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THE TRUTH ABOUT PHYSICIAN PARTICIPATION IN LETHAL INJECTION EXECUTIONS*

TY ALPER**

Recent court rulings addressing the constitutionality of states' lethal injection procedures have taken as a given the faulty notion that doctors cannot and will not participate in executions. As a result, courts have dismissed the feasibility of a remedy requiring physician participation, and openly expressed suspicion of the motives of lawyers who would propose such a remedy.

This Article exposes two myths that have come to dominate the capital punishment discourse: first, that requiring physician participation would grind the administration of the death penalty to a halt because doctors cannot participate; and second, that advocating for such a requirement is a disingenuous abolitionist strategy as opposed to a principled remedial argument. As this Article demonstrates through a review of available research and recent litigation, doctors can, are willing to, and in fact do regularly participate in executions, though often not in the manner necessary to ensure humane executions.

Lawyers for death row inmates have argued that skilled anesthetic monitoring by trained medical professionals is a necessary component of a constitutional three-drug lethal injection protocol. In response, state officials have strategically emphasized the positions of national medical associations (the ethical guidelines of which are not binding on doctors) and exaggerated their inability to

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find willing doctors. They have also exploited the activism of the death penalty abolitionist movement, which has long decried physician participation in executions. Abolitionist calls for discipline of medical professionals who participate in executions directly undermine the credibility of death row inmates' litigation, and feed the perception that death penalty lawyers are talking out of both sides of their mouths.

Lower courts grappling with how to address lethal injection procedures that violate the constitution should know the truth about physician participation. The requirement that trained medical personnel monitor lethal injection executions to ensure that inmates do not suffer excruciating pain should remain on the table as a plausible remedy.

INTRODUCTION	12
I. DOCTORS CAN, WILL, AND DO PARTICIPATE IN LETHAL INJECTION EXECUTIONS	19
A. <i>Doctors Can Participate in Lethal Injection Executions</i>	26
1. Ethical Guidelines Are Generally Not Enforceable	26
2. Ethical Guidelines Have Not Precluded Participation of Other Medical Professionals	34
B. <i>Doctors Will Participate in Lethal Injection Executions</i>	40
C. <i>Doctors Do Participate in Lethal Injection Executions</i>	44
II. PERPETUATION OF THE PHYSICIAN PARTICIPATION MYTHS	49
A. <i>The Role of State Actors</i>	49
1. Missouri	51
2. California and North Carolina	54
B. <i>The Role of Death Penalty Abolitionists</i>	57
1. Abolitionist Opposition to, and Activism Against, Physician Participation in Executions	58
2. Implications of Abolitionist Activism Against Physician Participation	63
CONCLUSION	67

INTRODUCTION

In December 2008, a prominent North Carolina doctor and professor of medicine, Charles van der Horst, published an op-ed in the Raleigh (North Carolina) *News and Observer*.¹ The title of the

1. Charles van der Horst, Op-Ed., *An Absolute: Doctors Don't Kill*, NEWS &

piece was *An Absolute: Doctors Don't Kill*, and in it, Dr. van der Horst wrote that doctors

don't worry about whether someone is a Jew or a Muslim, an illegal alien or a murderer, whether he has insurance or not. We simply take care of that person in front of us the best way we can, given the resources available. And we do not kill our patients.²

Dr. van der Horst was responding to litigation in North Carolina that halted executions in that state while various courts attempted to determine whether doctors could participate in lethal injection executions without fear of professional discipline.³ Dr. van der Horst's conclusion was that if doctors were necessary to assist in lethal injections to ensure that they were conducted humanely, the state should "[f]orget it; we aren't going to help anybody out of this one."⁴ His comments echoed those of the then-president of the American Society of Anesthesiologists ("ASA"), who wrote in 2006 that "[t]he legal system has painted itself into this corner and it is not [anesthesiologists'] obligation to get it out."⁵

Most people would agree that nobody should be forced to assist in an execution against his or her will.⁶ And few would dispute that Dr. van der Horst's stance against physician participation in executions is a principled one to which he is entitled. But has the legal system really painted itself into a corner? In this Article, I argue not.

OBSERVER (Raleigh, N.C.), Dec. 4, 2008, at 9A.

2. *Id.*

3. Since Dr. van der Horst published his piece, the Supreme Court of North Carolina has ruled that the state's medical board cannot discipline doctors for participating in lethal injection executions. *See infra* text accompanying notes 87–90.

4. van der Horst, *supra* note 1.

5. Orin F. Guidry, President, Am. Soc'y of Anesthesiologists, Message from the President: Observations Regarding Lethal Injection (June 30, 2006), <http://www.asahq.org/news/asanews063006.htm>.

6. Although participation on prison "execution teams" is generally regarded as voluntary, there is some anecdotal evidence to suggest that prison guards are expected to participate in executions if they want to advance their careers. In South Carolina, two former prison guards sued their former employers for forcing them to participate in what the guards claimed were gruesomely botched lethal injection executions. *See* Complaint at 2, *Baxley v. Ozmint*, No. 07-04067 (D.S.C. Dec. 18, 2007). In one of the complaints, the plaintiff alleged that he performed or participated in ten executions and that

[a]lthough these executions were barbaric, gruesome and repulsive to the plaintiff, he continued to perform them under the implied threat by [his superior] that such service was necessary if he was to continue to act as team leader and to receive the salary supplement and other benefits of his Major's position.

Id.

Because the ethical guidelines of many prominent national medical associations condemn the participation of doctors in executions, there is a widespread belief that medical professionals cannot in fact participate and that requiring such participation as a precondition of a constitutional lethal injection scheme would effectively abolish the death penalty. This view was on full display in *Baze v. Rees*,⁷ the Supreme Court's fractured and somewhat muddled 2008 ruling assessing the constitutionality of Kentucky's lethal injection procedures.⁸

In *Baze*, seven Justices wrote separate opinions, not one of which garnered more than three votes.⁹ Ultimately, the Court affirmed Kentucky's lethal injection procedures, and in what is generally assumed to be the controlling plurality opinion, Chief Justice Roberts articulated the test for assessing a challenge to lethal injection: to establish an Eighth Amendment violation, a petitioner must show that a state's procedures present a "substantial risk of serious harm."¹⁰

Kentucky is one of only two states in the country where doctors are forbidden by law from participating in executions.¹¹ As a result, no party in *Baze* claimed that physician participation was a realistic

7. 128 S. Ct. 1520 (2008).

8. *Id.* at 1520–72. In the interest of full disclosure, I note that I was counsel of record for an amicus curiae brief filed in *Baze* by the University of California, Berkeley, School of Law Death Penalty Clinic on behalf of several death row inmates. The views expressed herein are my own and should not be read to reflect the views of other lawyers participating in the *Baze* litigation.

9. Chief Justice Roberts announced the judgment of the Court and issued an opinion which Justices Kennedy and Alito joined. *Id.* at 1525. Justice Alito filed a concurring opinion. *Id.* at 1538. Justice Stevens filed an opinion concurring in the judgment. *Id.* at 1542. Justice Scalia filed an opinion concurring in the judgment, which Justice Thomas joined. *Id.* at 1552. Justice Thomas filed an opinion concurring in the judgment, which Justice Scalia joined. *Id.* at 1556. Justice Breyer filed an opinion concurring in the judgment. *Id.* at 1563. Justice Ginsburg filed a dissenting opinion, which Justice Souter joined. *Id.* at 1567. For in-depth analyses of the various opinions in *Baze*, see Eric Berger, *Lethal Injection and the Problem of Constitutional Remedies*, 27 YALE L. & POL'Y REV. 259, 273–80 (2009); Deborah W. Denno, *For Execution Methods Challenges, the Road to Abolition is Paved with Paradox, in ROAD TO ABOLITION? THE FUTURE OF CAPITAL PUNISHMENT IN THE UNITED STATES* 183, 196–204 (Charles J. Ogletree, Jr. & Austin Sarat eds., forthcoming Nov. 2009); Justin F. Marceau, *Lifting the Haze of Baze: Lethal Injection, the Eighth Amendment, and Plurality Opinions*, 41 ARIZ. ST. L.J. 159, 209–20 (2009).

10. *Baze*, 128 S. Ct. at 1532 (plurality opinion) (quoting *Farmer v. Brennan*, 511 U.S. 825, 842 (1994)). The designation of the Roberts opinion as controlling is not without controversy, given that it represented the views of only three Justices. See *Cooley v. Strickland*, 610 F. Supp. 2d 853, 919–22 (S.D. Ohio 2009); Marceau, *supra* note 9, at 160.

11. See KY. REV. STAT. ANN. § 431.220(3) (LexisNexis 1999). The other state is Illinois. See 725 ILL. COMP. STAT. 5/119-5(d-5) (2008).

remedy in Kentucky, and the issue was not developed in the record.¹² Nevertheless, Justice Alito wrote separately to emphasize that, as a result of ethical guidelines that “prohibit” the participation of doctors in executions, lower courts seeking to implement *Baze* in other states should understand that any remedial order requiring such participation would be tantamount to declaring the death penalty unconstitutional.¹³

At least three Justices shared Justice Alito’s concern about the ability of doctors to participate, even though such participation was not at issue in the case before the Court. During oral argument, Justice Scalia stated that “medical doctors, according to the Code of Ethics of the American Medical Association, can’t participate” in executions.¹⁴ Both Chief Justice Roberts’ plurality opinion and Justice Breyer’s concurrence questioned the feasibility of any remedy that required qualified medical personnel. The plurality, citing the ASA’s ethical guidelines, opined that “[t]he asserted need for a professional anesthesiologist . . . is nothing more than an argument against the entire procedure.”¹⁵ Justice Breyer, for his part, quoted the ethical guidelines of the American Medical Association (“AMA”) and the American Nurses Association (“ANA”), and he concluded that, as a result of these guidelines, “finding better trained personnel may be more difficult than might, at first blush, appear.”¹⁶ Justice Breyer noted that “the lawfulness of the death penalty is not before us.”¹⁷ The implication—that the Court was not prepared to allow anti-death penalty activists to do through the back door what they have not been able to do through the front—was as clear as when Justice Breyer made a similar comment at oral argument:

12. The petitioners in *Baze* sought only appropriate monitoring of the delivery of anesthesia to the condemned inmate but did not seek monitoring by a *physician* due to Kentucky’s unusual law. See Brief for Petitioners at 57, *Baze*, 128 S. Ct. 1520 (No. 07-5439) [hereinafter *Baze* Petitioners’ Brief] (“If Kentucky insists on continuing to use pancuronium and potassium, then an alternative means of reducing unnecessary risk would be to ensure that the inmate is sufficiently anesthetized throughout the execution by monitoring anesthetic depth.”).

13. *Baze*, 128 S. Ct. at 1539 (Alito, J., concurring). “[A] suggested modification of a lethal injection protocol cannot be regarded as ‘feasible’ or ‘readily’ available,” Justice Alito wrote, “if the modification would require participation—either in carrying out the execution or in training those who carry out the execution—by persons whose professional ethics rules or traditions impede their participation.” *Id.* at 1540.

14. Transcript of Oral Argument at 6, *Baze*, 128 S. Ct. 1520 (No. 07-5439) [hereinafter *Baze* Transcript].

15. *Baze*, 128 S. Ct. at 1536 (plurality opinion).

16. *Id.* at 1566 (Breyer, J., concurring).

17. *Id.* at 1567.

[W]hat do we do about the point . . . that the doctors or the nurses say it's unethical to help with an execution? I mean, if we are going to talk about the constitutionality of the death penalty per se, that isn't raised in this case. And what the other side says is, well, you're just trying to do this by the back door, insist upon a procedure that can't be used.¹⁸

Thus, in the Supreme Court's leading case on lethal injection, the first time in more than sixty years that the Court addressed the constitutionality of a method of execution under the Eighth Amendment,¹⁹ the plurality opinion, two concurrences, and one Justice's statement at oral argument rejected the possibility that doctors could ever participate in executions.²⁰ In fact, the Justices hinted that physician participation was such an impossibility that the whole concept must be a cynical gambit on the part of lawyers for death row inmates, a Catch-22 of the abolitionists' creation. That conclusion did not come from the record in *Baze*, however, because the issue was not presented in the lower courts in any meaningful way. Where did the Justices get the idea that doctors cannot participate in any executions in any state?

The opinions in *Baze* are illustrative of two reigning myths about physician participation: first, that requiring physician participation would grind the administration of the death penalty to a halt because doctors are unable to participate; and second, that advocating for such a requirement is a disingenuous abolitionist strategy as opposed to a principled remedial argument. This Article seeks to dispel both myths.

Part I demonstrates that requiring the participation of doctors would not, as has been assumed, effectively put an end to lethal injection executions. Understanding that doctors can and will participate in executions is of vital importance; lower courts implementing *Baze* will have to address the feasibility of requiring skilled oversight of the execution process by medical professionals. Because it was not at issue in *Baze*, the discussion of physician participation in that case is entirely dicta, uninformed by evidence or argument on point.

Part I reviews both the available research and information revealed through recent litigation to demonstrate that, upon closer

18. *Baze* Transcript, *supra* note 14, at 12–13.

19. *Baze*, 128 S. Ct. at 1520–72; Deborah W. Denno, *The Lethal Injection Debate: Law and Science*, 35 FORDHAM URB. L.J. 701, 701 & n.1 (2008).

20. See *supra* text accompanying notes 13–18.

inspection, not only can doctors participate in lethal injection executions without fear of professional consequences, and not only are many doctors willing to participate, but they do regularly participate and likely more often than is currently known. This is the case despite the fact that, as discussed in Part II, death penalty abolitionists have waged a decades-long campaign against both doctors who participate in executions and the state medical boards that have refused to discipline them. Part I suggests that the widely repeated refrain that medical ethics “prohibits” physician participation is misleading at best and disingenuous at worst. After all, states routinely rely on—and indeed regularly tout the participation of—medical personnel such as emergency medical technicians (“EMTs”) and nurses in the implementation of their lethal injection procedures. Despite the fact that these medical personnel also operate under ethical guidelines that condemn participation in executions, lawyers for many death penalty states persist in arguing that medical ethics render impossible the participation of doctors. This Part establishes that there is no reason to think that doctors are any different than nurses or EMTs with respect to their fidelity to the non-binding ethical guidelines of their professions.

Part II of this Article challenges the notion that lawyers for death row inmates are engaging in an unprincipled attempt to back-door the abolition of the death penalty. Professor Eric Berger suggests in a recent article that reluctance to order intrusive remedies in the lethal injection context has made courts overly cautious in determining whether constitutional rights have been violated in the first place.²¹ But as the opinions in *Baze* suggest, judges are also worried—sometimes explicitly so—that a determination that medical personnel are necessary to ensure humane lethal injection executions will play right into the hands of death row lawyers who are simply using lethal injection litigation as the latest ploy in their abolitionist agenda.

Part II of this Article explores how states resistant to mandated physician participation have managed to capture the rhetoric on this issue when the facts do not support their position. These states have done so by repeatedly emphasizing the positions of national medical associations and by exaggerating their inability to find willing doctors. They have also exploited the activism of the death penalty abolitionist movement itself. For decades, prominent abolitionist organizations have promoted the notion that doctors cannot participate in

21. See Berger, *supra* note 9, at 280–83.

executions and have publicly campaigned for disciplinary action against doctors who do so.²² This activism has fed both the perception that doctors cannot participate *and* the perception that death penalty lawyers are talking out of both sides of their mouths. After all, lawyers for death row inmates—many of whom consider themselves abolitionists—have argued in litigation that skilled anesthetic monitoring by trained medical professionals is a necessary component of a constitutional three-drug lethal injection protocol.²³ Abolitionist calls for discipline of medical professionals who participate in such executions directly undermine the credibility of this position.

The conflict in these positions is explained by the professional ethical responsibilities of the lawyers defending death row inmates; though willing to use any legal means to stop their clients' executions, these lawyers nevertheless have an additional obligation to seek a humane execution for their clients should that become an inevitability. Abolitionists who are not representing individual clients are unburdened by such responsibilities and are free to reject suggested improvements in the lethal injection process in a way that the lawyers for death row inmates are often not. This distinction is all the more subtle because the two groups, in most other contexts, have common interests and similar goals.

Lawyers representing death penalty states, however, have been quick to take advantage of the general perception of lawyers for death row inmates as anti-death penalty activists, and they have used the unwitting assistance of the abolitionist movement to explicitly promote both myths about physician participation.²⁴ Lawyers for death penalty states have managed thus far to convince courts to shy away from imposing remedies that would require physician participation by publicly questioning the motives of lawyers who advocate for the participation of qualified medical personnel.

22. See *infra* Part II.B.1.

23. See *infra* text accompanying notes 33–37.

24. This Article refers to such lawyers generally as shorthand for lawyers representing states that are defending their lethal injection procedures in court. Often these lawyers are in the State Attorney General's Office or work for the Department of Corrections. This shorthand is not meant to suggest that every state has employed precisely the same litigation strategy in defense of its execution procedures. However, on the question of physician participation, the states' litigation positions have been largely consistent. While it is true that some states have volunteered the use of a physician during executions, and while, as this Article demonstrates, physicians are in fact widely used, no state has yet conceded that the Eighth Amendment requires physician monitoring of the lethal injection process.

For the most part, courts, with *Baze* as the prime example, have accepted the premises of both myths about physician participation without criticism. As a result, these courts are reaching factually incorrect conclusions and rejecting out of hand a constitutional remedy that is feasible in almost every state.²⁵

As lower courts in other states continue to review lethal injection challenges in the wake of *Baze*, physician participation should remain a plausible remedy to be considered in the vast majority of states where it would be possible to obtain qualified medical professionals willing to ensure that executions are conducted humanely. Like any other potential remedy for a constitutional violation, the feasibility of physician participation in lethal injection should be subject to litigation and ultimately left to the discretion of the courts. In other words, it is a remedy that trial courts can work out in light of the facts of the cases in front of them. But the feasibility of physician participation as a remedy should not be bound by the unfounded assumptions and dicta of the *Baze* Justices.

I. DOCTORS CAN, WILL, AND DO PARTICIPATE IN LETHAL INJECTION EXECUTIONS

States that employ lethal injection typically use a three-drug formula to carry out executions.²⁶ The first drug in the formula is intended to anesthetize the inmate; the second one paralyzes him; and the third drug stops his heart, killing him.²⁷ The primary legal challenge to this method rests on the allegation that most states do not employ adequate safeguards to ensure that the person being executed is properly anesthetized before the second and third drugs are administered.²⁸ Because the second drug in the three-drug formula paralyzes the inmate, the concern is that an inadequately anesthetized person “may have the sensation of paralysis without anesthesia . . . and may feel the burning” of the third drug, potassium chloride.²⁹ In such a condition, the paralyzed inmate is unable to

25. At least one federal district court and one federal circuit judge have already cited the dicta in *Baze* to rule out physician participation as a potential remedy. See *infra* notes 130–31 and accompanying text.

26. See Deborah W. Denno, *When Legislatures Delegate Death: The Troubling Paradox Behind State Uses of Electrocutation and Lethal Injection and What It Says About Us*, 63 OHIO ST. L.J. 63, 97 (2002).

27. *Id.* at 97–98.

28. See Deborah W. Denno, *The Lethal Injection Quandary: How Medicine Has Dismantled the Death Penalty*, 76 FORDHAM L. REV. 49, 54–58 (2007).

29. David Waisel, *Physician Participation in Capital Punishment*, 82 MAYO CLINIC PROC. 1073, 1074 (2007). For an in-depth discussion of the potential dangers of the

indicate to correctional staff that he is experiencing the suffocating effects of the paralyzing drug and the excruciatingly painful effects of the potassium chloride.³⁰

Lawyers defending lethal injection procedures do not dispute that an unanesthetized execution—using these particular drugs—would constitute cruel and unusual punishment under the Eighth Amendment.³¹ They do dispute, however, the likelihood that the delivery of the first drug, the anesthetic, will somehow go awry, and typically this is where the question of the participation of medical professionals enters the equation.³²

Lawyers for death row inmates have generally taken the position that, given the degree of skill needed to adequately deliver, monitor, and maintain anesthesia, as well as the widely publicized problems with the administration of anesthesia in the lethal injection setting, states that insist on using the three-drug formula must employ the services of highly-trained medical personnel—often, but not always, doctors³³—in order to ensure that the risk of severe pain to the person being executed does not become “ ‘substantial.’ ”³⁴ If the states do not want to employ medical professionals, the argument goes, they should switch to a different protocol for lethal injections that would not require skilled anesthetic monitoring.³⁵ It is often suggested that

paralyzing drug, including the veterinary community's rejection of it for use in animal euthanasia, see generally Ty Alper, *Anesthetizing the Public Conscience: Lethal Injection and Animal Euthanasia*, 35 FORDHAM URB. L.J. 817 (2008).

30. See Alper, *supra* note 29, at 819 (“Because pancuronium paralyzes the inmate during the execution process, the inmate may experience excruciating pain and suffering but be unable to cry out or even blink an eyelid to let anyone know if the anesthesia has failed.” (citing Waisel, *supra* note 29, at 1074)).

31. See, e.g., *id.* at 819–20 & n.20 (describing the unanimity, even among experts for the states, that an unanesthetized execution by pancuronium and/or potassium chloride would be unbearably painful).

32. See, e.g., Defendants' Opening Brief in Support of Their Motion for Summary Judgment at 19, *Jackson v. Danberg*, 601 F. Supp. 2d 589 (D. Del. 2009) (No. 06-300) (“[T]he risk of maladministration of the sodium pentothal is . . . remote given the safeguards provided in the protocol.”); Defendants' Motion for Summary Judgment at 27, *Dickens v. Napolitano*, No. CV-07-01770 (D. Ariz. Jan. 9, 2009) (“Plaintiffs have not established a colorable claim that Arizona's current lethal injection protocol places any risk of pain to the inmate.”).

33. The required monitoring of anesthetic depth is a skill that can be performed by some doctors and some trained nurses, such as nurse anesthetists. See, e.g., Videotaped Deposition of Medical Team Member 1 at 34–36, *Dickens v. Napolitano*, No. CV-07-01770 (D. Ariz. Feb. 13, 2009). Thus, from the perspective of advocates seeking more humane executions, the relevant inquiry is whether trained medical professionals are available to perform that function.

34. See *Baze v. Rees*, 128 S. Ct. 1520, 1532 (2008) (plurality opinion) (quoting *Farmer v. Brennan*, 511 U.S. 825, 842 (1994)).

35. See, e.g., Reply Brief of Petitioners at 22, *Baze*, 128 S. Ct. 1520 (No. 07-5439) (“To

states consider a one-drug, anesthetic-only procedure similar to that used in most animal euthanasia; because this procedure does not employ the use of any painful drugs, the risk of severe pain if something goes wrong would be minimal.³⁶ As long as states insist on the three-drug formula, however, the litigation position taken by lawyers for death row inmates is that only the supervision of qualified medical personnel can reduce the risk of severe pain to a constitutional level.³⁷

To be clear, lawyers for death row inmates challenging states' lethal injection procedures have generally argued that there *are* humane ways to execute prisoners, and they have routinely presented expert testimony to support this position.³⁸ That lawyers for condemned inmates would make such an argument might be surprising, given that lawyers for such inmates typically raise every possible legal challenge to their clients' conviction and death sentence, in an effort to prevent the execution altogether. But separate and apart from those challenges, lawyers have a duty to ensure that if the execution of their client proceeds, it is conducted humanely and in conformity with the mandates of the Eighth Amendment. It is well-established, moreover, that a lethal injection

the extent that difficulties recruiting physicians have affected those States' conduct of executions, that is the result of the States' decision to retain their dangerous procedures, rather than explore other remedial options such as the barbiturate-only protocol—which can be administered without the participation of physicians, and which poses no danger of a torturous death when administration problems occur.”).

36. See, e.g., *Baze* Petitioners' Brief, *supra* note 12, at 51 (“By omitting [the second two drugs in the three-drug formula] and relying instead on a lethal dose of anesthetic, the [Department of Corrections] would virtually eliminate the risk of pain.”); Alper, *supra* note 29, at 833–39 (discussing the anesthetic-only procedure).

37. See, e.g., *Baze* Petitioners' Brief, *supra* note 12, at 57–59. Another legal challenge to lethal injection protocols has to do with establishing intravenous access in inmates with compromised veins. In such cases, it is often necessary to place a central line in, for example, the inmate's neck or groin. See Tom Beyerlein, *Does Lethal Injection Violate Doctors' Code?—Failed Execution Attempt of Romell Broom by Lethal Injection Raises Issue*, DAYTON DAILY NEWS, Sept. 20, 2009, at A4. Such a procedure almost always necessitates the skill of a trained physician. For example, in Georgia, Dr. Sanjeeva Rao has acknowledged supervising executions and inserting a central line in a condemned inmate when nurses were unable to find a suitable vein. See *infra* text accompanying note 189. The failure of executioners in Ohio to establish venous access during the attempted execution of Romell Broom in September 2009 has raised the question of whether it is possible for the state to execute Mr. Broom without the active participation of a physician. See Beyerlein, *supra*.

38. See Alper, *supra* note 29, at 850 (quoting expert for Maryland death row inmate as testifying that “lethal injection can be performed humanely”); see also Berger, *supra* note 9, at 315–23 (discussing the two most often-cited remedies proposed by lawyers for death row inmates—use of a one-drug, anesthetic-only protocol or the use of adequate medical monitoring of anesthetic depth).

challenge does not provide a vehicle to attack the state's legal authority to execute the inmate-plaintiff: the Supreme Court has made clear on two occasions that a challenge to the administration of lethal injection may proceed as a § 1983³⁹ civil rights action precisely because it is *not* a challenge to the underlying conviction and sentence.⁴⁰ Thus, although no lawyer representing a death row client wants the execution to take place, lethal injection litigation typically proceeds on a separate track from challenges to the execution itself. A lethal injection suit is predicated on the fact that the execution will occur, and the goal of the lawsuit is to obtain remedial measures that ensure that the client does not suffer an excruciatingly painful death. Lawyers who bring such challenges are therefore often prepared to present evidence regarding humane methods of execution.

Those seeking to preserve the lethal injection status quo, on the other hand, have argued that what attorneys for death row inmates really want is a judicially-created Catch-22, in which courts rule that the Constitution requires physician participation to ensure humane executions, doctors refuse to participate, and the impasse leads to a de facto moratorium on the death penalty. For example, the Criminal Justice Legal Foundation argued in a *Baze* amicus brief that “[c]onvincing courts to require doctor participation and then attacking the doctors is part of the cynical Catch-22 strategy that has served the anti-death-penalty movement so well in the past.”⁴¹

It is not only pro-prosecution advocacy groups that have sought to expose what they claim is a cynical ploy on the part of lawyers representing death row inmates in lethal injection challenges. Lawyers for death penalty states have made similar arguments. “‘The goal of death penalty opponents,’” claimed a spokesman for the California Attorney General in 2006, “‘is to get a court order that says that lethal injections can only be administered by licensed professionals, because the ethics of medical professionals prohibit them from participating.’”⁴² Often the arguments are couched as

39. 42 U.S.C. § 1983 (2006).

40. See *Hill v. McDonough*, 547 U.S. 573, 579–80 (2006); *Nelson v. Campbell*, 541 U.S. 637, 643–44 (2004).

41. Brief Amicus Curiae of the Criminal Justice Legal Foundation in Support of Respondents at 24, *Baze v. Rees*, 128 S. Ct. 1520 (2008) (No. 07-5439). Kent Scheidegger, the legal director of the Criminal Justice Legal Foundation, has said publicly that problems with executions by way of intravenous injection are inevitable, and that he favors a return to gas chambers or some kind of intramuscular injection of lethal chemicals. See Bob Driehaus, *Ohio Plans to Try Again as Execution Goes Wrong*, N.Y. TIMES, Sept. 17, 2009, at A14.

42. Emma Harris, *Will Medics' Qualms Kill the Death Penalty?*, 441 NATURE 8, 8–9

warnings of what a physician participation requirement would do to the administration of capital punishment. For example, in Missouri, lawyers for the state warned the Eighth Circuit that it should reject the petitioner's request for physician monitoring of anesthesia because "a requirement that a doctor participate at executions could effectively bar implementation of the death penalty in Missouri."⁴³ The Governor of Tennessee also recently described the requirement of medical personnel as a "'catch-22'" and criticized a judicial decision demanding more medical training for the execution team because "'[t]he catch is, people with medical training won't take part in executions.'"⁴⁴

The argument that a physician participation requirement would lead to abolition of the death penalty has surface appeal because several national medical associations have expressed their belief that physicians should not participate in executions. The AMA is a voluntary association of physicians in the United States that seeks to "promote the art and science of medicine and the betterment of public health."⁴⁵ The AMA has, since 1980, declared that the participation of doctors in executions clearly violates medical ethics.⁴⁶ The AMA's policy, last updated in 2008, defines "participation" broadly to include even "consulting with or supervising lethal

(2006) (quoting Nathan Barankin of the California Attorney General's Office).

43. Brief of Appellants at 64, *Taylor v. Crawford*, 487 F.3d 1072 (8th Cir. 2007) (No. 06-3651) [hereinafter *Taylor* Appellants' Brief].

44. Jeff Woods, *Machinery of Death: Governor Defiant, but Executions Could Stop for Months While Courts Decide Constitutionality of Lethal Injection*, NASHVILLE SCENE, Sept. 27, 2007, <http://www.nashvillescene.com/2007-09-27/stories/machinery-of-death/>. Lawyers for the United States made a similar argument in *Baze*. The Solicitor General argued in that case that "it is doubtful that Kentucky could even find a doctor to participate in an execution" and that "in a constitutional system that permits the death penalty, the baseline for measuring whether a method inflicts unnecessary pain must be a *feasible* alternative." Brief for the United States as Amicus Curiae Supporting Respondents at 31, *Baze*, 128 S. Ct. 1520 (No. 07-5439).

45. American Medical Association, Mission Statement, <http://www.ama-assn.org/ama/pub/about-ama/our-mission.shtml> (last visited Nov. 7, 2009).

46. See Council on Ethical and Judicial Affairs, Am. Med. Ass'n, Council Report, *Physician Participation in Capital Punishment*, 270 JAMA 365, 365 (1993); see also COUNCIL ON JUDICIAL AND ETHICAL AFFAIRS, AM. MED. ASS'N., CODE OF MEDICAL ETHICS § 2.06 (2008), available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion206.shtml> [hereinafter CODE OF MEDICAL ETHICS] ("A physician, as a member of a profession dedicated to preserving life when there is hope of doing so, should not be a participant in a legally authorized execution."); Ellen Kreitzberg & David Richter, *But Can It Be Fixed? A Look at Constitutional Challenges to Lethal Injection Executions*, 47 SANTA CLARA L. REV. 445, 499-501 (2007) (discussing the history of AMA's position on physician participation in capital punishment).

injection personnel.”⁴⁷ The ASA has adopted the AMA position,⁴⁸ and its then-President has advised members to “steer clear” of participation in lethal injections.⁴⁹ The Society of Correctional Physicians has for years dictated that the “correctional health professional shall . . . [n]ot be involved in any aspect of execution of the death penalty.”⁵⁰ The media has well documented the positions of these national organizations.⁵¹

Individual doctors have also publicly voiced their opposition to physician participation in executions. Several have waged a campaign over the past few decades to put a halt to the practice. Among them is Dr. Arthur Zitrin, a retired professor of psychiatry at New York University and self-described death penalty abolitionist.⁵² Dr. Zitrin’s stated objective is to identify doctors who participate in executions and seek disciplinary action against them for violating medical ethics.⁵³ As discussed below, Dr. Zitrin’s efforts have so far proven unsuccessful, as not a single doctor has faced disciplinary action in the United States for participating in a lethal injection execution.⁵⁴ But Dr. Zitrin’s activism has been quite public and has likely contributed to the growing public awareness of the AMA’s position.⁵⁵ Dr.

47. CODE OF MEDICAL ETHICS, *supra* note 46, § 2.06.

48. Guidry, *supra* note 5.

49. *Id.*

50. SOC’Y OF CORR. PHYSICIANS, CODE OF ETHICS (1998), <http://www.corrdocs.org/framework.php?pagetype=aboutethics&bgn=>; see also Denno, *supra* note 28, at 80–83 (discussing positions of various national medical associations); Atul Gawande, *When Law and Ethics Collide—Why Physicians Participate in Executions*, 354 NEW ENG. J. MED. 1221, 1223 (2006) (explaining that the American Pharmaceutical Association is the only national medical organization that accepts the “voluntary provision of execution medications by pharmacists as ethical conduct”).

51. See, e.g., Lawrence K. Altman, *Focus on Doctors and Executions*, N.Y. TIMES, Mar. 20, 1994, at A31 (discussing the AMA’s stance against physician participation); Don Colburn, *Lethal Injection: Why Doctors Are Uneasy About the Newest Method of Capital Punishment*, WASH. POST, Dec. 11, 1990, at Z12 (same); Adam Liptak, *Should Doctors Help with Executions? No Easy Ethical Answer*, N.Y. TIMES, June 10, 2004, at A16 (same); Valerie Reitman, *Doctors Wary of Crossing Line*, L.A. TIMES, Feb. 22, 2006, at A14 (noting opposition of medical associations to doctor participation in lethal injection executions); Rosanna Ruiz, *Hippocratic Oath Keeps Doctors Out of Death Chambers*, HOUSTON CHRON. (2 Star ed.), Feb. 24, 2006, at B4 (quoting the chairwoman of the AMA’s council on ethical and judicial affairs as stating that “doctors can’t participate in any way”); Henry Weinstein, *Anesthesiologists Advised to Avoid Executions*, L.A. TIMES, July 2, 2006, at A32 (noting that the president of the American Society of Anesthesiologists had strongly urged members not to participate in executions).

52. See Carlos Campos, *Doctors’ Execution Role Targeted*, ATLANTA J.-CONST., June 2, 2005, at C1; Liptak, *supra* note 51.

53. See Liptak, *supra* note 51.

54. See *infra* text accompanying notes 62–90.

55. See, e.g., Carlos Campos, *Lawyers: Don’t Let Doctors Execute*, ATLANTA J.-

Jonathan Groner, a professor of surgery at Ohio State University, is also a leading critic of doctor participation in executions and has repeatedly compared such participation to Nazi Germany's "euthanasia" program.⁵⁶

The repeated assertion that doctors cannot, will not, and do not participate in lethal injection executions has reached, and influenced, the courts. For example, even before the Justices in *Baze* appeared to take for granted that ethical guidelines preclude physician participation,⁵⁷ a panel of Ninth Circuit judges in *Beardslee v. Woodford*⁵⁸ wrote that "[d]espite the critical nature of correct medical procedure, lethal injection executions are hampered by ethical restrictions on physicians, who are prohibited from participating in executions."⁵⁹ As this Article demonstrates, the notion that doctors are "prohibited" from participating in executions is simply untrue.⁶⁰ Doctors in virtually every state can participate in lethal injections, many are willing to do so, and, in fact, many do regularly participate in executions.

CONST., Dec. 21, 2005, at E1 (describing Dr. Zitrin's abolitionist activities); Liptak, *supra* note 51 (same); Pauline Vu, *Executions Halted as Doctors Balk*, STATELINE.ORG, Mar. 20, 2007, <http://www.stateline.org/live/details/story?contentId=190836> (same).

56. See, e.g., Jonathan I. Groner, *Lethal Injection: A Stain on the Face of Medicine*, 325 BRIT. MED. J. 1026, 1028 (2002); Beyerlein *supra* note 37; see also Jennifer McMenamin, *Lethal Practice*, BALT. SUN, Oct. 22, 2006, at 1C ("Most times in history when doctors have forsaken their ethics to help a government program, it has usually worked out badly, not only for the doctors but also for society as well." (quoting Dr. Groner)). In 2004, Dr. Groner unsuccessfully attempted to persuade the Ohio State Medical Association to call for a moratorium on lethal injection. See Misti Crane, *Physicians Group Rejects Plea on Lethal Injections*, COLUMBUS DISPATCH, May 19, 2004, at 9B.

57. See *supra* text accompanying notes 13–20.

58. 395 F.3d 1064 (9th Cir. 2005).

59. *Id.* at 1074. Another example is in Maryland, where a federal judge hearing a challenge to that state's administration of lethal injection "told the lawyers handling the case that he wonders whether it would even be possible to find a doctor willing to participate in an execution, should he order the state to do so." McMenamin, *supra* note 56; see also *infra* notes 130–31 and accompanying text (discussing similar statements by two federal judges in Ohio).

60. Not surprisingly, lawyers for states have used the quote from *Beardslee* to full effect. See, e.g., *Taylor Appellants' Brief*, *supra* note 43, at 64 ("[A] doctor's participation in an execution is a violation of professional ethical standards." (citing and quoting *Beardslee*, 395 F.3d at 1074)). It is also not surprising that the message has trickled down to prison officials and wardens. For example, the warden of the Ohio prison that houses death row recently testified in federal court that, although it might be "prudent" to use an expert to monitor consciousness, "it was his understanding that medical professionals are prohibited from participating in executions." *Cooley v. Strickland*, 610 F. Supp. 2d 853, 879 (S.D. Ohio 2009).

A. *Doctors Can Participate in Lethal Injection Executions*

Simply put, doctors are not “prohibited” from participating in executions. As a legal matter, the ethical guidelines of the AMA and similar associations are not binding or enforceable. As a practical matter, they likewise do not impose a barrier to participation. No doctor has ever been disciplined for participating in an execution in this country, and every court that has considered the matter has concluded that state medical boards cannot impose discipline, particularly where, as in most states, the governing death penalty statute appears to contemplate some form of physician participation.⁶¹ Moreover, the ethical guidelines of other medical professionals (such as nurses and EMTs) are nearly identical to the AMA’s guidelines, and these guidelines have not stopped those medical professionals from participating in executions. This suggests that the ethical guidelines themselves play little role in medical professionals’ decisions about whether to participate in executions.

1. Ethical Guidelines Are Generally Not Enforceable

Without exception, courts have rejected the notion that state medical boards can discipline doctors for participating in lawfully-authorized executions. For example, in 2005, Dr. Zitrin filed a claim with the Georgia Composite State Board of Medical Examiners, seeking an investigation into whether doctors who participated in Georgia’s lethal injections were subject to discipline for violating the AMA’s ethical guidelines.⁶² The Board refused to open an investigation.⁶³ Dr. Zitrin and several other doctors sued in state court, seeking a declaration that Georgia law prohibits physician participation in executions and requiring the Board to open an investigation.⁶⁴

The doctors did not receive a warm welcome in court. According to a report in the *Atlanta Journal-Constitution*, the trial judge to whom the case was assigned noted during one hearing that “the AMA is simply a membership organization” and asked counsel for Dr. Zitrin, “ ‘How many Georgia physicians belong to the AMA? I’d say less than half. And you want to incorporate an ethical opinion [of

61. See *Taylor v. Crawford*, 487 F.3d 1072, 1082–83 (8th Cir. 2007); *Thorburn v. Dep’t of Corrs.*, 78 Cal. Rptr. 2d 584, 590 (Cal. Ct. App. 1998); *Zitrin v. Ga. Composite State Bd. of Med. Exam’rs*, 653 S.E.2d 758, 762–63; (Ga. Ct. App. 2007); *N.C. Dep’t of Corr. v. N.C. Med. Bd.*, 363 N.C. 189, 204, 675 S.E.2d 641, 651 (2009).

62. See *Zitrin*, 653 S.E.2d at 760.

63. See *id.*

64. See *id.*

the AMA] into Georgia law?”⁶⁵ The judge also accused the doctors’ legal team “of using the question of physician participation . . . as a way to try to undermine the legality of the death penalty in Georgia.”⁶⁶ The judge ruled against the doctors, finding that they had failed to state a claim.⁶⁷ The Court of Appeals of Georgia affirmed, noting that the medical board’s position in the matter “guarantees that no physician [in Georgia] will be subject to disciplinary proceedings as a result of his or her participation in an execution.”⁶⁸

The *Zitrin* case illustrates the legal irrelevance of the AMA’s guidelines to the actual threat of discipline that doctors who participate in executions face. The AMA is a membership organization. While the AMA’s ethical guidelines are the most frequently-cited support for the proposition that doctors cannot participate in lethal injection executions,⁶⁹ only about twenty percent of doctors in the United States are members of the association.⁷⁰ And, according to the Chief Executive Officer of the AMA, “[t]he other 80 percent either do not understand what we do, or they do not value what we do.”⁷¹

As the Court of Appeals of Georgia made clear in *Zitrin* and as several commentators have noted, the AMA’s position on physician participation is not, by itself, legally enforceable.⁷² Dr. Groner has explained that “[t]he most drastic action [the AMA] could take would be to revoke an individual’s membership, which would have minimal consequence for the individual physician” and would not affect the doctor’s ability to practice.⁷³

65. Campos, *supra* note 55 (alteration in original).

66. *Id.*

67. *Zitrin*, 653 S.E.2d at 758, 760.

68. *Id.* at 762.

69. *See supra* notes 46–51 and accompanying text.

70. *See* Michael D. Maves, Chief Executive Officer, Am. Med. Ass’n, A Challenge to the House of Delegates (Nov. 8, 2008), <http://www.ama-assn.org/ama/pub/news/speeches/challenge-house-delegates.shtml>.

71. *Id.*

72. *See, e.g.,* Jonathan I. Groner, *The Hippocratic Paradox: The Role of the Medical Profession in Capital Punishment in the United States*, 35 *FORDHAM URB. L.J.* 883, 904 (2008) (“The AMA is a voluntary organization. While its position on lethal injection is quite clear, the AMA has no legal enforcement authority.”). Even the Department of Justice has acknowledged that “the pronouncements of the AMA and other associations do not themselves bind physicians.” *Implementation of Death Sentences in Federal Cases*, 58 *Fed. Reg.* 4898, 4898 (Jan. 19, 1993).

73. Groner, *supra* note 72, at 904; *see also* Denno, *supra* note 28, at 82 (“[B]ecause the AMA[’s] . . . guidelines are not legally enforceable, it is difficult to assess how much weight they carry.”); Daniel N. Lerman, Note, *Second Opinion: Inconsistent Deference to Medical Ethics in Death Penalty Jurisprudence*, 95 *GEO. L.J.* 1941, 1950 (2007) (“[T]he

The ethical guidelines of the state-based medical associations, many of which mirror those of the AMA,⁷⁴ are similarly unenforceable. Although a doctor who participates in an execution may violate the guidelines of his or her state medical association, the most extreme sanction the doctor faces is revocation of membership in the association.⁷⁵ Such a sanction would have no effect on a doctor's ability to practice in the state.

The agencies that do have disciplinary authority over physicians are the state medical boards, which award licenses to practice medicine.⁷⁶ Were a particular state to adopt—and enforce—the AMA guidelines as its own ethical rules, one could fairly say that a doctor participating in an execution in that state may be subject to disciplinary action. Some death penalty states do adopt the AMA guidelines in their own state medical ethical rules.⁷⁷ But the vast majority of state medical boards have taken no position on the matter of participation in executions, and few have actually considered disciplining a doctor for participating in executions.⁷⁸ This is the case despite the fact that numerous doctors have participated in hundreds of executions over the past three decades,⁷⁹ and as discussed in Part

AMA has little recourse against violators of the Code [of Medical Ethics] beyond expulsion from the organization, which would be of little consequence.”).

74. See W. Noel Keyes, *The Choice of Participation by Physicians in Capital Punishment*, 22 WHITTIER L. REV. 809, 810 (2001) (citing author's study of state medical associations and their positions on physician participation in executions).

75. See Lee Black & Robert M. Sade, *Lethal Injections and Physicians: State Law vs. Medical Ethics*, 298 JAMA 2779, 2780 (2007) (“Societies that have incorporated ethical standards into their rules or bylaws have wide latitude to take action against a physician's membership.”).

76. See Kevin B. O'Reilly, *Physicians Resist Push for Execution Involvement*, AM. MED. NEWS, May 14, 2007, <http://www.ama-assn.org/amednews/2007/05/14/prl20514.htm> (“The AMA doesn't have any enforcement capabilities. Medical boards have the right and the responsibility to determine for themselves the acts that will have consequences.” (quoting the AMA's Chair-elect of the Board of Trustees)); see also Ross D. Silverman, *Regulating Medical Practice in the Cyber Age: Issues and Challenges for State Medical Boards*, 26 AM. J.L. & MED. 255, 256–58 (2000) (discussing generally the power of the states and the role of licensing boards in regulating medical practice).

77. Kentucky's statute, for example, provides that a doctor licensed in Kentucky may be subject to the loss or suspension of his license for departing or failing to “conform to the principles of medical ethics of the American Medical Association.” KY. REV. STAT. ANN. § 311.597(4) (LexisNexis 2007). Ohio's statute provides that “to the extent permitted by law,” the board may “limit, revoke, or suspend an individual's certificate to practice” for violating any provisions of the code of ethics of the American Medical Association or “any other national professional organizations that the board specifies by rule.” OHIO REV. CODE ANN. § 4731.22(B), (B)(18) (LexisNexis 2006 & Supp. 2009).

78. See Gawande, *supra* note 50, at 1223 (“[S]everal physicians have faced challenges, though none have lost their licenses as yet.”).

79. See *infra* text accompanying notes 160–92.

II, anti-death penalty activists have filed complaints against specific doctors on several occasions.⁸⁰ The North Carolina Medical Board is the only known example of a state board expressing an interest in disciplining a doctor for participating in an execution, and no doctor in that state has been disciplined.⁸¹ In fact, no doctor in the United States has ever been disciplined by a medical board for participation in a lethal injection execution.⁸²

One reason the state medical boards do not pose a practical threat to doctors who participate in executions is that medical boards typically address only allegations of illegal activity or inadequate patient care.⁸³ State medical boards do not ordinarily address alleged ethical transgressions, especially if the doctor involved is following, or carrying out, state law.⁸⁴ For example, when a group of doctors sued in California in 1996 for a declaration that physicians who participated in executions should lose their licenses under state law, the court of appeals found highly significant the fact that the state penal code appeared to authorize physician participation in executions.⁸⁵ “Surely,” the court reasoned, “the Legislature could not

80. See *infra* Part II.B.1.

81. See Kevin B. O'Reilly, *N.C. Court Overturns Ban on Doctor Participation in Executions*, AM. MED. NEWS, May 18, 2009, <http://www.ama-assn.org/amednews/2009/05/18/prsc0518.htm> (“There is no sign that other medical boards are considering a disciplinary policy similar to North Carolina’s.”); Vu, *supra* note 55 (noting that the medical board in North Carolina is the only board that has suggested a willingness to consider punishing doctors who participate in executions).

82. See Gawande, *supra* note 50, at 1223; Lerman, *supra* note 73, at 1951. Professor Eric Berger alludes to the theoretical possibility that a national certifying board, such as the American Board of Anesthesiology, could revoke certification as a sanction for participating in an execution. Berger, *supra* note 9, at 321 n.336. But as Berger explains, such action is neither likely to occur nor likely to have much practical effect. *Id.*

83. See Black & Sade, *supra* note 75, at 2780. As one bioethicist put it, medical licensing boards are “‘reluctant to call into question anything with broader implication beyond the individual physician, especially if it is impugning government officials or state policy.’” Justine Sharrock, *First, Do Harm*, MOTHER JONES, July–Aug. 2009, at 61, 63 (quoting Penn State bioethics professor Jonathan H. Marks), available at <http://www.motherjones.com/politics/2009/07/first-do-harm>.

84. See Black & Sade, *supra* note 75, at 2780 (“Transgressions of other kinds, including ethics violations, usually do not trigger disciplinary proceedings. Executions are legal; therefore, in states that require the presence of physicians at executions, licensing boards—established by state law and quasi-legal—are unlikely to take action against the licenses of physicians who participate.”); Joan M. LeGraw & Michael A. Grodin, *Health Professionals and Lethal Injection Execution in the United States*, 24 HUM. RTS. Q. 382, 417 (2002) (“At present, the state will not take away the licenses of health care professionals for participating in executions and the professional societies do not have the power to do so.”).

85. See *Thorburn v. Dep’t of Corrs.*, 78 Cal. Rptr. 2d 584, 590 (Cal. Ct. App. 1998) (citing various sections of the penal code that appear to require or authorize participation of physicians in executions).

have expressly and implicitly provided for physician involvement in executions, and simultaneously subjected participating physicians to discipline or other legal sanctions for engaging in lawful conduct.”⁸⁶

Even in the one state in which the medical board expressed a will to consider disciplining participating doctors, the state’s supreme court intervened. When the North Carolina Medical Board issued a statement in 2007 warning that doctors who facilitate executions “may be subject to disciplinary action,”⁸⁷ it was sued by the Department of Correction, which claimed that the Medical Board was interfering with its ability to carry out state law, which requires the presence of a physician during executions.⁸⁸ Earlier this year, the Supreme Court of North Carolina sided with the Department of Correction, noting that the state legislature had both written the state’s death penalty law and had created the Medical Board.⁸⁹ Thus, “[t]o allow [the Medical Board] to discipline its licensees for mere participation would elevate the created Medical Board over the creator General Assembly.”⁹⁰

Other states have preemptively protected doctors from medical board action by enacting various laws that are intended to trump any such efforts. These laws, typically referred to as “safe harbor” laws, specifically prevent medical boards from taking disciplinary action against medical providers who opt to participate in executions.⁹¹ In practice, these laws immunize doctors from licensing challenges.⁹² Illinois was among the first states to adopt such a provision; it did so in response to a 1994 complaint requesting that the Illinois Medical

86. *Id.*

87. N.C. Dep’t of Corr. v. N.C. Med. Bd., 363 N.C. 189, 193, 675 S.E.2d 641, 644 (2009).

88. *See id.* at 191, 675 S.E.2d at 643–44.

89. *Id.* at 204, 675 S.E.2d at 651.

90. *Id.* Interestingly, the court’s decision establishes that North Carolina law *requires* more than mere presence on the part of the physician during a lethal injection execution. *Id.* (“[T]he General Assembly has specifically envisioned some sort of medical participation in the execution process.”) (emphasis added). As discussed in Part I.C, the vast majority of death penalty statutes either require or permit some form of physician participation during executions. *See infra* text accompanying note 170.

91. *See Berger, supra* note 9, at 321 (“Even if state statutory law incorporates medical ethics’ rules regarding ‘professional conduct,’ a more specific statutory provision allowing physician participation in executions must trump more general ethical rules.”) (footnotes omitted); Nadia N. Sawicki, *Doctors, Discipline, and the Death Penalty: Professional Implications of Safe Harbor Policies*, 27 YALE L. & POL’Y REV. 107, 130 (2008) (explaining the “groundswell of safe harbor legislation and litigation” in several states since 2006).

92. *See Sawicki, supra* note 91, at 130 (noting that at least nine states prohibit state medical boards from taking disciplinary action on grounds of participation in lethal injection).

Board discipline doctors willing to participate in the execution of John Wayne Gacy.⁹³ Other states soon followed suit.⁹⁴ In addition, at least eight states have adopted “exclusionary” statutes, which provide that lethal injections do not constitute the practice of medicine, thus insulating doctors who participate in executions from medical board sanctions.⁹⁵ Finally, many states have various “shield” laws and policies to ensure the anonymity of doctors who do participate in executions. These laws effectively protect such doctors against any licensing challenges by third parties.⁹⁶

All of these statutory protections take place against a backdrop in which, for the reasons discussed above, no participating physician should reasonably fear professional discipline.⁹⁷ Yet state legislatures are not taking any chances. In order to guarantee doctors’ continued

93. See *id.* at 124–25; see also Editorial, *Execution: Punishment or Murder?; Physicians Are Healers, Not Killers*, CHI. SUN-TIMES, May 27, 1995, at 12 (discussing the passage of Illinois law).

94. For example, Arkansas passed similar legislation despite the fact that there had “not yet been reported efforts in Arkansas to instigate disciplinary action against participants.” Sawicki, *supra* note 91, at 126. Arkansas’ statute states that “[a]ny assistance rendered with any execution . . . by any licensed health care professional . . . shall not be cause for any disciplinary or corrective measures by any board or commission created by the state or governed by state law.” ARK. CODE ANN. § 17-80-108(a), (b) (2002).

95. See Denno, *supra* note 28, at 89 & n.263 (listing states); Lerman, *supra* note 73, at 1951 (“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.”).

96. The Illinois statute, for example, provides that

the identity of executioners . . . and information contained in records that would identify those persons shall remain confidential, shall not be subject to disclosure, and shall not be admissible as evidence or be discoverable in any action of any kind in any court or before any tribunal, board, agency, or person.

725 ILL. COMP. STAT. 5/119-5(e) (2008). Arizona law mandates that “[t]he identity of executioners and other persons who participate or perform ancillary functions in an execution and any information contained in records that would identify those persons is confidential and is not subject to disclosure.” ARIZ. REV. STAT. ANN. § 13-757(C) (2008). In Montana, “[t]he identity of the executioner must remain anonymous. Facts pertaining to the selection and training of the executioner must remain confidential.” MONT. CODE ANN. § 46-19-103(5) (2007); see also JOHN D. BESSLER, *DEATH IN THE DARK: MIDNIGHT EXECUTIONS IN AMERICA* 25 (1997) (“The only thing that was sometimes kept secret at early American executions was the executioner’s identity. At some executions, professional executioners wore disguises or hideous masks or had their faces blackened . . .”); Lesley Clark, *State Will Keep Black-Hooded Executioner*, MIAMI HERALD, Feb. 16, 2000, at 7B (noting that executioners arrived at Florida State Prison already wearing a black hood with eye slits).

97. See Sawicki, *supra* note 91, at 153 (“Given how infrequent and unsuccessful . . . disciplinary inquiries have been, it would be difficult . . . to argue in good faith that medical providers’ [participation in executions] is likely to be chilled by threats of board discipline.”).

participation in lethal injections, several legislatures have gone to great lengths to protect them from possible disciplinary actions⁹⁸ and public scrutiny.⁹⁹

The above discussion demonstrates that, although it is common shorthand, it is not true that the ethical guidelines of the AMA—or those of any other medical association—“prohibit” physician participation in lethal injection executions.¹⁰⁰ At most, it is accurate to state that the leading medical associations urge their members, in emphatic terms, not to participate in executions. Whether an individual medical professional chooses to do so, in most instances, remains a matter of personal choice.¹⁰¹

98. For example, Missouri recently passed a statute that not only created a safe harbor provision but also provided execution team members with coverage under the state legal expense fund in the event they faced legal challenges to their participation in an execution. See MO. ANN. STAT. § 546.720(4) (West 2009) (“[I]f a member of the execution team is licensed by a board or department, the licensing board or department shall not censure, reprimand, suspend, revoke, or take any other disciplinary action against the person’s license because of his or her participation in a lawful execution. All members of the execution team are entitled to coverage under the state legal expense fund . . .”). Nebraska recently amended its law to designate lethal injection as its method of execution, and the legislature took the opportunity also to statutorily protect physician participation in executions through several safe harbor provisions. See Legis. B. 36, 101st. Leg., 1st Sess. (Neb. 2009); *Introducer’s Statement of Intent for LB 36 Before the Judiciary Comm.*, Legis. B. 36, 101st Leg., 1st Sess. 1 (Neb. 2009) (statement of Sen. Mike Flood, Member, Judiciary Committee), available at <http://uniweb.legislature.ne.gov/FloorDocs/Current/PDF/SI/LB36.pdf> (“LB 36 would also provide members of the execution team protections from disciplinary actions by a licensing board as well as a level of confidentiality, unless extraordinary good cause is shown to a court.”). A newspaper reported that when “[a] doctor and an anesthesiologist also questioned whether competent people can be found to properly administer the lethal injection because, they said, it violates medical ethics to be involved in executions,” one senator responded “that nurses or emergency medical technicians have been used in other states to administer the injections and that his bill prevents a medical licensing board from disciplining anyone involved in the procedure.” Paul Hammel, *Both Sides Speak Out on Death Penalty*, OMAHA WORLD-HERALD, Jan. 30, 2009, at 1A.

99. See Tina Hesman, *Executioners Need Identity Shielded, State Says*, ST. LOUIS POST-DISPATCH, May 22, 2007, at D4 (describing effort in Missouri to pass law creating civil penalties for anyone who discloses identities of those involved in executions); Chris Tisch, *Ethics Clash with Justice in Executions*, ST. PETERSBURG TIMES, Dec. 28, 2006, at 1A (describing purple medical scrubs and blue mask that shield the identity of participating physicians in Florida executions). Note that the actions of these various state legislatures are at odds with the litigation position generally taken by lawyers defending states’ lethal injection protocols. After all, if, as lawyers for the states have argued, doctors do not and cannot participate in executions, see *supra* text accompanying notes 41–44, most of these state laws protecting participating doctors would be unnecessary. One way to understand this inconsistency is to suggest that the legislatures and the lawyers are working in concert, with the former providing statutory protection in case the latter’s litigation strategy fails.

100. See *supra* notes 57–60 and accompanying text.

101. As noted above, see *supra* text accompanying notes 76–77, where state law

Most doctors who are vocal opponents of physician participation are also vocal opponents of the death penalty,¹⁰² which suggests that a

incorporates the AMA guidelines into the state's ethical code, a doctor *could* in theory be disciplined for participating in an execution. And this Article does not make any normative argument about what individual doctors *should* do. In most states, doctors can perform executions legally and with no threat of professional sanction. But in those few states where the law is unclear, it is accurate to say that doctors face a theoretical threat of discipline. The point here is that the threat is *de minimis*, and, as an empirical matter, there is no evidence that the threat actually inhibits states' ability to find doctors. Recent events in Ohio are instructive. In September 2009, Ohio failed to execute inmate Romell Broom when executioners were unable, after more than two hours, to establish a working intravenous ("IV") line. See Alan Johnson, *Effort to Kill Inmate Halted*, COLUMBUS DISPATCH, Sept. 16, 2009, at 1A. The botched attempted execution raised questions about the qualifications of Ohio's execution team members, none of whom were required to be medical professionals. See Bob Driehaus, *Prisoner in Ohio Wins a Stay Against a Second Attempt*, N.Y. TIMES, Sept. 19, 2009, at A10. As noted earlier, Ohio is a state in which a doctor could theoretically face discipline for violating the AMA's ethical guidelines because Ohio law incorporates these guidelines. See *supra* note 77. Yet despite that theoretical threat, one local newspaper reported that Ohio officials were consulting with doctors and other "medical advisors" about alternative methods of executing Mr. Broom via lethal injection. See Beyerlein, *supra* note 37. As the report indicated, simply providing advice to prison officials violates the AMA guidelines and, in theory, subjects the consulting physicians to professional discipline. See *id.* Yet the state appears to have found at least one willing doctor, and, in fact, has him on a two-year retainer to consult on revisions to the state's lethal injection protocol. See *Ohio Can't Find Doctors to Offer Execution Advice*, N.Y. TIMES, Oct. 26, 2009, <http://www.nytimes.com/aponline/2009/10/27/business/AP-US-Death-Penalty-Ohio.html>. It is important to note, however, that, as this Article was going to press, Ohio's Attorney General filed a pleading in federal court claiming that it was evaluating several different alternatives to the three-drug formula for lethal injection, but that "identifying qualified medical personnel willing and able to provide advice to the State regarding lethal injection options continues to be challenging and time-consuming." Notice of Consideration by Defendants of Changes to Defendants' Policies and Procedures for the Execution of the Condemned Prisoners at 2, *Cooley v. Strickland*, No. 2:04-cv-1156 (S.D. Ohio). It remains to be seen whether Ohio's stated concerns about finding willing doctors will ultimately prove to be a roadblock in its reform efforts. Especially in light of the fact that the state does have a doctor on retainer to consult on lethal injection issues (a fact that was not mentioned in the state's pleading), it is possible to view the state's recent pleading with some cynicism. The cynical view would suggest that, rather than genuinely reporting its struggle to find qualified, willing medical personnel, the state is attempting to lay the groundwork for an eventual plea to the presiding judge not to mandate the participation of physicians as a remedy for fixing Ohio's troubled lethal injection procedures.

102. See, e.g., Groner, *supra* note 56, at 1028 ("The Nazis used the imagery of medicine to justify killing, and they corrupted doctors and, ultimately, an entire nation. Capital punishment in the United States now depends solely on the same medical charade. Without the respectability that lethal injection provides, capital punishment in the United States would probably cease."); LeGraw & Grodin, *supra* note 84, at 385 ("Lethal injection execution is a violation of medical ethics because it utilizes medical skills and knowledge to give judicial homicide the appearance of painless clinical competence and humanity, which in turn has insulated such executions from constitutional scrutiny and public attack."); Teresa A. Zimmers & David A. Lubarsky, *Physician Participation in Lethal Injection Executions*, 20 CURRENT OPINION ANAESTHESIOLOGY 147, 150 (2007)

primary reason some doctors refuse to participate is because they choose not to be a part of, or perpetuate, a process with which they have profound moral disagreement. Individual doctors' moral qualms with the death penalty may ultimately prove to be a much greater barrier to their participation in lethal injections than the non-binding ethical guidelines of various medical associations. In any event, contrary to the position taken by lawyers representing death penalty states and pro-prosecution advocacy groups, doctors can, for the most part, legally ignore those guidelines and allow their own moral and ethical compasses to guide them.¹⁰³

2. Ethical Guidelines Have Not Precluded Participation of Other Medical Professionals

Not only are the ethical guidelines adopted by the AMA and similar associations not binding on doctors, ethical guidelines adopted by other medical professional organizations have done little to

("[M]any prominent [medical] organizations and professional journals have publicly called upon physicians, scientists and medical professions to refuse to participate in executions, hoping to bring about the end of the death penalty by inaction.").

103. The point here is that there is no practical *legal* impediment to the violation of, for example, the AMA's ethical guidelines, and this point refutes the common equation of such guidelines with binding, legal mandates. Any profession's view of the enforceability of its own ethical guidelines, however, is not necessarily constrained by the law. There are good reasons to question or criticize, for example, the Supreme Court of North Carolina's ruling that the state's medical board is not the final arbiter of medical ethics in North Carolina, *see supra* text accompanying notes 89–90, and many, particularly in the medical community, have already done so. For example, the president of the AMA was immediately "troubled by the [Supreme Court of North Carolina's] apparent view that it, and not the medical profession, can establish ethical precepts for physicians in North Carolina." Kevin B. O'Reilly, *supra* note 81; *see also* Doug Clark, Editorial, *Execution Ruling May Not End Impasse*, NEWS & REC. (Greensboro, N.C.), May 6, 2009, at A13, available at http://www.news-record.com/content/2009/05/05/article/doug_clark_execution_ruling_may_not_end_impasse ("Who should decide what conforms to medical ethics if not those professional [medical] organizations? Surely not the courts nor any collection of politicians."). One doctor criticized the Supreme Court of North Carolina for interpreting state law "in dry, boring and dusty language . . . beyond what the words stated and beyond what any physician would consider ethical behavior." Charles van der Horst, Op-Ed., *Doctors Won't Kill for the State*, NEWS & OBSERVER (Raleigh, N.C.), May 5, 2009, at 9A. For a fuller discussion of courts' inconsistent deference to medical ethics, particularly in the death penalty context, *see generally* Lerman, *supra* note 73. In any event, it cannot be disputed that some (but not all) doctors see their profession's ethical standards as binding—not because they are legally or even professionally enforceable but because those doctors take their moral cues from their profession's ethical statements. Nor can it be disputed that some doctors (particularly in the academic setting) would face ostracization from colleagues were their participation in executions made public. This section demonstrates, however, that it is not true that the existence of ethical guidelines condemning physician participation presents an insurmountable (or even daunting) barrier to such participation by willing doctors.

prevent their own members from participating in executions. A look at the practices of other medical professionals such as nurses and EMTs reveals that most operate under ethical guidelines every bit as explicit as the AMA's guidelines. Yet lawyers defending lethal injection are quick to point out to reviewing courts that these medical professionals routinely participate in executions.¹⁰⁴

The medical associations that govern medical professionals other than doctors also spurn the participation of their members in lethal injection executions. In 1994, the ANA issued a position statement condemning the participation of nurses in executions:

The ANA is strongly opposed to all forms of participation, by whatever means Nurses should . . . not take part in assessment, supervision or monitoring of the procedure or the prisoner; procuring, prescribing or preparing medications or solutions; inserting the intravenous catheter; injecting the lethal solution; and attending or witnessing the execution as a nurse.¹⁰⁵

Two years later, the ANA joined the AMA and the American Public Health Association in issuing a joint press release reiterating the opposition of all three professional associations to the participation of medical personnel in executions.¹⁰⁶ The press release claimed that, because the associations' ethical codes are "integral parts" of state law, participation in executions "is a serious violation of ethical standards" and "violate[s] state law."¹⁰⁷ It went on to urge that professional societies "impose disciplinary action on those members who participate in executions."¹⁰⁸ The ANA is currently considering the adoption of an updated position statement that is even more thorough than past statements in its recitation of the history of the nursing profession's opposition to participation in executions.¹⁰⁹

104. See *infra* text accompanying notes 112–15.

105. Revised Position Statement, Am. Nurses Ass'n, Nurses' Participation in Capital Punishment (Dec. 8, 1994) (on file with the North Carolina Law Review).

106. Joint Press Release, Am. Med. Ass'n., Am. Nurses Ass'n & Am. Public Health Ass'n, Professional Societies Oppose Health Care Professionals Participation in Capital Punishment (Sept. 13, 1996) (on file with the North Carolina Law Review).

107. *Id.* As discussed in Part I.A.1 *supra*, state law generally *protects* medical professionals from sanctions for participation in executions.

108. *Id.*

109. Am. Nurses' Ass'n, Call for Public Comment on Nurses' Role in Capital Punishment (Aug. 26, 2009), <http://www.nursingworld.org/MainMenuCategories/HealthcareandPolicyIssues/ANAPositionStatements/Comments-Nurses-Role-Capital-Punishment.aspx>.

In 2006, the National Association of Emergency Medical Technicians (“NAEMT”) adopted a position statement “strongly oppos[ing]” participation in capital punishment by EMTs, paramedics, or other emergency medical professionals.¹¹⁰ The NAEMT statement, the language of which appears to be borrowed from the ANA, urges its members to refrain from “all forms of participation, by whatever means” and specifically enumerates the same discouraged acts as the ANA.¹¹¹

Despite these ethical guidelines, state after state has touted the participation of other medical professionals—nurses, EMTs, paramedics, etc.—as evidence of the care they take in the execution of their lethal injection procedures. For example, lawyers defending the State of Tennessee’s lethal injection protocol recently noted for the Sixth Circuit that “Tennessee currently uses two paramedics who have nineteen and fourteen years of professional experience, respectively, and who have daily experience establishing IV catheters, often under difficult circumstances.”¹¹² Lawyers for Oklahoma and Delaware have made similar arguments, noting the participation of EMTs and paramedics in an effort to convince courts that their protocols passed constitutional muster.¹¹³ And lawyers for the State of Georgia recently argued to the Eleventh Circuit that the state’s lethal injection procedures were even more safe than in other states, because licensed nurses (and not merely EMTs) were responsible for some of the key execution roles.¹¹⁴ “It is undisputed,” the lawyers wrote, “that two licensed nurses, with extensive experience in clinical settings, set up the IVs in condemned inmates in Georgia.”¹¹⁵

110. Position Statement, Nat’l Ass’n of Emergency Med. Technicians, EMT and Paramedic Participation in Capital Punishment (June 9, 2006) (on file with the North Carolina Law Review); *see also* *Baze v. Rees*, 128 S. Ct. 1520, 1539–40 (2008) (Alito, J., concurring) (referring to NAEMT position).

111. Position Statement, Nat’l Ass’n of Emergency Med. Technicians, *supra* note 110.

112. Final Brief of the Defendants-Appellants at 15, *Harbison v. Little*, 2009 FED App. 0227P, 571 F.3d 531 (6th Cir.) (No. 07-6225).

113. *See, e.g.*, Defendants’ Opening Brief in Support of Their Motion for Summary Judgment, *supra* note 32, at 16 n.3 (“Delaware’s protocol, precisely like Kentucky’s, requires that the members of the IV team be Certified Medical Assistants, Phlebotomists, Emergency Medical Technicians, Paramedics, or Military Corpsmen.”); Defendant’s Response to Memorandum and Motion to Reactivate Proceedings and Brief in Support at 5, *Taylor v. Jones*, No. CIV-05-825 (W.D. Okla. Sept. 3, 2008) (“The Oklahoma protocol also provides that a qualified EMT-P, or a similarly qualified individual will start the IV insertion.”).

114. *See* Brief on Behalf of Defendants/Appellees at 15, *Alderman v. Donald*, 293 F. App’x. 693 (11th Cir. 2008) (No. 08-12550).

115. *Id.* at 19.

This apparent inconsistency deserves exploration. After all, EMTs' and nurses' formal ethical constraints appear to be similar, if not identical, to those of doctors.¹¹⁶ In order to participate in executions, individual EMTs and nurses must decide that they are willing to do so despite the ethical positions of their professional organizations. States have knowingly chosen a method of execution, however, that presupposes that some medical personnel will be willing to participate despite the ethical concerns. After all, every lethal injection execution depends on the active participation of, at the very least, someone who knows how to place an intravenous ("IV") line; without an IV, there is no execution.¹¹⁷ And even if medical personnel were to train laypeople to place IVs, that too would violate the medical associations' ethical guidelines.¹¹⁸ Despite this very real ethical conundrum created by the states' first-order choices, every single state that performs lethal injection has successfully obtained the services of medical personnel willing to violate their profession's ethical precepts.¹¹⁹ It is also safe to assume that these ethical concerns have not deterred states from choosing lethal injection as a method of execution in the first place, as every death penalty state has chosen lethal injection as a method of execution.¹²⁰

Nevertheless, when lawyers representing death row inmates challenge lethal injection procedures, lawyers for the states typically have two reactions: (1) they point to their existing medical personnel

116. Some may suggest that the ethical guidelines of doctors carry more weight than those of EMTs and nurses, and that the guidelines of the AMA cannot be fairly compared to those of say, the ANA—even if the language of the ethical precepts is essentially the same. But to entertain this suggestion is to assume that doctors are more professional than EMTs, nurses, and other health care practitioners. I have not seen any evidence to support this assumption, and am aware of no empirical studies demonstrating that doctors take their ethical responsibilities more seriously than nurses or EMTs.

117. See Mark J. Heath, Commentary, *Revisiting Physician Involvement in Capital Punishment: Medical and Nonmedical Aspects of Lethal Injection*, 83 MAYO CLINIC PROC. 115, 116 (2008) (describing the necessity of intravenous access to a successful lethal injection execution).

118. See CODE OF MEDICAL ETHICS, *supra* note 46, § 2.06. The Code describes as unethical, inter alia, the "rendering of technical advice regarding an execution" and "consulting with or supervising lethal injection personnel." *Id.*

119. It is indisputable that ethics have been no bar to performing lethal injection executions around the country, as there have been an average of forty-one lethal injection executions every year for the past twenty-seven years. See Death Penalty Information Center, <http://deathpenaltyinfo.org> (last visited Nov. 7, 2009) (under the heading "Facts" select "Executions," and then click on the "By Year Since 1976" hyperlink); *id.* (under the heading "Facts" select "Executions," and then click on the "Methods of Execution" hyperlink).

120. See *id.* (under "DPIC Tools" select the "Death Penalty Fact Sheet" hyperlink).

to defend the procedures,¹²¹ implicitly acknowledging that they are willing to commit to having the existing personnel there; and (2) they claim that they could not possibly find anyone with higher qualifications than the people they already have participating because of medical ethics.¹²²

Courts have accepted this internally inconsistent and disingenuous argument uncritically: on one hand, they have assumed that all non-doctors can and will participate and have relied on that participation in upholding existing lethal injection procedures,¹²³ and on the other hand, they have assumed that existing procedures must be constitutional in part because there is no possible remedy that involves more qualified personnel.¹²⁴

Justice Alito's position in *Baze* is a prime example of this phenomenon. Justice Alito joined Chief Justice Roberts' plurality opinion, which evaluated the Kentucky record after announcing the Eighth Amendment standard governing lethal injection claims.¹²⁵ In concluding that Kentucky's procedures passed constitutional muster, the plurality made much of the fact that Kentucky employs medical professionals at various stages of the execution process: "The *most significant* of [Kentucky's safeguards] is the written protocol's requirement that members of the IV team must have at least one year of professional experience as a certified medical assistant, phlebotomist, EMT, paramedic, or military corpsman."¹²⁶

In his concurrence, Justice Alito acknowledged that "[e]very day, general anesthetics are administered to surgical patients in this country, and if the medical professionals who participate in these surgeries also participated in the anesthetization of prisoners facing execution by lethal injection, the risk of pain would be minimized."¹²⁷ However, Justice Alito wrote separately to emphasize that "[p]rominent among the practical constraints that must be taken into account in considering the feasibility and availability of any suggested modification of a lethal injection protocol are the ethical restrictions applicable to medical professionals."¹²⁸ Justice Alito went on to detail those ethical restrictions and even quoted the position statement of

121. See *supra* text accompanying notes 112–15.

122. See *supra* text accompanying notes 41–44.

123. See *infra* text accompanying notes 125–29.

124. See *supra* text accompanying notes 13–20.

125. See *Baze v. Rees*, 128 S. Ct. 1520, 1532–38 (2008) (plurality opinion).

126. *Id.* at 1533 (emphasis added).

127. *Id.* at 1539 (Alito, J., concurring).

128. *Id.*

the NAEMT, which, as noted above, “advises that emergency medical technicians and paramedics should refrain from the same activities” that the ANA condemns.¹²⁹

Justice Alito’s stance in *Baze*—that Kentucky’s use of an EMT is one of the most significant safeguards in the Court’s constitutional analysis *and* that the NAEMT’s strong condemnation of EMT participation is reason to doubt the practicality of any remedy that requires participation of medical personnel—is emblematic of, and reflects, the inconsistent position that states have taken in their defense of lethal injection.

It may be tempting for lower courts tasked with applying *Baze* to lethal injection procedures in other states to read Justice Alito’s concurrence as the final word on the feasibility of physician participation in lethal injection executions. This was the approach taken by a federal judge recently in Ohio, who faulted a death row inmate for failing to “present a feasible plan for involving medical professionals.”¹³⁰ The court cited to, and quoted at length from, Justice Alito’s concurrence in *Baze*, stating that Justice Alito’s summary of the governing ethical rules of medical professionals “undercuts [the plaintiff’s expert’s] testimony urging involvement of medical professionals.”¹³¹

To imbue the *Baze* dicta with such authority, however, is a mistake. Instead, courts should critically examine Justice Alito’s concurrence and ask whether there is any reason to think that doctors as a group are different from EMTs and nurses, who participate in lethal injections dozens of times each year and whose efforts do in fact contribute to the reliability of the procedure. The next two sections of this Article establish that doctors are willing to, and do, participate in executions, which suggests there is no practical difference in this respect between doctors, on one hand, and nurses and EMTs on the other. If Justice Alito and his colleagues in *Baze*

129. *Id.* at 1540.

130. *Cooley v. Strickland*, 610 F. Supp. 2d 853, 932–33 (S.D. Ohio 2009).

131. *Id.* A Sixth Circuit judge in a different Ohio case recently relied in a similar way on Justice Alito’s concurrence in *Baze*. Dissenting from the panel’s grant of a stay of execution for Lawrence Reynolds, Circuit Judge Jeffrey S. Sutton faulted Reynolds because he did not “explain why EMTs may not oversee this process or what should be done instead given the understandable reluctance of other members in the medical profession to assist in the effort.” *Reynolds v. Strickland*, 2009 FED App. 0356P, ¶ 22, (6th Cir.) (Sutton, J., dissenting). Judge Sutton’s dissent cited Justice Alito’s concurrence in *Baze*, but failed, as did Justice Alito, to explain why EMTs were more likely than other medical professionals to violate non-binding ethical guidelines. *Id.* (citing *Baze*, 128 S. Ct. at 1539 (Alito, J. concurring)).

considered the use of EMTs to be critical safeguards in a lethal injection procedure, nothing about the AMA's ethical guidelines should preclude doctors from providing an even greater degree of safety and reliability.

B. Doctors Will Participate in Lethal Injection Executions

Doctors *can* legally participate in lethal injection executions without fear of professional discipline. Undeniably, many nevertheless do not want to participate. But many others are willing to participate in executions. This is evidenced by the only survey ever done on the issue, as well as from anecdotal accounts of doctors who participate in executions.

In 2001, researchers surveyed physicians across the United States to explore their willingness to participate in various aspects of execution by lethal injection.¹³² The so-called "Farber study" asked doctors how willing they would be to perform one of eight actions discouraged by the AMA's ethical guidelines.¹³³ Results showed that forty-one percent of respondents were willing to perform at least one of the AMA's discouraged actions and twenty-five percent were willing to perform at least five.¹³⁴ Nineteen percent of respondents reported a willingness to administer the lethal drugs during an execution.¹³⁵

The Farber study is the only one of its kind and is widely cited for the proposition that, at least in theory, doctors are willing to violate the AMA's guidelines on physician participation in executions.¹³⁶ An acknowledged limitation of the study is that it does not assess whether doctors who report a willingness to participate in executions "would actually perform the actions as stated in their

132. See Neil Farber et al., *Physicians' Willingness to Participate in the Process of Lethal Injection for Capital Punishment*, 135 ANNALS INTERNAL MED. 884, 884–90 (2001).

133. See *id.* at 884.

134. See *id.* at 886.

135. See *id.* The study followed a previous study by the same group of researchers that sought only to assess physicians' attitudes about involvement in lethal injections. See Neil Farber et al., *Physicians' Attitudes About Involvement in Lethal Injection for Capital Punishment*, 160 ARCHIVES INTERNAL MED. 2912, 2912–16 (2000). The earlier study found that eighty percent of physicians surveyed believed that it was acceptable for doctors to perform at least one action that is condemned by the AMA's ethical guidelines. *Id.*

136. See, e.g., Peter Clark, *Physician Participation in Executions: Care Giver or Executioner*, 34 J.L. MED. & ETHICS 95, 98 (2006) (discussing Farber study); Zimmers & Lubarsky, *supra* note 102, at 147 (same); Alan Johnson, *Capital Punishment; Oath Bans Any Role by Doctors, Foe Says*, COLUMBUS DISPATCH, Jan. 13, 2003, at 1A (same); Liptak, *supra* note 51, (same).

responses.”¹³⁷ Nevertheless, individual doctors have explained why they would be willing to participate in lethal injection executions. Some have even expressed an obligation on the part of physicians to participate in order to ensure that the execution does not result in unnecessary pain or suffering.

For example, Dr. David Waisel, an anesthesiologist at Children’s Hospital in Boston, recently argued in a prominent Mayo Clinic journal that organized medicine has an obligation to permit physician participation in executions “to the extent necessary to ensure a good death.”¹³⁸ Dr. Waisel rejects the common arguments against physician participation as slippery-slope arguments that have little basis in reality.¹³⁹ He finds no evidence to support the arguments that physicians who participate in executions will lack the ability to act with compassion or independence in their normal practice or that the public trust in the medical profession will be lost as a result.¹⁴⁰ In the end, it is the capacity of the three-drug lethal injection procedure to inflict great suffering on the condemned that has convinced Dr. Waisel that physician participation in the process is necessary. Forbidding physician participation, he writes, “increases the chances of a botched execution. It seems cruel to permit capital punishment but not to permit participation of those who are capable of performing it humanely.”¹⁴¹

Dr. Atul Gawande, a Harvard Medical School professor who is himself opposed to physician participation in lethal injections, recently interviewed several doctors regarding their decisions to participate in executions.¹⁴² Published in the *New England Journal of Medicine*, Dr. Gawande’s account provides a rare view into the motivations of doctors who actually conduct executions in the United States. One doctor, anonymously referred to as “Dr. A,” originally agreed to assist in an execution with the understanding that his role would be limited to cardiac monitoring.¹⁴³ Soon, though, his participation increased by virtue of his presence on the scene, and he began placing IV lines in the men who were set to die and assisting whenever something went wrong during an execution.¹⁴⁴ Another

137. Farber et al., *supra* note 132, at 887.

138. Waisel, *supra* note 29, at 1073.

139. *See id.* at 1077–78.

140. *See id.*

141. *Id.* at 1079.

142. *See* Gawande, *supra* note 50, at 1221–29.

143. *See id.* at 1224.

144. *See id.* at 1225.

doctor, "Dr. C," worried about being exposed publicly as an executioner, but had no moral qualms about his role.¹⁴⁵ "I think that if I had to face someone I loved being put to death," Dr. C commented, "I would want that done by lethal injection, and I would want to know that it is done competently."¹⁴⁶

One of the interviewed doctors chose not to remain anonymous. Dr. Carlo Musso, who assists with executions in Georgia, told Dr. Gawande that he participates in spite of the AMA guidelines because he feels an obligation not to abandon inmates in their final moments.¹⁴⁷ As Dr. Musso explained, "[T]his is an end-of-life issue, just as with any other terminal disease. It just happens that it involves a legal process instead of a medical process. . . . [A death penalty] patient is no different from a patient dying of cancer—except his cancer is a court order."¹⁴⁸

Another oft-cited defense of physician participation in lethal injection executions is offered by Dr. Kenneth Baum, who argues that under the patient-centered conception of medical ethics, physicians are obligated to participate in lethal injections.¹⁴⁹ Dr. Baum echoes Dr. Musso's analogy to a dying cancer patient: "Condemned death row inmates are, for all practical purposes, terminally ill patients, albeit under a nontraditional definition of the term, and deserve to be treated as such."¹⁵⁰ Dr. Baum notes that doctors generally are thought to have a duty to minimize suffering when a patient is dying, and that "[t]o desert [condemned inmates] in their most vulnerable hour would be antithetical to the beneficent ideals of medical practice."¹⁵¹ It is the doctor who turns his or her back on a dying inmate, and

145. *See id.* at 1226.

146. *Id.*

147. *Id.* at 1228.

148. *Id.* Interestingly, in 1993, the Department of Justice ("DOJ") alluded to its own skepticism that the Hippocratic Oath forbade the participation of doctors in executions. Responding to public calls from the AMA and the American College of Physicians to remove doctors from the federal lethal injection protocols, the DOJ agreed to do so, but only in the more general public regulations related to lethal injection. *See Implementation of Death Sentences in Federal Cases*, 58 Fed. Reg. 4898, 4898 (Jan. 19, 1993). The Department left open the possibility that it would conclude at a later date that "a responsibly-conducted execution cannot conform with all of the medical associations' statements on medical ethics." *Id.* Not only did the DOJ go on to question explicitly whether the "Hippocratic injunction to 'do no harm' " precluded physician participation in executions, but it also pointed out that "most state death penalty procedures entail more physician involvement than desired by the AMA and College of Physicians." *Id.*

149. *See* Kenneth Baum, "To Comfort Always": *Physician Participation in Executions*, 5 N.Y.U. J. LEGIS. & PUB. POL'Y 47, 61–67 (2001).

150. *Id.* at 61.

151. *Id.* at 62.

refuses to do what he or she can to relieve suffering, “who truly violates the ethical code of the profession.”¹⁵² Or, as another doctor put it in a response letter to Dr. Gawande’s article, “the participation of physicians seems more humane than delegating the deed to prison wardens, for by condoning the participation of untrained people who could inflict needless suffering that we physicians might have prevented, we are just as responsible as if we had inflicted the suffering ourselves.”¹⁵³

In short, anecdotal evidence corroborates the results of the Farber study, at least with respect to the theoretical willingness of doctors to participate in executions. In 2003, two years after publication of the Farber study, an Ohio newspaper reported the activism of Dr. Jonathan Groner in opposition to physician participation in executions.¹⁵⁴ “[F]or the most part,” the report noted, “Groner’s is a voice in the wilderness in the United States when it comes to doctors’ participation in executions.”¹⁵⁵ The report noted the policy of the AMA and other medical groups, but concluded that “professionals tend to look the other way when it comes to execution duty.”¹⁵⁶ It is true that the positions of the AMA and other medical associations have received more publicity in recent years,¹⁵⁷ but there is little reason to believe that the results of Farber’s study would be

152. *Id.*

153. Bruce E. Ellerin, Letter to the Editor, *Why Physicians Participate in Executions*, 355 NEW ENG. J. MED. 99, 99 (2006). It is worth mentioning, but beyond the scope of this Article to fully explore, that empirical studies have consistently established the willingness of doctors in a variety of settings to engage in physician-assisted suicide, euthanasia, or what are sometimes called “mercy killings.” See, e.g., Diane E. Meier et al., *A National Survey of Physician-Assisted Suicide and Euthanasia in the United States*, 338 NEW ENG. J. MED. 1193, 1195 (1998) (reporting that eleven percent of surveyed physicians would, under certain circumstances, prescribe medication that would hasten a patient’s death and that thirty-six percent would do so if it were legal). Such practices are obviously quite controversial and, like the participation of doctors in executions, the subject of much debate. But the fact that doctors do in some circumstances hasten the death of their patients complicates the unequivocal position of doctors such as Charles van der Horst, who was quoted in the Introduction as saying, “[W]e do not kill our patients.” See *supra* text accompanying note 2. For a thoughtful discussion of these issues in the context of palliative care, see Roger S. Magnusson, *The Devil’s Choice: Re-Thinking Law, Ethics, and Symptom Relief in Palliative Care*, 34 J.L. MED. & ETHICS 559, 559–67 (2006). The point in raising the issue here is to suggest that further evidence may exist to support the proposition that, the Hippocratic Oath notwithstanding, doctors are not monolithically opposed to ensuring that some people who are going to die anyway do so painlessly and with dignity.

154. See Johnson, *supra* note 136.

155. *Id.*

156. *Id.*

157. See *supra* note 51 and accompanying text.

very different if conducted today.¹⁵⁸ In fact, as Farber and his co-authors noted, although only three percent of respondents in the survey (taken in 1998) were aware of the AMA guidelines on the subject, “AMA membership was associated with a willingness to perform *more* AMA-disallowed actions.”¹⁵⁹

C. *Doctors Do Participate in Lethal Injection Executions*

Perhaps the easiest refutation of the argument that doctors cannot participate in lethal injection executions (or that they are not willing to) is that doctors routinely *are* involved in such executions and have been since states first started using lethal injection almost three decades ago.¹⁶⁰ In fact, doctors have played a key role in the implementation of capital punishment since the eighteenth century, when Dr. Joseph Guillotine developed the machine that bore his name.¹⁶¹ Professor Deborah Denno, the leading expert on the history of lethal injection, has exhaustively detailed the origins of this method of execution.¹⁶² As she reports, it was a doctor who developed the procedure that states currently use.¹⁶³ And doctors continue to play an active role—a role specifically condemned by the AMA’s guidelines—in executions in virtually every state.¹⁶⁴

Fifteen years ago, several physician and human rights organizations released a report entitled *Breach of Trust*, which sought to expose the extent of physician participation in American executions.¹⁶⁵ The report was a thorough study of state-by-state practices, and it revealed not only that state law frequently mandated physician involvement, but that “in practice, physicians are often

158. As one prominent opponent of physician participation noted in a blog post in 2007, “[I]t is very easy to find physician or nurse anesthetists quite willing to kill prisoners for the state.” Posting of Dr. Lawrence D. Egbert to Right-to-Die, http://www.lists.opn.org/pipermail/right-to-die_lists.opn.org/2007-April/002175.html (Apr. 27, 2007, 10:37:03 PDT).

159. Farber et al., *supra* note 132, at 887 (emphasis added).

160. As noted earlier, the Department of Justice acknowledged in 1993 that “most state death penalty procedures entail more physician involvement than desired by the AMA and College of Physicians.” Implementation of Death Sentences in Federal Cases, 58 Fed. Reg. 4898, 4898 (Jan. 19, 1993).

161. See Baum, *supra* note 149, at 53 (“[T]he medical establishment has had a long and storied history of involvement in both the evolution and implementation of capital punishment.”).

162. See Denno, *supra* note 28, at 64–75.

163. See *id.* at 84 (describing origins of the lethal injection procedure).

164. See *id.* at 84–88.

165. THE AM. COLL. OF PHYSICIANS ET AL., *BREACH OF TRUST: PHYSICIAN PARTICIPATION IN EXECUTIONS IN THE UNITED STATES 9–11* (1994) [hereinafter *BREACH OF TRUST*].

directly involved in the execution process.”¹⁶⁶ The advocacy organizations that published *Breach of Trust* were sharply critical of the practices they had discovered, arguing that the public’s trust in the medical profession “is shattered when medical skills are used to facilitate state executions.”¹⁶⁷

Denno provided an update on the *Breach of Trust* report in 2007.¹⁶⁸ She reported that there is no reason to believe that physician participation in lethal injection executions has decreased in the last fifteen years: “In the majority of states, the existence of statutory language concerning medical personnel indicates that medical association guidelines and the [*Breach of Trust*] report have had minimal impact. In general, states—either ignorant of or with disregard for ethical guidelines—include physicians in their lethal injection statutes.”¹⁶⁹ Indeed, most death penalty statutes allow physician participation and approximately half require it in some form.¹⁷⁰ Only Kentucky and Illinois forbid physician participation during executions.¹⁷¹

Because of the very laws discussed earlier that shield the identities of doctors and restrict public access to lethal injection protocols, it is impossible to report a full accounting of the extent of physician participation in lethal injection executions.¹⁷² As a result of these laws, it is very likely that doctors participate in executions to a far greater extent than is currently known.¹⁷³ However, in addition to the anonymous doctors that Dr. Gawande interviewed in 2006,¹⁷⁴

166. *Id.* at 3.

167. *Id.*

168. Denno, *supra* note 28, at 88–91.

169. *Id.* at 89.

170. *Id.* at 88–89.

171. Lerman, *supra* note 73, at 1950. Some states that appear to limit the participation of physicians do not in fact do so. LeGraw and Grodin provide the example of Louisiana, the governing statute of which does not “compel” any health care professional to participate in an execution. LeGraw & Grodin, *supra* note 84, at 414 (citing LA. REV. STAT. ANN. § 15:569 (2001)). The governing regulations, however, list a doctor as one of the four witnesses required to be in the execution room during the execution. *Id.* at 414–15 (citing BREACH OF TRUST, *supra* note 165, at 57).

172. See Black & Sade, *supra* note 75, at 2780 (“Other physicians have also apparently assisted in executions, but state laws and policies have hidden their identities from public view.”).

173. Groner, *supra* note 72, at 910 (“Although information on execution team members is often kept secret, it is likely that doctors participate to some extent in almost every state.”).

174. See Gawande, *supra* note 50, at 1223–28.

recent litigation challenging lethal injection has illuminated the extent of physician participation in certain states.¹⁷⁵

One high-profile example of physician participation was revealed in the *Taylor* litigation in Missouri.¹⁷⁶ In *Taylor*, it was discovered that Dr. Alan Doerhoff, a surgeon, was responsible for virtually every aspect of executions in Missouri, from the development of the unwritten protocol to the carrying out of the executions themselves.¹⁷⁷ The case received a great deal of national attention when the apparent incompetence of Dr. Doerhoff came to light and when the *St. Louis Post-Dispatch* revealed his identity.¹⁷⁸ But the scandalous nature of Dr. Doerhoff's lack of qualifications for the role of executioner obscured another point: Missouri had for years been relying on a doctor to perform its executions. And that is not all; it has since been revealed that this same doctor has participated in executions for the federal government,¹⁷⁹ Arizona,¹⁸⁰ and Connecticut.¹⁸¹

175. Denno, *supra* note 28, at 82 ("Recent revelations show that the extent of physician participation in executions has been underestimated.").

176. See, e.g., *Taylor v. Crawford*, 487 F.3d 1072, 1075–78 (8th Cir. 2007).

177. See Ty Alper, *Lethal Incompetence: Lethal Injection Litigation is Exposing More than Torturous Executions*, CHAMPION, Sept.–Oct. 2006, at 34, 42 (describing revelation about "Dr. Doe").

178. See *id.*

179. Henry Weinstein, *Doctor Barred by State Helps in U.S. Executions*, L.A. TIMES, Nov. 15, 2007, at A17, available at <http://articles.latimes.com/2007/nov/15/nation/najohndoe15> ("Doerhoff's role is to place intravenous lines in condemned inmates, monitor their levels of consciousness and sign death certificates.").

180. Michael Kiefer, *Doctor Banned from Executions in Mo. Now in Ariz.*, ARIZ. REPUBLIC, July 24, 2008, available at <http://www.azcentral.com/arizonarepublic/news/articles/2008/07/24/20080724deathpenaltydoc0724.html> ("A Missouri surgeon who was banned by a federal judge from taking part in capital executions by lethal injection in his home state apparently participated in Arizona's most recent execution.").

181. *Dickens v. Brewer*, No. CV07-1770, 2009 WL 1904294, at *14 (D. Ariz. July 1, 2009) (noting Dr. Doerhoff's participation in Connecticut execution). One might question why a state would continue to use Dr. Doerhoff to perform executions after his incompetence had been exposed, and one may even wonder whether only doctors as incompetent as he are willing to participate in executions. The answer likely has more to do with the fact that Dr. Doerhoff was a known entity and could be signed on to execution teams with minimal effort. For example, the Director of the Arizona Department of Corrections, Dora B. Schriro, had previously overseen executions as the Director of the Missouri Department of Corrections. *Id.* In that capacity, she and Dr. Doerhoff participated together in more than a dozen executions. *Id.* Although she was likely aware of the problems with Dr. Doerhoff that had been exposed by the time she hired him to work on Arizona executions, she also knew him personally, had worked with him, and apparently trusted her own judgment over that of the federal court in Missouri that had banned him from participating in further executions in that state. But it is unlikely that the decision to use Dr. Doerhoff had anything to do with the unavailability of more qualified doctors. After Arizona's use of Dr. Doerhoff put the state's lethal injection procedures in

In Arizona, after Dr. Doerhoff's involvement in executions was revealed, prison officials hired another physician to mix and draw the drugs, ensure that they are injected properly, and establish a central line if other members of the execution team are unable to achieve peripheral IV access.¹⁸² This doctor, whose name has not been publicly disclosed, also participated in the 2007 execution of Robert Comer in Arizona.¹⁸³ The doctor, who is not a member of the AMA,¹⁸⁴ testified in a recent deposition that he was "surprised" by the number of people who argued that it was "totally inappropriate" for doctors to participate in executions.¹⁸⁵ To the contrary, the doctor testified, "I think as long as it's something that the government thinks is appropriate and should be done, it should be done correctly. So that's why I'm . . . participating."¹⁸⁶

Other examples of doctors participating in ways that violate the AMA's guidelines continue to trickle out through the media and litigation. In Maryland, for example, the *Baltimore Sun* reported that nursing assistants and paramedics conduct the executions, although a doctor is present, and monitors an EKG machine and pronounces death, in violation of the AMA guidelines.¹⁸⁷ In Florida, the *St. Petersburg Times* reported that a doctor presiding over the apparently botched execution of Angel Diaz made critical decisions during the execution, including to skip one of the drugs as a second dose of the three-drug formula was injected into the dying inmate.¹⁸⁸ In Georgia, Dr. Sanjeeva Rao supervised executions and ordered the injection of additional chemicals when he deemed necessary; during one execution, he inserted a central line when the nurse was unable to find a suitable vein.¹⁸⁹ In Oklahoma, a licensed physician is present in

an unflattering light, the state agreed not to use him and has since found another willing doctor to participate. See *infra* text accompanying notes 182–86.

182. Videotaped Deposition of Medical Team Member 1, *supra* note 33, at 11.

183. *Id.* at 12.

184. *Id.* at 24.

185. *Id.* at 263.

186. *Id.*

187. McMenamin, *supra* note 56. Despite the *Baltimore Sun*'s own report in 2006 that revealed the participation of a doctor in Maryland's executions, the newspaper recently stated in an editorial that the need for medical expertise in the execution process presents a "fundamental contradiction" because it is "unethical for doctors to participate." Editorial, *A Moral Oxymoron*, BALT. SUN, October 13, 2009, at 12A, available at <http://www.baltimoresun.com/news/opinion/editorial/bal-ed.death13oct13,0,4649937.story>. Doctors are no more prohibited from participating in executions in Maryland in 2009 than they were in 2006; rather, the *Sun*'s editorial reflects the pervasive nature of the myths about physician participation even among those who presumably are privy to the facts.

188. Tisch, *supra* note 99.

189. Liptak, *supra* note 51.

the execution chamber, monitoring the inmate's level of consciousness "by whatever means he deems appropriate."¹⁹⁰ In California, execution logs indicate that doctors have been present in each of the state's eleven lethal injection executions, monitoring heart rate and respiration.¹⁹¹ And, at least two doctors, including regular state's expert Dr. Mark Dershwitz, assisted the State of Tennessee in the development of new lethal injection protocols, including advising the state on how the drugs work and recommending specific changes to the protocol.¹⁹²

* * *

The term "Hippocratic paradox" has been used to explain the dilemma that doctors face with respect to participation in lethal injections.¹⁹³ Doctors are needed to ensure that the executions are humane, yet "medical professionals are ethically forbidden from participating in lethal injection because their participation risks irreparable harm not only to physician-patient relationships but to the medical profession and even society as a whole."¹⁹⁴

The problem with the concept of a Hippocratic paradox is that lethal injection creates a paradox or dilemma only to the extent that physicians agree that participation in lethal injection executions *is* ethically forbidden. In fact, as evidenced by the doctors who express a willingness to participate and the doctors who actually do participate, many doctors do not agree that their participation is unethical,

190. Defendant's Response to Memorandum and Motion to Reactivate Proceedings and Brief in Support, *supra* note 113, at 5; *see also* Malicoat v. State, 2006 OK Crim App. 25, ¶¶ 4-6, 137 P.3d 1234, 1236 (describing Oklahoma's lethal injection protocol).

191. Zimmers & Lubarsky, *supra* note 102, at 148-49.

192. Harbison v. Little, 511 F. Supp. 2d 872, 876-77 (M.D. Tenn. 2007), *vacated and remanded*, 2009 FED App. 0227P, 571 F.3d 531 (6th Cir.). Dr. Dershwitz also recently consulted with Ohio prison officials attempting to revise their lethal injection protocols in the wake of the botched execution attempt of Romell Broom in September 2009. *See* Alan Johnson, *Ohio May Overhaul Execution Policies*, COLUMBUS DISPATCH, Oct. 7, 2009, at 1A, available at http://www.dispatchpolitics.com/live/content/local_news/stories/2009/10/07/copy/DEATH_CHANGES.ART_ART_10-07-09_A1_ANFA6LR.html?adsec=politics&sid=1011. In other states, doctors are used or will be used if incisions are necessary to gain venous access. *See, e.g.*, Noonan v. Norris, No. 5:06CV00110, 2008 WL 3211290, at *9 (E.D. Ark. Aug. 5, 2008) (noting testimony of Arkansas official that only a "licensed physician" will make such an incision if it becomes necessary during an execution). As these examples make clear, doctors do regularly participate in various ways in executions in this country. None of these examples, however, involve doctors monitoring anesthetic depth sufficiently to ensure that the person being executed does not experience the excruciating pain of the lethal drugs, and it is this kind of participation that lawyers for death row inmates have typically been seeking. *See supra* notes 33-37 and accompanying text.

193. *See, e.g.*, Groner, *supra* note 72, at 909.

194. *Id.*

immoral, or damaging to the medical profession, let alone society as a whole. So long as the law does not prohibit their participation, these doctors will continue to legally assist in lethal injection executions.¹⁹⁵

II. PERPETUATION OF THE PHYSICIAN PARTICIPATION MYTHS

Given that doctors can, will, and do participate in lethal injections, why do so many people, including judges, believe that they cannot, will not, and do not? There are at least two forces at work, forces that have opposite objectives but overlapping results. First, lawyers for lethal injection states, in an effort to avoid court-mandated improvements to their lethal injection protocols, have explicitly argued—contrary to the facts described in Part I—that doctors cannot participate in executions and that any remedy requiring such participation is infeasible. Second, opponents of the death penalty have publicly decried physician participation in executions, and, in many cases, have actively attempted to thwart such participation. The states have taken advantage of the public perception, generated in part by years of activism by abolitionists, that doctors cannot participate in executions. In so doing, they have fostered that particular myth as well as the myth that *lawyers* for death row inmates are disingenuous in their advocacy for physician participation.

A. *The Role of State Actors*

Lawyers defending lethal injection procedures on behalf of states have, at times, grudgingly acknowledged that the ethical guidelines

195. It is worth noting here that the calls from death penalty abolitionists for state medical boards to discipline doctors who participate in executions is reminiscent of some prominent doctors' criticism of medical associations and medical boards for not disciplining doctors who participate in the abuse and torture of prisoners. See STEVEN H. MILES, *OATH BETRAYED: AMERICA'S TORTURE DOCTORS*, at xix (2d ed. Univ. of Cal. Press 2009) (2006) ("Although medical societies are moving toward asserting a duty to record and report the abuse of prisoners, they are not acting to hold clinicians accountable for participating or acquiescing in this abuse."); Sharrock, *supra* note 83, at 63 ("[N]o state medical board has ever disciplined a doctor for assisting in military torture."). The analogy is noted here, but it is beyond the scope of this Article to explore it fully. One critical difference is that there can be no doubt about the current legality (and, indeed, general public acceptance) of American executions. Such is not the case with the torture of detained prisoners. Doctors who are opposed to capital punishment are free to reject entreaties to participate in executions. But those who do participate are involved in a lawful exercise of state power. Armed Forces physicians, psychologists, and medics who participated in the abuse of prisoners detained in Iraq and Afghanistan very likely violated both domestic and international law by doing so; it seems natural to suggest that the medical profession should be more concerned with their actions than those of doctors who participate in lawful executions.

discussed in Part I above are non-binding. But in their effort to convince courts that a judicially-imposed remedy requiring participation would be unworkable, they have routinely suggested to courts that, as a practical matter, it is prohibitively difficult to find willing doctors.¹⁹⁶ The Missouri Attorney General's argument, made in a 2006 brief to the Eighth Circuit, is typical:

The ethical standards of the AMA are not necessarily binding on Missouri's licensing board, but could carry decisive weight with that board in the event charges were filed against a doctor who did participate in an execution. Thus, a requirement that a doctor participate in executions could effectively bar implementation of the death penalty in Missouri.¹⁹⁷

The litigation position is clear: courts that require physician participation do so at the risk of ending the death penalty altogether.

This litigation strategy raises the question of why the states do not simply acquiesce to the demand for greater physician involvement in an effort either to curtail litigation, ensure more humane executions, or both. Any answer to that question would necessarily entail speculation, but it is worth noting that states have also been unwilling to seriously consider adopting a one-drug, anesthetic-only lethal injection procedure that many independent experts have suggested as a feasible alternative to the current three-drug procedure.¹⁹⁸ An anesthetic-only protocol would also curtail litigation and ensure more humane executions, but no state has yet decided to make the switch.¹⁹⁹

There are some hypotheses to explain states' unwillingness to agree to improved execution standards and their willingness to perpetuate the twin myths about physician participation. One explanation is that the departments of correction are institutionally loathe to accede to any intervention in the way they conduct their business unless literally forced to do so by the courts. They and their attorneys may be concerned that any change or improvements they

196. See, e.g., Posting of Jeff Woods to Nashville Scene, http://blogs.nashvillescene.com/pitw/2009/02/tennessees_machinery_of_death.php (Feb. 2, 2009, 11:27 EST) ("If the Vanderbilt anesthesiology department would come over and perform executions for us, there wouldn't be any issues." (quoting the Governor of Tennessee)).

197. *Taylor Appellants' Brief*, *supra* note 43, at 64.

198. See Alper, *supra* note 29, at 831-32 (discussing unwillingness of states to change their procedures).

199. See Adam Liptak, *States Hesitate to Lead Change on Executions*, N.Y. TIMES, Jan. 3, 2008, at A1 (raising the question of why all lethal injection states "are wedded to a cumbersome combination of three chemicals").

agree to make will tie their hands later; once they include physician monitoring of consciousness in their lethal injection protocols, for example, the concern is that such monitoring will become the new Eighth Amendment standard. A more stringent standard may be problematic, in their view, if they ever want to return to a less rigorous form of monitoring, but it may also be problematic from the perspective of other states who have not taken steps to improve their protocols. The actions of some states could have the effect of increasing the constitutional obligations of other states in a way that perhaps no individual department of correction wants to be responsible for. A related hypothesis is that the states are concerned that any voluntary improvement will be seen as an implicit admission that the existing system was problematic or unconstitutional, which may be untenable for either legal or public relations purposes. A final possibility, of course, is that some state actors, influenced by the myths discussed in this Article, are legitimately (but unnecessarily) concerned that willing doctors will be hard to find.

In any event, the position that doctors cannot participate is a consistent one for state attorneys defending the lethal injection status quo. Recent events in Missouri exemplify the way in which state officials profess an inability to find doctors as a way of strengthening this litigation position.

1. Missouri

In June 2006, federal district court Judge Fernando J. Gaitan, Jr., after hearing extensive evidence regarding problems with the administration of lethal injection in Missouri, concluded that the state's procedures put inmates at an "unnecessary risk that they will be subject to unconstitutional pain and suffering when the lethal injection drugs are administered."²⁰⁰ He ordered that the state take remedial action, including, among other things, revising its protocol to include a requirement that a board certified anesthesiologist participate in the process.²⁰¹

The ASA reacted to Judge Gaitan's order by issuing a statement in specific condemnation of the order, advising its members to "steer clear" of executions.²⁰² Following the ASA's statement, lawyers for Missouri responded to Judge Gaitan several weeks later with a

200. *Taylor v. Crawford*, No. 05-4173, 2006 WL 1779035, at *8 (W.D. Mo. June 26, 2006), *rev'd*, 487 F.3d 1072 (8th Cir. 2007).

201. *Id.* at *8-9.

202. Guidry, *supra* note 5.

revised protocol that it acknowledged did not “completely implement all the provisions set out by the Court.”²⁰³ Among the provisions the state rejected was the requirement that a board certified anesthesiologist participate. The state’s lawyers explained to the judge that their attempts to find willing anesthesiologists had failed, which was “unsurprising” in light of the AMA’s guidelines and the ASA’s statement specifically advising doctors not to assist the state in complying with the judge’s order.²⁰⁴

The state went on to suggest that its revised procedures should satisfy the court, however, because “medical personnel”—including “a physician, nurse, or pharmacist”—is responsible for preparing the chemicals prior to injection.²⁰⁵ Thus, without apparent irony, the state argued in one pleading both that the AMA and ASA guidelines render anesthesiologist participation unlikely *and* that the judge should rest assured that a physician or other medical personnel will be involved. But what is most striking about the state’s response is how it made its case that its efforts to find a willing anesthesiologist were futile.

Attached to the state’s pleading was a letter from the Director of Missouri’s Department of Corrections (“DOC”) sent to 298 board-certified anesthesiologists in Missouri and neighboring states.²⁰⁶ The letter was a “cold call” to these doctors, requesting they get in touch with the DOC if they were interested in participating in Missouri’s executions:

You might have seen recent news reports that a federal judge ordered the Missouri Department of Corrections to use the services of a board-certified anesthesiologist when the department executes a condemned prisoner by means of lethal injection. . . . If you think that you might be willing to provide your professional services as an anesthesiologist during executions, please contact me as soon as possible²⁰⁷

203. Defendant Correctional Officials’ Submission of Proposed Execution Protocol at 2, *Taylor v. Crawford*, 2006 U.S. Dist. LEXIS 51008 (W.D. Mo. July 14, 2006) (No. 05-4173) [hereinafter *Correctional Officials’ Submission*].

204. *Id.* at 5 (citing the AMA guidelines). In its pleadings in both the District Court and the Eighth Circuit, the state referenced the ASA statement as explanation for its alleged failure to recruit a willing anesthesiologist. See *Taylor Appellants’ Brief*, *supra* note 43, at 63 (mentioning ASA’s exhortation to anesthesiologists to “steer clear”); *Correctional Officials’ Submission*, *supra* note 203, at 5 (same).

205. *Correctional Officials’ Submission*, *supra* note 203, at 5.

206. See *id.* at 4 (referencing attachment).

207. *Id.*, exhibit B. The letter assured potential executioners that although “[t]here is no regular schedule for executions,” they “would be notified well in advance of each

According to the state, the letter was sent via first class mail on July 6, 2006, which was a Thursday.²⁰⁸ On July 14, 2006, the next Friday, the DOC Director filed a sworn affidavit with the court.²⁰⁹ In that affidavit, the Director described the letter he had sent to the anesthesiologists and informed the court that “[d]espite this attempt to obtain a board-certified anesthesiologist, to date no one has been retained.”²¹⁰ In other words, the state mailed out the letter, allowed for a handful of working days to pass, and then gave up and declared to the court that it had failed to retain a qualified anesthesiologist.

One might legitimately question whether this outreach was a good faith attempt to comply with the court’s order. In any event, the state’s declaration that it could not find a doctor had its intended effect. The media widely reported that Missouri was having trouble finding a doctor to comply with the judge’s order,²¹¹ and the Eighth Circuit ultimately reversed Judge Gaitan’s order requiring the participation of a doctor.²¹²

The significant epilogue to the story is that, as was later revealed, the state had in fact received several responses to its July 6, 2006, letter. Although the state had represented to the district court²¹³ and the Eighth Circuit²¹⁴ throughout proceedings in 2006 and 2007 that it was unable to find an anesthesiologist, it had actually received

execution and would be compensated for these services.” *Id.* The letter is attached as an appendix to this Article. *See infra* Appendix A.

208. *See* Correctional Officials’ Submission, *supra* note 203, exhibit B; Appendix A.

209. *See id.* The affidavit is attached as an appendix to this Article. *See infra* Appendix B.

210. *See infra* Appendix B.

211. *See, e.g.,* Monica Davey, *Missouri Says It Can’t Comply on Executions*, N.Y. TIMES, July 15, 2006, at A1 (“The State of Missouri, facing a deadline today for changing the way it executes condemned prisoners by lethal injection, told a federal judge last night that it was simply unable to meet his demand that the state hire a board-certified anesthesiologist to oversee executions.”); Jeremy Kohler, *Execution Overhaul Submitted*, ST. LOUIS POST-DISPATCH, July 15, 2006, at A16 (“Missouri officials submitted a plan Friday for a court-ordered overhaul of the state’s lethal injection procedures but warned they would not be able to satisfy a judge’s requirement to involve an anesthesiologist in executions.”); Henry Weinstein, *Missouri Says It Can’t Find Execution Doctor*, L.A. TIMES, July 16, 2006, at A32.

212. *Taylor v. Crawford*, 487 F.3d 1072, 1085 (8th Cir. 2007).

213. Correctional Officials’ Submission, *supra* note 203, at 4 (“After the Court issued its June 26, 2006 order, defendant . . . sent letters to 298 board certified anesthesiologists in this State and southern Illinois inquiring of their willingness to participate in executions, as outlined by the court’s order. To this date, no one has accepted.”).

214. *Taylor* Appellants’ Brief, *supra* note 43, at 63 (“The Department of Corrections sent letters to 298 board certified anesthesiologists in this state and southern Illinois inquiring of their willingness to participate in executions, as outlined by the court’s order. None accepted.”).

multiple responses to its letter, and ultimately hired a qualified anesthesiologist whom it plans to employ in future executions. The Director of the Department of Corrections testified in the summer of 2008 that he could not recall precisely how many responses the department had received to the “cold call” letter, but it was enough that they had to “pare” the list down to three board-certified anesthesiologists.²¹⁵ From that list of three, they then chose one whom they planned to employ.²¹⁶

Thus, what appeared to be a token effort, perhaps even designed to fail, was all it took for Missouri to find several willing, qualified anesthesiologists. The “cold call” was successful, despite the AMA guidelines, and despite the fact that the ASA had, days earlier, specifically warned anesthesiologists to “steer clear.”

Missouri’s experience trying to find a doctor is generally cited for the proposition that willing, qualified doctors are difficult to acquire.²¹⁷ But the real lesson is the opposite; what the Missouri experience demonstrates is both the lengths that the states will go to convince courts that doctors will not participate *and* that doctors *will* participate, even when the head of their professional organization directly exhorts them not to do so.

2. California and North Carolina

Lest one conclude that the Missouri experience is an anomaly, consider events in California and North Carolina. These states have also experienced controversy over the ability of prison officials to procure the services of doctors. As in Missouri, events in these states are generally thought to support the notion that doctors will not

215. Deposition of Larry Crawford filed with Suggestions in Support of Plaintiff’s Motion for Further Discovery, exhibit 1, at 28, 105, *Clemons v. Crawford*, 2008 WL 2783233 (W.D. Mo. July 15, 2008) (No. 05-4129) [hereinafter *Crawford Deposition*]; see also *Missouri Poised to Resume Executions; State Has Added Anesthesiologist to Death Row Team*, ST. LOUIS POST-DISPATCH, May 27, 2008, at B5 (noting that Missouri added an anesthesiologist to its execution team in spite of medical ethics guidelines discouraging involvement).

216. *Crawford Deposition*, *supra* note 215, at 103.

217. See, e.g., Black & Sade, *supra* note 75, at 2779 (“Missouri [has] attempted unsuccessfully to recruit physicians to assist in lethal injection.”); Zimmers & Lubarsky, *supra* note 102, at 149–50 (“None of the 298 anesthesiologists surveyed by the Missouri corrections officials was willing to [participate], a position in concert with the guidelines issued by the American Society of Anesthesiologists.”); Lerman, *supra* note 73, at 1957 (noting that Missouri’s trouble finding a doctor was “not surprising” given Dr. Guidry’s directive to “steer clear”); *Ohio Can’t Find Doctors to Offer Execution Advice*, *supra* note 101 (“The [Missouri] Corrections Department met with resistance from anesthesiologists wary of crossing an ethical line that could cost them their practice.”).

violate the AMA guidelines; in fact, they tell a story quite to the contrary.

In February 2006, in light of concerns raised about the effectiveness of California prison officials' delivery of anesthesia to condemned inmates, the federal judge presiding over the execution of Michael Morales ordered that the state either procure the services of an anesthesiologist to monitor consciousness or change its method of execution to an anesthetic-only procedure.²¹⁸ The California Medical Association immediately objected to the judge's order, issuing a press release reminding the public of its position that physician participation is unethical and that the association has "for decades sought to end physician participation in capital punishment."²¹⁹ Nevertheless, within a week, the state had found two willing anesthesiologists.²²⁰ Just hours before the scheduled execution, however, the doctors backed out, apparently because they had not been told by state officials that they would have to intervene if something went wrong during the execution.²²¹

In North Carolina, a federal judge allowed two executions to proceed on the express understanding that a licensed physician and licensed registered nurse would be present to track the inmates' consciousness on a bispectral index monitor (known as a BIS monitor).²²² Dr. Obi Umesi was present for both executions.²²³ Dr. Umesi later claimed, however, that although he stood in the observation room with a heart monitor and a brain-wave monitor, he did not in fact monitor consciousness, as lawyers for the state had previously represented to the presiding judge.²²⁴

218. *Morales v. Hickman*, 415 F. Supp. 2d 1037, 1047–48 (N.D. Cal. 2006) (order denying conditionally plaintiff's motion for preliminary injunction), *aff'd*, 438 F.3d 926 (9th Cir. 2006).

219. Press Release, Cal. Med. Ass'n, California Medical Association Objects to Physician Participation in Executions (Feb. 16, 2006), <http://www.cmanet.org/publicdoc.cfm?docid=2&parentid=1> (select Feb. 16, 2006 from the "Archive" drop-down menu).

220. See Gawande, *supra* note 50, at 1221 (noting that the state found two doctors in two days).

221. See Stacy Finz et al., *Killer's Execution Rescheduled*, S.F. CHRON., Feb. 21, 2006, <http://www.sfgate.com/cgi-bin/article.cgi?f=/c/a/2006/02/21/MNG14HC1HG16.DTL>.

222. See Andrea Weigl, *Doc's Execution Role: 'Be Present,'* NEWS & OBSERVER (Raleigh, N.C.), Mar. 30, 2007, at 1A.

223. See *id.*

224. See Andrea Weigl, *Did Doctor Stand Idle, or Monitor Executions?*, NEWS & OBSERVER (Raleigh, N.C.), Mar. 29, 2007, at 1A ("[Dr. Umesi] said in an interview . . . he did not monitor their level of consciousness, and prison officials never asked him to, despite a federal judge's order requiring that.").

These two accounts of doctors shying away from what they perceive to be actual participation in an execution are often cited as examples of the enduring relevance of the AMA's ethical guidelines that supposedly govern physician participation.²²⁵ But the real story is how easy it was for the states to find doctors when courts ordered them to do so. When the judge in the *Morales* case ordered California officials to find a willing anesthesiologist to monitor consciousness, they had no problem finding two such doctors in short order.²²⁶ The two doctors quickly volunteered, despite the vocal condemnation of the judge's order by the AMA, the ASA, and the California Medical Association.²²⁷ Likewise, in North Carolina, when the presiding judge in that state ordered executions to proceed only if the prison could obtain a doctor to review the brain-wave monitor, Dr. Umesi stepped forward without apparent hesitation.²²⁸

It is true that the doctors in California backed out at the last minute. But they did so because lawyers for the state had not explained to them accurately what their role was actually going to be during the execution.²²⁹ Apparently, the doctors thought that their only role was to monitor consciousness. In fact, the judge had contemplated that the doctors would intervene and take steps to render Morales unconscious if necessary.²³⁰ “ ‘Any such intervention would clearly be medically unethical,’ ” the doctors said in a written statement.²³¹ Likewise, in North Carolina, Dr. Umesi stated that although standing in the observation room with the monitors did not violate his medical ethics, actually looking at the machines would have. “ ‘I would not participate in an execution. . . . I would not voluntarily take a life,’ ” Dr. Umesi said.²³²

What has been overlooked in the many public discussions about both of these episodes is that *even what the doctors thought they were doing* was a clear violation of the AMA's ethical guidelines. In

225. See, e.g., Black & Sade, *supra* note 75, at 2780 (“This case [in North Carolina] illustrates the difficulties that states may face in complying with mandated physician participation when physicians limit their roles based on ethical standards.”); Lerman, *supra* note 73, at 1955 (describing ethical concerns of doctors who backed out of Morales’ execution at the last minute).

226. See Finz et al., *supra* note 221.

227. See Gawande, *supra* note 50, at 1221 (noting that these associations “immediately and loudly opposed” Judge Fogel’s order).

228. Andrea Weigl, *Doctor Details Execution Procedure: Medical Ethics, State Rules Clash*, NEWS & OBSERVER (Raleigh, N.C.), May 22, 2007, at B5.

229. See Finz et al., *supra* note 221.

230. See *id.*

231. *Id.*

232. Weigl, *supra* note 224.

California, the doctors thought that they were there to monitor consciousness. In North Carolina, the doctor claimed simply to be observing as a physician but otherwise taking no active role. The AMA guidelines define participation as, among other things, “attending or observing an execution as a physician.”²³³ Thus, in both cases, there is no question that each of the doctors would have been violating the AMA’s guidelines, regardless of what their role in the execution was actually supposed to be. Doctors in both states had no problem “attending” the execution as a physician. The doctors just happened to draw the line in a different place than where the AMA drew it. Given how quickly state officials were able to procure the assistance of these doctors who were willing to violate the AMA’s guidelines, nothing about this episode suggests that—had they been more clear with potential doctors about what was actually involved—the states could not have found doctors who were willing to carry out the tasks actually envisioned by the presiding judges.

The experiences of Missouri, California, and North Carolina are lessons in the *willingness* of doctors to participate in lethal injection executions. But state officials have managed to spin them as evidence to the contrary.²³⁴ Their success in doing so is both a testament to the enduring power of the twin myths about physician participation and a further perpetuation of both myths.

B. The Role of Death Penalty Abolitionists

It is not only lawyers for the states who have had a hand in perpetuating the twin myths of physician participation. Activist groups opposing the death penalty (often referred to as abolitionist groups), and other individuals opposed to the death penalty, have contributed to the conventional wisdom (1) that doctors cannot participate in lethal injection executions; and (2) that the litigation position taken by lawyers for death row inmates is a disingenuous one.

There is, of course, a critical difference between the ways in which state representatives and abolitionists have advanced their positions on physician participation. Counsel for the states have perpetuated both myths about physician participation explicitly with an aim toward discrediting a plausible legal remedy offered by

233. CODE OF MEDICAL ETHICS, *supra* note 46, § 2.06.

234. See, e.g., Kevin B. O’Reilly, *Physicians Resist Push for Execution Involvement*, AM. MED. NEWS, May 14, 2007, <http://www.ama-assn.org/amednews/2007/05/14/pr120514.htm> (reporting that prison officials in Missouri, California, and North Carolina “have said they cannot find doctors willing to aid”).

lawyers for death row inmates.²³⁵ Abolitionists, on the other hand, have attempted to discourage physician participation in order to disrupt the death penalty in states where physicians are required to participate and to delegitimize capital punishment generally by touting its rejection by the respected medical profession. These tactics have played a role in perpetuating the first myth, that doctors cannot participate in executions. With respect to the second physician participation myth, abolitionists have not suggested that death penalty lawyers are disingenuously invoking physician participation as a back door route to abolition. Nevertheless, because of the general perception of lawyers for death row inmates as synonymous with abolitionists, the abolitionist position against physician participation has unwittingly perpetuated the myth that lawyers who advocate for physician participation are being less than candid about their true motives.

1. Abolitionist Opposition to, and Activism Against, Physician Participation in Executions

Doctors have been protesting physician participation for decades.²³⁶ But leading human rights and abolitionist groups have also taken strong positions against physician participation in executions. Amnesty International, for example, has long sought to publicize the fact that physician participation violates the AMA's ethical code.²³⁷ Two other leading abolitionist organizations, the National Coalition to Abolish the Death Penalty ("NCADP") and Human Rights Watch, were two of the four organizational authors of the *Breach of Trust* report discussed earlier.²³⁸ Although *Breach of Trust* did not take a position on the death penalty,²³⁹ the report did take a strong position

235. See *supra* text accompanying notes 41–44.

236. See, e.g., Scott Fornek, *MDs Sue to Avoid Gacy Execution*, CHI. SUN-TIMES, April 29, 1994, at 16 ("[A] group of doctors Thursday filed a lawsuit seeking to ensure that physicians will play no role in the serial killer's death by lethal injection."); Ed Lion, *Two Doctors Condemn Injection Executions*, UNITED PRESS INT'L, December 9, 1982, LEXIS (discussing the opposition of physicians to participation in lethal injection executions, following the first such American execution in 1982); Joyce Price, *Doctors in Hot Seat for Execution Role*, WASH. TIMES, January 3, 1991, at A4 (reporting reaction of AMA and other medical associations to participation of doctors in the Illinois execution of Charles Walker); Henry Weinstein, *supra* note 51 (reporting opposition of the American Society of Anesthesiologists to participation in executions).

237. See, e.g., Andis Robeznieks, *Human Rights Groups Hit Doctors' Role in Executions*, AM. MED. NEWS, Feb. 11, 2002, <http://www.ama-assn.org/amednews/2002/02/11/prsb0211.htm> (noting Amnesty International's strong opposition to physician participation in executions).

238. BREACH OF TRUST, *supra* note 165, at 1.

239. *Id.*

against physician participation, recommending, among other things, that “[s]tate medical boards . . . should define physician participation as unethical conduct, and take appropriate action against physicians who violate ethical standards.”²⁴⁰ The report concluded that “[s]ociety must decide whether, how, and when to impose capital punishment—without involving physicians in the execution process.”²⁴¹

Abolitionist groups have been instrumental in publicizing the ethical guidelines of the national and state medical associations in an effort to convince doctors not to participate.²⁴² For example, the NCADP has posted the AMA’s press releases in opposition to physician participation on its Web site,²⁴³ as well as an Amnesty International press release entitled *Medical Professionals Break Ethical Oath with Lethal Injection*,²⁴⁴ and has noted on its Web page devoted to lethal injection issues that “forcing physicians to participate in killing a human being is generally considered a breach of the Hippocratic Oath.”²⁴⁵ When executions in the United States were temporarily on hold pending the Supreme Court’s ruling in *Baze*, the World Coalition Against the Death Penalty (“WCADP”) published an article on its Web site entitled, *Opportunity to End US Lethal Injections*.²⁴⁶ The article stated that doctors “should ‘stay away’ from execution rooms” and quoted Dr. Groner as saying that “[t]here is a need for a wide campaign to publicise [the ethical guidelines], and for peer pressure to make sure that no doctors, no nurses take part in executions.”²⁴⁷

240. *Id.* at 46.

241. *Id.* at 3.

242. See Zimmers & Lubarsky, *supra* note 102, at 150 (“[A]ctivists have led the charge against lethal injection by publicizing the American Medical Association prohibitions, publicizing and pursuing legal action against physicians participating in executions, attacking state laws classifying lethal injections as nonmedical procedures . . . , and lobbying specifically against statutory requirements for physician participation.”).

243. See, e.g., Press Release, Am. Med. Ass’n, AMA: Participation in Lethal Injection Violates Medical Ethics (July 17, 2006), <http://www.demaction.org/dia/organizations/ncadp/pressRelease.jsp?key=188&t=>.

244. Press Release, Amnesty Int’l, Medical Professionals Break Ethical Oath with Lethal Injection (Oct. 5, 2007), <http://www.ncadp.org/news.cfm?articleID=149>.

245. Nat’l Coalition to Abolish the Death Penalty, Problems Associated with Lethal Injection, <http://www.ncadp.org/index.cfm?content=46> (last visited Nov. 8, 2009).

246. Thomas Hubert, *Opportunity to End US Lethal Injections*, WORLD COALITION AGAINST THE DEATH PENALTY (Nov. 15, 2007), <http://www.worldcoalition.org/modules/smartsection/item.php?itemid=237&keywords=physician>. The WCADP is an international coalition of non-governmental organizations, bar associations, local authorities, and trade unions working together to oppose capital punishment worldwide.

247. *Id.* State-based abolitionist groups also publicize the medical associations’ positions and regularly assert that doctors cannot participate in executions. See, e.g., Death Penalty Focus, Lethal Injection, <http://www.deathpenalty.org/article.php?id=52> (last

Amnesty International even provides talking points for members of the public to use when speaking about the issue.²⁴⁸ The talking points, reprinted below, neatly encapsulate both Amnesty's stance against physician participation and the organization's active efforts to deter doctors from participating:

Lethal injection risks involving medical personnel in unethical practices that run counter to their professional mandate.

- Lethal injection has a corrosive effect on the medical profession, which finds itself reluctantly conscripted to play a lead role in state-sponsored executions. Employing medical knowledge and skills in executions is in direct breach of internationally accepted standards of medical ethics. It represents a clear perversion of the Hippocratic Oath and compromises the integrity of all medical practitioners involved.
- Numerous organizations have declared that physician participation in executions constitutes a serious violation of professional ethical standards. These include: *The American Medical Association*, *The American Society of Anesthesiologists*, *The American Public Health Association*, *The California Medical Association*, *Physicians for Human Rights*, and *The American Nurses Association*, among others.
- Such professional associations should ensure that their membership is informed of the relevant medical ethics standards as they pertain to participation in executions and should take action against physicians who violate such standards.
- Efforts to discipline doctors who take part in executions have been hampered by protections (including laws that protect their identity from public scrutiny) accorded them by the state.²⁴⁹

visited Nov. 8, 2009) (arguing that “[m]edical ethics preclude doctors from participating in executions” and linking to press releases from various organizations opposing physician participation in executions).

248. Amnesty Int’l, Call to Action: Speak Out Against Lethal Injections!, <http://www.amnestyusa.org/abolish/lethalinjection.html> (last visited Nov. 8, 2009).

249. *Id.*

Human Rights Watch also recently reiterated its position on physician participation in the 2006 report *So Long as They Die*.²⁵⁰ In that report, the organization recognized “that the ethical prohibition on physician participation in executions limits the way states can conduct lethal injection executions. This is a dilemma of the states’ making—by their refusal to abolish capital punishment—and it is a dilemma states must resolve if they continue to use lethal injection executions.”²⁵¹

Abolitionist organizations, as well as individuals opposed to the death penalty, have also taken direct action in an effort to deter physician participation.²⁵² Earlier this year, a national abolitionist organization founded by Sister Helen Prejean launched a campaign to persuade medical licensing boards in each state to declare it unethical for doctors to participate in executions.²⁵³ The stated goal of the campaign is to “mak[e] it impossible for states to carry out their own protocols for capital punishment.”²⁵⁴ The tactic is not a new one; a 2002 article in the AMA’s weekly newspaper reported the steps Amnesty International was taking to recruit doctors to speak out against physician participation, as well as target specific doctors who were revealed to have participated in executions.²⁵⁵ For example, Amnesty International, aided by the consumer rights organization Public Citizen, sought to revoke the license of the top medical officer in New Mexico after he had authorized the use of lethal drugs for an execution.²⁵⁶

Other, less centralized, efforts have taken similar forms. In Georgia, for example, “a group of anti-death penalty doctors,” led by Dr. Zitrin, recently filed a complaint against a doctor who had admitted to participating in several Georgia executions.²⁵⁷ As

250. HUMAN RIGHTS WATCH, *SO LONG AS THEY DIE: LETHAL INJECTIONS IN THE UNITED STATES 1–65* (2006), available at <http://www.hrw.org/sites/default/files/reports/us0406webwcover.pdf>.

251. *Id.* at 42.

252. See Robeznieks, *supra* note 237 (reporting Amnesty International’s activism against physician participation).

253. Nancy Frazier O’Brien, *Doctors’ Role in Executions Part of New Tactic Against Death Penalty*, CATH. NEWS SERVICE, February 4, 2009, <http://www.catholicnews.com/data/stories/cns/0900540.htm>.

254. *Id.*

255. Robeznieks, *supra* note 237 (“Physicians who participate in capital punishment executions can expect to come under Amnesty International scrutiny. The group seeks to highlight how this practice conflicts with established ethical policies. And it’s also looking to recruit doctors to its cause.”).

256. *Id.*

257. Campos, *supra* note 55; see also Campos, *supra* note 52 (“The 37-page complaint, filed with the Composite State Board of Medical Examiners by a group of local and out-

discussed earlier, the complaint was ultimately dismissed.²⁵⁸ Yet newspaper reports noted that the complaint was part of a “recent volley in a campaign to revoke the licenses of doctors who participate in executions.”²⁵⁹

Indeed, the previous year, four death penalty opponents (one lawyer, two doctors, and a chaplain) filed a complaint with the Kentucky Medical Licensure Board against Governor Ernie Fletcher.²⁶⁰ The complaint alleged that, because he is a licensed physician, the Governor could not sign a death warrant for inmate Thomas Clyde Bowling without violating the AMA guidelines.²⁶¹ Dr. Zitrin, also a vocal opponent of the death penalty,²⁶² followed the complaint filing by publishing an op-ed in the *Los Angeles Times* entitled *Doctor, Reread Your Oath* and arguing that Governor Fletcher’s actions violated the AMA ethical guidelines.²⁶³ The Kentucky Medical Board ultimately dismissed the complaint, ruling unanimously that although he was a physician, Fletcher was acting in his role as governor, not as a doctor, when he signed the warrant.²⁶⁴ Following the ruling, the chairman of the Kentucky Coalition to Abolish the Death Penalty told reporters that the decision would not end their efforts to save Bowling’s life: “We’re not going to give up.”²⁶⁵

Just last year in Georgia, opponents of the death penalty sought to disrupt the execution of Troy Davis by targeting the medical office that had contracted with the Department of Corrections to assist in executions.²⁶⁶ Because Georgia law requires the participation of physicians, activists hoped to thwart the event by picketing the offices of Rainbow Medical Associates and deterring their employees from

of-state physicians, claims that lethal injections in Georgia are carried out by doctors in violation of their medical ethics code and state law.”).

258. See *supra* text accompanying notes 62–68.

259. See Campos, *supra* note 52.

260. See Deborah Yetter, *Medical Ethics Issue Dismissed; Foes of Execution Challenged Fletcher*, COURIER-J. (Louisville, K.Y.), Jan. 14, 2005, at B1.

261. See *id.*; Andis Robeznieks, *Ethics Charges Related to Executions Dropped*, AM. MED. NEWS, Jan. 31, 2005, <http://www.ama-assn.org/amednews/2005/01/31/prsg0131.htm>.

262. See Campos, *supra* note 52 (noting that Dr. Zitrin describes himself as a “death penalty abolitionist”).

263. Arthur Zitrin, Op-Ed., *Doctor, Reread Your Oath*, L.A. TIMES, Dec. 8, 2004, at B11, available at <http://articles.latimes.com/2004/dec/08/opinion/oe-zitrin8>.

264. Yetter, *supra* note 260.

265. *Id.*

266. See Marcus K. Garner & Rhonda Cook, *Davis Being Prepared for Execution*, ATLANTA J.-CONST., Sept. 23, 2008, http://www.ajc.com/metro/content/metro/stories/2008/09/23/davis_execution_georgia.html.

assisting in the Davis execution.²⁶⁷ Death penalty opponents also urged people to write to the President of Rainbow Medical Associates, urging him not to allow his company to get involved.²⁶⁸

These are but a few examples of activism on the part of death penalty opponents.²⁶⁹ These actions share the goal of publicizing the medical profession's ethical guidelines and preventing or discouraging individual doctors from participating in executions.

2. Implications of Abolitionist Activism Against Physician Participation

As discussed in Part I, the argument that requiring physician participation will lead to abolition has surface appeal because of the vocal stance of the AMA and other medical associations,²⁷⁰ and because lawyers for the states, defending the lethal injection status quo, often take any available opportunity to suggest that the ethical guidelines of these associations serve as a practical barrier to physician participation. For example, when a federal judge proposed that a doctor perform Michael Morales's execution in California with a single drug—the anesthetic sodium pentothal—the state balked. “‘Nobody with a medical license could do this,’” said Dane Gillette, a senior assistant attorney general and the state's “death penalty coordinator.”²⁷¹

Mr. Gillette finds a strange bedfellow, though, with an organizations such as Death Penalty Focus (“DPF”), the leading California abolitionist group. DPF's Web site currently states that “[m]edical ethics preclude doctors from participating in executions” and links to a California Medical Association press release arguing, as

267. *See id.*

268. *See* Georgians for Alternatives to the Death Penalty, Troy Anthony Davis: Updates, <http://www.gfadp.org/News/TroyDavis/Updates/tabid/99/Default.aspx> (last visited Nov. 8, 2009) (“Please take a moment to send a letter . . . to Dr. Musso, president of Rainbow Medical Associates and ask him to remember his humanity and to NOT participate in the execution of a man who may be innocent.”).

269. Other abolitionists, for example, have sought to expose the identities of doctors who participate in executions, in the hopes that fear of public scorn would dissuade other doctors from volunteering to participate. As discussed in Part I.A.1, *supra*, these actions have typically led to legislative calls for stricter laws protecting the identities of executioners. *See generally* Ellyde Roko, Note, *Executioner Identities: Toward Recognizing a Right to Know Who Is Hiding Beneath the Hood*, 75 *FORDHAM L. REV.* 2791 (2007) (discussing the issues regarding identity disclosure of physicians who participate in executions).

270. *See supra* text accompanying notes 45–51.

271. Stacy Finz et al., *State Postpones Morales Execution*, S.F. *CHRON.*, Feb. 22, 2006, at A1, available at <http://www.sfgate.com/cgi-bin/article.cgi?file=/c/a/2006/02/22/MNGSUHCJFB1.DTL>.

did Mr. Gillette, that no doctor could carry out the judge's suggested execution procedure.²⁷² Abolitionist groups have pushed the message that doctors cannot participate in executions, in some ways as forcefully and vocally as lawyers for the states defending their lethal injection procedures. Though clearly with a different goal in mind, the abolitionists have been no less intentional about this activism. The goal with respect to physician participation is to discourage and ultimately prevent doctors from participating in executions,²⁷³ both as a way of halting individual executions²⁷⁴ and as a way of discrediting the entire enterprise of capital punishment.

Importantly, abolitionist groups have been protesting physician participation in executions for years, long before the recent spate of legal challenges to the administration of lethal injection.²⁷⁵ Unlike the states, abolitionists have not been made parties to pending litigation. Therefore, their public statements and actions related to the issue have not directly affected the outcome of any particular lethal injection case. The abolitionists' role in the debate is critical, though, to the extent that it has fostered, over the years, the public perception that doctors cannot participate in executions, a perception that state representatives have subsequently exploited in order to advance the twin myths about physician participation, and hence their litigation positions.

It is not difficult to see how this comes about. Lawyers for death row inmates, typically seen as "cause lawyers,"²⁷⁶ argue that as long as the states insist on using the three-drug formula, it is necessary for trained medical personnel to monitor the delivery and maintenance of anesthesia.²⁷⁷ In some cases, that will require the participation of a physician, and such a requirement should remain on the table as a

272. Press Release, Cal. Med. Ass'n, Cal. Med. Ass'n Sponsors Bill to Eliminate Physician Participation in Executions (Feb. 1, 2006), <http://www.cmanet.org/publicdoc.cfm/2/1/pressection2/353>.

273. See Campos, *supra* note 52 (discussing goals of Dr. Zitrin's activism).

274. See *supra* text accompanying notes 257–68.

275. See *supra* text accompanying note 237.

276. See, e.g., C. Lee Harrington, *Mental Competence and End-of-Life Decision Making: Death Row Volunteering and Euthanasia*, 29 J. HEALTH POL. POL'Y & L. 1109, 1140 (2004) ("The data reveal a considerable uniformity among this small community of cause lawyers, reflecting their common goal of ending capital punishment as it is currently practiced in the United States."); J.C. Oleson, *Swilling Hemlock: The Legal Ethics of Defending a Client Who Wishes to Volunteer for Execution*, 63 WASH. & LEE L. REV. 147, 163 (2006) ("[A]lmost all death-penalty attorneys are cause lawyers inasmuch as they oppose capital punishment."); cf. SISTER HELEN PREJEAN, *DEAD MAN WALKING* 112 (1993) (discussing need for lawyers with "passion" for the death penalty issue to represent death row inmates for little pay).

277. See *supra* text accompanying notes 33–37.

potential remedy. Abolitionists, on the other hand, have long targeted participating doctors for public scorn and professional discipline and have sought statutory revisions that would make participation illegal. If a judge were inclined to view death penalty lawyers and death penalty abolitionists as of a same piece, it would not be difficult to conclude that the lawyers' litigation position is a poorly disguised plan to create a Catch-22 that leads to abolition of the death penalty. Whether it is because the lawyers are seen as *being* abolitionists or because they are seen as being in cahoots with the abolitionists, the conclusion is the same: the remedy the lawyers are proposing should not be taken seriously.

It is no doubt true that many lawyers who represent death row inmates also consider themselves abolitionists. And there is a long history of lawyers' involvement in political and activist efforts to end the death penalty in this country and worldwide.²⁷⁸ In individual cases, lawyers have for decades raised claims alleging that various provisions of the Constitution prohibit the death penalty either altogether,²⁷⁹ in a particular state,²⁸⁰ or with respect to a particular class of defendants.²⁸¹ So it is accurate to suggest that, in many instances, death row litigators and anti-death penalty activists make common cause and at times work in concert with one another.

However, there is a critical difference between lawyers representing clients on death row and abolitionists advocating for the end of the death penalty; the former have a professional ethical obligation to their clients that does not end when the clients are

278. See, e.g., W.J. Michael Cody, Lecture, *The Death Penalty in America: Its Fairness and Morality*, 31 U. MEM. L. REV. 919, 919–35 (2001) (speaking from experience, the former Tennessee Attorney General advocating for abolition of the death penalty); Michael Mello, *Certain Blood for Uncertain Reasons: A Love Letter to the Vermont Legislature on Not Reinstating Capital Punishment*, 32 VT. L. REV. 765, 765 (2008) (putting forth a plea from long-time capital defense attorney to keep capital punishment off the books in Vermont); *Lawyers Push Ryan to Commute Death Sentences*, CHI. DAILY L. BULL., Nov. 20, 2002, at 6 (discussing letter signed by 671 lawyers urging Illinois Governor George Ryan to issue a blanket commutation of death sentences to life in prison without parole); Maurice Possley, *Lawyers Seek U.S. Pause of Executions*, WICHITA EAGLE, Oct. 29, 2007, at 1A (describing the American Bar Association's renewed call for a nationwide moratorium on the death penalty).

279. See, e.g., *Furman v. Georgia*, 408 U.S. 238, 239–40 (1972) (per curiam) (addressing claims that Eighth Amendment prohibits the death penalty in all instances).

280. See, e.g., *People v. LaValle*, 817 N.E.2d 341, 359 (N.Y. 2004) (agreeing with appellant that New York's statutorily mandated deadlock instruction was unconstitutional under the state constitution).

281. See, e.g., *Roper v. Simmons*, 543 U.S. 551, 553 (2005) (successful challenge to the execution of juveniles); *Atkins v. Virginia*, 536 U.S. 304, 321 (2002) (successful challenge to the execution of those with mental retardation).

strapped onto the gurney to be executed. At that moment, the lawyers must continue to vindicate their clients' rights, including the Eighth Amendment right not to be subjected to an execution procedure that is likely to involve excruciating pain and suffering. Even those attorneys who would, in other contexts, seek the abolition of the death penalty outright must in these instances have only one goal, and that is to represent the interests of their clients. With respect to the issue of physician participation, it is the lawyers' role—and their ethical duty—to seek whatever safeguards are necessary, including the participation of trained medical professionals, to protect their clients' rights to a humane execution.

The second myth about physician participation—that death row litigators are simply trying to back-door their way to abolition—presupposes a caricature of lawyers and abolitionists as one and the same entity. It is a caricature that has a basis in reality, but one that falters when the professional role of the lawyer is considered. For it is surely the case that the positions death row litigators take are sometimes at odds with the goals of the abolitionist movement.²⁸² This is particularly commonplace in the lethal injection context, where, as discussed in this Article, lawyers explicitly argue that it is possible to execute their clients in a humane manner.²⁸³

Some say that increasing physicians' role in executions will only further legitimize the institution of capital punishment.²⁸⁴ That may be so. But a lawyer who represents the person being executed cannot tell her client that she did not advocate for effective anesthetic monitoring because to do so would be damaging to the anti-death penalty movement. This nuance accounts for the lawyer's good faith argument for the involvement of qualified medical personnel on the execution team. But nuances are subtle. Caricatures, on the other hand, are easily exploited. The activism of abolitionists who campaign against physician participation has been so exploited and now in front of no less a court than the Supreme Court. Recall Justice Breyer's comment during oral argument in *Baze*: “[W]hat the other side says

282. For a particularly thoughtful discussion of the ethical questions raised by “cause lawyering” in the criminal defense (but not capital) context, see generally Margareth Etienne, *The Ethics of Cause Lawyering: An Empirical Examination of Criminal Defense Lawyers as Cause Lawyers*, 95 J. CRIM. L. & CRIMINOLOGY 1195 (2005).

283. See *supra* text accompanying notes 38–40; see also Denno, *supra* note 9, at 194–95 (discussing popular conflation of arguments against death penalty and arguments against lethal injection).

284. Denno, *supra* note 9, at 204 (“Some death penalty opponents believe . . . that enhancing the humaneness of an execution method may make executions far more acceptable scientifically and politically than ever before.”).

is, well, you're just trying to do this by the back door, insist upon a procedure that can't be used."²⁸⁵ Justice Breyer's opinion in *Baze*, in which he pointedly explained that "the lawfulness of the death penalty is not before us," confirmed that he was suspicious of the motives of petitioner's counsel.²⁸⁶ His colleagues' opinions in *Baze* confirmed that his suspicion was shared.²⁸⁷

CONCLUSION

The Supreme Court in *Baze* was concerned that Baze's attorneys were trying to "back door" their way into abolition of the death penalty. But there was no evidence in the *Baze* record to support this suspicion, and it was indeed unfounded. If anything, it is lawyers for the states who are using the back door, and they are using it to convince courts not to impose feasible remedies that would likely reduce all substantial risk of serious harm during lethal injection executions. They are doing so with the unwitting assistance of death penalty abolitionists, whose principled activism happens to undermine, in this context, the credibility of lawyers with whom they typically make common cause.

Courts grappling with how to implement *Baze* in the vast majority of states that permit physician participation should understand the truth about the ability of medical professionals to assist in the execution process. Consistent though they were, the Justices' references to physician participation in *Baze* were merely dicta.²⁸⁸ Physician participation was not actually at issue in that case, and the Justices' comments on the subject reflected the lack of information in the record. Given the problems of incompetent administration of lethal injection that have come to light,²⁸⁹ lower courts should critically examine the underpinnings of the leading Supreme Court opinion on the subject, particularly because the opinion appears to rule out a remedy for potential constitutional violations that is, in fact, both feasible and practical.

285. *Baze* Transcript, *supra* note 14, at 13.

286. *Baze v. Rees*, 128 S. Ct. 1520, 1567 (2008) (Breyer, J., concurring); *see supra* text accompanying notes 16–18.

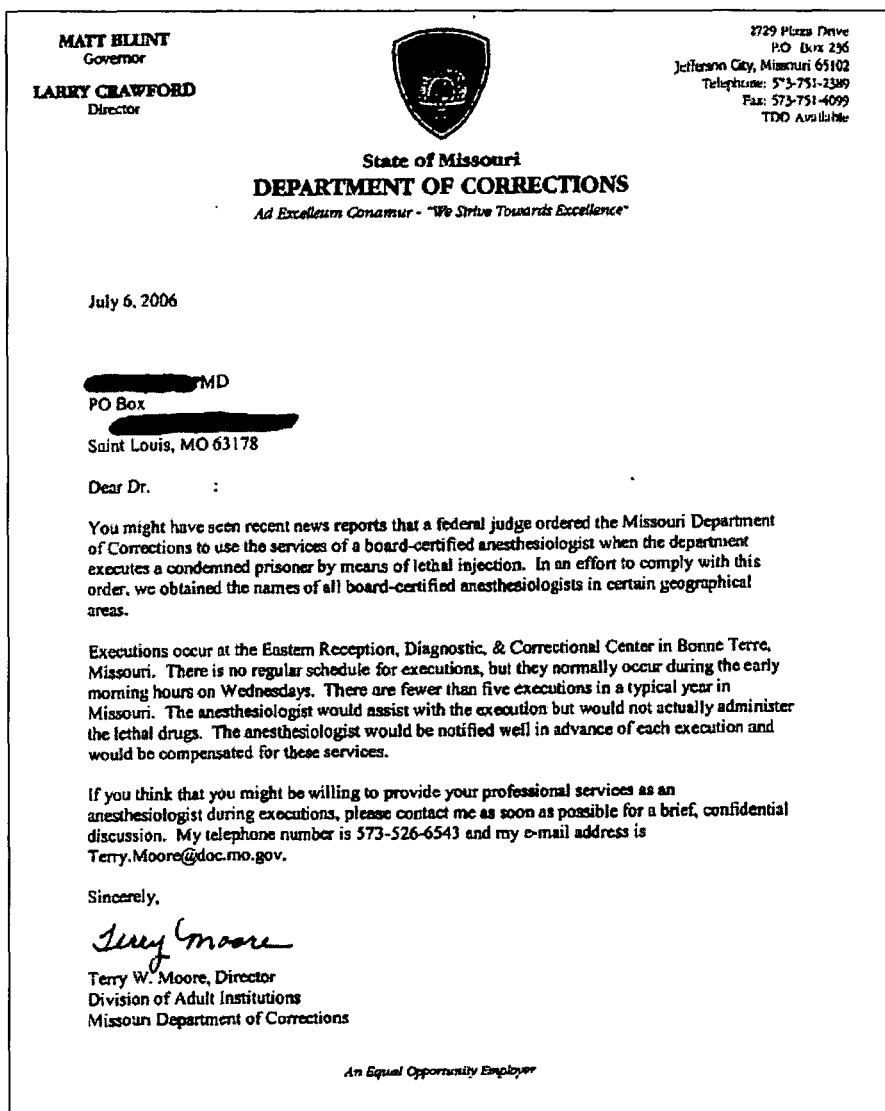
287. *See supra* text accompanying notes 19–20.

288. *See supra* text accompanying notes 19–20.

289. *See Denno, supra* note 28, at 107–16 (describing recent revelations of incompetent administration of lethal injection in several states).

APPENDIX A

Letter from Terry Moore, Director, Division of Adult Institutions, Missouri Department of Corrections, to 198 board-certified anesthesiologists in Missouri and Illinois, July 6, 2006.



APPENDIX B

Affidavit of Terry Moore, Director, Division of Adult Institutions, Missouri Department of Corrections, filed July 14, 2006.

**THE UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF MISSOURI
CENTRAL DIVISION**

MICHAEL ANTHONY TAYLOR,)

Plaintiff,)

v.)

Cause No. 05-4173-CV-W-FJG

LARRY CRAWFORD, et al.,)

Defendants.)

AFFIDAVIT OF TERRY MOORE

I, Terry Moore, being of lawful age and duly sworn upon my oath, state the following:

1. I am the Director of the Division of Adult Institutions within the Missouri Department of Corrections. As the Division Director, I oversee the operations at the Eastern Reception and Diagnostic Center, the correctional center where executions are carried out.

2. After receiving the court's June 26, 2006 order in this case, I directed my assistant to obtain the names and addresses of board-certified anesthesiologists in Missouri and southern Illinois. On July 6, 2006, we sent by first-class mail a letter to 298 anesthesiologists. A representative copy of that letter is attached. In the letter, I requested that the anesthesiologist contact me if he or she might be willing to provide services to the department.

3. Despite this attempt to obtain a board-certified anesthesiologist, to date no one has been retained.

Affiant states nothing further in *Michael Taylor v. Crawford, et. al* (05-4173-CV-W-FJG).

Terry Moore

Terry Moore, Division Director

County of Cole)
) ss
State of Missouri)

Subscribed and sworn to before me this 14th day of July 2006.

Tracy Clemm

Notary Public

My commission expires: 1-24-07



TRACY CLEMM
Notary Public - State of Missouri
COUNTY OF MONTEAU
My Commission Expires Jan. 24, 2007