peers. A great deal of the evidence above will probably be considerations stated earlier in this essay. These physicians would consider their professional duties of respecting the autonomy of their patients, not causing harm, the moral status of capital punishment, and whether or not the empirical evidence leads them to believe that their complicity in capital punishment is morally problematic or not. Since there is disagreement on if or how these elements apply to physician participation in capital punishment, as demonstrated above, then both of the these groups should suspend judgment on the moral permissibility of participating in capital

punishment. On the other hand, there is a lack of significant disagreement among all members in both groups that refraining from participating is not morally wrong. Those who oppose participation believe that it is morally obligatory that physicians stay out of the execution chamber, while those who are not opposed to participation believe that it is morally permissible for physicians to refuse the opportunity. Therefore, because physicians have a duty to play it safe when possible according to MC, physicians who fall into either of these two groups have a duty to not participate in capital punishment. What matters then for any physician, is determining whether they are in such an epistemic situation and whether or not a consensus remains regarding the moral permissibility of refraining from participating.

Standards of Normative Epistemology: Epistemic Peerhood, Dependence, and Authority

One way someone who supports physician participation in capital punishment may want to counter this argument is by exploiting the likelihood of physicians being in the right epistemic situation for MC to be applicable. In practice, epistemic peerhood is a high standard to meet. It is not likely that you will encounter an actual epistemic peer in the real world, and so even if it is possible for MC to apply in the debate about physician participation in capital punishment, no prescription of moral caution will actually apply to them. Physicians are primarily medical practitioners, not moral philosophers. This is no more evident than in where it was found that out of 413 physicians surveyed, only 3% knew of any guidelines on the issue (Farber, 2001). This means that the vast majority of physicians where not well-versed in the body of evidence regarding physician participation in capital punishment. While they may have had a positive reason to believe that participating was either morally permissible or morally impermissible, according to this objection it is not reasonable to believe that they would be epistemic peers because they are not privy to the same body of evidence. MC fails to prescribe any action for physicians on this issue

because condition (i) is not satisfied. If this study reflects the medical profession as a whole, MC fails to provide a persuasive argument against physician participation in capital punishment.

There are at least two problems with this objection. First, although encountering epistemic peerhood may be rare, it may not be the primary reason to suspend judgment about a proposition in cases of actual epistemic disagreement. Actual disagreement may be epistemically significant because it rationally requires us to question our total epistemic position; it provides higher-order evidence that our epistemic aptitude is weaker than anticipated, that we are lacking some epistemic virtues that we thought we possessed, that our own evidential circumstances are lacking, and that we lack independent access to determine which one of us is epistemically worse off (King, 2012). A skeptical attitude towards the moral permissibility of some action may not be due to the determination of the opposition's peerhood, but due to the inability of rationally believing that your position is superior in the face of disagreement itself.

Second, even if the first response to this objection is not persuasive and disagreement of epistemic peers is the standard of choice, the dim epistemic situation presented by this objection turns out to better support MC's applicability. This is because the epistemic peerhood is not the only relevant standard in this debate. Epistemic authority is also a normative epistemological standard that has implications for one's moral beliefs. The testimony of an epistemic authority has the normative power such that one is rationally required to preemptively adopt the doxastic attitude of the considered authority in the matter (Zagzebski, 2012). When someone goes to a physician for a diagnosis of their illness, it is rational for the patient to adopt the beliefs of the physician regarding their illness and how to treat it without weighing them or aggregating them with their own beliefs on the issue (Zagzebski, 105). This is because the patient regards the physician to be an expert on the issue; that they are in a better position to form a true belief rather than a false one

by believing what the physician believes or that doing so means that the formed belief will survive one's conscientious reflection (Zagzebski, 232). Physicians may need to seek expert guidance from moral philosophers or other physicians on the debate about physician participation in capital punishment.[19]

The picture painted above is that physicians are epistemically dependent upon the moral guidance of others. If a physician learns that there is wide and complicated body of evidence about whether or not it is permissible to participate in capital punishment that they are unfamiliar with, and also judge that the time and energy required to be considered well-informed on the matter would jeopardize the care they could provide for their patients, then it would be rational for physicians to appeal preemptively to authority about their obligation. But if the purported moral experts turn out to be peers, however unlikely that is, and they disagree and must suspend judgment, then it is rational for them to suspend judgment too because of their epistemic inferiority rather than disagreement with their peers (Hardwig, 1985).[20] This has widespread implications for the applicability for MC. Rather than think that MC only applies to a few physicians if at all, the majority of the medical professional may succumb to suspension of judgment regarding the moral permissibility of their participation in capital punishment and the duty to mitigate moral risk by

[19] The problem of epistemic dependence is relevant to other models of epistemic authority that do not advocate for preemptive belief, but rather that the authority takes on an advisory role for one's doxastic attitude towards the proposition in question. See Lackey, J. (2018). "Experts and Peer Disagreement". Knowledge, Belief, and God: New Insights in Religious Epistemology. Eds. Matthew A. Benton, John Hawthorne, and Dani Rabinowitz. Oxford, UK: Oxford University Press, 2018.

[20] This argument takes into account actual peer disagreement, but the argument is even stronger if it is epistemically appropriate to take into account merely possible peer disagreement into forming one's doxastic attitude about a proposition. This means that it is not only rational to amend one's doxastic attitude when encountering a peer who disagrees, but also that it is rational to amend it based on if one could disagree. If all one needs is peer disagreement from an epistemic agent in a nearby possible world, then suspension of judgment on the matter might be more widespread than previously imagined. This all depends on if merely possible peer disagreement is actually epistemically significant at all or if there are limitations to what we should consider to be epistemically significant merely possible disagreement. See Carey, B. (2011). "Possible Disagreement and Defeat". Philosophical Studies, 155, 371-381 and Barnnet, Z., & Han. (2016). "Conciliationism and Merely Possible Disagreement". *Synthese*, 193: 2973-85.

not participating if they possess such a high degree of epistemic dependence in relation to disagreement about epistemic authorities.

Conclusion

In this essay, I have argued that we can look to Jonathan Matheson's Moral Caution Principle in order to evaluate the moral permissibility of a physician's participation in capital punishment. Physicians have duties to play it safe when they can and mitigate moral risks, even in cases where a physician's involvement would lower the risk of a painful death, provide an avenue of reconciliation for the condemned, and save the lives of those facing organ failure. Although appealing to the duty to be morally cautious depends on a physician's epistemic situation, it may apply to a great deal of the medical community due to their dependence on moral expertise and the widespread disagreement among those experts.

Still, there is something deeply uncomfortable about the implications of this argument. There is something distressing about the medical community's attempt to distance itself from a population of those in medical duress. Indeed, denying physician presence comes at a moral cost; a cost felt only by those with the greatest need of medical competence in order to have a humane death or those seeking a second chance at life. I do not believe that The Moral Caution Principle is unconditional, and so the duty to play it safe is merely a *pro tanto* duty; there may be reasons to override the MC. Yet it is hard to see how MC can be overridden, especially when there are more obvious solutions for ending the potential suffering of the condemned and acquiring transplantable organs: end the death penalty and end the prohibition against a well-regulated transplantable organ market.[21] This is not to say that both of these prohibitions are without their controversy and

[21] For an overview of this debate and argument in favor of an immediate well-regulated organ market, see Taylor. J.S. (2005). Stakes in Kidneys: Why Markets in Human Body Parts Are Morally Imperative. New York, NY: Taylor & Francis Group.

philosophical difficulties and I do not intend to defend either of them here. The point is this: Real alternatives are available for consideration and they should be taken into account when thinking about the costs of not participating. No one has to suffer if the medical community can come together and advocate for greater systemic change to our criminal justice and healthcare system.

CHAPTER 2

Environmental and Criminal Justice: Toxic Prisons, Punishment, and Medicine in the U.S.

In 2017, The U.S. Environmental Protection Agency (EPA) announced that it would be adding a "prison layer" to its Environmental Justice Screening and Mapping Tool (EJSCREEN), a publically accessible tool that maps possible pollutants in areas around the country. The additional layer allows one to access and assess potential environmental hazards present around jails, detention centers, and prisons (U.S. Environmental Protection Agency, 2018a). Such an addition to the surveillance of environmental hazards was received in a positive light by prison rights activists and is seen as a necessary step for progress in environmental justice policy (Loftus-Farren, 2017) given the poor track record of the EPA's response to the environmental harms prisoners face and the ever growing discussion of the enduring existence of "toxic prisons" across the nation (Geltman, et. al, 2016; Wright, 2015).

California prisoners suffered through water pollution issues for years. It was discovered in Salinas Valley State Prison that agricultural nitrates had leached into the nearby water sources, forcing prisoners to either drink from a contaminated water supply or severely limit their access until a new filtration system could be installed. Similar water issues were experienced in prisons such as Sierra Water Conservation Center state prison, the California Rehabilitation Center in Norco, and the California Institution for Men, among others. In all of these cases, prisoners' water access was severely restricted and in some cases there were outbreaks of food and water based illnesses that incapacitated large portions of the prison population. (Dannenberg, 2007). On the East coast, prisoners in a correctional institute in Labelle, PA began experiencing deteriorating health and symptoms consistent with exposure to toxic coal waste. These symptoms ranged from

impairment to their respiratory and gastrointestinal tracts all the way to diagnoses of cancer. According to the Abolitionist Law Center, who conducted a preliminary investigation of prisoner health concerns alongside other environmental and human rights advocacy groups such as the Center for Coalfield Justice and the Human Rights Coalition, concluded that these health concerns affected nearly 81% of the prison population and was mostly likely caused by the neighboring 506-acre toxic coal site. (Abolitionist Law Center and the Human Rights Coalition, 2014).

With this empirical evidence in mind, the addition to the EJSCREEN can be seen as a useful tool for establishing legal precedent for future cases of environmental injustices experienced by prisoners. However, this new addition to environmental policy also raises pertinent ethical questions: What justifies the claim that prisoners can experience environmental injustices? Are environmental harms morally problematic? Questions such as this are important because there is a significant difference between environmental injustices toward prisoners and more traditional claims of environmental injustices in the U.S. Take, for example, Shane Epting's evaluation of the environmental injustices faced by the people of Vieques, Puerto Rico in his essay "The limits of environmental remediation protocols for environmental justice cases: lessons from Vieques, Puerto Rico." By drawing on U.S colonial history, Epting argues that the population of Vieques has suffered environmental injustices by eliminating or replacing the identity of the indigenous population and causing public health concerns through environmentally destructive U.S military training operations (2015). Epting is able to demonstrate this thesis by appealing to a narrative of criminality and victimization. The U.S. as a colonial power committed injustices against the people of Vieques, who are wholly victims of mistreatments from a substantial political and military powerhouse. But the same narrative cannot be established with prisoners. In analyzing the relationship between environmental harms experienced by a prison population, one does not

encounter the population first as victims, but as perpetrators of crimes and victims due to their own criminal wrongdoing. This difference in culpability between the two situations is especially important because a foundational presupposition in theories of criminal justice is that a criminal's rights-based claims have been modified due to their criminal activity. One way to elaborate on this idea is to say that coercive action by the state, and any harsh treatment that follows thereof, is morally justified because criminal activity forfeits some or all of the individual's rights (Morris, 1991). This means that those who wish for modifications in environmental health conditions for prisoners cannot just merely appeal to a criminals basic rights in order to establish a protection from environmental harms. Criminal wrongdoing precludes such a claim because such behavior entails that criminals are morally justified in experiencing certain harms (Boonin, 2008). Establishing the relationship between environmental justice and prisoners first requires establishing the compatibility of claims of environmental justice with incarceration as a form of morally justified punishment. An analysis between environmental justice and criminal justice, therefore, is necessary in order to provide an adequate justification of protection for environmental protections for prisoners. But such protections lack full realization if inmates don't have opportunities for medical resources to alleviate environmental health problems when they occur. Therefore, the analysis must also explore the role of medical ethics in the environmental protections for prisoners.

The purpose of this essay is to provide justification for such protection and evaluate the role of medical professionals. The analysis is separated into two parts: In section I, I will demonstrate how the particular conditions faced by U.S prisoners constitute the possibility that prisoners can experience environmental injustices. I will argue that prisoners in the U.S. can, and do, face environmental injustices because they properly fit into Robert M. Figueroa's

Environmental Justice Paradigm (2006). Prisoners face unique environmental health burdens while incarcerated and lack the political power to address these problems. In section II, I will make the necessary connection between environmental justice and criminal justice by raising the objection that prisoners do not face environmental injustices because they have lost the right to protections from these health burdens. While prisoners facing these health issues are being harmed, these harms are not morally problematic. Just as a prisoner has lost their right to freedom of movement and other rights due to their criminal acts, they have forfeited their right to be free from these health problems. In section III, I will argue that despite losing their right to freedom of movement among others, they do not lose their right to environmental protections. This is a much needed analysis in the literature of criminal justice because criminologists and prisoner rights activists have yet, as far as I am aware, to deal with objections to prisoners facing environmental injustices. The underlying strategy on how to defend a prisoner's right to freedom from environmental health burdens, and prisoners' rights in general, is to demonstrate how the loss of their right is incompatible with their morally justified legal punishment: incarceration. I will demonstrate that environmental health burdens undermine the justification of incarceration as a form of morally justified legal punishment along three major schools of thought regarding theories of legal punishment: consequentialist, deontological, and expressive theories of legal punishment. Lastly, section IV will discuss the moral permissibility of medical professionals in treating the environmental health issues of prisons and the moral dilemma that ensues from considerations of medical justice and criminal justice.

Figueroa's Environmental Justice Paradigm and Incarceration

In order to understand how Figueroa's environmental justice paradigm works, it is helpful to begin with other established definitions of environmental justice. The EPA defines

environmental justice as "the fair treatment and meaningful involvement of all people regardless of race, color, national origin, or income, with respect to the development, implementation, and enforcement of environmental laws regulations and policies (U.S. Environmental Protection Agency, 2018b). Such a definition reflects the change in definitions of environmental justice to be more inclusive of the aspect of recognition justice and a movement away from discussing environmental justice exclusively using the language of distribution (Schlosberg, 2007). Ultimately, one must be careful in moving away from a discussion of the distribution of environmental harms and focusing on the inclusion of historically silenced groups to participate in environmental policy decisions. If environmental justice is exclusively defined in terms of recognition, then such a definition may turn out to undermine environmental policy initiatives. Environmental health issues, if not properly addressed, may be detrimental to the ability of individuals to be involved in the environmental decision-making process. Without the possibility that concerns over the distribution of burdens will be properly addressed, definitions of environmental justice initiatives risk being merely formal and thus become powerless to change situations where someone cannot participate in policy decisions due to unfair environmental health burdens.

Figueroa's environmental justice paradigm avoids this problem by having a more nuanced view that incorporates both concepts of distributive justice and recognition justice. To Figueroa, distributive justice in environmental justice claims has both a dimension of distribution and compensation. An investigation of how environmental burdens (and benefits of groups that avoid such burdens) requires that one look at who is having the experiences, and if those who are disproportionately affected by the environmental burdens are getting proper restitution for such an experience (Figueroa, 360). Figueroa points out that this aspect of environmental justice should be

considered a necessary, rather than a sufficient, condition of environmental justice. Compensation can turn out to be problematic for community cohesion and may ultimately fail to keep environmental health problems from reoccurring in the future, or properly shift the burdens and benefits appropriately (Figueroa, 364-65).

The issue of proper compensation is not lost in discussions of environmental problems and prison construction. In 2005, the Sandy Correctional Complex in the town of Sandy Hook, Kentucky began having drastic sewage problems that created a horrendous stench around town. Even though the prison served as a major employer of the town, providing 224 jobs to a town of only 1,100 people, the town was billed for the expenses to fix the prison's poorly designed sewer system (Dannenberg, 2007). In order to properly deal with the possibility of compensation issues, this requires a definition to include the public recognition of all voices involved in the environmental situation. Issues in compensation can only ever be properly addressed when all are able to level their complaint with voices that are fundamentally equal and public. Thus, Figueroa is able to build recognition justice into his definition as necessary for environmental justice alongside distributive justice. Environmental justice is about the proper regulation of power relations among different groups in an environmental situation.

How does the environmental justice paradigm apply to prisoners? More specifically, what are the issues of distribution of burdens that prisoners face and how do prisoners lack recognition as a group if they are facing environmental injustices? In order to answer these questions, we must briefly look at the history of serious mental health issues in the prison population and how this has become a major problem in prison health. In the 1960's, the closing of state psychiatric facilities created a deficit in health facilities that could properly deal with the predicaments of a population suffering with mental health issues. The deinstitutionalization of psychiatric treatment facilitates,

meant to facilitate a shift to an increase in the quality of care for these individuals, backfired. Many suffering from serious mental health problems have ended up in prison, an institution designed for harsh treatment, rather than healing. Since this time, the percentage of individuals with serious mental health issues who are incarcerated have risen to 21% of the total prison population with over 50% of the population meeting some criteria for mental health issues (Kuppers, 1999; The Center for Prisoner Health and Human Rights, 2018).

Issues of Distributive Justice and Incarceration

These facts have led to prison administration taking drastic measures in order to deal with dangerous behavior among inmates. In order to deter violence, solitary confinement became a popular mode of dealing with this problem despite being notoriously detrimental to one's mental health (Arriago, B., et. al, 2008; Pizzaro, P., et. al, 2006). Those who suffer from serious mental health issues are more likely to exhibit violent behavior, they are more likely to face conditions of solitary confinement. But solitary confinement is well known to cause greater mental instability among inmates and an increased likelihood of violent behavior in turn (Haney, 2018). This means that the current state of incarceration in the U.S. involves a vicious cycle of violence and the exacerbation of serious mental health issues. Such a health burden is unique to those in captivity and not encountered by those outside the correctional system. Law-abiding citizens have legal protection from such coercive action and have the freedom to seek medical resources at their discretion when encountering mental health problems. This means that environmental health becomes a disproportionate burden to prisoners whenever the environmental problems affect the population's mental health. In 2014, the Wallace Pack Unit in Navasota, Texas, a correctional facility that holds mostly elderly and disabled inmates, it was discovered that inmates were drinking water contaminated with arsenic and lead for an extended period of time before a federal

judge ordered the facility to find alternative means to provide clean water to inmates (Banks, 2016). Arsenic and lead are two chemicals that are strongly linked to adverse effects on cognitive and neuropsychological functioning in adults from long-term exposure (Brinkel, et. al 2009; Gidlow, 2003). Furthermore, this was not an isolated case. Evidence suggests that a number similar cases of contaminated drinking water have taken place in correctional institutions across the country. The EPA is aware of a number of informal and formal actions brought against multiple state's violations of the Safe Drinking Water Act of 1974 and the Clean Water Act of 1972; two principal federal laws that set drinking water standards, in their regulation of prisons, jails, and detention centers (Equal Justice Initiative, 2017). If prisoners face environmental health burdens that already negatively affect their mental health, then the unique vicious cycle of violence and serious mental health issues that these individuals face are heightened.

Issues of Recognition Justice and Incarceration

Although a general consciousness of the intersection between public health and environmental harms is growing among scholars and environmental policy groups, this awareness does not entail that prisoners have gained public recognition. Incarceration does not remove all aspects of political participation for prisoners, but they are almost universally disenfranchised due to their incarceration in the U.S.[22] This legislation removes an important *ex ante* aspect to a prisoner's ability to combat environmental harms during their incarceration; an equal say in

[22] Notable exceptions to penal disenfranchisement policies across the U.S. are Vermont and Maine, who have no legislation of disenfranchisement of serious offenders while every other state has some legislation that bars criminals from voting while in prison. Although the justification of penal disenfranchisement is slowly being reconsidered, with the most notable change recently being Florida's decision to lessen the severity of their disenfranchisement policies. A considerable portion of our population is currently disenfranchised due to their incarceration. See Whitt, M. (2017). "Felon Disenfranchisement and Democratic Legitimacy." Social Theory and Practice, 43:2. 283-311 for a discussion of the implications of this result and Brennan Center for Justice. (2018). Criminal Disenfranchisement Laws Across the United States. https://www.brennancenter.org/criminal-disenfranchisement-laws-across-united-states for a detailed overview of current disenfranchisement laws in the U.S.

environmental policy decisions that could either positively or negatively affect their criminal sentencing. Currently prisoners have the ability to politically deal with environmental health burdens through *ex post* means such as the rights to pursue legal actions through either the civil or criminal court in order to be compensated for environmental harms (Bernd, 2017). But the removal of their right to vote precludes the possibility of their voices to be publically heard in decisions about environmental policy and before any health problems could be experienced. Penal disenfranchisement, therefore, serves as a form of silencing of a whole population of individuals who frequently experience environmental harms.[23] It is hard imagine how many harms could have been curtailed if, for instance, the prisoners in Labelle, PA were given a chance to take part in the decision on the placement of the coal waste dump that sits at their doorstep. Instead, prisoners in these situations must rely on activists to be their political representatives in these decisions rather than taking part directly.

Rights Forfeiture, Incarceration, and Environmental Health

What I attempted to demonstrate in the previous section is how prisoners fit into Figueroa's environmental justice paradigm and provides an explanation of how they can experience environmental injustices. The current conditions of incarceration in the U.S. have led to a vicious cycle of violence and mental health issues that are made worse whenever environmental health burdens are present; a unique problem of distributive justice experienced by incarcerated

[23] This leads to an interesting tension between environmental justice and penal disenfranchisement. While it is clear the right to vote in prison for many would help alleviate the problem of recognition in environmental injustices, it is not clear, for instance, why voting, rather than changes to prison conditions that allow for a more substantial political presence could allow for one to have sufficient public recognition in order to satisfy requirements of justice. There would need to be further elaboration on what changes need to be made in prison and what kind of increased political power would be satisfactory. See Marshall, P. (2018). "Voting from prison: against the democratic case for disenfranchisement." Ethics and Global Politics, 11, 1-16 for a more detailed analysis of prison conditions and its relationship to a justification for the enfranchisement of prisoners.

individuals due to the intersection of multiple issues of current penal practices in prison and environmental problems. Alongside the issue of distributive justice, prisoners also experience recognition injustice due to their political disenfranchisement. The voices of prisoners in environmental policy decisions are silenced due to their lack of right to vote and so they are precluded from an effective means to deal with possible environmental harms.

Even with the establishment of the possibility of prisoners as victims of these burdens, this cannot be the end of the discussion. One plausible objection to the possibility that prisoners face morally problematic environmental health burdens and thus environmental injustices is that prisoners, as criminal offenders, have lost their right to be free from such burdens while incarcerated.[24] According to this line of reasoning, criminal offenses change an individual's moral status as full moral subjects; direct moral objects who are owed moral consideration of justice due to their capacity to rationally impose limiting conditions on their actions (Morris, 60-2). Moral status can change due to either one losing their capacity to restrict their actions (i.e. extreme brain damage) or by an unwillingness to respect these restrictions (Morris, 63). A just society is one that is organized by a set of constraints that allow members to be rational maximizers and define the moral rights of its members. Human beings are fickle creatures that are often burdened by temptations that violate the constraints of a just society. Due to this fact, just societies impose punishments for violations of their imposed constraints. Without penalties for the violations of

[24] Although this is one way of thinking about the relationship between rights and the permissibility of legal punishment, it isn't the only way. Other theories reject the forfeiture theory of rights and instead appeal to a theory where prisoners have weakened, yet nevertheless retained, rights or a theory of permissible-infringement in order to protect other important rights. Regardless of the theory of rights, I suggest that the following considerations in this section will apply to them as well; they give us a prima facie reason to believe that prisoners do not face environmental injustices and that in order to justify their imprisonment, their right to protection from environmental health problems must not be either weakened or infringed upon. See Lippke, R. (2007). "Initial Challenges to Rights". Rethinking Imprisonment. Oxford, UK: Oxford University Press for a defense of weakened but retained rights and Tadros, V. (2011). The ends of harm: The moral foundations of criminal law. New York: Oxford University Press for a defense of the theory of permissible-infringement of rights.

rules, the ability to cooperate with one another would be extremely difficult, if not impossible, and the means to follow one's ends would be either detrimentally impeded or lost entirely (Morris, 64). Those who violate the rights of others show disrespect for the imposed rules of society and thus forfeit their protection from rights infractions. Criminal offences that violate the rights of others indicate unwillingness to respect the rules of society (Morris, 65). The loss of full moral status by criminal offenders perpetuates incarceration as a legal punishment and the loss of freedom of movement, association, privacy, and property that are protected by law abiding citizens that possess full moral status. But this also implies that other rights may have been forfeited by prisoners, such as the freedom from environmental health burdens while incarcerated, and thus fail to be victims of environmental injustice.

Rights Forfeiture and Standards of Suitability

One initial reply is to point out that while the rights forfeiture theory implies that prisoners lose a right to be protected from environmental health burdens, it does not entail it. Any rights forfeiture theory must answer the question of which rights are lost when someone violates the rights of others. It does not seem correct, for instance, to say that when Bill takes a baseball bat to Jim's legs and cripples him for life, he deserves to lose his right to protection from environmental health burdens. It seems more plausible that many of the rights that Bill loses from his actions are the ones closely associated with incarceration. By breaking Jim's legs, Bill seems to be infringing on Jim's freedom of movement because it limits his ability to move as he could before the incident. It is also plausible that crippling Bill violated his right to free association, privacy, and property by affecting his relationships with others and his ability to provide a source of income for himself. Friends and family treat him differently, give him less privacy out of concern for his own safety, and Jim is unable to return to his job without extensive changes to work responsibilities. On the

other hand, there seems to be a lack of justification for Bill losing his freedom from environmental health burdens by crippling Jim. Bill surely violates Jim's right to health, but there is a difference between Jim taking a baseball bat to Jim's legs and negligently giving Bill cancer by putting environmental waste in his backyard.

Unfortunately, this reply is unsatisfactory because a rights forfeiture theorist need not be committed to such an account of suitability. Rights forfeiture theorists need not be committed to a principle of killing killers, raping rapists, and torturing tortures. Forfeiture theorists can instead suggest that the rights forfeited must be equivalent in some way to the rights violated. This allows the rights forfeiture theorists to avoid the more troublesome problem that the previous standard struggles with, such as what right does a blind person lose if they take the sight of someone else? (Kershnar, 2010). If the violation of someone's right to see turns out to be a severe violation, then what is needed is the forfeiture of the blind perpetrators rights that are considered significant, whatever that may be. This solves the predicament of punishing Bill for his crimes against Jim. If both the right to be free from environmental health burdens and the freedom of movement are important rights, then it seems like there are other ways for a right forfeiture to answer this question, but I will not pursue that here. It is more important to see why this reply is wrongheaded in the first place. While it is the burden of the rights forfeiture theorist to figure out what the suitability conditions of the loss of rights actually are, it is the burden of the defender of prisoner's rights to show that such a right has not actually been lost even if the suitability condition has been met. What makes an appeal to rights forfeiture such a powerful objection is that it shifts the burden of proof in our typical moral reasoning. Evaluations of justice normally revolve around the rights violations of two or more rational agents with full moral status. This is consistent with Epting's evaluation of the environmental injustices imposed upon the people of Puerto Rico by the U.S.

The people of Puerto Rico are victims of a rights violation by the U.S. government because each individual affected is presupposed to have full moral status. The challenge of rights forfeiture is that it changes the paradigm to the treatment of those who have some limited moral status. This means that the proper reply is to demonstrate that even though prisoners have lost some of their rights, they have not lost their right to be free from environmental health burdens.

The Beginnings of a Solution

The first part of this argument is to clearly demarcate the limits of the rights forfeiture theory explained above. The theory above states that punishment of criminal offenders is just because they have forfeited their rights. But this serves only as a *necessary* condition for any theory of punishment, not as a *sufficient* condition (Morris, 68). The loss of rights by the perpetrators of crimes explains why the state can impose harsh treatment without committing an act of injustice themselves. It does not explain the purpose or aim of that harsh treatment (Wellman, 2012). It is one thing to say that when Bill cripples Jim he forfeits some of his rights and whatever rights he forfeits must be as important as the right he infringed, but it is entirely different to give a *reason* for the forfeiture of one important right over another. Out of a set of rights that meet the suitability condition, we must independently demonstrate that the rights lost are compatible with the theory of punishment. For example, the rights that are lost must lead to good consequences, it is merely what the perpetrator deserves, or the state taking away these rights expresses the proper message of moral censure. The second part of this argument is to show that even though prisoners have justifiably lost some of their rights, they have not lost their right to be free from environmental health burdens. For the sake of argument, I will presuppose that the loss of rights typically associated with incarceration-- freedom of movement, association, a limited form of privacy, and property-- is morally justified and in turn their incarceration is morally justified. What needs to be

shown then, is that environmental health problems, as a condition of their incarceration, is morally unjustified on different accounts of punishment because it makes their imprisonment morally problematic. If a prisoner's incarceration is to be held as morally justified, then their right to environmental health burdens must be protected and not forfeited.

Environmental Health and Morally Justified Punishment

Theories of punishment come in three broad forms: consequentialist, deontological, and expressive. Consequentialist theories of punishment are forward-looking and see the justification of any form of punishment determined by whether or not the criminal sentencing leads to good consequences (Duff, 2001). According to this view, punishment is a form of harsh treatment that is necessary in order to either prevent other harms from occurring and lacks any essential connection to the morality of the criminal action itself. If there are other means that either reduce or stop the harsh treatment associated with criminal wrongdoings, and these means do not harm the criminal themselves, then we should take these actions instead of punishing criminal offenders because this will lead to better consequences overall. In contrast to this consequentialist theory of punishment, there are theories that take on a deontological form and an expressivist form. Deontological theories of punishment see an essential connection between punishment and the morality of the action itself; rejecting the idea that it is the consequences of forms of punishment that justify the institution itself. The very practice of punishing criminal offenders possesses an intrinsic value, and any good consequences that may or may not fall out of practicing certain forms of punishment have no bearing on the morality of punishment itself (Duff, 2001). Deontological theories of punishment are therefore backward-looking theories of punishment. Expressivist theories of punishment differ from both deontological and consequentialist theories of punishment by focusing on the social meaning of the punishment itself as a response to the immoral actions of

the offender. The value of punishing the offenders does not come from giving the criminal what they deserve nor reducing future harms, but rather comes from the moral condemnation of the criminal act and the understanding of this condemnation that follows in the intended audience (Duff, 2001). Expressivist theories thus incorporate both forward-looking and backward-looking elements; they are concerned with the effects the moral condemnation has on the audience while placing value on the expression of the censure itself.

Consequentialist Theories of Punishment: Rehabilitation as Moral Fortification

Out of any kind of good consequences that can be brought about by the institution of legal punishment, the most widely accepted consequence is crime-reduction. The consequentialist could justify the practice of incarceration by appealing to different means of crime reduction. Incarceration, for instance, could be justified by appealing to its ability to deter future crimes (Walker, 1991; Wilson, 1985). The threat of incarceration could be effective to strike fear in potential criminal offenders in order to keep individuals from committing crimes. Incarceration may be used to reduce criminal activity or provide other valuable consequences, such as the one I wish to focus on – rehabilitating offenders. Under the right conditions, correctional facilities could be the ideal grounds for instilling a disposition to avoid violating the law imposed by that society. Although related, the concept of rehabilitation is distinct from the concept of deterrence because while deterrence invokes a fear of external restraints on one's behavior, rehabilitation would appeal to one's own free agency in obedience to the law. Crime reduction follows naturally from rehabilitation because the offender is morally reformed and is deterred from committing future crimes because of their newfound understanding of their past deviant behavior.[25]

[25] Another way incarceration could reduce crime is by incapacitating offenders. Incarceration can be used as a vehicle for quarantining criminal wrongdoing from the general public and thus keeping instances of crime down.

One account of criminal rehabilitation is to think about it as a type of fortification of their moral capacity. Criminal offenders violate a duty to maintain such capacity and the state enacts reform to bring their moral capabilities up to an adequate level of reliability (Howard, 46). Among the many duties that moral agents must adhere to, one type of duty that we have are fortificational duties; duties to remain morally compliant. Barbara may have duties not to steal, but she also has duties to make sure that she does not violate such a duty. She may need to avoid locations where she would be tempted to steal, take measures to better understand why stealing is wrong, and pursue ways to develop countervailing desires not to steal (Howard, 47). Rehabilitative programs are concerned with developing the moral agency of the criminal offender; specifically working to avoid mistaken conclusions about what is morally permissible and mitigating temptations that interfere with the pure motivation of doing one's duty (Howard, 49). By breaking the law, offenders have provided evidence that they lack moral strength and are no longer morally trustworthy, thus lacking the immunity of coercive action by the state to assist in fortifying their moral agency (Howard, 51-2). The primary aim of the legal punishment, therefore, is to make its citizens morally reliable and not just to deter future criminal activity. But the main aim of rehabilitating offenders and deterring crimes cannot be separated so easily. In order to properly fortify those who demonstrate a lack of moral strength, one must pay careful attention to the criminogenic effects of certain forms of punishment. It would be entirely self-defeating for the state to take coercive action on an offender in such a way that would put them in a position where they are incentivized to repeat the offense.

Other types of penal law practiced by administrators could be justified in keeping criminal wrongdoings from happening inside the prisons.

But there is evidence that certain forms of punishment create vicious cycles of criminal behavior. High rates of imprisonment have been strongly correlated to a high degree of concentrated social and economic disadvantage and increased crime rates in communities (Clear, 2007). Communities with concentrated disadvantage have poor social organization and competing value systems (Shaw & McCay, 1942). Imprisonment affects a community's social control by creating issues of stigmatization in their community (Clear, 2007) and transmission of prison culture and values to a traditional value system (Roberts, 2004). For individuals, this translates to poor close interpersonal relationships (Western, 2002), the inability to find and maintain long-term, stable legal employment opportunities outside their previous criminal networks (Freeman, 2003), and the lack of public institutional support to remedy these deficiencies (Shaw & McCay, 1942). These kinds of ecological circumstances make it difficult for an individual to take measures to learn about what is morally permissible and to avoid bad influences. This makes it clear that improving environmental circumstances that are statistically tied to crime rates will have an impact on also rehabilitating individuals in these communities.

Environmental health burdens, when they negatively affect the mental health of prisoners, undermine the ability of incarceration to reduce crime by either deterring future criminal activity or rehabilitating criminals to choose a life without crime. Criminal offenders who suffer from serious mental and physical health issues statistically have a higher chance of recidivism (Wilson, et. al, 2011; Stogner, et. al, 2014), so any environmental conditions that a criminal would face while incarcerated that adversely affect one's mental and physical health may risk increasing the chances of recidivism. More broadly, there is evidence that suggests that both physical and mental health issues impact a prisoner's ability to find and maintain legal employment after being released

(Western, 2018) and may create social strain on primary avenues of emotional support, such as family members (Magliano, et. al, 2005; van der Sanden, et. al, 2016).[26]

Deontological Theories of Punishment: Retributivism and Self-Determination

In contrast to consequentialist theories, deontological theories of punishment, traditionally, are theories of retributive justice. Some versions appeal to our intuitions around punishment in order to motivate the idea that punitive desert is an essential feature that justifies legal punishment. On this view, we are tasked with judging how just a world is where individuals are either punished for crimes they didn't commit, or given obviously cruel punishments for relatively minor crimes.. If one's intuitive response is to regard that world as unjust, then that motivates the notion that punitive desert is a necessary condition for a theory of punishment (Kershnar, 2000). Other versions of retributivism equate retributive justice with distributive justice and focus on the nature of society in order to justify certain forms of punishment rather than appealing to intuition pumps.

According to this later view, mutually cooperative behavior is necessary for there to be a mutually beneficial society. Criminal behavior allows one to circumvent this situation of reciprocity by occurring benefits from their actions while also circumventing the costs and an institution of legal punishment practices forms of deprivations that compensate for unfair gain (Boonin, 120). Incarceration, for example, could be justified as a form of punishment by depriving

[26] One has the same problem if incarceration is justified on the grounds of incapacitation except that the location of criminal activity has shifted. Instead of criminal wrongdoings taking place in the general public, the wrongdoings would be perpetuated by other prisoners. If a consequentialist theory of punishment justifies the institution by appealing to crime reduction, then it must reduce crimes inside and outside of prisons. A consequentialist theory of punishment has no built-in distinction in defining what counts as a crime and who can experience crimes. Thus, incarcerated offenders and law abiding citizens alike are both included in the calculus of crime reduction, regardless of how a society may define what counts as a crime. If what I have said so far is correct, then environmental injustices that many prisoners face currently in the U.S. which undermine their mental health also undermine the justification for their incarceration as a deterrent, a mode to incapacitate criminals, or the ability to rehabilitate criminals.

them of their liberties just as they deprived the liberties of others. An important part of retributivism is an aspect of blameworthiness (Von Hirsch, 1976). Legal punishment is only appropriate for those who are self-governed by moral laws. To deprive someone of their previously held liberties due to their unfair gain is to treat them as moral agents. One part of limiting the type and severity of harsh treatment is that the object of punishment must always be considered to possess moral agency. Here, retributivism shares the same criticism that environmental health problems in prison have morally problematic effects as the fortificationist theory above. Physical and psychological pathologies that undermine the prisoner's capacity to exercise their moral powers are unjustifiable and the prisoner retains the set of rights that protect them from such conditions while incarcerated.

However, there are at least two differences between the fortificationist criticism and the retributive criticism of environmental health problems. First, while the fortificationist sees protection from these issues as important for the prisoner to become morally reliable, the retributivist sees the protection from such burdens as necessary to ensure that the prisoner doesn't fall below a minimal standard of psychological competency and is no longer eligible for punitive desert. Second, retributivism is concerned not just with the prisoner's capacity for moral autonomy, but also about treating them as beings with personal autonomy; the capacity to determine for one's self the nature and meaning of the good life (Rawls, 47). We can see this concern in other contexts of criminal justice reform such as whether or not a prisoner has a right to privacy. According to some advocates for this right, having control over information about oneself and who has access to it is necessary to develop an understanding that one is a self-determining agent, especially in an environment of constant surveillance and bodily intrusions (Lippke, 113).

My suggestion here is that we can look at a prisoner's right to environmental health protections through a similar retributive lens. Illness is a pervasive and all-consuming aspect of human existence that compromises one's personal autonomy. While one is sick, pain and anxiety become a primary focus and pursuit for its remedy preemptively takes control (Pellegrino, 2004). Opportunities for medical treatment of illness should always be available, but it is also important that the preclusion of illnesses that are preventable should always be pursued at the same time because healing requires a great deal of bodily intervention and decision-making is transferred over to medical professionals. In a context where a number of deprivations of one's personal autonomy is already present and issues of personal identity and self-worth are present (Clear, 2007), having protection from environmental health problems becomes essential for a prisoner to retain a sense that they are self-determining agents.

Expressive Theories of Punishment: Communication and Secular Penance

There are many different types of expressive theories of punishment; mainly differing over who is the appropriate audience for the state's moral condemnation of a criminal act. Some argue that the whole moral community, both the public at large and the criminal offender themselves, is who the state should be in dialogue with while others argue that mere expression of censure itself is sufficient for justified legal punishment whether or not there is an audience at all.[27] I wish to focus on R.A. Duff's (2001) influential version of expressivism called the communicative theory of punishment. According to the communicative theory of punishment, the focus of legal punishment should be on the attempt at communicating a moral censure to the criminal offender rather than to the whole moral community or merely the value of expression itself. The aim of the

[27] For a discussion of the different types of expressivism, see Wringe, B. (2017). "Rethinking Expressive Theories of Punishment: Why Denunciation is Better Than Communication or Pure Expression". Philosophical Studies. 174, 681-708.

state's coercive harsh treatment toward someone who has broken the law should be to persuade them that what they have done is wrong, invoke appropriate moral emotions such as guilt, shame, and indignation toward their own criminal wrongdoing, and in doing so provide opportunities for reintegration with the moral community (Duff, 91-2).

Punishment is justified because it invokes secular penance: it aims at causing repentance and making reconciliation over the broken social and moral bonds of the community possible. According to Duff, imprisonment is an important form of punishment because it holds the place as an ultimate sanction for those who fail to be moved by the moral condemnation in other forms of punishment. Inevitably, there will be those who fail to be convinced of their wrongdoing and hold steadfast to their beliefs of innocence during mediation processes and education programs. For these offenders, harsher treatments are appropriate to get the social meaning across and shock the criminal into repentance. The severity of incarceration serves to provide this necessary stimulus to kick-start moral reflection (Duff, 53).

The communicative theory of punishment shares a similar worry that both fortificationism and retributivism have of environmental health issues of prisoners: the possible degradation of their moral agency due to physical and psychological pathologies. The harsh treatment of punishment must treat criminal offenders as moral agents, and the harsh treatment of imprisonment acts as a way to persuade them of the wrongdoing rather than manipulate them into acts of reconciliation and repentance (Duff, 14). According to Duff, punishing offenders in order to deter or rehabilitate fail to respect moral agency nor is it appropriate to provide self-interested incentives for the criminal to obey the law. The moral condemnation must be free of threats of harsh treatment in order to have a proper dialogue and invoke moral reflection (Duff, 45). But communicating

censure is undermined if the prisoner has lost the capacity for moral reflection due to arsenic and lead poisoning in their water system, for example.

There is also a unique issue that the communicative theory of punishment has with environmental health issues. Part of what it means to properly express moral condemnation is to invoke a moral response in the offender. Moral reform comes from them understanding the message and feeling guilt, shame, and indignation for what they have done and justified forms of punishment act as the vehicle for inducing these emotions. But certain deprivations in the prison environment can undermine the experience of these moral emotions in relation to their criminal behavior. There is empirical evidence that the severe lack of privacy in prison leads to painful experiences of frustration, depression, despair, and even resentment and rebellion toward their current situation (Lippke, 114). If the purpose of incarceration is to shock the inmate into repentance, then these emotional dispositions surely serve to interfere with it. The pains of illness may have similar effects on the possibility of moral reflection and reform. Rather than understanding their past wrongs, prisoners who face environmental health problems will be preoccupied with their health and may even feel indignation and resentment for their situation in prison.

Environmental Justice and The Role of Medical Professionals

How might environmental injustices experienced by prisoners be relevant to the duties of medical professionals in correctional healthcare? One example is that the medical treatment of environmental health problems is morally complex and the ethical duty of a physician to treat these conditions can only be determined on a case by case basis. There are good moral reasons for medical professionals to treat illnesses caused by poor environmental health conditions in

prisons. These issues are environmental injustices due to the unfair distribution of these burdens in comparison to the rest of the moral community. But from a medical perspective these cases of environmental injustice are also cases of *medical injustice.* Physicians have a duty to fairly allocate medical resources to their patients and respond to discriminatory medical burdens (Beauchamp & Childress, 248). If prisoners really do face both physical and psychological pathologies from poisoned water, toxic coal waste, other food and water based illnesses, etc. and these burdens are morally unjustified from a criminal justice perspective as argued above, then physicians in correctional healthcare have reason to advocate for the opportunity to provide the medical resources necessary to relieve them of these burdens.

However, the normative significance of medical ethics is not the only relevant moral feature in determining the moral permissibility of medical treatment of environmental harms. The role of the medical professional is never the only role one must play in these situations. Physicians also play the role of citizens and must take into account that environmental injustices make their punishment of incarceration morally problematic. Whenever a physician provides medical treatment for their patient's environmental health issues, they are acting in such a way that will send them back to a morally problematic state of imprisonment. There is the possibility that there will not be long-term improvements to their health because they will be sent back to face the conditions that caused their illness in the first place. Physicians would be complicit in their unjust punishment. Although physicians may have good moral reasons to treat the symptoms of an inmate's environmental health problems, they must also take into account the systemic issues that caused their decline in health in the first place. Thus, medical professionals in correctional healthcare have conflicting moral reasons to be involved in an inmate's care when it comes to environmental health issues. From the perspective of medical ethics, these medical

pathologies are unfairly discriminatory and responding by providing the opportunity for treatment is morally appropriate. But, they may also know that their incarceration is unjust because of the presence of environmental injustices.

I suggest that this moral dilemma can be resolved by appealing to three factors to determine the permissibility of their complicity in their medical treatment: (1) the consequences on the physician, the patient, and how it affects the practice of the principal wrong, (2) the preferences and requests of their patients involved in the principal act, and (3) the degree of complicity in the principal act (Lepora & Goodin, 151). Medical professionals should take into account how treatment will affect their credentialing in the medical community, how short-term treatment will affect their health given their condition, and whether or not treatment or withholding treatment will have consequences on future criminal justice policies regarding the systemic issues of environmental injustices in prison. They should also take into account the interests of their patients. If their patient has given their informed consent for medical intervention despite its possible short-term effects once they are healed, then this gives a *prima facie* reason to be involved. Lastly, medical professionals need to understand how complicit their involvement in the unjust punishment of imprisonment will be by providing medical resources. Physicians will need to make considered judgments about how voluntary their involvement is, how much they are contributing to their incarceration or if they are taking additional action to minimize their contribution such as taking part in measures to change the environmental conditions of imprisonment, and to what degree of injustice incarceration is as a punishment given the violation of prisoner's rights to protections against environmental health issues.

Conclusion

In this essay, I have argued that prisoners can experience environmental injustices because they fit into Robert M. Figueroa's environmental justice paradigm. When the environmental harms heighten their preexisting public health burdens, the issue of distributive justice becomes one with a distinctly environmental tone. The disproportion of these burdens are further problematized due to the common practice of penal disenfranchisement in the U.S., excluding prisoners from an effective means to address these burdens in the public sphere, and protect themselves from further harms. I have also argued that the reality of environmental injustices can undermine incarceration as a form of justified punishment on consequentialist, deontological, and expressivist grounds and that this is relevant to limits of correctional healthcare. The environmental harms faced by prisoners are problematic for a prisoner's development of moral resilience, punitive desert, and moral reform. Physicians in correctional healthcare must take these ideas into consideration during treatment. Therefore, a connection between environmental justice, criminal justice, and medical ethics can be established and used for the continuing fight for prisoner's rights and addressing problems in correctional healthcare.

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