Second Opinion: Inconsistent Deference to Medical Ethics in Death Penalty Jurisprudence

DANIEL N. LERMAN*

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* Georgetown University Law Center, J.D. expected 2008; University of Chicago, Ph.D., 2003; Brown University, B.A., 1996. I thank Professor Gregg Bloche for his valuable advice and guidance.

INTRODUCTION

On April 21, 2006, Willie Brown, Jr. was executed by lethal injection in North Carolina by officials using a machine—rather than a trained physician—to ensure he did not suffer unconstitutional pain.[1]

In response to mounting evidence that inmates were not properly anesthetized during lethal injections and may therefore have experienced excruciating pain in violation of the Eighth Amendment, U.S. District Judge Malcolm Howard ordered that Brown's execution could proceed only in the presence of "personnel with sufficient medical training to ensure that [Brown] is in all respects unconscious prior to and at the time of" the execution.[2] But that order placed the state in a potentially untenable position because medical ethics forbid physicians from participating in executions.[3] Thus, the state devised an execution protocol that used the machine, a bispectral index (BIS) monitor, rather than physicians and nurses, to monitor Brown's level of consciousness.[4] The problem with this strategy was that while the state claimed the machine would ensure that Brown was rendered unconscious during the execution, it was widely accepted by anesthesiologists that the BIS monitor alone is insufficient to monitor anesthetic depth, as the manufacturer of the machine itself stated in its product literature.[5] Indeed, the company's medical director called the sale of

1. Robert Steinbrook, *New Technology, Old Dilemma—Monitoring EEG Activity During Executions*, 354 NEW ENG. J. MED. 2525, 2525 (2006).

2. Brown v. Beck, No. 5:06-CT-3018-H, 2006 U.S. Dist. LEXIS 60084, at *7 (E.D.N.C. Apr. 7, 2006), *aff'd*, 445 F.3d 752 (4th Cir. 2006).

3. *See* Brief of the Appellees Opposing Appellant's Motion for Preliminary Injunction at 12, Brown v. Beck, 445 F.3d 752 (4th Cir. 2006) (No. 06-9), 2006 WL 1348298 (arguing that because medical ethics would inhibit the willingness of medical professionals to participate in executions, "the requirement that a physician . . . be present injects foreseeable, and likely insurmountable, difficulties." *See infra* notes 12–18 and accompanying text for a discussion of the medical community's proscription on physician participation in executions.

4. Steinbrook, *supra* note 1. A physician and nurse viewed the execution and the BIS monitor from an observation room adjacent to the execution chamber. *Id.* at 2527.

5. *See* Affidavit of Scott D. Kelley, M.D. at 3–4, Brown v. Beck, No. 5:06-CT-3018-H, 2006 U.S. Dist. LEXIS 60084 (E.D.N.C. Apr. 7, 2006) ("Clinical judgment should always be used when

the device "a regrettable system failure"[6] and accused the North Carolina Department of Corrections of lying about its intended use in order to obtain the device.[7] Despite these problems, however, Judge Howard accepted the state's proposal to use the monitor during Brown's execution.[8]

The use of the BIS monitor during Brown's execution highlights the difficult question of the extent to which courts should defer to medical ethics where physicians are participants in the criminal justice system. Physicians serve a variety of roles in criminal proceedings, from evaluating a defendant's competency to stand trial or be executed, to providing voluntary and involuntary medical treatments to prisoners, to participating in executions of condemned inmates. But who should decide whether such procedures at the intersection of law and clinical practice are acceptable—the legislature, the courts, or the medical profession? Should judicial decisions rely on medical ethics, and if so, when? Recent death penalty jurisprudence suggests that, despite the importance of these questions, the courts have failed to present a coherent answer. In some recent cases, courts have deferred to medical ethics when rendering decisions on the constitutionality of clinical activities that would facilitate an inmate's execution, while in others courts have dismissed or ignored medical ethics.

This conflict is in urgent need of resolution. In response to recent challenges, executions by lethal injection have been suspended in several states,[9] as officials struggle to develop constitutional execution protocols. Moreover, litigation challenging lethal injection is likely to increase in light of the Supreme Court's decision in *Hill v. McDonough*, which cleared the way for death row inmates to challenge the constitutionality of their method of execution under 42 U.S.C. § 1983.[10] Thus, a growing number of courts, including the Supreme Court, will

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interpreting the BIS in conjunction with other clinical signs. Reliance on the BIS alone for intraoperative anesthesia management is not recommended.").

6. Adam Liptak, *State Proposes Using Device, Not Doctors, In Execution*, N.Y. TIMES, Apr. 13, 2006, at A14.

7. *See* Steinbrook, *supra* note 1, at 2527 (noting that in its purchase request the Department of Corrections claimed the monitor was to be used only "to monitor vital signs and sedation scales of patients recovering from surgery").

8. *Id.*

9. *See* Henry Weinstein, *N.C. is 11th State to Halt Lethal Injections*, L.A. TIMES, Jan. 26, 2007, at A16 (noting that eleven states have halted executions because of challenges to lethal injection); *see also* Adam Liptak & Terry Aguayo, *After Problem Execution, Governor Bush Suspends the Death Penalty in Florida*, N.Y. TIMES, Dec. 16, 2006, at A11 (noting that the Governor halted all executions in Florida and appointed a commission to review lethal injection); Laura Mansnerus, *Panel Seeks End to Death Penalty for New Jersey*, N.Y. TIMES, Jan. 3, 2007, at A1 (reporting that a New Jersey commission recommended abolishing the death penalty); Jennifer McMenamin, *Md. Executions Halted; State Court Finds Procedures Established Improperly*, BALT. SUN, Dec. 20, 2006, at 1A (reporting that Maryland's highest court, the Court of Appeals suspended executions until the legislature reviewed the lethal injection protocol); Peter Whoriskey & Sonya Geis, *Lethal Injection Is On Hold in 2 States*, WASH. POST, Dec. 16, 2006, at A1 (reporting that lethal injections were suspended in Florida, ordered reformed in California, and delayed in Missouri and South Dakota).

10. Hill v. McDonough, 126 S.Ct. 2096, 2100 (2006) (holding that a challenge to the method of execution can be brought under § 1983 and therefore should not be dismissed as a second habeus petition).

likely have the opportunity to address the constitutionality of lethal injection methods—along with the larger issue of whether and when medical ethics should inform constitutional jurisprudence.[11]

This Note illustrates the inconsistent judicial deference to medical ethics by focusing on two increasingly controversial roles physicians play in capital proceedings: their direct participation in the lethal injection process itself and their treatment of insane inmates to restore the condemned's competency to be executed. Part I of this Note provides an overview of the medical community's ethical proscription against physician involvement in executions and outlines some reasons why physicians nonetheless breach medical ethics by participating in executions. Parts II and III demonstrate the inconsistent deference to medical ethics in two lines of cases. Part II discusses recent court decisions suggesting that the Eighth Amendment requires physician participation in lethal injection, and argues that these decisions force physicians to violate their professional ethics. Part III analyzes decisions regarding involuntary medication of inmates with mental illnesses to render them competent to be executed. Courts striking down such medication schemes do so in deference to medical ethics, while the one court to allow forced medication ignored the ethical problems inherent in such treatment. Thus, an inconsistency exists between courts that defer to medical ethics and courts that dismiss medical ethics when rendering decisions in death penalty cases, and this deference differential is outcome determinative. Finally, Part IV suggests that the decisions discounting medical ethics contradict a longstanding Supreme Court tradition of deference to medical ethics and practice and argues for increased judicial deference to medical ethics in death penalty jurisprudence.

I. PHYSICIAN PARTICIPATION IN LETHAL INJECTION: MEDICAL ETHICS AND STATE LAWS

Medical ethicists oppose physician participation in capital punishment on the grounds that such involvement violates physicians' ethical obligation not to harm patients and inappropriately subsumes the interests of the patient to those of the state. Yet doctors are often compelled to serve not just the interests of their patients but also those of society, and the ethical conflict that arises when physicians participate in lethal injections results from this "dual loyalty" problem. Moreover, many state laws allow or even require physician participation in executions, often shielding physicians from liability by providing that such participation does not constitute the practice of medicine and presumably does not trigger the doctors' professional ethical obligations. As a result of these laws, and their underlying denial of ethical obligations, physicians play a

11. The question of deference to medical ethics and practice has significant implications beyond the death penalty debate for other important issues at the intersection of medical ethics and constitutional law, including abortion, assisted suicide, and withdrawal of life-sustaining medical treatment. *See infra* Part IV.A for a discussion of judicial deference to medical ethics in such contexts.

variety of roles that facilitate capital punishment, in spite of the widespread ethical consensus prohibiting such involvement. Moreover, in denying that ethical obligations are even implicated, this view that physicians are acting outside of their normal medical role when participating in executions circumvents the question of judicial deference to medical ethics.

A. THE ETHICAL PROSCRIPTION AGAINST PHYSICIAN PARTICIPATION IN EXECUTIONS

Virtually every medical and humanitarian organization to address the issue opposes the participation of physicians in capital punishment.[12] For many medical societies and ethicists, this opposition is rooted in the Hippocratic dictum, "first do no harm," as well as the modern professional ideal of nonmaleficence.[13] As the American Medical Association's (AMA's) Council on Ethical and Judicial Affairs noted, "[p]hysician participation in executions contradicts the dictates of the medical profession by causing harm rather than alleviating pain and suffering."[14] Accordingly, the AMA's Code of Medical Ethics states that "[a] physician, as a member of a profession dedicated to preserving life where there is hope of doing so, should not be a participant in a legally authorized execution."[15] Many other medical societies have also adopted policies prohibiting physician participation in execution, including the American College of Physicians (ACP), American Psychiatric Association (APA), World Medical Association, American Nurses Association, and the Society of Correctional Physicians,[16] and more than half of state medical associations have also spoken against physician participation in executions.[17] The AMA Code also explicitly forbids physicians from treating a condemned prisoner for the purposes of restoring his competency to be executed, unless a commutation is granted prior to the commencement of treatment.[18]

Opponents of physician participation in execution also argue that such partici-

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12. *See* Robert D. Truog & Troyen A. Brennan, *Participation of Physicians in Capital Punishment*, 329 NEW ENG. J. MED. 1346, 1349 (1993).

13. *See* AM. COLL. OF PHYSICIANS ET AL., BREACH OF TRUST: PHYSICIAN PARTICIPATION IN EXECUTIONS IN THE UNITED STATES 37 (1994) [hereinafter BREACH OF TRUST]; Kenneth Baum, M.D., *"To Comfort Always": Physician Participation in Executions*, 5 N.Y.U. J. LEGIS. & PUB. POL'Y 47, 56 (2001–02).

14. Council on Ethical and Judicial Affairs, *Council Report: Physician Participation in Capital Punishment*, 270 JAMA 365 (1993).

15. AMA Code of Medical Ethics, E – 2.06: Capital Punishment, http://www.ama-assn.org/ama/pub/category/8419.html [hereinafter AMA Code].

16. *See* BREACH OF TRUST, *supra* note 13, at 11 (listing physician groups opposed to physician participation in executions); Atul Gawande, *When Law and Ethics Collide—Why Physicians Participate in Executions*, 354 NEW ENG. J. MED. 1221, 1221 (2006) (same).

17. *See* Christopher J. Levy, *Conflict of Duty: Capital Punishment Regulations and AMA Medical Ethics*, 26 J. LEGAL MED. 261, 268 (2005) (noting that more than half of state medical associations have "issued statements either declaring physician participation in criminal executions unethical or discouraging it overall").

18. AMA Code, *supra* note 15. The ethical arguments outlined in this Part apply both to physicians participating in lethal injections and those who medicate condemned inmates to restore competency to be executed, unless otherwise noted. Ethical dimensions unique to the issue of medicating to restore competency are discussed in Part III.B, *infra*.

pation will erode the public trust in the medical profession. This breach of trust can occur at various levels, ranging from the individual patient to society at large. At the individual level, trust is essential to the doctor-patient relationship. While one could reasonably argue that no such relationship exists between a doctor and the inmate she is helping to execute, or that trust is not essential in this context, concerns over an erosion of trust are heightened when a physician forcibly medicates an inmate to render him competent to be executed. Such involuntary medication prevents a trustful relationship between the physician and her patient and therefore inhibits the efficacy of any subsequent treatment of that patient's mental illness.[19] Further, participation in either lethal injection or involuntary medication can compromise a doctor's relationship with the entire inmate population,[20] thereby interfering with effective treatment of this class of patients. Finally, physician involvement in lethal injection erodes the public's trust in the medical profession as a whole. Society trusts that physicians work to heal, not harm, their patients, and this trust is threatened by physician involvement in lethal injection[21] or in medicating to restore competency for execution. "When doctors enter the death chamber, they harm not only their relationship with their own patients but the relationships of all doctors with their patients."[22]

Supporters of physician participation in lethal injection respond that physicians are obligated to relieve suffering, and it is thus in the patient's best interest that trained physicians be involved with starting intravenous lines and measuring and administering drugs to ensure that the execution proceeds as quickly and painlessly as possible. The patient here has no hope—like a terminally ill patient, his death is unavoidable, and failure of a doctor to participate would actually cause the patient more pain.[23] However, this argument fails for several reasons. First, while a physician may wish to comfort a condemned inmate, strictly speaking the inmate is not her patient.[24] The inmate cannot refuse the physician's care, nor is he or his family permitted to know the doctor's

19. *See* Jennifer E. Lloyd, *Primum Non Nocere:* Singleton v. Norris *and the Ethical Dilemma of Medicating the Condemned*, 58 ARK. L. REV. 225, 243–44 (2005).

20. *See* Brief for the American Psychiatric Association and the American Medical Association as Amici Curiae Supporting Petitioner, Perry v. Louisiana, 498 U.S. 38 (1990) (No. 89-5120) (arguing if psychiatrists are perceived as assisting in the execution process, "the ability of all physicians to maintain an effective patient-physician relationship with prisoners will be significantly impaired").

21. *See* BREACH OF TRUST, *supra* note 13, at 37.

22. Jonathan I. Groner, *Lethal Injection: A Stain on the Face of Medicine*, 325 BRIT. MED. J. 1026, 1028 (2002); *see also* Truog & Brennan, *supra* note 12, at 1348 ("[I]ndeed, such participation offends the sense of community by prostituting medical knowledge and skills to serve the purposes of the state and its criminal-justice system.").

23. *See* Baum, *supra* note 13, at 61 ("Condemned death row inmates are, for all practical purposes, terminally ill patients."); Truog & Brennan, *supra* note 12, at 1348–49 (noting that condemned inmates may be viewed as terminally ill patients but arguing that the physician who participates in execution still does harm by acting outside the moral sphere of medicine).

24. *See* Gawande, *supra* note 16, at 1229.

identity.[25] Second, physician participation gives lethal injection the veneer of humanity: it sanitizes the perception of the procedure by the public, and gives it an "aura of medical legitimacy."[26] Support for lethal injection over other execution methods derives in large part from this medicalization: it mimics anesthesia techniques, uses known drugs, and relies on the technical expertise of physicians, contributing to society's perception of a professionally-administered and humane method of execution.[27] Indeed, "without the respectability that lethal injection provides, capital punishment in the United States would probably cease."[28] Widespread accounts of botched executions[29] lend urgency to calls for increased physician participation in and oversight of lethal injections. Third, the very constitutionality of lethal injection may depend on physician participation.[30] Thus, it is misleading to suggest that physicians who participate in lethal injections are merely comforting a "terminally ill" patient who would otherwise die; in many respects, such physicians are a but-for cause of the execution. Without their involvement, the procedure would not enjoy such widespread societal—and perhaps even legal—support.

Supporters of physician participation in executions also suggest that opponents overstate the resultant erosion in trust in the medical profession. Kenneth Baum, for example, argues that just as the presence of priests at executions does not destroy the public's trust in the church, a doctor's involvement in executions will not erode the public's trust in physicians.[31] However, this analogy is inappropriate because physicians participate more directly in executions than do priests. Further, the Supreme Court has argued that physician participation in assisted suicide could "undermine the trust that is essential to the doctor-patient relationship by blurring the time-honored line between healing and harming."[32] If assisting a patient who *wants* to die will undermine trust, then so too would participating in the execution of an inmate who wants to live.

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25. *Id.* This argument does not apply with equal force to medication to restore competency, as in that situation the inmate may be considered the doctor's patient.

26. BREACH OF TRUST, *supra* note 13, at 37.

27. The role physicians have played in legitimizing and humanizing capital punishment is evidenced by the key involvement of physicians in the development, implementation, and evolution of execution techniques through much of modern history. During the French Revolution, Joseph Guillotin, a physician and death penalty opponent, developed his namesake device as a more "humane" alternative to slower and more painful approaches such as hanging, and lethal injection was developed by an anesthesiologist specifically to simulate the intravenous administration of anesthesia. *See* Gawande, *supra* note 16, at 1222; Groner, *supra* note 22, at 1026–27.

28. Groner, *supra* note 22, at 1028.

29. *See, e.g.*, Michael L. Radelet, Some Examples of Post-Furman Botched Executions, http://www.deathpenaltyinfo.org/article.php?scid=8&did=478 (last visited Jan. 20, 2007) (listing examples of botched executions).

30. *See infra* Part II and notes therein.

31. Baum, *supra* note 13, at 68.

32. Washington v. Glucksberg, 521 U.S. 702, 731 (1997).

B. THE PROBLEMS OF DUAL LOYALTY AND EXTRACLINICAL HARM

The ethical conflict faced by physicians who participate in executions typifies the problem of dual loyalty. While various ethical codes mandate undivided loyalty to the welfare of the patient, in practice physicians have simultaneous (and often conflicting) obligations to a patient and third parties such as family members, employers, and the state.[33] These obligations represent dual loyalties, defined as "clinical role conflict[s] between professional duties to a patient and obligations, express or implied, real or perceived, to the interests of a third party."[34] In some situations where dual loyalties exist, elevating the state's interest over that of the individual patient may serve justifiable social interests. For example, vaccination is often justified for its population-level benefit of preventing epidemics, even though it can pose a greater risk than benefit for a given individual.[35] Physician participation in execution, however, presents a particularly dramatic conflict between the interests of the patient and the state, because when a doctor assists with a lethal injection, she is exclusively serving the government's interest rather than the inmate's needs as a patient.[36]

The most challenging embodiments of the dual loyalty problem often arise when a physician uses her clinical skills to serve social purposes unrelated to health. For example, health interventions that advance medical ends, such as vaccination, intuitively present less of an ethical conflict than interventions that serve nonmedical purposes, such as participating in torture or lethal injection.[37] The debate over the extraclinical consequences of clinical activities by physicians who are effectively "double agents" has been particularly robust and illuminating in the field of forensic psychiatry. While most commentators agree that there are at least some situations in which extraclinical harms render clinical treatment unethical, there exists sharp disagreement over where to draw the line.

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33. *See* INT'L DUAL LOYALTY WORKING GROUP, DUAL LOYALTY & HUMAN RIGHTS IN HEALTH PROFESSIONAL PRACTICE: PROPOSED GUIDELINES & INSTITUTIONAL MECHANISMS 1 (2002) [hereinafter DUAL LOYALTY].

34. *Id.* at 2.

35. *See* M. Gregg Bloche, *Clinical Loyalties and the Social Purposes of Medicine*, 281 JAMA 268, 268 (1999). More difficult questions arise in other contexts where physicians are called on to serve controversial social and state interests, such as advising military interrogators on effective torture methods, participating in the development of biological weapons, engaging in forensic evaluations for courts or administrative bodies, or making managed care coverage decisions that balance group costs and individual medical needs. *See generally* BRITISH MED. ASS'N, THE MEDICAL PROFESSION AND HUMAN RIGHTS: HANDBOOK FOR A CHANGING AGENDA 56–96 (2001) (discussing dual loyalties in the context of torture and cruel and degrading treatment in military situations); DUAL LOYALTY, *supra* note 33, at 88–92 (discussing dual loyalties in forensic evaluations).

36. In some situations, subordination of a prisoner-patient's interests to those of the state justifiably serves legitimate social interests, such as when a doctor breaches confidentiality to stem the spread of infectious diseases in prison or to protect inmates from sexual abuse. *See* DUAL LOYALTY, *supra* note 33, at 69.

37. *See* Bloche, *supra* note 35, at 269 (noting that use of clinical skills to serve nonmedical ends is more controversial than when serving public health needs).

On the one hand, an ethic of undivided loyalty to patients may severely restrict the range of permissible extraclinical harms. Alan Stone suggests that the entire field of forensic psychiatry is problematic because the goal of serving the justice system causes physicians to lose the ethical boundaries delineated by their imperative to heal patients and do no harm.[38] Stone would not only forbid a psychiatrist from medicating an inmate to render him competent to be executed, but would even prohibit a psychiatrist's medical testimony at trial in some cases: "forensic psychiatrists have an ethical duty to excuse themselves from testifying whenever an evaluation for a criminal tribunal has turned into a therapeutic encounter."[39] Thus, a threshold question is: when does a psychiatrist's conduct become "therapeutic" or clinical? For Stone, even conduct that might appear to be merely evaluative may be therapeutic, because a psychiatrist's use of his clinical skills during an evaluation can result in "a positive transference/countertransference relationship [leading] to unguarded and incriminating disclosures."[40]

An alternative approach to the problem of extraclinical harm dismisses traditional medical ethics as irrelevant in the context of forensic psychiatry. Paul Appelbaum argues that "psychiatrists operate outside the medical framework when they enter the forensic realm, and the ethical principles by which their behavior is justified is simply not the same."[41] Because "the forensic psychiatrist in truth does not act as a physician,"[42] he is not bound by the traditional ethical principles of beneficence and nonmaleficence, but is rather obligated only to adhere to the ethical principle of truthfulness. Just as a doctor selling his house is not bound by professional ethics because he happens to be a doctor, Appelbaum argues, a psychiatrist evaluating a defendant is not bound by medical ethics because he is not acting as a doctor.[43] Testifying to a defendant's competency to stand trial based on a clinical evaluation would therefore pose no ethical problem, even if such testimony harmed the defendant, as long as the

38. *See* Alan A. Stone, *Revisiting the Parable: Truth Without Consequences*, 17 INT'L J.L. & PSYCHIATRY 79, 82 (1994).

39. *Id.* at 90.

40. *See id.* at 79–80. One problem with the extreme version of this approach, however, is that it potentially forecloses the entire field of forensic psychiatry and any other clinical work that might result in harmful extraclinical consequences. *See, e.g.*, Paul S. Appelbaum, *The Parable of the Forensic Psychiatrist: Ethics and the Problem of Doing Harm*, 13 INT'L J.L. & PSYCHIATRY 249, 255 (1990) ("If taken seriously, therefore, the duty of nonmaleficence would appear to preclude psychiatrists from involvement in almost all aspects of criminal trials."). Indeed, any clinical work that might result in harmful extraclinical consequences, such as treating a soldier's injuries so he can return to battle and suffer potentially even greater harm (or harm others), may be prohibited. *See* M. Gregg Bloche, *Psychiatry, Capital Punishment, and the Purposes of Medicine*, 16 INT'L J.L. & PSYCHIATRY 301, 317 (1993).

41. Appelbaum, *supra* note 40, at 258.

42. *Id.* at 252.

43. *Id.* One problem with this analogy is that while a doctor selling his house does so without using his clinical skills, a psychiatrist evaluating a patient does so only after using his clinical judgment after a medical examination. *See* Stone, *supra* note 38, at 83; *see also infra* notes 60–62 and accompanying text.

testimony was truthful. Appelbaum therefore draws a different line than Stone when answering the threshold question of what constitutes treatment,[44] and by defining the testifying psychiatrist as a non-doctor, he avoids triggering the applicability of medical ethics. As discussed below, supporters of physician participation in executions similarly attempt to redefine a physician's clinical activities as occurring outside the practice of medicine in order to sidestep the ethical implications of such participation.

C. BREACH OF ETHICS: WHY PHYSICIANS PARTICIPATE IN LETHAL INJECTION

While the medical community has spoken decisively against physician involvement in executions,[45] doctors continue to participate in lethal injections in the United States. This willingness of doctors to breach medical ethics stems from several factors. First, state laws explicitly provide for physician participation in executions. Of the thirty-seven death penalty states using lethal injection, seventeen require the presence of a physician, and eighteen allow physician assistance.[46] Only two states, Kentucky and Illinois, forbid physician participation or presence in executions.[47] By officially sanctioning (if not requiring) physician participation in execution, these states exacerbate the dual loyalty problem, creating an obligation of doctors to serve state and social interests that are at odds with the best medical interests of the condemned.

Second, the persuasive power of the AMA guidelines on capital punishment is unclear. While the AMA's Code of Medical Ethics represents the leading professional statement on the participation of physicians in lethal injection, only one-third of American doctors and medical students are AMA members.[48] Moreover, because AMA membership is not required to practice medicine, the AMA has little recourse against violators of the Code beyond expulsion from the organization, which would be of little consequence. Further, a survey of physicians published in 2001 found that only 3% of doctors surveyed were even aware of any guidelines on the subject, and 41% indicated that they would perform at least one action disallowed by the AMA.[49] And in spite of the AMA guidelines, its members were actually more willing to perform disallowed

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44. Appelbaum agrees that treatment of a prisoner to render him competent for execution does constitute clinical treatment, and therefore implicates a psychiatrist's ethical duty to do no harm, but he argues that testimony as to a defendant's competence to be executed does not trigger the obligations of medical ethics. Appelbaum, *supra* note 40, at 256–57 ("Treatment of prisoners found incompetent to be executed, however, is a different matter. As a treating physician, the physiatrist's therapeutic ethics are implicated. Treatment should not be undertaken unless the demands of beneficence and nonmaleficence can be satisfied.").

45. *See* Levy, *supra* note 17, at 268.

46. *See id.* at 264 n.21.

47. *Id.* at n.22.

48. *Id.* at 269.

49. *See* Neil J. Farber et al., *Physician's Willingness to Participate in the Process of Lethal Injection for Capital Punishment*, 135 ANNALS INTERNAL MED. 884, 884, 886–87 (2001).

actions than other doctors.[50] Thus, even if more doctors were aware of the AMA guidelines, the guidelines may still fall on deaf ears. Interestingly, several respondents indicated that their perceived duty to society outweighed their concerns over harming the individual patient,[51] underscoring the significance of the dual loyalty problem. Taken together, these data suggest that beyond the impotence of the AMA to enforce its guidelines, one reason why physicians are willing to violate the ethical proscription against participation in lethal injections is that they do not recognize the ethical problems inherent in such involvement.

Third, while state medical licensing boards have the authority to delicense doctors who participate in lethal injections, no state board has yet disciplined a physician for doing so.[52] While membership in a medical society such as the AMA is voluntary, all doctors must be licensed to practice medicine, and state medical boards enforce licensing laws.[53] Medical practice acts often provide for physicians to be delicensed or otherwise disciplined for "dishonorable" or "unprofessional" conduct, often defined as conduct "contrary to prevailing ethical norms within the profession."[54] Thus, state medical boards can find support for disciplinary action in the widespread consensus of professional societies that participation in lethal injection is antithetical to the role of physician as healer,[55] but various legal obstacles have inhibited such attempts.

The chief obstacle to initiating disciplinary proceedings against physician participants in lethal injection is the enactment of legislation providing that participation in lethal injection does not constitute the practice of medicine. Several states have enacted such laws, which effectively shield doctors who participate in lethal injection from disciplinary actions by state medical boards.[56] For example, Florida law provides that "prescription, preparation, compounding, dispensing, and administration of a lethal injection does not constitute the practice of medicine, nursing, or pharmacy."[57] In addition to providing safe harbor for doctors who breach medical ethics by participating in executions, these laws essentially declare that such physicians are "non-doctors" when participating in executions. That is, a doctor is defined not by her actions, but rather by what hat she is wearing when she commits such actions. This assertion

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50. *Id.* at 886.

51. *Id.* at 887.

52. *See* Gawande, *supra* note 16, at 1223.

53. *See, e.g.*, Ross. D. Silverman, *Regulating Medical Practice in the Cyber Age: Issues and Challenges for State Medical Boards*, 26 AM. J.L. & MED. 255, 256 (discussing the role of licensing boards in regulating the practice of medicine, which has long been recognized to fall within the state police power).

54. Baum, *supra* note 13, at 72.

55. For a discussion of one medical board that incorporated the AMA guidelines and threatened to punish physicians who participate in executions, see *infra* notes 99–102 and accompanying text.

56. *See* Baum, *supra* note 13, at 77 & n.96 (listing statutes declaring that participation in executions does not constitute the practice of medicine).

57. FLA. STAT. ANN. § 922.105(6) (West 2005).

that lethal injection is not the practice of medicine is analogous to Appelbaum's argument that the application of psychiatric expertise in a legal context is not the practice of psychiatry, and similarly results in a dismissal of the relevance of medical ethics. As a result of such safe harbor provisions, none of the physicians who have faced challenges for violating professional ethics by participating in lethal injections have lost their licenses as a result.[58] Further, even in the absence of statutes specifically providing legal immunity to physicians for participating in executions, courts have rejected claims that such participation constitutes unethical or unprofessional conduct.[59]

Yet the notion that a physician who participates in lethal injection is not practicing medicine is particularly absurd in light of the doctor's extensive involvement in the procedure.[60] Rather than defining medical practice according to whether the physician is serving the clinical interests of a patient versus the extraclinical interests of a third party, the practice of medicine should be defined as any practice in which a physician uses her clinical skills and training. This skills-based rather than role-based definition would go a long way toward resolving disputes over when ethical duties attach to a physician's activities. For example, under this definition, a military doctor's participation in torture would implicate (and violate) professional ethics, but a military doctor who happens to be a bomber pilot would not violate medical ethics when bombing human targets, because in the latter case the pilot is not using his clinical skills to do harm, whereas in the former case the physician is relying on his medical skills to harm the subject.[61] Further confusing the issue, however, some opponents of

58. *See* Gawande, *supra* note 16, at 1223 (describing fate of an anonymous physician participant in lethal injection whose license was upheld under a law explicitly permitting physician participation in executions and noting that no doctor has yet to be disciplined by a medical board for participation in an execution).

59. For example, in 1996, thirteen physicians in California claimed that physician participation in executions constitutes "unprofessional conduct" under the California Code, and sought an injunction against such participation. Thorburn v. Dep't of Corr., 78 Cal. Rptr. 2d 584, 585 (Cal. Ct. App. 1998). The court concluded that "the Legislature did not intend to include physician participation in executions within the ambit of 'unprofessional conduct,'" relying in part on California law permitting the presence of physicians at executions. *Id.* at 590. The court acknowledged declarations by medical societies that such participation violates medical ethics but found that physician participation in execution is not "likely to erode trust between individual physicians and patients who have not been sentenced to death for a capital crime, or undermine public confidence in physicians or the medical profession as a whole." *Id.* at 589–90. Thus, while acknowledging the important role of professional ethics, the court discounted such ethical codes in its ruling.

60. *See, e.g.*, *id.* at 586 (describing duties performed by physicians in California lethal injections, which included "preparing syringes with the lethal solution; . . . locating appropriate veins for insertion of catheters that will carry the lethal solution; inserting the catheters; monitoring the flow of the lethal substances to ensure that there will be no interruption and death will occur; monitoring the inmate to notify the warden when death has occurred; and pronouncing death").

61. This definition also helps resolve the controversy that ensued when Kentucky Governor Ernie Fletcher, a licensed physician, signed a death warrant for Thomas Clyde Bowling, prompting vigorous objections from doctors and medical students throughout the state, several of whom filed formal complaints with the Kentucky Board of Medical Licensure. *See* Fred Charatan, *Kentucky Governor Signs Death Warrant Despite Medical Association Guidance*, 329 BRIT. MED. J. 1364, 1364 (2004).

physician participation in executions also suggest that lethal injection is not the practice of medicine in order to highlight the impropriety of such participation.[62]

Thus, while medical ethicists and professional societies are nearly unanimous in their opposition to physician participation in capital punishment, supporters of such participation attempt to circumvent this problem by characterizing physicians who participate in capital punishment as non-doctors serving the societal goal of justice. But this approach only serves as an end-run around the debate over judicial deference to medical ethics. That is, if we accept that a physician is not acting as a doctor when serving the interests of the criminal justice system, then we need not confront the question of whether a court should defer to medical ethics—because such ethical obligations are not implicated in the first place. Courts allowing physician participation in capital proceedings appear to endorse this approach in asserting that no ethical obligations are implicated by physician involvement in capital punishment. On the other hand, courts that do defer to medical ethics squarely address the ethical implications of physician participation in executions.

II. PHYSICIAN INVOLVEMENT AS NECESSARY FOR CONSTITUTIONAL EXECUTIONS

The Eighth Amendment to the U.S. Constitution prohibits the infliction of "cruel and unusual punishments."[63] What constitutes cruel and unusual punishment depends on "the evolving standards of decency that mark the progress of a maturing society."[64] While the death penalty does not itself constitute cruel and unusual punishment,[65] execution methods that "involve the unnecessary and wanton infliction of pain"[66] or "involve torture or a lingering death"[67] are prohibited under the Eighth Amendment.

Thus, the level of pain involved in a method of execution is a key factor in

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While this action would likely be encompassed by the AMA's expansive definition of "participation" in an execution, the Board dismissed the suit, finding that Governor Fletcher was acting in his capacity as governor, not doctor, when he ordered Bowling's execution. *See* Albert Salvato, *Medical Board Dismisses Complaint Against Governor*, N.Y. TIMES, January 14, 2005, at A21. Yet while the Board was correct to dismiss the suit, this decision should not have relied on the capacity in which Fletcher was acting, but rather on the fact that he was not using his clinical skills and training when serving in that capacity.

62. *See, e.g.*, AMNESTY INT'L, LETHAL INJECTION: THE MEDICAL TECHNOLOGY OF EXECUTION 1, 11 (1998), *available at* http://web.amnesty.org/library/pdf/ACT500011998ENGLISH/$File/ACT5000198.pdf; HUMAN RIGHTS WATCH, CONTROVERSY IN CALIFORNIA: PHYSICIAN PARTICIPATION IN EXECUTIONS IN THE UNITED STATES, *available at* http://hrw.org/english/docs/2006/02/22/usdom 12706.htm (2006).

63. U.S. CONST. amend. VIII.

64. Gregg v. Georgia, 428 U.S. 153, 173 (1976). In 1972, the Supreme Court declared that executions in Georgia were unconstitutional because of their arbitrary application. *See id.* at 256–57 (Douglas, J., concurring); Furman v. Georgia, 408 U.S. 238, 239–40 (1972) (per curiam). After Georgia rewrote its death penalty laws, the Court ruled in *Gregg* that the death penalty did not constitute cruel and unusual punishment. *Gregg*, 428 U.S. at 206–07.

65. *Gregg*, 428 U.S. at 187.

66. *Id.* at 173.

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

determining its constitutionality, and two recent federal court cases in California and Missouri suggest that evolving standards of decency require a physician's presence at, or participation in, lethal injections to minimize the chances of unnecessary pain.[68] These decisions, however, directly conflict with ethical proscriptions against physician involvement in executions. A third decision, *Brown v. Beck*,[69] implicitly acknowledged medical ethics, but it too ultimately failed to resolve this ethical conflict. As a result of this confusion over physicians' proper role in executions, the death penalty is effectively on hold in all three states.

A. *MORALES V. HICKMAN*

In *Morales v. Hickman*, U.S. District Judge Jeremy Fogel concluded that California's lethal injection protocol created an undue risk that an inmate would suffer unconstitutional pain when he is executed.[70] The plaintiff, Michael Angelo Morales, was tried and sentenced to death for the rape and murder of seventeen-year old Terri Winchell. Morales filed a § 1983 action alleging that the method in which lethal injection was administered in California created an undue risk of causing excessive pain.[71] The California protocol called for the injection, in succession, of five grams of sodium thiopental (to induce unconsciousness); 50 or 100 milligrams of pancuronium bromide (to induce paralysis); and 50 or 100 milliequivalents of potassium chloride (to induce cardiac arrest).[72] It was undisputed that injection of either of the last two drugs while a person was conscious would cause excruciating pain.[73] Accordingly, the court focused on the narrow issue of "whether or not there is a reasonable possibility that Plaintiff will be conscious when he is injected with pancuronium bromide or potassium chloride, and, if so, how the risk of such an occurrence may be avoided."[74]

To support his assertion that the administration of the lethal injection protocol

68. Morales v. Hickman, 415 F. Supp. 2d 1037 (N.D. Cal.), *aff'd*, 438 F.3d 926 (9th Cir. 2006); Taylor v. Crawford, No. 05-4173-CV-C-FJG, 2006 WL 1779035, at *8–9 (W.D. Mo. June 26, 2006).

69. Brown v. Beck, No. 5:06-CT-3018-H, 2006 U.S. Dist. LEXIS 60084, at *7 (E.D.N.C. Apr. 7, 2006).

70. *Morales*, 415 F. Supp. 2d at 1047.

71. *Id.* at 1039.

72. *Id.*

73. In the absence of a properly administered anesthetic, the pancuronium bromide would induce a sensation of suffocation, and the potassium chloride would cause excruciating pain as it acted on the nerves in the inmate's veins. *See Morales*, 438 F.3d at 928.

74. *Morales*, 415 F. Supp. 2d at 1040. Judge Fogel noted that because the pancuronium bromide masks outward signs of consciousness, it is crucial to implement an injection protocol that ensures the inmate will be adequately anesthetized. Morales v. Tilton, 465 F. Supp. 2d 972, 980 (N.D. Cal. 2006). Indeed, Ty Alper has argued that the sole purpose for using pancuronium bromide in lethal injections is to "maintain the illusion" that lethal injection is painless by masking the "potentially horrifying effects of inadequately administered doses of the anesthetic and heart-stopping drugs." Ty Alper, *Lethal Incompetence: Lethal Injection Litigation is Exposing More Than Torturous Executions*, THE CHAMPION, Sept./Oct. 2006, at 41.

created a risk of undue pain, Morales provided evidence from execution logs suggesting that in six out of thirteen lethal injections in California, prisoners were breathing long after they should have ceased to do so.[75] This evidence raised concerns that the inmates were conscious when injected with the pancuronium bromide and potassium chloride, in which case they would be subject to unconstitutional pain, and the court found "substantial questions" that the protocol created "an undue risk that [Morales] will suffer excessive pain when he is executed."[76] Thus, to minimize the risk of a cruel and unusual execution, Judge Fogel ordered the state to either use: (1) only sodium thiopental or a combination of other barbiturates to execute Morales;[77] or (2) the standard three-drug cocktail but retain the services of an anesthesiologist to monitor and verify that Morales was actually unconscious prior to the administration of pancuronium bromide and potassium chloride.[78] The state elected for the second option and lined up two anesthesiologists to monitor the administration of the drugs.

On February 20, 2006, just hours before the execution was slated to proceed, the anesthesiologists backed out when they were told that they would be required to intervene if Morales was not properly sedated.[79] "That was an affirmative duty to act, which was a very large step beyond observation. . . . I had a responsibility to rescue a botched execution," one of the doctors said.[80] "I just didn't feel like getting painted as an executioner."[81] The two doctors concluded that participating in the execution would violate their Hippocratic Oath, and they refused to do so.

Subsequently, the state abruptly switched course and sought approval to execute Morales later that same day using only sodium thiopental, the method of lethal injection it initially rejected.[82] Because the state indicated its desire to proceed using sodium thiopental only hours before the execution, had never before used that method of lethal injection, and presented no details of how the injection would be carried out, the court allowed the execution to proceed only if the drug was injected intravenously by a person licensed to do so.[83] Yet the state was unwilling to execute Morales according to the court's requirements, and the execution was postponed pending further hearings, after which Judge Fogel concluded that the "implementation of California's lethal-injection proto-

75. *See Morales*, 415 F. Supp. 2d at 1045.
76. *Id.* at 1047.
77. Administration of sodium thiopental alone is itself lethal.
78. *Morales*, 415 F. Supp. 2d at 1047.
79. *See* David Kravets, *Doctor: Ethics Stopped Me in Morales Execution*, SACRAMENTO UNION, Sept. 29, 2006, *available at* http://www.sacunion.com/pages/california/articles/8538/.
80. Transcript of Proceedings at 987–88, Morales v. Hickman, 465 F. Supp. 2d 972 (N.D. Cal. 2006).
81. *Id.* at 988.
82. Morales v. Tilton, 465 F. Supp. 2d 972, 976 (N.D. Cal. 2006).
83. *Morales*, 415 F. Supp. 2d at 1047.

col lacks both reliability and transparency,"[84] resulting in an undue risk of an Eighth Amendment violation. As a result, executions in California—the state with the largest death row population—have effectively been put on hold until the state comes up with a lethal injection protocol that does not present an unconstitutional risk of pain.[85]

Morales thus placed constitutional law on a collision course with medical ethics. The court held that without trained anesthesiologists to monitor the injection and intervene to ensure the inmate's unconsciousness, the three-drug lethal injection procedure as employed by the state presented a risk of unconstitutional pain and suffering.[86] Yet it was precisely this active role in the execution that violated medical ethics, prompting the physicians to refuse to participate.

B. *TAYLOR V. CRAWFORD*

A similar standoff between medical ethics and the Eighth Amendment occurred in Missouri shortly after the first *Morales* order. On June 26, 2006, U.S. District Judge Fernando Gaitan, Jr. ruled in *Taylor v. Crawford* that Missouri's lethal injection procedure subjected prisoners to an unreasonable risk of cruel and unusual punishment because of the lack of a written protocol for administration and the arbitrary and inconsistent application of these drugs.[87] The condemned, Michael Taylor, filed a § 1983 action alleging that the state's lethal injection protocol was unconstitutional because it created a foreseeable likelihood that he might be conscious but paralyzed and unable to convey that he is

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84. *Morales*, 465 F. Supp. 2d at 981. Judge Fogel found that execution team members were not properly screened and lacked proper training and supervision, executions lacked reliable record keeping, the drugs were improperly prepared, mixed and administered, and the execution facilities were overcrowded, improperly lighted, and poorly designed. *Id.* at 979–80.

85. *See* Liptak & Aguayo, *supra* note 9.

86. In his most recent order, on December 15, 2006, Judge Fogel clarified that his earlier order giving the state the choice of using just sodium thiopental or of having an anesthesiologist administer the three drug cocktail to ensure Morales was unconscious "was intended as a one-time solution to permit Plaintiff's execution to proceed as scheduled." *Morales*, 465 F. Supp. 2d at 983 n.15. Judge Fogel further stated:

> Because an execution is not a medical procedure, and its purpose is not to keep the inmate alive but rather to end the inmate's life, the Court agrees with [the state] that the Constitution does not *necessarily* require the attendance and participation of a medical professional. However, the need for a person with medical training would appear to be inversely related to the reliability and transparency of the means for ensuring that the inmate is properly anesthetized: the better the delivery system, the less need there is for medical participation.

Id. at 983 (emphasis added). Physician participation in lethal injections may therefore be constitutionally required only where the reliability of the injection protocol is called into question. Even though Judge Fogel did not find physician participation in lethal injection constitutionally required in all cases, the Eighth Amendment would demand physician involvement in some cases, depending on the lethal injection protocol used. And such cases would create the same ethical dilemma that resulted in the refusal of the anesthesiologists to participate in Morales's execution.

87. Taylor v. Crawford, No. 05-4173-CV-C-FJG, 2006 WL 1779035, at *8 (W.D. Mo. June 26, 2006).

suffering excruciating pain.

The surgeon who oversaw executions in Missouri testified that the lethal injection protocol was not written down, that he had independent authority to alter the protocol, and that he often administered only 2.5 grams of the anesthetic sodium thiopental (as opposed to the five grams commonly used in lethal injections). When asked why he used this lower dose, the doctor explained that he was dyslexic and often transposed numbers and made mistakes in administering the drugs.[88] Because of the lack of a written protocol for administration of the drugs and their arbitrary and inconsistent application, Judge Gaitan held that Missouri's method of administering lethal injection subjected prisoners to an undue risk of unconstitutional pain and suffering.[89]

Citing *Morales*, the *Taylor* court asserted its "equitable powers to fashion a remedy that 'preserves both the State's interest in proceeding with Plaintiff's execution and Plaintiff's constitutional right not to be subject to an undue risk of extreme pain.'"[90] Accordingly, Judge Gaitan ordered the Department of Corrections to design a new lethal injection protocol that incorporates several specific provisions, including a requirement that a board-certified anesthesiologist mix all drugs, that no less than five grams of sodium thiopental be used, and that the anesthesiologist certify that the inmate could not feel any pain before administering the pancuronium bromide and potassium chloride.[91] While these provisions are similar to those ordered by the court in *Morales*, they are notable for their high level of specificity.[92] Further, unlike the California order, in which the presence of an anesthesiologist was one of two options presented, here the court indicated that an anesthesiologist was constitutionally required.

In what may become a familiar pattern, however, the state had trouble finding doctors willing to participate in the execution. While state officials sent inquiries to 298 board-certified anesthesiologists in Missouri and Illinois, none agreed to mix the drugs for the lethal injection.[93] The dearth of willing anesthesiologists was perhaps not surprising: four days after the court's order, Dr. Orin Guidry, the president of the American Society of Anesthesiologists (ASA), sent letters to ASA's 40,000 members singling out the *Morales* and *Taylor* decisions and urging all anesthesiologists to "steer clear" of participation in executions.[94] Dr. Guidry argued that "the court cannot modify physicians' ethical principles to meet its needs," and was particularly troubled by the Missouri court's efforts to create an environment more like an operating room:

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88. *Id.* at *4–5.

89. *Id.* at *8.

90. *Id.* (quoting Morales v. Hickman, 415 F. Supp. 2d 1037, 1046 (N.D. Cal. 2006)).

91. *Id.* at *8–9.

92. *See* Orin F. Guidry, Message From the President: Observations Regarding Lethal Injection (June 30, 2006), http://www.asahq.org/news/asanews063006.htm (last visited May 14, 2007).

93. *See* Henry Weinstein, *Missouri Says It Can't Find Execution Doctor*, L.A. TIMES, July 16, 2006, at 32.

94. Guidry, *supra* note 92.

> The more the execution looks like an anesthetic, the less comfortable patients are likely to be with anesthesia. . . . The last thing patients need is to equate the O.R. with a death chamber, to equate anesthetic drugs with death drugs, or to have in their subconscious the specter of the anesthesiologist as an executioner.[95]

Thus, the medicalization of the death penalty, which the California and Missouri courts suggest is constitutionally required in some circumstances, serves to undermine patients' trust in physicians, resulting in the refusal of doctors to participate in the executions.

In light of the state's failed but apparent good-faith effort to find anesthesiologists willing to participate in Taylor's execution, on September 12, 2006, the judge modified his order to permit any physician in good standing and trained in the administration of anesthesia to oversee the execution.[96] At the same time, the court rejected the state's proposed protocol, including its proposed use of "medical personnel" rather than physicians, and ordered the state to submit a revised protocol that provides adequate constitutional protections.

C. *BROWN V. BECK* AND ITS AFTERMATH

In *Brown v. Beck*, the state of North Carolina used a brain wave BIS monitor in lieu of direct clinical observation by a physician to ensure that Willie Brown was adequately anesthetized prior to and during his execution.[97] This decision unleashed a cascade of events culminating in a de facto death penalty moratorium in North Carolina.

The use of the monitor was a creative attempt by the state to avoid the tension between constitutional law, which may require the presence of a physician to prevent undue suffering, and medical ethics, which forbid physician participation in executions. However, the state's attempt to circumvent this dilemma was ultimately unsuccessful for two reasons. First, as noted above, the use of the BIS monitor alone to measure anesthetic depth has been widely criticized by anesthesiologists and even the manufacturer of the machine. Thus, even assuming that the use of the monitor minimized the ethical problem posed by physician involvement in the death penalty, its use likely did not solve the constitutional requirement of ensuring that inmates do not suffer undue pain during the execution. Second, the use of the monitor apparently did not eliminate the ethical conflict of physician participation in executions. The AMA Code explicitly prohibits doctors from monitoring a condemned inmate's vital signs either on site or remotely, in part because the monitoring physician could still be called upon to intervene and assist with the execution should something

95. *Id.*
96. Taylor v. Crawford, No. 05-4173-CV-C-FJG, at 2 (W.D. Mo. Sept. 12, 2006).
97. *See* Steinbrook, *supra* note 1, at 2525.

go wrong.[98] Thus, the state's effort, sanctioned by the court, to take a middle ground by using the BIS monitor failed to either reduce the risk of unconstitutional pain or to prevent physicians from breaching medical ethics.

The controversial use of the BIS monitor in Brown's execution, and the fact that a doctor and nurse observed the monitor during the execution, prompted the North Carolina Medical Board to adopt a new policy declaring that participation of doctors in executions violated medical ethics and would be grounds for punishment.[99] In developing the new policy the Board struggled to reconcile the conflict between state law and medical ethics. On the one hand, North Carolina law requires the presence of a jailhouse physician during executions.[100] Thus, the new policy clarifies that the Board "will not discipline licensees for merely being 'present' during an execution in conformity with N.C. Gen. Stat. 15-190."[101] On the other hand, the Board adopted the portion of the AMA Code that prohibited physicians from participating in executions and provided that "any physician who engages in any verbal or physical activity, beyond the requirements of N.C. Gen. Stat. 15-190, that facilitates the execution may be subject to disciplinary action by this Board."[102]

In response to the Medical Board's policy, prison officials proposed a new execution protocol in which a nurse and emergency medical technician would monitor the inmate's vital signs, while a physician would be present but play no active role in the execution.[103] However, Superior Court Judge Donald Stevens found that because the new procedure "eliminates the physician's participation in an execution," it constituted a significant change in protocol that must be approved by North Carolina's Governor and Council of State.[104] Accordingly, on January 25, 2007, Judge Stevens halted the executions of two plaintiffs who alleged that the lack of physician participation created a risk of unconstitutional pain and suffering.[105] On February 7, 2007, however, the Council of State approved a revised protocol that apparently *increases* the role of physicians in executions: under the approved protocol, doctors would "'monitor the essential

98. *See* AMA Code, *supra* note 15.

99. *See* Kevin B. O'Reilly, *North Carolina Considers Limits on Physicians' Role in Executions*, AMEDNEWS.COM, Aug. 28, 2006, http://www.ama-assn.org/amednews/2006/08/28/prsb0828.htm.

100. N.C. GEN. STAT. § 15-190 (2006).

101. NORTH CAROLINA MEDICAL BOARD, POSITION STATEMENT, CAPITAL PUNISHMENT (Jan. 2007), http://www.ncmedboard.org/Clients/NCBOM/Public/PublicMedia/capitalpunishment.htm.

102. *Id.*

103. *See* Weinstein, *supra* note 9. While this proposal would limit physician participation, medical ethics also prohibit involvement of nurses in executions. *See* AMERICAN NURSES ASS'N, ETHICS AND HUMAN RIGHTS POSITION STATEMENTS: NURSES' PARTICIPATION IN CAPITAL PUNISHMENT (1994), http://www.nursingworld.org/readroom/position/ethics/etcptl.htm.

104. Robinson v. Beck, No. 07 CVS 001109 (Super. Ct., Wake County, Jan. 25, 2007) (order allowing preliminary injunction).

105. *Id.* Judge Stevens subsequently stayed another scheduled execution, and two additional executions are also likely to be delayed. *See* Gary D. Robertson, *Two New Execution Dates Set, But They Are Likely to be Delayed*, NEWS & OBSERVER (Raleigh), Feb. 13, 2007.

body functions of the condemned inmate.'"[106] Thus, the approved protocol fails to adhere to the Medical Board's proscription against physician participation in executions—which prompted the Department of Corrections to alter the protocol in the first place.

Further, left unclear is precisely what role the observing physician would play if a problem arises during the lethal injection. The policy approved by the Council of State would require the monitoring physician to alert the warden if the inmate appears to be experiencing "undue pain and suffering."[107] What happens next is uncertain, though presumably the physician would then intervene to save the inmate's life[108]—an unusual action at an execution to say the least. At the same time, the Medical Board's policy statement appears to explicitly forbid a physician from intervening, even by making suggestions, in which case the physician would be forced to watch as an inmate suffers, an even less acceptable outcome.[109] Thus, the policies adopted by the Medical Board and the Council of State are at odds with each other—and yet nether satisfactorily addresses the underlying ethical problem. Ultimately the state legislature will likely need to settle the dispute and determine what role physicians should play in North Carolina executions; until then, the death penalty is on hold in the state.

D. DISMISSING MEDICAL ETHICS

The *Morales*, *Taylor*, and North Carolina decisions illustrate varying degrees of deference to medical ethics—or lack thereof. In *Brown*, the use of the BIS monitor at least represented an acknowledgement of the conflict between the law and medical ethics—though Judge Howard ultimately allowed a level of physician involvement that nonetheless violated the AMA Code, and it is unclear if future executions will adhere to the Medical Board's policy, which forbids physician participation, or the prison's policy, which allows physicians to monitor vital signs. In both *Morales* and *Taylor*, however, the courts discounted the consensus by medical ethicists and professional societies proscribing physician participation in executions. While in *Morales* the court ignored medical ethics altogether, in *Taylor* Judge Gaitan asserted that he "did not find that Missouri physicians who are involved in administering lethal injections were violating their ethical obligations."[110] Indeed, Judge Gaitan went so far as to order that "[t]he physician selected [to participate in Taylor's execution] shall

106. Margaret Lillard, *New Execution Procedure Backed*, NEWS & RECORD (Greensboro), Feb. 6, 2007.

107. *Id.*

108. *See* Andrea Weigl, *Death Penalty Stuck in Quagmire*, NEWS & OBSERVER (Raleigh), Feb. 11, 2007, at A1.

109. Nor does the Medical Board's policy provide any clear guidance on the acceptability of using the BIS monitor—the very situation that provoked the new policy.

110. Taylor v. Crawford, No. 05-4173-CV-C-FJG, 2006 WL 1779035, at *1 (W.D. Mo. June 26, 2006).

not have any disciplinary action taken against them by their State's licensing authority."[111] Thus, under this ruling, even doctors from states that do not explicitly exclude participation in execution from the practice of medicine would appear to be immunized from sanction by their own state medical boards, thereby further weakening the power of such boards to police unethical medical conduct.

Not only did the California and Missouri courts—and to a lesser extent the North Carolina courts—fail to show deference to medical ethics, they suggested that the constitutionality of the death penalty may depend on doctors breaching their professional ethics. Thus, those decisions directly conflict with medical ethics: essentially, evolving standards of decency demand that physicians participate in executions, in clear violation of their Hippocratic Oath. As the *Morales* and *Taylor* cases demonstrate, this conflict can result in a standstill: by adhering to ethical guidelines and refusing to participate in executions, physicians can effectively bar implementation of the death penalty. Both the *Morales* and *Taylor* courts acknowledge the "State's interest in proceeding with Plaintiff's execution."[112] In modifying his order to allow a physician with training in anesthesiology to participate in Taylor's execution, Judge Gaitan affirmed that it "was never the intention of this Court to prevent the State of Missouri from executing its death row inmates."[113] Judge Fogel similarly noted that California's "implementation of lethal injection is broken, but it can be fixed."[114] History suggests that states will eventually find doctors willing to participate in executions; indeed, the number of physicians who fail to see physician participation as a violation of medical ethics[115] suggests that doctors will answer the state's call. Nonetheless, *Morales* and *Taylor* demonstrate that judges' efforts to rescue lethal injection from unconstitutionality by requiring unethical physician participation could ultimately prove the undoing of lethal injection.

Indeed, the North Carolina decisions even more vividly illustrate the problems inherent in tinkering with the death penalty. While North Carolina prison officials and courts were cognizant of the ethical implications of physician involvement in executions, efforts to address this moral dilemma failed. The simultaneous involvement of the courts, Medical Board, Department of Corrections, Council of State, and other administrative bodies[116] resulted in multiple, irreconcilable policies with varying degrees of respect for medical ethics. At the

111. Taylor v. Crawford, No. 05-4173-CV-C-FJG, 2006 WL 1779035, at *1 (W.D. Mo. Sept. 12, 2006).

112. Morales v. Hickman, 415 F. Supp. 2d 1037, 1046 (N.D. Cal. 2006); Taylor v. Crawford, No. 05-4173-CV-C-FJG, at 13 (W.D. Mo. June 26, 2006).

113. Taylor v. Crawford, No. 05-4173-CV-C-FJG, 2006 WL 1779035, at *1 (W.D. Mo. Sept. 12, 2006).

114. Morales v. Tilton, 465 F. Supp. 2d 972, 974 (N.D. Cal. 2006).

115. *See* Farber, *supra* note 49, at 886–87.

116. *See* Andrea Weigl, *Plan Riles Death Row*, NEWS & OBSERVER (Raleigh), Feb. 17, 2007, at B5 (describing inmates' challenge to the new execution plan before the North Carolina Office of Administrative Hearings).

same time, in threatening to discipline physicians who participate in executions, the North Carolina Medical Board prompted the state—at least initially—to forbid direct physician participation in lethal injections. The Medical Board's statement also provoked a public debate not just on the appropriate role of doctors in executions, but also on the extent to which courts—and state officials—will defer to medical ethics.

III. INVOLUNTARY MEDICATION TO RESTORE COMPETENCY TO BE EXECUTED

While the rulings on the constitutionality of lethal injection protocols demonstrate somewhat varying degrees of deference to medical ethics, recent cases addressing the constitutionality of forced medication to restore competency for execution illustrate even more dramatically the inconsistent judicial deference to medical ethics. In *State v. Perry*[117] and *Singleton v. State*,[118] the courts explicitly deferred to medical ethics in holding that this practice constitutes cruel and unusual punishment. In *Singleton v. Norris*,[119] however, the Eighth Circuit ignored medical ethics and held that the Eighth Amendment does not prohibit execution of a prisoner whose competency was restored through involuntary medication. This contrast highlights a fundamental inconsistency in courts' deference to medical ethics and practice when making determinations about the constitutionality of medical practices surrounding lethal injection.

A. FORCED MEDICATION OF MENTALLY ILL PRISONERS AND THE PROHIBITION AGAINST EXECUTION OF INSANE INMATES

Mentally ill prisoners have a liberty interest in avoiding unwanted treatment with antipsychotic drugs under the Due Process Clause of the Fourteenth Amendment.[120] However, in *Washington v. Harper*, the Supreme Court held that forced medication of a prison inmate with antipsychotic drugs against his will does not violate due process if: (1) the inmate is dangerous to himself and others; and (2) treatment is in the prisoner's best medical interests.[121] In formulating this two-part test, which has become the standard for involuntary treatment of mentally ill inmates, the Supreme Court explicitly relied on the role that medical ethics would play to protect the prisoner's liberty interest: physicians would not prescribe antipsychotics "for reasons unrelated to the medical needs of the patients," the Court found, because "the ethics of the medical

117. State v. Perry, 610 So. 2d 746 (La. 1992).
118. Singleton v. State, 437 S.E.2d 53 (S.C. 1993).
119. Singleton v. Norris, 319 F.3d 1018 (8th Cir. 2003).
120. Washington v. Harper, 494 U.S. 210, 221 (1990).
121. *Id.* at 227. In *Riggins v. Nevada*, the Court held that a non-dangerous inmate could be forcibly medicated to make him competent to stand trial where such treatment is "medically appropriate and, considering less intrusive alternatives, essential for the sake of [the inmate's] own safety or the safety of others." Riggins v. Nevada, 504 U.S. 127, 135 (1992).

profession are to the contrary."[122]

The Constitution also permits involuntary administration of antipsychotic drugs to render a mentally ill defendant competent to stand trial on serious criminal charges. However, such forced medication is permissible "only if the treatment is medically appropriate, is substantially unlikely to have side effects that may undermine the fairness of the trial, and, taking account of less intrusive alternatives, is necessary significantly to further important governmental trial-related interests."[123]

These standards for involuntary medication have important consequences on death row, because in *Ford v. Wainwright* the Supreme Court held that execution of insane persons violates the Eighth Amendment's bar against cruel and unusual punishment.[124] In his concurring opinion, Justice Powell set the standard for determining competency to be executed: "[T]he Eighth Amendment forbids the execution only of those who are unaware of the punishment they are about to suffer and why they are to suffer it."[125] Given the high frequency of psychoses among death row inmates,[126] *Ford* presents an obstacle to the execution of a potentially large number of condemned prisoners. Thus, the crucial question that remains at the intersection of *Harper* and *Ford* is whether involuntary medication of mentally ill inmates to establish *Ford*-competency to be executed violates the Constitution—that is, can the problem presented by insane inmates on death row be fixed through forced medical treatment? Surprisingly only three courts have directly addressed this question, and the outcomes of these cases depend on the deference shown by the court to medical ethics.

1. *State v. Perry*

In *State v. Perry*, the Supreme Court of Louisiana held that the state could not "circumvent the centuries old prohibition against execution of the insane by medicating an incompetent death row prisoner against his will with antipsychotic drugs and carrying out his death sentence while he is under the influence of the drugs."[127] Michael Perry, who had a long history of mental illness, was

122. *Harper*, 494 U.S. at 223 n.8. In making this assertion, Justice Kennedy relied on the Hippocratic Oath and the APA's code of professional responsibility. *Id.* The court also argued that "the fact that the medication must first be prescribed by a psychiatrist, and then approved by a reviewing psychiatrist, ensures that the treatment in question will be ordered only if it is in the prisoner's medical interests, given the legitimate needs of his institutional confinement." *Id.* at 222.

123. Sell v. United States, 539 U.S. 166, 179 (2003). The Court held that involuntary medication was not appropriate for Sell because the lower courts did not consider the side effects of the drugs. *Id.* at 185–86.

124. Ford v. Wainwright, 477 U.S. 399, 409–10 (1986).

125. *Id.* at 422 (Powell, J., concurring).

126. *See, e.g.*, Julie D. Cantor, *Of Pills and Needles: Involuntarily Medicating the Psychotic Inmate When Execution Looms*, 2 IND. HEALTH L. REV. 119, 136 (2005) (citing research that forty to seventy percent of death row inmates are psychotic as well as a report indicating that ten percent of death row prisoners are insane).

127. State v. Perry, 610 So. 2d 746, 747 (La. 1992).

sentenced to death for the murder of his mother, father, nephew and two cousins.[128] The trial court concluded that because Perry suffered from schizoaffective disorder, he would be incompetent for execution without antipsychotic treatment, and ordered forcible administration of antipsychotic medication to render him competent for execution.[129] The Supreme Court of Louisiana reversed, holding that involuntary medication for execution violated Perry's right to privacy[130] and the cruel and unusual punishment clause of the state constitution.[131]

In rejecting the state's medicate-to-execute scheme, the court explicitly relied on principles of medical ethics in two key ways. First, the court found that because drugging inmates for execution constitutes punishment, not medical treatment, it is "antithetical to the basic principles of the healing arts" as espoused in the Hippocratic Oath.[132] While the Oath obligates doctors to do no harm and act only in the best interests of the patient, a doctor who forcibly drugs an inmate against his will to render him competent for execution "knowingly handles the prisoner harmfully and contrary to his ultimate medical interest."[133] The court further recognized the physician's dilemma in such a situation: by administering drugs, the doctor violates her oath to act in the patient's best interest; but by withholding treatment, the physician is perpetuating suffering she is obligated to allay.[134]

Having found that the administration of drugs to a prisoner against his will for the purpose of carrying out the death penalty does not constitute medical treatment, the court distinguished *Harper*. While in *Harper* the permissible state purpose was appropriate medical treatment, here the purpose was to implement his execution—that is, to punish.[135] Accordingly, *Harper* is inapposite, because "forcible administration of drugs to implement execution is not medically appropriate."[136] Thus, the court drew on ethical guidelines to define ethical medical treatment, to demonstrate that forcing a prisoner to take antipsychotics to facilitate his execution is "antithetical to the basic principles of the healing

128. *Id.* at 748.

129. *Id.* Perry appealed this decision. Ultimately the U.S. Supreme Court granted certiorari, but it then remanded the case for reconsideration in light of *Harper*, which had recently been decided. Perry v. Louisiana, 498 U.S. 38, 38 (1990).

130. *Perry*, 610 So. 2d at 755.

131. *Id.* at 771.

132. *Id.* at 751.

133. *Id.* at 752 ("Because the physician is required by his oath both to alleviate suffering and to do no harm, the state's order forces him to act unethically and contrary to the goals of medical treatment.").

134. *See id.* The court also highlighted several "pernicious" repercussions of involuntary medication, including the subordination of the patient's well-being to the duty the doctor owes the state, the erosion of trust that is essential to a therapeutic doctor-patient relationship, and the technical "participation" of a physician in an execution in violation of AMA and APA ethical guidelines. *Id.* at 752–53.

135. *Id.* at 754.

136. *Id.*

arts,"[137] and to distinguish *Harper*.

Second, the *Perry* court's deference to medical ethics was a key factor in its conclusion that forced medication to restore competency would offend society's standards of decency and thus constitute cruel and unusual punishment. After reviewing the statutory and common law evidence that society will not tolerate exceptions to the prohibition against executing the insane, the court noted that "[t]he ethical standards of the medical profession reinforce this view and constitute further objective evidence of this standard of decency."[138] The court reiterated the proscription by the AMA and APA against physician involvement in executions and underscored the inherent conflict between forced medication for execution and medical ethics.[139] Thus, the court deferred to the widespread consensus among medical professional societies and medical ethicists in its finding that drugging to execute would offend civilized standards of decency and violate the state's constitution. The court stayed Perry's execution, allowing a modification of the stay only if Perry regained his sanity and competence for execution without the use of antipsychotic drugs.[140]

2. *Singleton v. State*

The Supreme Court of South Carolina also drew on medical ethics in finding that forced medication solely to facilitate execution of a prisoner violated the state constitution's right to privacy and federal due process in *Singleton v. State* ("*Fred Singleton*").[141] After being convicted for murder and sentenced to death, Fred Singleton was found incompetent under *Ford*, and the court addressed whether the state could forcibly administer medication to render him competent for execution.[142] As in *Perry*, *Fred Singleton* made explicit reference both to the medical profession's ethical precepts as illustrated in the Hippocratic Oath and to AMA and APA guidelines proscribing physician involvement in execution.[143] Further, the court noted that "[t]here is also ample precedent which shows the deference the medical profession receives from the courts in medical matters."[144] Thus, the court asserted, "[t]he positions of the medical community are, if nothing else, an indication of the unusual nature of forced medication solely to facilitate execution."[145] Finding that antipsychotic medication would cause

137. *Id.* at 751.
138. *Id.* at 769.
139. *Id.*
140. *Id.* at 771.
141. Singleton v. State, 437 S.E.2d 53, 61 (S.C. 1993).
142. *Id.* at 55.
143. *Id.* at 61 (noting the basis of the AMA and APA opposition to physician participation in executions is the causal relationship between administration of the drug and the execution).
144. *Id.* at 61 n.3 (citing Vitek v. Jones, 445 U.S. 480 (1980), and Addington v. Texas, 441 U.S. 418 (1979)).
145. *Id.* at 61. While the court asserted the "unusual" nature of forcibly medicating to execute, it is unclear whether the court was making a reference to cruel and unusual punishments. It probably was not, because the court held that the forced medication violated federal due process and the right to

Singleton harmful side effects and likely would not render him competent, the court concluded, "[o]n these facts, the medical ethical position reinforces the mandates of our constitutional law, which dictate that we prohibit the State's use of antipsychotic drugs solely to facilitate an execution."[146] Thus, as in *Perry*, the *Fred Singleton* court relied on medical ethics to buttress its holding that involuntary medication violates the right to privacy and federal due process unless the inmate presents a danger to himself or others and the medication is in his best medical interest. The court further held that the appropriate remedy for an incompetent inmate on death row is a stay of execution.[147]

3. *Singleton v. Norris*

In *Singleton v. Norris* ("*Singleton*"), the most recent case to address this issue, the Eighth Circuit held that the Eighth Amendment and the Due Process Clause do not prohibit the execution of a prisoner who became incompetent while on death row but who regained competency through forced medication.[148] In reaching this conclusion, the court refused to address the medical community's strong ethical proscription against such forced medication.[149] Charles Laverne Singleton, who was sentenced to death in Arkansas for murder, became psychotic while on death row. In 1997, after a review panel found him to be a danger to himself and others, the state placed Singleton under a *Harper* involuntary medication order. Singleton petitioned for a writ of habeas corpus, arguing that this forced medication scheme, though legal under *Harper*, became unconstitutional once an execution date was set because the treatment was no longer in his medical interest.[150]

The Eighth Circuit denied Singleton's habeas petition, finding that the forced medication was in his best medical interest.[151] Because all parties agreed that medication was in Singleton's short-term medical interest, the court faulted Singleton for focusing on his long-term medical interest: "the best medical interests of the prisoner must be determined without regard to whether there is a pending date of execution."[152] Noting that states are obligated to provide medical care to prisoners, the court declined to question whether treatment was the state's true motive or if the state's intent was rather to render Singleton competent to be executed.[153] Because "the state was under an obligation to

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privacy afforded by the state constitution, but did not explicitly address the prohibition against cruel and unusual punishment. *See id.*

146. *Id.*

147. *Id.* at 62 ("[J]ustice can never be served by forcing medication on an incompetent inmate for the sole purpose of getting him well enough to execute.").

148. Singleton v. Norris, 319 F.3d 1018, 1027 (8th Cir. 2003).

149. *See* Lloyd, *supra* note 19, at 241 (noting the court failed to address the "medical appropriateness of the procedure" and overlooked ethical considerations).

150. *Singleton*, 319 F.3d at 1023.

151. *Id.* at 1026.

152. *Id.*

153. *Id.* at 1027.

administer antipsychotic medication . . . any additional motive or effect is irrelevant."[154] Thus ignoring the consequence of the looming execution, the court held that forced medication was in Singleton's best medical interests, and therefore did not violate the Constitution.[155]

The United States Supreme Court declined to address the issue of whether forcible medication to restore competency to be executed violates medical ethics and the Constitution when it denied Singleton's final writ of certiorari,[156] and at 8:06 p.m. on January 6, 2004, Arkansas executed Charles Singleton by lethal injection.[157] An irony of *Singleton* is that despite being involuntarily medicated to treat his psychosis, Singleton remained mentally ill when he was executed. He still heard voices threatening to kill him, and he made ranting, incoherent statements up until the moment of his death, including his final statement that "[t]he blind think I'm playing a game. They deny me, refusing me existence. But everybody takes the place of another. As it is written, I will come forth as you go."[158] Thus, while the antipsychotic treatment may have been successful in restoring Singleton to narrowly defined *Ford*-competency (that is, he understood his punishment and why it was being inflicted upon him), it was unsuccessful in adequately treating his underlying mental illness—the state's putative justification for treating him in the first place.

B. *SINGLETON*'S FAILURE TO ACKNOWLEDGE MEDICAL ETHICS

While the courts in *Perry* and *Fred Singleton* explicitly deferred to medical ethics as embodied in the Hippocratic Oath in finding that forced medication to execute directly conflicted with a patient's medical interests, in *Singleton* the Eighth Circuit was silent on the question of medical ethics and practice. This inattention underscores several ethical problems inherent in the medicate-to-execute scheme, and the failure to recognize these problems enabled the *Singleton* court to dismiss medical ethics altogether.

1. *Singleton*'s Dismissal of Long-Term Extraclinical Consequences of Treatment

The *Singleton* decision erred by prioritizing short- over long-term treatment consequences and by ignoring extraclinical consequences of clinical intervention. *Singleton's* failure to address medical ethics enabled the court to assert that involuntary medication was in Singleton's short-term medical interests despite the inevitable long-term consequence of execution. In contrast, the dissent in *Singleton*, like the courts in *Perry* and *Fred Singleton*, deferred to medical ethics, and therefore saw through this legal fiction. Citing the APA, Judge

154. *Id.*
155. *Id.*
156. Singleton v. Norris, 540 U.S. 832, 832 (2003).
157. *See* Cantor, *supra* note 126, at 168.
158. *Id.* at 167.

Heaney asserted in dissent that "it matters little if the drugs benefit the prisoner in the short term when the overall effect of the drug treatment is his ultimate death."[159]

Yet the Eighth Circuit dismissed the significant long-term consequence of medicating Singleton—death by execution—arguing that "[e]ligibility for execution is the *only* unwanted consequence of the medication."[160] While physicians routinely balance short- and long-term consequences when making determinations of which treatment would be in the patient's best medical interests, they typically focus on the clinical consequences of treatment, while the repercussion discounted by the court in *Singleton* was the legal consequence of execution. *Singleton* can therefore be viewed as supporting the proposition that because execution is merely an extraclinical repercussion of treatment, this inevitability should not be considered by doctors when making clinical decisions—or by courts evaluating executions. Thus, just as Appelbaum argues that a forensic psychiatrist is not obligated to consider whether a defendant might be convicted as a result of the doctor's expert testimony, neither should a physician consider the fact that the patient will be executed as a result of his treatment.

But this dismissal of extraclinical harms is problematic for two reasons. First, Appelbaum himself agrees that medicating to restore competency implicates ethical obligations because such medication clearly constitutes "treatment"—the threshold inquiry in determining the applicability of medical ethics.[161] Thus, *Singleton* represents an extreme form of the argument that the legal consequences of treatment are ethically irrelevant. According to this argument, as long as the physician minimizes psychological suffering, he bears no responsibility if the inmate is put to death as a result.[162]

Second, while physicians most commonly balance clinical benefits against clinical harms, extraclinical considerations are not beyond the realm of legitimate medical concern. Indeed, many medical interventions, such as growth hormone treatment, cosmetic surgery, and circumcision, primarily serve extraclinical, rather than clinical, goals.[163] Such interventions are generally ethically permissible as long their extraclinical benefits outweigh the medical risks. The dismissal of non-clinical treatment outcomes therefore ignores the fact that

159. *Singleton*, 319 F.3d at 1036 n.11 (Heaney, J., dissenting) (citing Rhonda K. Jenkins, Comment, *Fit to Die: Drug-Induced Competency for the Purpose of Execution*, 20 S. ILL. U. L.J. 149 (Fall, 1995)).

160. *Id.* at 1026 (emphasis added).

161. *See* Appelbaum, *supra* note 40, at 257.

162. *See* Bloche, *supra* note 40, at 346 ("To proponents of this view, the legal consequences of treatment success are ethically irrelevant. Accordingly, they hold, treatment is beneficial—and ethical—if it ameliorates symptoms and their accompanying psychological distress or restores (or maintains) a patient's ability to act freely and rationally.").

163. In a dramatic and controversial example of prioritizing non-medical over clinical considerations, doctors recently artificially stunted the growth of a severely mentally and physically disabled girl to make it easier for her family members to carry her and include her in family activities. *See* Sam Howe Verhovek, *Parents Defend Decision to Keep Disabled Girl Small*, L.A. TIMES, January 3, 2007, at 1.

physicians often consider non-medical repercussions when evaluating the costs and benefits of an intervention. Thus, the proper inquiry should not be whether the consequence is clinical or non-clinical, but rather if, on balance, the long-term deleterious consequences of treatment—whether clinical or not—outweigh the short-term benefits.

2. The Creation of an Intractable Ethical Dilemma for Physicians

The second problem with the *Singleton* decision, also noted by the dissent, is that the court's holding imposed a stark ethical dilemma on doctors. Citing the Hippocratic Oath as well as AMA and APA prohibitions on physician participation in executions, the dissent argued that the majority's holding placed doctors in the "untenable position" of choosing between treatment that would result in execution and withholding treatment, leaving the prisoner in a debilitating psychotic state.[164] Indeed, this ethical dilemma is similar to that experienced by physicians who agree to participate in lethal injections in order to minimize the risk of pain and suffering that may occur in the absence of physician participation.[165] Yet here the bind on doctors is perhaps more acute, as the option of leaving a patient in a prolonged state of severe psychosis is directly at odds with the physician's mandate to heal. As a result, some opponents of involuntary medication to restore competency nonetheless acknowledge circumstances in which an ethical obligation to the patient as a whole person would allow treatment, even in light of the legal consequences of therapeutic success:

> For example, a delusional prisoner's self-mutilating behavior or a severely disorganized psychotic inmate's inability to eat invite the judgment that the urgency of relieving agony or forestalling an immediate threat to life outweighs the prospect of execution. . . . But this exception should be sharply limited, to cases of extreme suffering or immediate danger to life.[166]

Again, the key is that medical ethics require doctors to balance the consequences of different treatment options—including the option of non-treatment. If, as under the extreme circumstances envisioned by this exception, the physician believes that treatment would relieve a patient of a fate worse than death, then such treatment may be permissible—but only where the physician appropriately considered both the clinical and legal consequences of treatment, includ-

164. *Singleton*, 319 F.3d at 1036–37 (Heaney, J., dissenting).

165. *See supra* note 23 and accompanying text.

166. BREACH OF TRUST, *supra* note 13, at 41–42. But this exception presents a risk that physicians will exploit the prevention of suffering rationale to justify medication of a condemned inmate who is not suffering extreme psychological pain. *See* Bloche, *supra* note 40, at 347 ("Psychiatrists anxious to escape the cognitive dissonance between their therapeutic mission and the state's penal purposes could come to view an incompetent inmate's mild anxiety, or even psychotic symptoms *per se*, as suffering enough to merit treatment that might result in execution.").

ing the impending execution.[167] However, *Singleton* disables physicians from making these considerations in accordance with their ethical obligations.

3. The Problem of Intent

The majority in *Singleton* also erred in concluding that because the intent of the physician and the state is to treat mental illness rather than make Singleton competent to be executed, such treatment is ethically and constitutionally permissible. Even assuming arguendo that the state's forced treatment did in fact have this beneficent intent, this argument is specious. Courts frequently look beyond intent in other medical contexts. For example, medical treatment of a patient without her consent constitutes battery, and the beneficent intent—or even consequence—of the physician's actions serves as no defense.[168] Thus, while the law makes exceptions for treating a patient against his wishes—especially in cases of mental illness—it is clear that a beneficent intent alone offers no absolution of impropriety.

Further, the majority essentially cloaked the state and its doctors in the protection of the double effect doctrine, which allows an action that has a foreseeable bad effect as long as it was undertaken for a permissible purpose.[169] This principle is often invoked to justify aggressive pain management in the palliative care setting, which may hasten death, as long as the intention is to alleviate suffering and not to cause death.[170] Thus, Julie Cantor argues that "[i]f hastening death is an unintended but foreseeable consequence of aggressive pain management at the end of life, then rendering Singleton competent for execution can be characterized as an unintended but foreseeable consequence of neuroleptics that treat dangerous psychotic symptoms."[171] While a full critique of the double effect doctrine is outside the scope of this Note, the principle itself is inappropriate in this context. Death may, in some circumstances, be a foreseeable but uncertain and unintended result with respect to palliative care. But as is the case with termination of treatment cases,[172] it is insincere to claim that death is an unintended consequence in the medicate-to-execute scenario,

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167. Medical ethicists have also suggested that medication to restore competency to be executed may be permissible where the condemned expressed a prior preference to be so treated if he were to become incompetent. *See* Bloche, *supra* note 40, at 348.

168. *See, e.g.*, Gragg v. Calandra, 696 N.E.2d 1282, 1287 (Ill. App. Ct. 1998) (noting that "[i]t is not the hostile intent of the defendant but rather the absence of consent by the plaintiff that is at the core of an action for battery").

169. *See* Richard S. Kay, *Causing Death for Compassionate Reasons in American Law*, 54 AM. J. COMP. L. 693, 712 (2006).

170. *See* Vacco v. Quill, 521 U.S. 793, 808 n.11 (1997) ("Just as a State may prohibit assisting suicide while permitting patients to refuse unwanted lifesaving treatment, it may permit palliative care related to that refusal, which may have the foreseen but unintended 'double effect' of hastening the patient's death."); Cantor, *supra* note 126, at 152 (arguing that "medical consensus" generally supports pain management that hastens death "as long as pain relief remains the primary goal").

171. Cantor, *supra* note 126, at 153.

172. *See* Kay, *supra* note 169, at 714 (arguing that it is specious to say that death is unintended in termination of treatment cases).

because death is a *certain* (even though not the only) outcome of the forced medication. Moreover, the rightness of terminating treatment or providing aggressive pain management results not from a dubious intent/foreseen distinction,[173] but rather because in both those cases the patient *wants* those actions in spite of—or indeed, because of—the risk of death. It is therefore disingenuous to claim that the state's sole intent is to heal Singleton, when it is clear that the result of such treatment would be certain death.[174]

Because the *Singleton* court failed to recognize the ethical problems implicated by forced medication to restore competency to be executed, it effectively sidestepped the question of deference to medical ethics. In contrast, the *Perry* and *Fred Singleton* decisions frankly addressed these ethical problems and ultimately deferred to medical ethics in striking down forced medication schemes. Clearly the outcome of similar cases will be determined in large part by the degree of deference afforded to medical ethics. Thus, a key question is whether courts are ever justified in deferring to medical ethics.

IV. THE NEED FOR INCREASED JUDICIAL DEFERENCE TO MEDICAL ETHICS

The above analysis demonstrates that a fundamental incoherence exists in the extent to which courts draw on medical ethics in the context of capital punishment. Yet the Supreme Court has long recognized the importance of medical ethics and practice in deciding cases. Thus, increased judicial notice of medical ethics is required to resolve the current judicial incoherence on the issue and to respect Supreme Court precedent, and this Note proposes a framework for determining why and when judicial deference to medical ethics is warranted.

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173. *See* Edward C. Lyons, *In Incognito—The Principle of Double Effect in American Constitutional Law*, 57 FLA. L. REV. 469, 488–89 (critiquing the intent/foreseen distinction implicit in the double effect doctrine).

174. Supporters and opponents of forced medication to restore competency and physician participation in lethal injection also invoke causation arguments to determine whether physicians are absolved of responsibility for the inmate's execution and thus whether an ethical problem arises in the first place. *Compare* Cantor, *supra* note 126, at 156 (arguing that medicating Singleton does not constitute participation in an execution because "[t]he chain of causation is too attenuated") *and* Baum, *supra* note 13, at 63 (asserting that physicians participating in executions are not the but-for cause of death because "death would take place regardless of whether the physician was involved or not") *with* Singleton v. State, 437 S.E.2d 53, 61 (S.C. 1993) (noting the "causal relationship between administering a drug which allows the inmate to be executed, and the execution itself") *and* Rochelle Graff Salguero, *Medical Ethics and Competency to be Executed*, 96 YALE L.J. 167, 177 (1986) (arguing that the "act of treatment and restoration of sanity is the only condition precedent for the execution of the individual"). While a complete causation analysis is outside the scope of this Note, it is difficult to imagine how an inmate's execution is not the reasonably foreseeable consequence of, and therefore proximately caused by, the physician's intervention (whether treatment to restore competency or direct involvement in the execution itself). Further, proximate cause arguments are essentially policy arguments about line-drawing. Accordingly, Gregg Bloche suggests asking whether "clinical work at a particular stage in capital proceedings evoke[s] the *impression* that the doctor is working *primarily* for the executioner" to determine whether a physician's involvement constitutes a breach of ethics. Bloche, *supra* note 40, at 340. Under this view, both medicating to restore competency for execution and participation in lethal injections would violate professional ethics because both actions create the impression that the physician is working primarily for the state rather than for the patient.

A. SUPREME COURT DEFERENCE TO MEDICAL ETHICS AND PRACTICE

The dismissal of medical ethics in *Morales*, *Taylor*, *Singleton,* and to a lesser extent *Brown*, is at odds not only with the *Perry* and *Fred Singleton* decisions, but also with the rich tradition of U.S. Supreme Court deference to medical ethics and the standards of the medical profession. For example, in 1952, the Court upheld a finding that restraints on entry into the prepaid medical care business "could be justified as reasonable to maintain proper standards of medical ethics."[175] In *Ferguson v. City of Charleston*, the Court relied on the contention by the AMA, the American Public Health Association, and other medical groups that disclosure of drug tests performed on maternity patients violated a reasonable expectation of privacy and thus constituted an unreasonable search under the Fourth Amendment.[176] And in *Harper*, the Court cited the Hippocratic Oath and APA guidelines in asserting that medical ethics would ensure that physicians would not involuntarily medicate prisoners for reasons unrelated to their best medical interests.[177]

Moreover, in *Washington v. Glucksberg* the Court recognized that "[t]he State . . . has an interest in protecting the integrity and ethics of the medical profession,"[178] and held that the right to physician-assisted suicide was not a fundamental liberty interest protected by the Due Process Clause.[179] In reaching this decision, the Court relied on statements by the AMA and other physicians' groups as proof that the medical community views assisted suicide as incompatible with the physician's role as healer, and the Court argued that "physician-assisted suicide could . . . undermine the trust that is essential to the doctor-patient relationship by blurring the time-honored line between healing and harming."[180] Thus, the Supreme Court has consistently shown a striking degree of deference to the ethical standards of the medical community, and there exists a fundamental incoherence between this deference, which was also applied by state courts in *Perry* and *Fred Singleton*, and the failure to acknowledge the ethical consensus of the medical community in *Morales*, *Taylor*, and *Singleton*.

It is therefore clear that that the recent decisions in *Taylor*, *Morales*, *Single-*

175. United States v. Oregon State Med. Soc'y, 343 U.S. 326, 331 (1952).

176. Ferguson v. City of Charleston, 532 U.S. 67, 76–78 (2001). In its amicus brief, the AMA argued that "[b]y requiring physicians to act as agents of law enforcement, the . . . policy undercuts the physicians' ethical obligation to act as patient advocates and protectors." Motion For Leave to File Brief as Amicus Curiae and Brief Amicus Curiae of the American Medical Association in Support of Neither Party at 3–4, *Ferguson*, 532 U.S. 67 (No. 99-936), 2000 WL 1506967.

177. Washington v. Harper, 494 U.S. 210, 223 n.8 (1990). *Roe v. Wade* also recognized the importance of medical ethics. Roe v. Wade, 410 U.S. 113, 130–32 (1973) (discussing the Hippocratic Oath and the ethical implications of abortion). The Court also cited the opinion of the AMA Judicial Counsel that "[t]he Principles of Medical Ethics of the AMA do not prohibit a physician from performing an abortion that is performed in accordance with good medical practice . . . ." *Id.* at 144 n.39; *see* Lloyd, *supra* note 19, at 233–34 (noting that the Court's recognition of medical ethics is embedded in the *Roe* opinion).

178. Washington v. Glucksberg, 521 U.S. 702, 731 (1997).

179. *Id.* at 705–06.

180. *Id.* at 731.

ton, and perhaps *Brown*, which ignored or discounted medical ethics, are at odds not just with the *Perry* and *Fred Singleton* decisions, but also with the longstanding Supreme Court deference to medical ethics in constitutional jurisprudence. The Supreme Court itself declined to weigh in on this incoherence when it denied certiorari in *Singleton*.[181] However, *Morales*, *Taylor*, and other challenges to the constitutionality of lethal injection are being mounted across the country.[182] Thus, the Court will likely have opportunities to address the issue of physician involvement in capital punishment again, and when it does, the ethics of such participation will be a critical, if not dispositive, issue.

B. A MODEL FOR JUDICIAL DEFERENCE TO MEDICAL ETHICS

To resolve questions at the intersection of medical ethics and constitutional law, courts need a framework for determining whether respect for, or deference to, medical ethics is justified in the first place. In determining whether judicial deference to medical ethics is warranted, courts should look to: (1) the effect of the practice on the integrity of the medical profession; (2) the extent to which medical ethics reflect contemporary standards of decency; (3) whether violation of the ethical standard would offend human dignity; and (4) whether breaching medical ethics would interfere with a constitutionally protected liberty interest. Analysis of these four factors supports judicial deference to medical ethics regarding physician participation in executions.[183]

First, as noted above, the Supreme Court has repeatedly recognized an interest in protecting the integrity and ethics of the medical profession.[184] One rationale for this interest is the preservation of the public trust in physicians that is essential to the doctor-patient relationship. Physician participation in the death penalty and forced medication to restore competency to be executed deeply undermine this public trust. Moreover, the Supreme Court has relied on ethical statements from the AMA and other medical groups in determining whether a practice would violate the integrity of the medical profession,[185] and the medical community is virtually unanimous in its condemnation of physician involvement in capital punishment and forced medication to restore *Ford*-competency. Thus, any interest in protecting the integrity and ethics of the medical profession would support a prohibition on physician involvement in the

181. Singleton v. Norris, 540 U.S. 832, 832 (2003) (denying certiorari).

182. *See supra* note 9 and accompanying text.

183. David Katz suggested that courts defer to medical ethics where a consensus exists on a widely-held, long-standing medical principle. David L. Katz, Note, *Perry v. Louisiana: Medical Ethics on Death Row—Is Judicial Intervention Warranted?*, 4 GEO. J. L. ETHICS 707, 722 (1991). As discussed below, such a consensus exists with respect to physician participation in executions. *See infra* notes 187–189 and accompanying text.

184. *See supra* Part IV.A.

185. *See* Washington v. Glucksberg, 521 U.S. 702, 731 (1997) (finding that physician-assisted suicide threatens the integrity of the medical profession and erodes trust in the doctor-patient relationship based on the AMA's assertion that it is "fundamentally incompatible with the physician's role as healer").

death penalty.

A second justification for judicial deference to medical ethics is that these professional standards often provide objective indicia of currently prevailing standards of decency.[186] The Supreme Court recently relied on such standards of decency when it decided that executions of juveniles and mentally retarded prisoners constitute cruel and unusual punishments,[187] demonstrating its willingness to curb particular applications of the death penalty where a national consensus against the practice exists. Not only is there a clear ethical consensus proscribing physician involvement in the death penalty, but this consensus is only growing stronger.[188] This consensus exists, moreover, in the very community best equipped to judge the decency of these practices; physicians are uniquely sensitive to the ways in which participation in execution violates the long-standing Hippocratic tradition of undivided loyalty to the patient and erodes trust in the medical profession. Thus, the medical community's clear statement that physician participation in executions is unacceptable is a powerful indication that such participation is offensive to contemporary society, and courts should therefore take heed of such professional standards when assessing evolving standards of decency.[189]

Third, deference to medical ethics is warranted where ethical violations would be degrading to a person's dignity.[190] Medical guidelines often serve to protect against degradations of human dignity; indeed, the AMA Code of Ethics asserts that physicians should provide medical care with "respect for human

186. *See* State v. Perry, 610 So. 2d 746, 769 (La. 1992).

187. Roper v. Simmons, 543 U.S. 551, 559–60 (2005) (pointing to evidence of a national consensus against executing juveniles in holding that the Eighth Amendment forbids executing those who were under the age of 18 when crime was committed); Atkins v. Virginia, 536 U.S. 304, 321 (2002) (holding that in light of evolving standards of decency, execution of mentally retarded criminals is excessive and violates the Eighth Amendment).

188. *See Atkins*, 536 U.S. at 315 (noting in the context of state laws forbidding the execution of mentally retarded criminals the importance of not just a consensus but also "the consistency of the direction of change"). The growing consensus in the medical community is evidenced by the mounting number of professional organizations to oppose physician involvement in executions. The AMA first detailed its opposition to physician participation in capital punishment in 1980. Within the next five years, the American College of Physicians, American Public Health Association, American Nurses Association, and American Psychiatric Association issued their own pronouncements against physician participation in executions. *See* BREACH OF TRUST, *supra* note 13, at 13–14; Council on Ethical and Judicial Affairs, *supra* note 14. More recently, in 2006 the American Society of Anesthesiologists and the North Carolina Medical Board announced their opposition to the practice. *See* Guidry, *supra* note 92; NORTH CAROLINA MEDICAL BOARD, *supra* note 101. Moreover, the Illinois legislature adopted a statutory ban on physician participation in executions in 2003. *See* Levy, *supra* note 17, at 271 n.71.

189. While professional societies nearly unanimously oppose physician participation in execution, a majority of states do allow such participation. *See* Levy, *supra* note 17, at 264 n.21. Thus, courts cannot point to enactments of state legislatures to suggest that such participation violates contemporary standards of decency as the Supreme Court did in the context of execution of juveniles and the mentally retarded.

190. *See* Trop v. Dulles, 356 U.S. 86, 100 (1958) (noting that "[t]he basic concept underlying the Eighth Amendment is nothing less than the dignity of man").

dignity and rights."[191] The court in *Perry* invoked the dignity argument in asserting that the forced medication scheme is "severely degrading to human dignity" in that Perry was forced to "yield to the state the control of his mind, thoughts, and bodily functions . . . [and] will not be afforded a humane exit but will suffer unique indignities and degradation."[192] While this argument applies with particular force to the medicate-to-execute scenario, one may argue more generally that whenever physicians participate in executions in any way, they violate a deeply-rooted expectation that when patients place themselves in the hands of physicians, the physician will use her powers in a fashion consistent with her ethical obligations to her patient. Denying the application of this core principle of medical ethics to the condemned inmate constitutes a devaluation of the inmate's humanity and therefore violates the Eighth Amendment. While this line of argument finds less direct support in Supreme Court precedent than the first two, judicial notice of medical ethics would certainly provide guidance to courts as to which practices do degrade human dignity.

Fourth, and related to the above factor, deference is necessary when medical ethics implicate a liberty interest protected by the Fourteenth Amendment. The Due Process Clause protects those liberty interests that are "deeply rooted in this Nation's history and tradition,"[193] and the Supreme Court has applied this substantive due process analysis in the medical context on several occasions. In *Cruzan v. Director, Missouri Department of Health*, the Court recognized a liberty interest in refusing lifesaving hydration and nutrition, based on a right to refuse unwanted medical treatment that was deeply rooted in this country's history, tradition, and practice.[194] In *Washington v. Glucksberg*, on the other hand, the Court held that the right to physician-assisted suicide is not a protected liberty interest because no such right was deeply rooted in our history and traditions: "opposition to and condemnation of suicide—and, therefore, of assisting suicide—are consistent and enduring themes of our philosophical, legal, and cultural heritages."[195] Implicit in these decisions is that medical ethics provide a signpost for practices that are deeply rooted in our history and traditions. Thus in *Glucksberg*, the Court pointed to the AMA's proscription on physician assisted suicide,[196] and in her concurrence in *Cruzan*, Justice O'Connor relied on the AMA's ethical guidance that unwanted artificial feeding is indistin-

191. AMA Code of Medical Ethics, E – 0.00: Principles of Medical Ethics, http://www.ama-assn.org/ama/pub/category/8292.html.

192. State v. Perry, 610 So. 2d 746, 766 (La. 1992).

193. Washington v. Glucksberg, 521 U.S. 702, 720–21 (1997).

194. Cruzan v. Director, Mo. Dept. Health, 497 U.S. 261, 276–80 (1990) (recognizing a liberty interest in refusing lifesaving medical treatment but holding that the Constitution did not forbid the state's requirement that the incompetent's wishes be demonstrated by clear and convincing evidence); *see also Glucksberg*, 521 U.S. at 722 n.12 (noting that *Cruzan* found that the right to refuse treatment was grounded in our history and traditions and therefore required protection under the Fourteenth Amendment).

195. *Glucksberg*, 521 U.S. at 711.

196. *Id.* at 731.

guishable from other forms of unwanted medical treatment.[197]

Application of this due process analysis suggests that physician participation in executions violates an inmate's constitutionally protected liberty interest. As in *Cruzan*, and unlike *Glucksberg*, the proscription against physician involvement in executions is deeply rooted in our nation's history and traditions. Prior to and throughout the existence of this nation, the Hippocratic Oath has prohibited doctors from harming patients, and the AMA issued its report banning the participation of physicians in capital punishment two years before the first lethal injection in the United States.[198] Further, the Due Process Clause also protects against actions that offend human dignity[199]—and as discussed above, physician participation in lethal injections and forced medication to restore competency to be executed is uniquely degrading. Thus, physician participation in executions violates the core ethical principle—which preceded our existence as a nation—that doctors will help rather than harm us when we are most vulnerable. The violation of this longstanding expectation undermines the trust that is essential to the doctor-patient relationship—the importance of which the Supreme Court has recognized on numerous occasions.[200]

All four factors will not necessarily apply to review of all actions at the intersection of medical ethics and the law. Indeed, a state practice may be contrary to medical ethics without rising to the level of degrading dignity or violating due process, and in the absence of such threats, any putative damage to the integrity of the medical profession may not support judicial deference. For example, for 130 years the AMA's Code of Ethics proscribed advertisements by physicians as unethical.[201] The original Code, published in 1847, asserted that "[i]t is derogatory to the dignity of the profession, to resort to public advertisements."[202] But after the Supreme Court in 1975 rejected the claim that a learned profession exception to the Sherman Act allowed professional bans on public advertisements,[203] the AMA removed its prohibition on physician advertisements.[204] Under the model presented here, deference to the

197. *Cruzan*, 497 U.S. at 288 (O'Connor, J., concurring).

198. *See* Council on Ethical and Judicial Affairs, *supra* note 14. At the same time, a majority of death penalty states allow or require physician participation in lethal injections. *See supra* notes 46–47 and accompanying text. However, while state practices are important to determining legal traditions, the universal ethical proscription against physician participation in executions, which preceded these state laws, serves as a strong indicator of the philosophical and cultural heritages the Court relied on in *Glucksberg*. *See Glucksberg*, 521 U.S. at 711.

199. *See* Rochin v. California, 342 U.S. 165, 173–74 (finding that stomach pumping of accused drug dealer violated the Due Process Clause because it was "brutal" and "offensive to human dignity").

200. *See, e.g.*, *Cruzan*, 497 U.S. at 341 n.12 (Stevens, J., dissenting) ("We have recognized that the special relationship between patient and physician will often be encompassed within the domain of private life protected by the Due Process Clause.").

201. *See* N.D. Tomycz, *A Profession Selling Out: Lamenting the Paradigm Shift in Physician Advertising*, 32 J. MED. ETHICS 26, 26 (2006).

202. *AMA Original Code of Medical Ethics, 1847*, at 98, www.ama-assn.org/ama/upload/mm/369/1847code.pdf.

203. Goldfarb v. Virginia State Bar, 421 U.S. 773, 792–93 (1975).

204. *See* Tomycz, *supra* note 201, at 26.

profession's ethical proscription against advertising would not be warranted because while such advertising presented a potential threat to the integrity of the medical profession, it did not pose a threat to human dignity or interfere with a liberty interest. Moreover, any threat to the integrity of the profession presented by physician advertising was minimal at best.

The medical community has promulgated ethical guidelines regarding numerous practices, ranging from the obligation to retain patients' medical records[205] to the prohibition on charging hospital admission fees.[206] Like the former proscription on advertising, these ethical standards likely warrant little judicial deference, because they do not sufficiently implicate the factors of professional integrity, decency, dignity and liberty. In contrast, physician involvement in capital proceedings strongly implicates all four factors, and courts should therefore take notice of professional ethics in the death penalty context. Physician participation in other activities, such as euthanasia, state-sponsored torture, or expert testimony at earlier stages of legal proceedings (such as determinations of competency to stand trial), likely fall somewhere in between the lethal injection and advertising extremes. Analysis of the factors described here will assist courts in determining whether and to what extent they should defer to professional ethics governing these and other medical practices.

CONCLUSION

Analysis of death penalty jurisprudence reveals a fundamental inconsistency in the extent to which courts defer to medical ethics. This incoherence is not surprising, given that courts addressing execution are often forced to resolve intractable ethical dilemmas. Physician participation is probably essential to ensuring that lethal injections do not present a risk of unconstitutional pain, but such involvement nonetheless contradicts deeply rooted principles of medical ethics and threatens the critical bond of trust between doctors and patients. And allowing an insane inmate to languish in severe psychotic pain contradicts a doctor's ethical obligation to ease suffering, but so too would forcible medication where the certain result of such treatment would be death by execution.

Yet as this Note demonstrates, sidestepping these difficult dilemmas by ignoring medical ethics is no solution. Indeed, judicial respect for medical ethics is not only consistent with Supreme Court precedent, but is necessary to adequately address the constitutional concerns implicated in death penalty challenges. Thus, when courts fail to adequately address medical ethics, they render decisions that potentially violate both ethical standards and individual liberties guaranteed by the Constitution. It is therefore essential that courts develop a framework, such as the one proposed here, for whether and when to

205. AMA Code of Medical Ethics, E – 7.05: Retention of Medical Records, http://www.ama-assn.org/ama/pub/category/8382.html.

206. AMA Code of Medical Ethics, E – 4.01: Admission Fee, http://www.ama-assn.org/ama/pub/category/8338.html.

defer to medical ethics and practice—not just in the context of the death penalty, but also for other questions at the intersection of medical ethics and constitutional law. Increased deference to medical ethics and standards will resolve the incoherence in death penalty jurisprudence, strengthen the doctor-patient relationship, and put an end to state practices that are offensive to contemporary society.