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Physician Participation in Executions, the Morality of Capital Punishment, and the Practical Implications of Their Relationship

Paul Litton

Over the past several years, the most widely publicized issue in capital litigation has been the constitutional status of states' lethal injection protocols. Death row inmates have not challenged the constitutionality of lethal injection itself, but rather execution protocols and their potential for maladministration. The inmates' concern is due to the three-drug protocol used in the vast majority of capital jurisdictions: if the anesthetic, which is administered first, is ineffectively delivered, then the second and third drugs – the paralytic and heartbeat-ceasing agents – will cause torturous pain and suffering in violation of the Eight Amendment. Inmates have argued that the participation of anesthesiologists or other highly trained medical professionals is constitutionally required to minimize the risk of unnecessary suffering.¹ This litigation, in conjunction with evidence that some executed inmates suffered torturous pain, has reinvigorated the ethical debate about physician participation in executions. Even though the United States Supreme Court has signaled that physician participation is not constitutionally required,² lawmakers in death penalty states must consider the ethics of physician involvement.

For many years, commentators supported the ethical ban on physician participation reflected in professional ethics codes. However, a recent wave of scholarship concurs with inmate advocates, arguing that physicians should be required or at least permitted to participate to reduce the risk of unnecessary suffering.

With some exception, both the anti- and pro-physician-participation literature share a

common premise: the ethics of physician participation should be analyzed independently from the morality of the death penalty. Commentators on both sides agree that it is essential to separate the moral status of physician participation from whether the death penalty is a morally justified form of punishment. Many opponents of physician participation do not want their arguments dependent on a showing that the death penalty is immoral. Inmate advocates in favor of physician participation, though, view many grounds for objection as merely a “stalking horse” for abolishing the death penalty.³ As such they, too, claim that the morality of capital punishment is irrelevant.

This considerable literature on the ethics of physician participation in executions implausibly divorces the ethics of physician participation from the moral status of the death penalty. Any ethical position on physician involvement requires some judgment about the moral status of capital punishment. The moral status of the death penalty is not necessarily dispositive of the morality of physician involvement. Rather, capital punishment’s moral status is one important factor that must be considered within a complex ethical analysis of the ethics of physician participation. As I argue below, if the death penalty is immoral, physicians have reason not to be complicit in the practice, yet they could have reasons related to the inmate’s interest to participate. In evaluating the strength of relevant considerations and weighing them, it is essential to assess the extent to which the death penalty is immoral: *how* immoral or unjust is this practice, assuming it is? Likewise, if the death penalty is morally permissible or even required by justice, that fact would affect the reasons physicians have to participate. In fact, even though there could still be reasons counseling against physician participation, if the death penalty is required by justice, the case against physician involvement is seriously weakened.

Recognizing and appreciating the relationship between the morality of capital punishment

and the physician issue is practically important for multiple reasons. First, lawmakers considering the issue of physician involvement should understand the relevance of their opinion about capital punishment. The case against physician participation is weak if justice requires the law to have capital punishment as an option in some cases. Accordingly, the strength of the case against physician participation is dependent on whether capital punishment is morally unjustified or worse.

Second, the analysis provided herein can shed light on ethical issues surrounding physician participation in other controversial non-clinical care activities. Physician involvement in forensic psychiatry, military medicine, medical research, occupational medicine, as well as the death penalty, is controversial precisely because physicians and other health professionals generally aim to preserve and restore the health of individuals.⁴ The Hippocratic ethic famously enjoins physicians to “do no harm.” But forensic psychiatrists may testify that an individual should be detained for the good of others, even when such confinement harms that individual.⁵ A medical researcher can expose a patient-subject to some risk of harm for the good of others.⁶ Military doctors may have helped design harsh interrogation procedures employed in both Guantanamo and Iraq.⁷ Does it violate medical ethics for physicians to use their special skills to harm individuals to achieve a societal goal? Is it ethically permissible for physicians to harm individuals for societal interests within some institutional practices but not others? If so, what is the ethical difference between physician participation in those respective practices? This article aims to shed light on those questions by discussing physicians and executions. Too many ethical assessments assume that an appeal to Hippocratic ethics or generally accepted bioethical principles are sufficient. An adequate analysis of physician participation in a non-clinical-care activity is necessarily much more complex than commonly acknowledged. The ethics of

physician participation within a practice cannot be divorced from the moral status of that practice.

Background: Practices and Laws Governing Lethal Injection

Execution Protocols: The Drugs and the Risks

All death penalty states use lethal injection, though a few authorize other methods based on the date of sentence,⁸ the inmate's choice,⁹ or as a backup should lethal injection be held unconstitutional.¹⁰ According to a typical lethal injection protocol,¹¹ the execution team inserts a primary intravenous line, either as a peripheral (arms, legs, hands or feet) or central (neck, chest, or groin) venous line, and then, if possible, an additional peripheral line.¹² Saline solution is then sent through the lines to confirm proper functioning. If the department director approves, a barbiturate - either sodium thiopental or pentobarbital¹³ - is injected through the lines, followed by more saline solution. After at least three minutes from the start of the barbiturate injection and after the team confirms the inmate is unconscious, a team member injects pancuronium bromide, a paralytic agent, followed again by saline solution. Finally, a team member injects potassium chloride to stop the inmate's heart. If the electrocardiograph, attached to the prisoner's chest detects electrical activity after five minutes, additional potassium chloride is sent through the prisoner.

In constitutional litigation regarding, death row inmates have asked for required involvement of a physician or other highly trained medical professional because of the risk of suffering.¹⁴ If the first drug is delivered inadequately, the pancuronium bromide will cause paralysis, and the inmate will be consciously aware while suffocating and unable to communicate. The Supreme Court stated that "[i]t is uncontested that, failing a proper dose of

[the barbiturate] that would render the prisoner unconscious, there is a substantial, constitutionally unacceptable risk of suffocation from the administration of pancuronium bromide and pain from the injection of potassium chloride.”¹⁵

If the procedure is administered correctly, the unconscious inmate will not feel the effects of the second and third drugs. However, potential problems can cause inadequate delivery of the anesthesia. First, a team member must correctly mix the anesthetic solution. Multiple powder kits of the barbiturate must be mixed separately with solution and drawn to multiple syringes.¹⁶ Inappropriate concentrations can cause inadequate anesthetization.¹⁷ Members of California’s execution team admitted in testimony that when mixing the drugs they “fail[ed] to follow the simple directions provided by the manufacturer of sodium thiopental.”¹⁸ According to the federal district court, this admission “complicate[d] [its] inquiry as to whether inmates being executed have been sufficiently anesthetized.”¹⁹

Second, if the intravenous catheter is incorrectly inserted or becomes dislodged, the inmate might not be rendered unconscious by the barbiturate, yet the pancuronium bromide will have its intended paralytic effect if delivered subcutaneously or intramuscularly.²⁰ The risk of improper catheter placement and consequent infiltration into surrounding tissue is particularly worrisome with some inmates whose veins have been damaged by drug addiction.²¹ Moreover, the catheter could “blow out” if the drugs are delivered too quickly, with too much force;²² different drugs have different proper delivery rates.²³

Risks to the inmate are more serious where the personnel monitoring his consciousness are unable to assess anesthetic depth competently because they lack training.²⁴ During the *Baze v. Rees* litigation, the Kentucky prison warden who monitors inmates during execution “candidly admitted: ‘I honestly don’t know what you’d look for.’”²⁵ Other commentary and court opinions

discuss additional potential problems.²⁶ However, our discussion thus far provides sufficient reason to see why Justice Alito observed that the participation of medical professionals trained in anesthesia would minimize the risk of unnecessary pain.²⁷ A well-trained anesthesiologist will have significant experience and expertise in drug preparation, catheter insertion, drug delivery, and consciousness monitoring.

To eliminate the risk of suffocation and torturous pain, a handful of states have eliminated pancuronium bromide and potassium chloride, choosing to execute with a barbiturate overdose.²⁸ The remainder of this article, though, will assume a three-drug protocol when discussing lethal injection. A switch to a one-drug protocol could affect the ethical analysis of physician participation. To illustrate, one might argue that with a three-drug protocol, a physician participates not to kill but to ensure proper anesthesia delivery; but with a one-drug protocol, the distinction collapses between delivering anesthesia and the death-causing drug. But we will assume a three-drug protocol for two reasons: first, the vast majority of capital jurisdictions maintain it;²⁹ and second, assessing that context should be fruitful to reflection on general moral criteria for physician participation in other non-clinical-care activities, such as forensic psychiatry and military interrogations.

Physician Participation: Current Codes, Laws, and Practices

The American Medical Association (AMA), World Medical Association, General Assembly, American College of Physicians, American Public Health Association, and American Society of Anesthesiologists all condemn physician participation.³⁰ The American Nurses Association, the American Academy of Physician Assistants, and the National Association of Emergency Medical Technicians also concur with respect to their respective professions.³¹ According to the

AMA, participation includes any act which would directly cause death, would assist or supervise another person in directly causing death, or could “automatically cause an execution to be carried out.”³² Specifically, the AMA Code of Ethics prohibits prescribing the drugs, choosing injection sites, inserting the IV line, inspecting the lethal injection equipment, monitoring the inmate’s vital signs, and consulting and advising the execution team.

Despite the position of medical societies, physicians and other health professionals do participate. State laws permit or require the participation of medical professionals, and members of the medical community do not unanimously share the ethical position of professional societies. Regarding state laws, Professor Deborah Denno published research in 2007 on the extent to which laws in capital jurisdictions permit, require, or prohibit physician involvement.³³ According to her findings, adjusted slightly for the subsequent abolishment of the death penalty in New Jersey, New Mexico, and Illinois, more than half of death penalty statutory schemes contemplate the potential presence of a physician at an execution, and more than 40 percent state that a physician shall pronounce or certify death.³⁴ Many states also protect physicians who participate from state medical board disciplinary action.³⁵ Even where physicians are not required, states employ other medical professionals whose professional organizations also condemn involvement.³⁶

Therefore, it should not surprise that physicians are participating.³⁷ During litigation in 2008, Missouri’s Department of Corrections informed the court that its execution team includes an anesthesiologist.³⁸ In Alabama litigation, an affidavit submitted by the senior warden in charge of executions verified that a “medical doctor is on hand to establish a central venous catheter” in case EMTs are unable to establish a peripheral live.³⁹ Atul Gawande’s well-known article in the *New England Journal of Medicine* reports interviews with three doctors and a nurse

who admitted (all anonymously except for one) to participation.⁴⁰ In addition, doctors have testified in proceedings regarding the efficacy of the drugs,⁴¹ which arguably violates the AMA's prohibition on actions "which would assist ... the ability of another individual to directly cause the death."⁴² The litigation regarding execution protocols has reinvigorated the ethical debate about physician participation, to which we now turn.

The Standard Medical Ethics Approach: Separating the Issues

The AMA maintains that its ethical rejection of physician participation is not based on any condemnation of capital punishment. It deems the death penalty's moral status irrelevant to the physician issue:

An individual's opinion on capital punishment is the personal moral decision of the individual. A physician, as a member of a profession dedicated to preserving life when there is hope of doing so, should not be a participant in an execution.⁴³

The AMA claims that even if an individual doctor thinks the death penalty is required by justice, she should nonetheless conclude that her involvement would be immoral. In 1994, the American College of Physicians and Physicians for Human Rights co-authored with two other organizations a report which condemned physician participation.⁴⁴ The first page states explicitly that each co-authoring organization "has different viewpoints on the death penalty itself, and all members agreed that this report would not take a position supporting or opposing capital punishment."⁴⁵ Similarly, the president of the American Society of Anesthesiologists, in a letter to its members, stated that his subject was "the involvement of anesthesiologists in lethal injections[,] ... NOT what [anyone] think[s] about the morality or legality of capital punishment"⁴⁶

Standard academic commentary also sets aside the morality of capital punishment. For

example, Robert Truog and Troyen Brennan identify their goal as “develop[ing] arguments against participation by physicians that are independent of arguments about the morality of capital punishment itself.”⁴⁷ Writing more recently, David Waisel argues in favor of physician participation but follows his opponents and other commentators in tabling the morality of capital punishment. He acknowledges moral issues surrounding the death penalty, including whether it is distributed fairly, but deems them “beyond the scope” of his article; his only purpose “is to address physician participation in . . . lethal injection.”⁴⁸ In a 2011 article, Lawrence Nelson and Brandon Ashby argue that professional organizations should allow each individual physician to decide for herself whether to participate, and in doing so, Nelson and Ashby deem it crucial to table the morality of capital punishment: “Unfortunately, the debate about the ethics of physician participation in executions has been thrown into confusion by the failure to separate this issue from the ethical propriety of the death penalty itself.”⁴⁹ This standard approach to the ethics of physician participation deems the moral status of executions normatively irrelevant.

Nelson and Ashby are right that some commentators have rebuffed the standard approach, resting their conclusions about physician participation – usually in opposition – based on their views about the death penalty. Robert Veatch argues for a position diametrically opposed to the standard approach: normatively, the moral status of the non-clinical practice – whether capital punishment, forensic psychiatry, or other – is everything. Whether physicians may ethically participate “is surely settled by resolving the more fundamental societal moral question – the morality of capital punishment itself.”⁵⁰ Arthur Caplan, too, writes that the ethics of physician participation depends on “where, how, and for what reasons the death penalty is being carried out.”⁵¹

Though Veatch is right that the moral status of capital punishment is normatively

significant, I will argue that it is not necessarily dispositive. The ethics of physician participation in executions and other non-clinical care activities is *complex*, and the right approach resides in between the standard view and Veatch's. To establish that claim, this article will examine anti- and pro-participation arguments to show that each one either is unpersuasive without discussion of the death penalty's moral status or implicitly assumes a view on the social worth of the death penalty.

Assessing Arguments Against Physician Participation

Respecting the Prisoner

The core of medical professional ethics requires physicians to provide competent medical service while exhibiting compassion and respect for human life and dignity.⁵² The World Medical Association claims that physician participation violates these core obligations. Peter Clark agrees, adding that physician involvement “violates the principle of respect for persons by denying individuals, who at this stage are the most vulnerable, of their basic dignity and respect.”⁵³

But the practical requirements of compassion and respect for persons, human life, and dignity are not so clear in this context for physicians. A physician may reasonably claim that her participation is motivated precisely by her respect for the inmate as a person and his dignity. Carlo Musso, a physician who opposes capital punishment yet has participated in executions,⁵⁴ reasonably claims that refusal to participate represents an abandonment of a dying patient.⁵⁵ The inmate's vulnerability requires, not prohibits, a physician to ensure a painless death. In fact, Clark's statement acknowledges that the inmate, nearing execution, is in this vulnerable position *before* the doctor enters the picture. Thus, Musso plausibly asserts that the question is whether a

doctor can help this vulnerable person, and the answer is yes: she can minimize the risk of unnecessary suffering.⁵⁶ In addition, an inmate's mere knowledge of a physician's presence might bring some mental comfort.

Nevertheless, opponents of physician involvement are not persuaded that a physician's admirable motivation justifies involvement. In their view, motivation is irrelevant because the outcome of the procedure – death – is contrary to the inmate's interests. For instance, Lee Black and Hilary Fairbrother, members of the AMA's Council on Ethical and Judicial Affairs [the "Council"], recently write, "Actions that directly and intentionally lead to the death of a patient, even one who is required by the state to die, contravene [physicians' obligation to promote the health of their patients]."⁵⁷

However, causing death, by itself, cannot be determinative. Withdrawing life-sustaining treatment causes death and, depending on the circumstances, can be ethically permissible. The Council attempts to ethically distinguish the death penalty context from withdrawal of life support:

First, although death may ensue from the physician's actions, the individual patient is voluntarily choosing to risk death upon the withdrawal or withholding of care. With capital punishment, the physician is causing death against the will of the individual. Second, when life-sustaining treatment is discontinued, the patient's death is caused primarily by the underlying disease; with capital punishment, the lethal injection causes the prisoner's death.⁵⁸

The first response regards the respect owed to the inmate as a person, but is unpersuasive. Its premise is that a dying patient may voluntarily choose to cease treatment but a condemned inmate does not choose execution. That is true, but the analogy is inapposite. The dying patient has not chosen her disease but chooses to ask her physician to withhold treatment. The condemned inmate has not chosen execution but could choose to ask a physician to monitor his

consciousness. In the patient scenario, the disease is a given, a background condition to her choice; in the inmate scenario, the sentence is given, a background condition to his possible choice, if the state were to grant a choice. The fact that current law does not permit the inmate to make such a choice does not resuscitate the AMA's absolutist position against physician participation. Here is a simple response: let the inmate choose to have a physician present. The execution would be perfectly analogous to the patient's disease, and both the patient and inmate would voluntarily choose whether a physician intervenes in a manner the patient or inmate finds beneficial. The AMA's argument does not require an ethical ban on involvement, but rather speaks in favor of prisoner choice.

Nevertheless, an opponent of physician participation might respond that what matters is not whether the physician's involvement would reduce the risk of unnecessary harm; rather, physicians may not participate in any practice or procedure that is, *overall*, contrary to the individual's interests. Because the end-result of the procedure is contrary to the inmate's interests, the rejoinder maintains, physicians must not participate at all. But if a physician actually demonstrates respect for an individual inmate with a desire to reduce the risk of suffering, why is the procedure's end-result determinative? What could justify a prohibition on participating in such a practice? Let us first turn to the AMA's second argument.

Causing No Harm: The "Primary Cause" of Death

Trying to distinguish the life-support withdrawal from lethal injection, the AMA argues that a disease is the *primary* cause of death for the patient refusing treatment, whereas lethal injection is the primary cause of the inmate's death. This assertion also should fail to persuade. The notion of a *primary* or *direct*⁵⁹ cause cannot do the moral work the AMA intends for it. The notion of a

primary cause here rings of the tort and criminal law notion of a *proximate* or *legal* cause. The idea is that some cause, among the infinite set of but-for causes of an event, should have some special significance for assigning responsibility.⁶⁰ But, like the identification of a proximate cause in criminal or tort law, the designation of one cause as “primary” relative to the infinite set of an event’s other causes, is dependent on a moral or policy judgment. Imagine two patients with the same disease, receiving life-sustaining interventions. One patient requests her physician to cease treatment, and, after proper deliberation and procedures, the physician grants her request. The second patient wants treatment, but a malicious physician removes her life-sustaining intervention without consent. In both cases the underlying disease *and* the physician’s act of ceasing treatment were but-for causes of death. Which cause of death was “primary” in each scenario? If one is tempted to say that the disease was the primary cause of death in the first scenario, one should be tempted to reach the same conclusion in the second, assuming one refrains from appealing to a moral assessment of the physicians’ respective actions. On what basis could we identify the disease as the primary cause of death in the first scenario but the physician’s act in the second? The basis would be our judgment that the physician in the second scenario violated her obligations to the patient. The “primary cause” analysis is informed by our views regarding the physician’s ethical duties.

Let us return to the execution context and stipulate that a physician’s participation would qualify as a but-for cause of death. Now ask whether the primary cause of death was the inmate’s sentence (along with the intent of state actors to carry it out), the lethal injection, or the involvement of a physician whose intention is to minimize the risk of pain? Any answer to that question is necessarily colored by an opinion about the physician’s obligations. To say that the physician’s involvement in the lethal injection is the primary cause of death is to already assume

a moral view about the physician's obligations. As such, the "primary cause" notion cannot do any moral work in establishing the physician's moral obligation to refrain from participation.

"This Is Not a Medical Procedure"

Many arguments regarding physician participation in controversial non-clinical-care settings share an interesting premise: that the controversial use of medical skills and knowledge does not count as the practice of medicine. Others argue similarly that when using her skills for a social purpose, the physician does not act *as* a physician.⁶¹ Strangely, commentators draw opposing conclusions from these premises. To some, the premises imply that physicians *may* participate, even if their skills are used to harm an individual. For these commentators, lethal injection's status outside medical practice does not make it unethical; its non-medical status implies that the Hippocratic ethic is inapplicable. Jay Chapman, the Oklahoma physician who fathered current lethal injection protocols, made this exact argument.⁶² Similarly, David Tornberg, Secretary of Defense for Health Affairs, argues that military physicians who help devise interrogation techniques do not breach medical ethics because they "act as combatants, not physicians, when they put their knowledge to use for military ends."⁶³

Opposing commentators argue that physicians may *not* participate if the controversial activity is outside medical practice because physician skills may not be employed for non-medical purposes. For example, the American College of Physicians and its institutional co-authors condemn physician involvement because "execution is not a medical procedure, and is not within the scope of medical practice."⁶⁴ Linda Emanuel and Leigh Bienen state, "Execution facilities are chillingly clinical in appearance, but lethal injection is no more a medical procedure than is killing with a knife or a gun."⁶⁵ Truog and Brennan argue similarly, asserting that an

execution “lies far outside the medical sphere.”⁶⁶

Why would these commentators describe lethal injection as a non-medical procedure? After all, as Emanuel and Bienen observe, much about the setting *looks* medical: syringes, intravenous lines, drugs, and, often, medical professionals. Plus, the reason physicians are asked to participate is because they possess *medical* skills and knowledge and, perhaps, the “cultural authority” that accompanies them.⁶⁷ Let us assess two proposals that could explain the claim that physician participation is unethical because it is non-medical.

An Alleged Morality Internal to Medicine

Edmund Pellegrino offers one response. He famously argues that the essence of medicine is defined by the good at which it aims, which, on his account, is healing. We perceive medicine’s essence when we reflect upon the clinical encounter where the lives of the vulnerable patient and knowledgeable physician intersect. According to Pellegrino, whether the goals for which we use medicine “are morally good or bad ... depends upon whether they fulfill the ends for which medicine exists and which define it qua medicine.”⁶⁸ When the “ends, purposes, and goals” of a proposed use of medical knowledge conflict, they “can only be resolved by reference to a primary defining good, which takes priority over other goods.”⁶⁹ On his view, the obligations rooted in the universal essence of medicine cannot be sacrificed for other values or goods. Thus, when discussing physician participation in an execution, Pellegrino argues that even if (a) a physician and inmate have had an ongoing relationship, (b) the inmate requests that the physician administer the lethal injection, and (c) the inmate would view the doctor’s participation as beneficent, the physician would have a duty to refuse because “the act of killing controverts the healing purposes of medicine.”⁷⁰ Perhaps Black and Fairbrother hold a similar view of medical

ethics in arguing that physician participation is wrongful because it “contravenes their training[,]”⁷¹ the focus of which is healing and promoting health.

However, neither the Pellegrino nor Black-Fairbrother view can sustain an ethical prohibition against physician participation. Reducing the risk of suffering is also an uncontroversial goal of medicine and object of medical training.⁷² When an orthopedist sets a broken bone, she will first administer anesthesia to reduce the risk of suffering. The anesthesia is not necessary for healing. If it is fair to describe the prison physician’s conduct as fulfilling one end of medicine (reducing the risk of suffering) *and* conflicting with another end (healing), reflection on the nature or essence of medicine and medical training will not reveal whether participation is ethical.⁷³ Physician participation in non-clinical-care activities raises difficult ethical questions precisely because they involve “different principles, all of which are internal to the role of the physician [and] come into conflict.”⁷⁴

Moreover, medical services and technology are used for non-healing purposes in numerous contexts⁷⁵ which do not provoke the same moral outcry as physicians involved in executions. First, medical services and technology are used in research purely to measure study outcomes, not to heal or promote the health of individual research participants. In fact, administering a non-therapeutic research intervention is arguably worse than participation in an execution if evaluated according to medicine’s “essence”: the non-therapeutic intervention is not motivated by a desire to heal or reduce a risk of pain; and because the research setting is similar to clinical care, it often causes the therapeutic misconception.⁷⁶ Condemned inmates, on the other hand, have no misconception regarding the purpose of the lethal injection procedure. Second, consider forensic psychiatry. Imagine a capital defendant who wishes to offer mitigating evidence that he suffered from a serious mental impairment at the time of his crime. A forensic

psychiatrist can use her medical training to examine this defendant, then testify that the proffered mitigating circumstance is unsubstantiated.⁷⁷ The psychiatric examination had no healing purpose, and its outcome ultimately harmed the defendant.

Pellegrino's account – in some parts of his writings – of what makes a physician act unethical seems mistaken. On his account, what makes a physician act wrongful is that it that it conflicts with the universal essence of medicine. However, his view cannot account for the truth that when a physician violates a patient's legitimate expectations, the physician has not only done something wrong, but has *wronged the patient*. What makes a physician's violation of trust *wrongful* is that it disrespects the patient's value as a person, as one *to whom a duty was owed*. Common moral principles regarding promise-keeping and meeting others' legitimate expectations justify this conclusion. But, despite Pellegrino's apt description of the clinical encounter, he often denies that the wrongfulness of such acts is explained by their violation of common moral principles (such as "one should keep one's promises" and "one should not exploit others' vulnerabilities").⁷⁸ He argues that the foundation of a physician's duties cannot be adequately justified by Kantian considerations regarding the patient's value as a person.⁷⁹ Rather, Pellegrino argues, the source of medical ethical duties is "in the nature of [medical] professions, in what is distinctive about them and the good at which they aim."⁸⁰ But the implication is that the feature of a physician's wrongful act which makes it wrongful is that it conflicts with some Platonic essence of medicine, as if something were owed to medicine's essential nature.

In other parts of his work, Pellegrino offers a more plausible basis for the Hippocratic ethic: "The vulnerability of the patient, and the trust patients must ultimately place in the physician's skill, are the foundation for the obligation to be competent in performance as well as in knowledge."⁸¹ On this more plausible account, the Hippocratic ethic is justified by the general

moral obligation to respect persons, applied to the specific context in which vulnerable persons legitimately expect a physician's good will. In light of our earlier observation though, the respect owed to a death-sentenced inmate does not justify an absolute prohibition on participation: the physician can respect the inmate by trying to reduce the risk of pain.

Acting in the State's, Not Individual's, Interests

Other opponents of physician participation describe lethal injection as "non-medical" because it is performed for the state's interests, not the individual's. Truog and Brennan find physician participation "outside the medical sphere" and offensive to medicine's sense of community because it "prostitut[es] medical knowledge and skills to serve the purposes of the state and its criminal justice system."⁸² Elsewhere, Pellegrino echoes these sentiments, arguing that a physician may not participate because the injection serves the state's and not the patient's interest.⁸³

The question, then, is why may not a physician use her skills to advance a state or societal interest? Should societal or state interests have no weight in reasoning about physician obligations?

Let us start with the observation that even in clinical care settings, societal interests provide physicians with reasons to limit their pursuit of patient best interests.⁸⁴ For example, a physician must consider the growing societal danger posed by antibiotic-resistant bacteria in formulating her policy for antibiotic prescriptions.⁸⁵ A psychiatrist may have a moral and legal duty to sacrifice a patient's confidentiality and chances for psychiatric improvement in order to protect an identifiable third party.⁸⁶ Doctors and other medical professionals also have legal duties to report child or elder abuse even if knowledge of that abuse was obtained through

interaction with a non-victim patient and disclosure contravenes the patient's interests. The law also imposes on medical professionals a duty to report certain infectious diseases even though such disclosure breaks patient confidentiality and is, presumably, not in the best interests of a patient.⁸⁷

One might object that these observations are irrelevant to the ethics of physician involvement in executions for the following reasons: First, the examples involve physician policies aimed at improving or maintaining *health*; not the health of each individual patient, but the physical health of society. Overprescribing antibiotics threatens public health. Second, these examples only demonstrate *limits* to physician obligations. They are consistent with an ethical orientation towards maximizing patients' best interests and do not show that doctors may use their skills primarily for a societal interest.

The first objection essentially states that only the promotion of societal health may limit a physician's duty to optimize a patient's best interests. Why is public health the only legitimate limit? Clearly, physicians' primary role in society is to protect and restore health. But this fact does not imply that non-health-related reasons should have no purchase on physician decisions and obligations. Indeed, we accept many non-health-related reasons as legitimate limits on a physician's duty of patient loyalty. First, consider their reason not to prescribe extravagantly expensive therapies accompanied by little expected benefit. This reason exists even though it is not solely about health. Cost is important regardless of whether savings are used to advance health. Second, a physician's personal interests, unrelated to promoting health, represent legitimate limits to the duty of patient loyalty. As David Wendler points out, "physicians do get to retire, take vacations and have days off, even when doing so is not in the interests of their present patients."⁸⁸ On a given day, a physician could be quite able to continue providing high-

quality care to her patients yet have strong family-related reasons to leave the hospital. She needs to find a colleague to cover her patients, but the risk of medical error rises when shift changes take place. The coverage change is not in the *best* interests of the physician's patients, yet ethically acceptable. This point may seem obvious, but its implications are important: despite lofty talk of physicians' duty to individual patients and health in general, we plainly accept non-health-related reasons as relevant to the scope of physician obligations.

The second objection was that examples involving antibiotics and duties to report abuse and infectious diseases only justify limits on a physician's pursuit of a patient's best interests; they do not justify use of medical skills for societal purposes. This objection either ignores that physicians have other practical identities besides "physician" or insists that their identity as physician must always trump their other practical identities. Physicians are also spouses, parents, adult children of their parents, friends, co-workers, community members, and citizens. Each role entails its own obligations and responsibilities. A physician's practical identities as caretaker-of-patient and citizen can produce conflict. Other professionals have no choice but to grapple with moral conflict among their professional, familial, and citizen identities. We should be suspicious of a claim that spares physicians this inevitable aspect of moral life by insisting that their identity as caretaker-of-patient always trumps their other identities.

Now stipulate for argument's sake that the death penalty is morally justified because it effectively deters homicides more effectively than other means. If a physician has the social obligation to report an infectious disease to preserve public health even though the report provides no direct benefit to the relevant patient, then participation in a lethal injection protocol could be less ethically problematic: the physician would be serving the public good (according to our stipulation) by lending physician's cultural authority to the procedure, *and* bestowing at least

some benefit on the condemned inmate (reducing the risk of suffering). In addition, if societal interests can justify limits on the pursuit of patient best interests, then it is reasonable that a societal interest could be so strong as to require or permit a physician to use her skills for advancing that societal interest (assuming certain conditions hold, such as the state interest is legitimate). Our society and the medical profession do, in fact, accept physician use of medical skills for societal purposes, even when they use those skills directly on individuals. In the next sub-section, I argue that medical research represents one such context and emphasize the normative significance of the worth of medical research in justifying physician participation. The aim of the discussion is to demonstrate the normative significance of the alleged purpose of capital punishment to the ethics of physician participation in lethal injection.

Normative Significance of the Goal of the Non-Clinical-Care Activity

(a) Human subjects research

Physicians and other health professionals conduct human subjects research. The purpose of research is to produce generalizable knowledge about health, conditions and illnesses, and the safety and effectiveness of therapies and diagnostic instruments, with hopes of improving medical care for future patients.⁸⁹ The practice of clinical research is not the documentation of findings in clinical care interactions. As explained below, research does not embrace the Hippocratic ethical orientation. Is it morally permissible for physicians and other health professionals to engage in clinical research? The socially valuable goals of medical research and the important role that doctors play in pursuing its goals are normatively significant for determining the ethics of physician participation in the practice.

First, note crucial differences between medical research and clinical care. Because the

purpose of research is to produce generalizable knowledge, physicians necessarily treat patient-subjects differently than clinical care patients. In clinical care, a doctor orders treatments and diagnostic tests for an individual patient based on the needs and characteristics of that individual. The physician's duty is to tailor the course of treatment or series of diagnostic measures according to the individual's needs.⁹⁰ In research, however, valid scientific results require controlled experimentation, which implies that a protocol's scientific design determines treatment and diagnostic measures, often precluding individualized tailoring.⁹¹ To secure scientifically valid results, some protocols limit treatments to those prescribed by protocol regardless of whether an individual patient-subject's well-being would be maximized by a tailored course of treatment.⁹² In addition, protocols often require patient-subjects to undergo non-therapeutic procedures that are necessary to measure study outcomes yet present pain and/or risk of other harm, even though such procedures are not clinically indicated for each patient-subject.⁹³ In clinical care, a physician may perform or recommend a lumbar puncture, biopsy, CT scan, or other medical procedure only if its risks are outweighed by potential benefit to the patient. But in research, these procedures are used for scientific purposes without contribution to the patient-subjects' well-being. Even in therapeutic research, doctors expose patient-subjects to risks that are for the good of society, not to benefit the individual.

Yet professional medical organizations do not call for physicians to halt clinical research. Moreover, law permits exposing patient-subjects to limited risk for the good of others. The federal regulations state that to approve research, an institutional review board must find that "[r]isks to subjects are reasonable in relation to anticipated benefits, if any, to subjects, *and the importance of the knowledge that may reasonably be expected to result.*"⁹⁴ In other words, research is approvable even if it presents risks to patient-subjects that are not outweighed by

potential direct benefit to its patient-subjects; the importance of generalizable knowledge is placed on the benefit side of the scales.

Why is physician participation in this activity morally justified? We need to explain why the Hippocratic ethic does not bind physician-researchers in the research setting.

Any satisfactory answer must begin, though not end, with recognizing the distinct and normatively significant goal of research.⁹⁵ The production of generalizable medical knowledge has great social value, which provides powerful reason to search for an ethically acceptable way for physicians to pursue that goal while respecting patient-subjects and safeguarding the medical profession's primary identity. Regardless of whether exposing persons to some research risks for the good of others is ultimately justifiable, it is crucial to recognize why we have good reason to articulate ethical principles for physician-researchers that deviate from the Hippocratic ethic. We have good reasons to permit physicians to expose patient-subjects to some limited and reasonable risk in research because of (a) the significant social value of generalizable medical knowledge, the goal of research, and (b) the significant social value of having physicians involved in the production of that end.

If pursuing the goals of research cannot be done without disrespecting patient-subjects as persons, then physician-researchers may not deviate from the Hippocratic ethic. However, as it turns out, it is ethically acceptable for physician-researchers to expose patient-subjects, in many circumstances, to some limited risk for the good of others. A distinct set of ethical standards for research exists that is sufficient for respecting patient-subjects without endangering physicians' core identity. Though we cannot and need not detail here all obligations owed to patient-subjects, they include duties which aim to protect patient-subjects from exploitation and unjustifiable harm:⁹⁶ Physician-researchers must minimize risks to patient-subjects and ensure that those risks

are proportionate to the potential benefits to them and society. Accordingly, physician-researchers must protect patient-subjects from risks that are unnecessary for answering a socially valuable and scientifically important question. To respect the autonomy of potential patient-subjects, physician-investigators must disclose conflicts of interest and provide true and digestible information about the protocol, including its purpose, potential risks and benefits, and alternatives in the clinical care settings. Physician-researchers must invite potential patient-subjects based on scientific objectives, not on vulnerability or privilege. These and other obligations demonstrate a respectful stance towards research participants without binding investigators to the Hippocratic ethic.

Implications for Physicians and Lethal Injection

The great social value of research and of having physicians participate are normatively significant: they provide strong reason to divorce the ethics of research from the ethics of clinical care, given that the latter would prohibit physicians from involvement in many valuable protocols. Accordingly, to see the connection between the ethics of physician participation in executions and the morality of capital punishment, let us stipulate again that the practice of capital punishment has great social value, whether because it is required by justice, reduces the number of murder victims better than other deterrents, or both.⁹⁷ Moreover, let us stipulate that it is valuable to have physicians involved in lethal injection because physicians do reduce the risk of undue suffering.

These stipulations, if true, would significantly strengthen the case for physician involvement. They provide good reason to construe the ethics of physician involvement differently than the ethics of clinical care. As with medical research, though, we would have to

determine whether physician involvement is consistent with the duties owed to the condemned prisoners. Our earlier discussion is relevant here. Assuming (based on the stipulation) that the execution itself does not violate the inmate's rights, then physician participation, aimed at reducing his risk of suffering, would not disrespect the prisoner, unless, perhaps, the inmate did not want a physician involved.

One might object that intentionally exposing a research subject to risks posed by non-clinically-indicated biopsies, lumbar puncture, or other research risks is morally distant from participating in a practice that deliberately kills. Administering a lethal injection intentionally is different than intentionally exposing someone to a low risk of serious harm. But one point of our discussion of clinical research is that *if* the practice of punishment is of great social value and morally justified, physicians need not construe the practice's goal as "killing" any more than they should construe medical research's goal as "exposing people to risks that are not in their best self-interest to bear." The important goal of research is to produce valuable knowledge. The (stipulated) important goal of the practice of lethal injection would be to serve justice, save innocent lives, or whatever end allegedly justifies its existence.

The objection, though, is worth contemplating further. It highlights that it would be more difficult psychologically for physicians, on average, to administer a lethal injection than a non-clinically-indicated biopsy, given the way physicians are socialized by the profession. That physicians are trained to adhere to the Hippocratic ethic is good for society. But the fortunate fact that physicians generally would find it more difficult psychologically to administer a lethal injection only speaks in favor of not requiring any particular doctor to participate. No law or institution should ever force a physician to provide his or her skills to an execution. Not requiring a particular physician to participate is different than permitting doctors to do so.

Doctors' Cultural Authority and the Morality of Capital Punishment

The morality of capital punishment is also relevant to the ethical stance against physician participation because of concern that physician presence adds legitimacy to the practice.

Jonathan Groner, an opponent of physician participation, argues that medicalization of executions legitimizes the practice in the same disturbing way that “[m]edicalization allowed Nazi physicians – and ordinary citizens – to endorse the necessity of killing.”⁹⁸ Groner cites a Nazi doctor who claimed that some people represent a “gangrenous appendix in the body of mankind,” and therefore must be removed.⁹⁹ A California court argued similarly that a murderer is a “cancer on society” that must be surgically eliminated.¹⁰⁰ Groner realizes that these rationalizations offered by the Nazis and the court “are ... used to justify capital punishment, regardless of the execution method.”¹⁰¹ His argument against physician involvement is that

lethal injection, because of its medical appearance, has made this type of reasoning more compelling. Physicians who participate in lethal injection could argue that the procedure is clinical and therefore humane to the prisoner, and, for the victim’s family and community, it relieves pain, ends suffering, and brings healing and closure.¹⁰²

Let us concede that physician participation and medical language describing executions make pro-death penalty arguments “more compelling.” These stipulated facts would speak against physician involvement in lethal injection only if there is something morally questionable about the death penalty. If the death penalty truly is required by justice, then making pro-death-penalty arguments more compelling would be morally good rather than problematic. On the other hand, if capital punishment is barbaric or otherwise morally unjustified, then physicians have strong reason not to lend their “cultural cachet”¹⁰³ to it. Below we will discuss whether that strong consideration against participation would outweigh the reason to help lower the inmate’s risk of

suffering. Here, it is important to acknowledge the multiple ways in which the arguments against participation depend on an assessment of the death penalty's value.

Assessing Arguments in Support of Physician Participation

Proponents of physician participation do not advocate a redefinition of core principles of medical ethics. They argue that respect for the condemned prisoner – a desire to act in his best interests – justifies physician involvement. Though this pro-participation argument is strong, we have seen that the public good should also have purchase on the scope of physician obligations. In some contexts, like medical research, the social value of medical research provides good reason to investigate whether doctors may ethically *use* their medical skills on individuals in ways that cause some harm or risk. In other contexts, reasons related to the social good might imply that physicians should *abstain* from offering their skills to a practice, even though participation would advance the best interests of a potential individual patient. With regard to executions, proponents of physician participation must consider societal reasons for doctors *not* to participate, and such deliberation requires consideration of capital punishment's moral status.

Complicity and the Morality of Capital Punishment

To begin, if the death penalty is immoral, then willing participation in an execution represents complicity in an immoral act and, as such, would be *prima facie* wrongful. A discussion of complicity within criminal law will be helpful.

The legal doctrine of accomplice liability recognizes that an agent may be blameworthy for the acts of another. When an agent chooses to assist another's wrongful act, she voluntarily identifies herself with the wrongdoer's actions, at least to some degree. Even if one's motivation

for assisting is beneficent, she cannot escape the social fact that intentional assistance in wrongdoing expresses some identification with the wrongful act. As such, complicity in wrongdoing is *prima facie* wrongful. A complicit agent may have an excuse (e.g., insanity, duress), but otherwise her assistance may be morally permissible only if a justification exists for committing the *prima facie* wrong of assisting in wrongdoing.

Assuming that complicity for moral wrongdoing parallels the legal doctrine, complicity involves assisting a primary actor (*actus reus*) while having a proscribed state of mind (*mens rea*). The previous paragraph briefly touched on the latter requirement: as a general rule, accomplice liability involves *intentional* assistance. If a physician intentionally assists an execution, and all executions are wrongful, then the physician possesses the *mens rea* for complicity in moral wrongdoing.

However, as evidenced by our moral experience and many aspects of criminal law,¹⁰⁴ an agent's motives also impact the moral quality of his assistance. It matters morally whether a defendant killed his father because he was motivated to collect insurance money or to honor his father's request not to live if unable to care for himself.¹⁰⁵ Also, as evidenced by the necessity defense, motive can also serve to exculpate an agent from liability if she committed the *prima facie* wrongful act with the purpose of avoiding an even greater harm.¹⁰⁶ Thus, a physician's motivation in participating in an execution is relevant to determining the moral status of her involvement. If capital punishment is immoral and participation implies complicity, the physician's degree of moral blameworthiness (if blameworthy at all) will depend, in part, on her motivation, such as whether she participates solely to minimize the inmate's risk of pain or to inflict the punishment herself.

With regard to actual assistance, the degree to which an agent assists in wrongdoing

matters morally. But, again assuming a parallel between morality and criminal law, even trivial assistance is sufficient to establish accomplice liability.¹⁰⁷ Encouragement through psychological or moral support suffices.¹⁰⁸

Physician involvement does lend moral support to the practice. This fact explains why death penalty proponents – at least initially – sought physician involvement and increased medicalization of executions. Their aim was to make the public as comfortable as possible with executions. Presumably, physician involvement can strengthen or maintain public support for executions by creating the image of a caring doctor overseeing a hospital-type procedure in which an inmate peacefully falls asleep. At present, many death penalty supporters argue against the need for physician involvement because of inmates' litigation claim that physician participation is constitutionally required. But putting aside the constitutional claim, the involvement of doctors serves the state by lending an aura of legitimacy to the practice.¹⁰⁹

One might object that physicians do not really assist the perpetuation of executions because few, if any, voters would change their opinion about the death penalty should physicians not participate; states will continue to execute prisoners regardless of the means of execution. The objection essentially is that physician assistance at an execution could not qualify as immoral complicity because a physician's involvement would not be a but-for cause of the death penalty's persistence. However, the objection is unpersuasive because causation is not an element of accomplice liability. Even if a defendant's assistance was not a but-for cause of the principal actor's crime, the defendant is complicit in the crime.¹¹⁰ Complicity implies blameworthiness for the acts of others. The only causation analysis relevant to complicity regards the causal relationship between the principal agent's actions and the prohibited harm. If an accomplice provides either a weapon or psychological support to another who plans a

robbery, the accomplice is morally blameworthy for the robber's crime even if the robber would have committed the crime without the accomplice's support. The state need not prove that the defendant's assistance was a but-for cause of the crime.

Kenneth Baum, a proponent of physician involvement, agrees that "physician participation may have the consequence of providing a surface appearance of humanity or adding an aura of medical legitimacy to the execution process[,]” and that “[t]his is undoubtedly a troubling proposition.”¹¹¹ However, Baum responds that this “troubling proposition” is only a “concern with the death penalty itself, not physician participation.”¹¹² Baum continues: “The unease that underlies this potential whitewashing of the core identity of the death penalty concerns the morality of any state-sanctioned taking of life, not the involvement of physicians in carrying out that penalty.”¹¹³ Baum joins the list of commentators deeming the morality of capital punishment irrelevant to the ethics of physician participation. But our discussion of complicity demonstrates why the morality of capital punishment is crucial to the ethics of physician participation. Baum states that the “physician’s obligation is to the patient, not to the political agenda of special interest groups – not even to the American Medical Association.”¹¹⁴ Baum fails to realize that the morality of the death penalty is relevant, not because a physician owes anything to the “political agenda” of any organization, but because physicians have obligations to their fellow citizens. If the death penalty is unjust (or worse), then participating doctors will be complicit in unjust (or worse) actions, which means, at the least, they commit a very serious *prima facie* wrong.

Article 3 of United Nations Resolution 37 reflects this position regarding complicity and the moral status of the death penalty.

It is a gross contravention of medical ethics, as well as an offence under

applicable international instruments, for health personnel, particularly physicians, to engage, actively or passively, in acts which constitute participation in, complicity in, incitement to or attempts to commit torture or other *cruel, inhuman or degrading treatment or punishment*.¹¹⁵

Obviously, many opponents of the death penalty, including some former U.S. Supreme Court justices, argue that the death penalty is cruel, inhuman, and degrading.¹¹⁶ Deciding whether a participating physician is complicit in wrongdoing requires assessment of their claims.

Slippery Slope Concerns and the Morality of Capital Punishment

Some critics of physician involvement argue that physician participation damages medicine's caring ethos. Some suggest, implicitly or explicitly, that the damage to that caring ethos leads to a slippery slope where we inevitably see Nazis and their atrocities at the bottom.¹¹⁷ Condemning physician participation, Alfred Freedman and Abraham Halpern, write:

The history of the twentieth century gives us many examples of how compromises lead us down a slippery slope to disaster and abandonment of ethical principles. The rationale that physicians should assist in the administration of justice, insofar as capital punishment is concerned, is frighteningly reminiscent of how German physicians justified their involvement in the torture and killing of thousands of innocent human beings and carried out the Nazi programs of sterilization and "euthanasia" by murdering countless children and adults.¹¹⁸

Baum rejects this "slippery slope" concern. However, contrary to his claims, his defense of physician participation implicitly appeals to moral judgments about the social worth and moral status of capital punishment. Baum identifies some moral distinctions between Nazi doctors and American death penalty: capital punishment has been democratically endorsed in death penalty jurisdictions, as opposed to policies in Nazi Germany; a death penalty jurisdiction's goal is to give effect to the voters' will; death row inmates had trials with the protection of Constitutional rights; and "[w]e do not arbitrarily choose whom to execute."¹¹⁹

Baum's observations are undoubtedly morally relevant to a comparison of the American death penalty and the horrors of Nazi Germany. Nonetheless, Baum's response fails to recognize that the death penalty can still be barbaric and unjust even if it is not the moral equivalent of Nazi atrocities. Even if not on par with Nazi atrocities, the capital system could be sufficiently unjust to give doctors strong reason not to be complicit in the practice or seen as endorsing it.

Is the death penalty sufficiently unjust to give physicians reason to avoid involvement? Baum does not explicitly address that question, but some of his arguments entail his answer. In his response to the "Nazi slippery slope concerns," he writes that "[w]e do not arbitrarily choose whom to execute."¹²⁰ Baum acknowledges that studies show that arbitrary factors (such as the victim's race) affect how the death penalty is distributed in the United States. But clearly he does not find the moral flaws with the American death penalty *so* serious as to require physicians to disassociate themselves with the practice and signal to society that it is too unjust for their participation.¹²¹ He further states that "as long as state ordered executions persist, physicians' primary ethical obligation is to make them as painless and humane as possible for the condemned."¹²² But if the death penalty is gravely unjust and perhaps evil, and if physician involvement only slightly reduces the risk of suffering, then physicians' primary obligation might be outweighed by their obligations to humanity to take a stand against injustice and avoid complicity. Baum's defense of physician participation – like the arguments of his opponents – rests on his perceptions about the morality of the American death penalty.

Is the Moral Status of Capital Punishment All That Matters?

Recall that some supporters of physician participation argue that lethal injection is a non-medical procedure and, as such, the Hippocratic duty of patient loyalty is inapplicable. One immediate

response is that even if the Hippocratic ethic is inapplicable, a physician's actions can be immoral on other grounds. One might argue that if the Hippocratic ethic is irrelevant, then the moral status of the physician's actions is entirely dependent on the moral status of the relevant practice. Robert Veatch does argue that the moral status of physician participation in a non-clinical-care activity, such as a lethal injection, is determined completely by the moral status of the practice itself:

If the society is correct in executing criminals, surely it is within its right to construct the role of physician professional in such a way that some of its members . . . can participate in executions. On the other hand, if the society should not be executing any criminals, then it should not formulate any of its medical professional roles in a way that they include physician participation in execution.¹²³

Even if ultimately unpersuasive, Veatch's view has a certain virtue. Imagine a physician who insists that justice requires the state to have the death penalty, but also believes that physicians' professional integrity prohibits their participation in executions. On this view, because *someone* has to be executioner, someone else may kill, but participation would be morally beneath a doctor. One might accuse this physician of having a "holier than thou" elitist attitude about her profession. Veatch's position stays clear of any such objection. Physicians are not on some higher moral plane than everyone else. If the death penalty is justified, no one's hands are too pristine to be executioner.

This appealing feature of Veatch's account, though, should not persuade if strong reasons that do not entail moral elitism counsel against participation. Orin Guidry, as president of the American Society of Anesthesiologists, argued that such reasons exist. Urging members to "steer clear" of executions, Guidry's concern was public trust in anesthesia and anesthesiologists:

The more the execution looks like an anesthetic, the less comfortable patients are likely to be with anesthesia. Surgery is already a frightening time and one in which patients need to trust their anesthesiologist. The last thing patients need is to equate the [operating

room] with a death chamber, to equate anesthetic drugs with death drugs, or to have in their subconscious the specter of the anesthesiologist as an executioner.¹²⁴

Guidry's argument does not entail moral elitism. It does not suggest that anesthesiologists are "too good" to get their hands dirty. Rather, it claims that anesthesiologist-participation would have bad societal consequences, which would not result from the participation of others. The claim is that anesthesiologists would have reason not to participate – reasons that do not apply to others – because the *societal consequences* of anesthesiologist-participation differ from the likely consequences from others participating in executions. The argument goes to protecting the "therapeutic mission [as] the professions' primary role and the core of physicians' professional identity."¹²⁵ Black and Fairbrother raise a similar concern, stating that participating physicians "contravene[] . . . the trust that society has placed in them."¹²⁶

Guidry's argument may rest on a dubious empirical assumption that physician participation actually causes public distrust in anesthesiologists or anesthesia. Nonetheless, Veatch's view is unpersuasive even if Guidry's arguments do not provide a counterexample. Stipulate that capital punishment or other non-clinical-care practice in which physicians participate is immoral. Even if that practice is immoral, physician participation could be morally acceptable. Consider a society in which a woman's, but not a man's, virginity is a prerequisite to marriage. A woman, who plans to marry but whose hymen has been ruptured, asks her gynecologist for hymen reconstruction surgery. Let us reasonably assume that the requested procedure would contribute to a practice which is immoral because it discriminates against women.¹²⁷ As such, "professionals who participate in the procedure would be complicit" in perpetuating wrongful discrimination¹²⁸ and thereby would commit a *prima facie* wrong. But now assume the woman will suffer very serious consequences without the surgery. In some

cultures, failing the virginity requirement could result in “women’s expulsion from their families and communities, terminated betrothal, divorce, personal violence, and at its most extreme, so-called ‘honor killing,’ usually by close family members.”¹²⁹ If a patient faces a possible honor killing, the ethics of the gynecologist’s decision to grant or refuse the requested procedure is not determined by the moral status of the practice within which the request was made. Any complicity in contributing to a discriminatory practice is justified by the need to protect the patient’s life. Likewise, even if the practice of capital punishment is immoral, an anesthesiologist may have compelling reason to participate to reduce the inmate’s risk of suffering excruciating pain.

Practical Implications

For Lawmakers

Should legislators require or ban participation by a physician or other medical health professional on its jurisdiction’s execution team? A separate legal question is whether state medical boards should ever discipline doctors for participation. However, as Ty Alper demonstrates, it is unlikely that any state medical board in a capital jurisdiction has legal authority to discipline a physician for participation.¹³⁰ In addition, even if a medical board had that authority, it should not discipline physicians for participating to reduce an inmate’s risk of suffering, given the complexity of the ethical question and the reasonableness of concluding that it is morally permissible to participate with that motivation. Thus, the practical question is whether legislatures should direct their respective departments of corrections to include or ban physicians or other medical professionals from execution teams.

The foregoing arguments strongly support the proposition that legislators who favor the

death penalty should require participation of physicians or other highly trained medical professionals. Assuming, as they believe, that the death penalty is morally justified and socially valuable, then the case against physician participation is very weak. First, *if* the death penalty truly does advance justice, then it is good if physicians lend their cultural authority to the practice and ease citizens' consciences about the execution procedure. Second, it is reasonable to conclude that the respect owed to the condemned inmate permits a physician to try to reduce the risk of suffering. Third, the arguments examined in Part III against physician participation – based on an alleged morality internal to medicine, on being a primary cause of death, and on the non-medical status of lethal injection – are unpersuasive.

In addition, pro-death penalty legislators need not be moved by a concern for the public's trust in anesthesiologists. Of course, any legislator should want to protect the physician-patient relationship and avoid causing undue anxiety for surgery patients. However, these concerns do not support a ban on physician participation. Ironically, the position of the American Medical Association and other professional organizations actually solidifies the case in support of physician participation because it alleviates these concerns. When news outlets publicize the participation of a physician in an execution, they also publicize the fact that medical organizations oppose such participation. The professional codes of ethics allow the public to view physicians who participate as rare outliers who reject their profession's norms. Thus, the codes of ethics guard against any erosion of public trust in anesthesiologists and other physicians that otherwise might be caused by physician participation.

For anti-death-penalty lawmakers in capital jurisdictions, the practical implications are less clear and more complex. Assuming that the death penalty is immoral and anesthesiologists could reduce the risk of suffering, a satisfactory ethical analysis nonetheless would be complex

and depend on many related details. For example, the degree to which the death penalty is unjustified – whether the moral status of capital punishment is a close case (it is morally impermissible but barely so)¹³¹ or whether it represents an absolutely evil and barbaric practice¹³² -- would matter. The degree of the death penalty's wrongfulness would then have to be balanced against the degree to which an anesthesiologist's involvement reduces the inmate's risk of torture. If the death penalty is barbaric and physicians only slightly reduce the risk of unnecessary suffering, then the case for banning physician participation is very strong: in those circumstances, we should not want physicians lending their cultural authority to the death penalty and easing the public's conscience about executions. On the other hand, if the death penalty is unjustified but barely so, and if physician involvement significantly reduces the risk to each inmate, then the case for physician involvement is stronger. On those stipulated facts, the decision for the anti-death-penalty legislator is more difficult and sensitive to the details. No algorithm reveals the right answer.

For Professional Medical Organizations

Should medical professional organizations change their ethical codes to acknowledge the relationship between the ethics of participation and the moral status of the death penalty? If the AMA wants to retain its ethical ban on participation, should it remove from its code any suggestion that the morality of the death penalty is irrelevant? Before directly addressing this question, let us acknowledge that such organizations do not have self-interested reason to take a particular stand on capital punishment. The AMA – the largest association within organized medicine - holds out itself to prospective members as an aggressive advocate for physicians' interests and provider of benefits to physicians in their daily practice.¹³³ It specifies its core

mission as “promot[ing] the science and art of medicine and the betterment of public health.”¹³⁴

Insofar as the AMA hopes to represent as many doctors as possible, it has good reason to avoid alienating any physicians with a stance on capital punishment or any other controversial political issue. The expertise of organized physicians also fails to provide reason for the AMA to take a stand on capital punishment or other political issue apart from its relevance to medicine.

Professional medical societies have good reasons to develop ethical standards for medical practice¹³⁵ based on their knowledge and critical experience regarding the practice of medicine. But they have no special interest in, knowledge of, or insight into the death penalty.

In addition, it is also important to consider that physicians and other health professionals are participating in executions. Given that fact, these organizations have good reason *not* to change their codes. Their ethical stance prevents the potential negative effects to the physician-patient relationship and public trust that worry Dr. Guidry and other opponents of physician participation. Thus, even if the death penalty is morally justified, the primary mission of these organizations supports their clear and simple ban on participation.

Medical professional organizations would have additional reasons not to change their codes if the capital punishment is an immoral practice. Condemning the participation of medical health professionals is the closest these organizations can come to condemning the death penalty without doing so explicitly and alienating actual and potential members.¹³⁶ Second, their ethical ban would effectively represent a refusal, on the part of their members, to be complicit in the practice. Finally, these ethical bans provide a readily accessible defense for any physicians solicited to participate.¹³⁷

Conclusion

The ethics of physician participation is complicated. Contrary to so much commentary, many factors are relevant to ethically assessing physician involvement. The moral status of the death penalty is crucial. It affects whether participating physicians are complicit in an immoral practice, thereby committing a *prima facie* moral wrong. If they are complicit, the seriousness of that *prima facie* wrong depends on the degree to which the death penalty is unjustified. The moral status of capital punishment is also important because physician involvement may render the practice more palatable and morally acceptable to the public. But the moral status of the practice is not all that matters. Other factors include the respect owed to the inmate and whether he requests physician participation. In considering the respect owed to the inmate, it is important to weigh the degree to which involvement of a physician or other health professional can reduce the actual risk of suffering unnecessary pain. In other non-clinical-care contexts in which medical health professionals participate (such as military medicine and forensic psychiatry), additional considerations will be relevant. But the ethics of physician participation in those contexts, too, is complex and depends on the moral status of the relevant practice. Appeals to the Hippocratic ethic and traditional principles of medical ethics are insufficient.

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References

1. T. Alper, "The Role of State Medical Boards in Regulating Physician Participation in Executions," *Journal of Medical Licensure & Discipline* 95, no. 3 (2009): 16-26. See also *Morales v. Hickman*, 415 F. Supp. 2d 1037 (N.D. Cal. 2006), *aff'd per curiam*, 438 F.3d 926 (9th Cir. 2006), cert. denied, 546 U.S. 1163 (2006) (holding that California may proceed with execution only if it eliminates the second and third drugs or involves a "person with formal training and experience in the field of general anesthesia"); *Taylor v. Crawford*, 487 F.3d 1072 (8th Cir. 2007) (vacating district court's order requiring Missouri Department of Corrections to adopt protocol calling for participation of a board-certified anesthesiologist).

2. In *Baze v. Rees*, the Court upheld Kentucky's lethal injection protocol against a constitutional challenge. *Baze*, 553 U.S. at 35. One argument submitted by petitioners was that the execution protocol must direct qualified personnel to assess the condemned inmate's consciousness after delivery of the anesthetic with monitoring equipment, such as a Bispectral Index (BIS) monitor or blood pressure cuff. *Id.*, at 58-59. In rejecting that claim, the plurality opinion states that the "asserted need for a professional anesthesiologist to interpret the BIS monitor readings is nothing more than an argument against the entire procedure, given that both Kentucky law and the American Society for Anesthesiologists' own ethical guidelines prohibit anesthesiologists from participating in capital punishment." *Id.*, at 59-60 (citations omitted).

In addition, Justice Alito's concurrence, not joined by any colleague, rejects the possibility of constitutionally requiring participation of a physician or any other medical health professional whose professional ethics prohibits such participation. *Id.*, at 66 (Alito, J., concurring).

3. D. Waisel, "Physician Participation in Capital Punishment," *Mayo Clinic Proceedings* 82, no. 9 (2007): 1073-1080, at 1079.

4. M. G. Bloche, *The Hippocratic Myth* (New York: Palgrave MacMillan, 2011): at 7, 10; M. G. Bloche, "Clinical Loyalties and the Social Purposes of Medicine," *JAMA* 281, no. 3 (1999): 268-274, at 270.

5. P. Sen et al., "Ethical Dilemmas in Forensic Psychiatry: Two Illustrative Cases," *Journal of Medical Ethics* 33, no. 6 (2007): 337-341 (noting that in contrast to the traditional clinical setting, it is a "given" in the forensic psychiatric setting that third parties have a claim within the doctor-patient relationship); G. Adshead, "Care or Custody? Ethical Dilemmas in Forensic Psychiatry," *Journal of Medical Ethics* 26, no. 5 (2000): 302-304 (describing other ethical dilemmas as well, such as prescribing medications to reduce a patient's risk of violence to others even when the drug causes him harm).

6. See *infra* text accompanying notes 89-96 __.

7. M. G. Bloche and J. H. Marks, "When Doctors Go to War," *New England Journal of Medicine* 352, no. 1 (2005): 3-6.

8. See, e.g., *Ky. Rev. Stat. Ann.* § 431.220(1)(b) (year) (stating that prisoners sentenced to death before March 31, 1998 shall choose lethal injection or electrocution).

9. See, e.g., *Cal. Penal Code* § 3604 (West year) (giving persons sentenced to death the “opportunity to elect to have the punishment imposed by lethal gas or lethal injection”).

10. See, e.g., *Okl. Stat. Ann. tit. 22* § 1014 (West year) (authorizing electrocution if lethal injection is “held unconstitutional by an appellate court of competent jurisdiction,” and by firing squad if both lethal injection and electrocution are deemed unconstitutional).

11. The protocol described here is Missouri’s. Missouri Department of Corrections, Preparation and Administration of Chemicals for Lethal Injection (on file with author).

12. *Id.* See also *Baze*, 553 U.S. at 45 (describing Kentucky’s execution protocol).

13. Sodium thiopental has been the drug used by states since the death penalty was reinstated in the 1970s. However, recently some states, including Texas, Virginia, and Oklahoma, have replaced sodium thiopental with pentobarbital because thiopental’s sole U.S. manufacturer, Hospira, decided to cease its production. N. Koppel, “Drug Halt Hinders Executions in the U.S.,” *Wall Street Journal*, January 22, 2011, at A1; N. Koppel, “Texas Adopts Animal Drug for Executions,” *Wall Street Journal*, March 17, 2011; J. Q. Wu, “Virginia’s Death Row Prepares for First Lethal Injection Using New Drug Mix,” *Washington Post*, August 17, 2011.

14. T. Alper, “The Truth about Physician Participation in Lethal Injection Executions,” *North Carolina Law Review* 88, no. 1 (2009): 11-69, at 20. See, e.g., *Taylor v. Crawford*, 487 F.3d 1072, 1084 (8th Cir. 2007).

15. *Baze v. Rees*, 553 U.S. 35, 53 (2008).

16. Brief for Petitioners at 12, *Baze v. Rees*, 553 U.S. 35 (2008) (No. 07-5439), 2007 WL 3307732.

17. *Baze v. Rees*, No. 07-5439, 2007 WL 4790797, app. at 472-73 (Testimony of Dr. Mark Heath).

18. *Morales v. Tilton*, 465 F. Supp.2d 972, 980 (N.D.Cal. 2006).

19. *Id.*

20. T. A. Zimmers et al., “Lethal Injection for Execution: Chemical Asphyxiation?” *PLoS Medicine* 4, no. 4 (2007): e156. doi:10.1371/journal.pmed.0040156

21. Brief for Petitioners at 13, *Baze v. Rees*, 553 U.S. 35 (2008) (No. 07-5439), 2007 WL 3307732.

22. Brief for Petitioners at 13, *Baze v. Rees*, 553 U.S. 35 (2008) (No. 07-5439), 2007 WL 3307732.

23. M. E. Martelli, “Intravenous Medication Administration,” *Gale Encyclopedia of Nursing and Allied Health*, 2002, available at <<http://www.healthline.com/galecontent/intravenous-medication-administration>> (last visited February 25, 2013).

24. Brief for Petitioners at 16-17, *Baze v. Rees*, 553 U.S. 35 (2008) (No. 07-5439), 2007 WL 3307732.

25. *Baze v. Rees*, 553 U.S. 35, 119 n.4 (2008) (Ginburg, J., dissenting).

26. See, e.g., Waisel, *supra* note 3, at 1074-1075.

27. *Baze v. Rees*, 553 U.S. 35, 64 (2008) (Alito, J., concurring).

28. See Death Penalty Information Center, “State by State Lethal Injection,” available at

<<http://www.deathpenaltyinfo.org/state-lethal-injection>> (last visited February 25, 2013).

29. *Id.*

30. American Medical Association Council on Ethical and Judicial Affairs, "Physician Participation in Capital Punishment," *JAMA* 270, no. 3 (1993): 365-68, at 368; American Medical Association, *Code of Ethics, E-2.06* (2005), available at <<http://www.law.berkeley.edu/clinics/dpclinic/LethalInjection/LI/QA/docs/AMA>> (last visited February 25, 2013); World Medical Association General Assembly, "WMA Resolution on Physician Participation in Capital Punishment," 2008, available at <<http://www.wma.net/en/30publications/10policies/c1/index.html>> (last visited February 25, 2013) (affirming same position taken by the assembly in 1981 and 2000); L. Snyder for the American College of Physicians Ethics, Professionalism, and Human Rights Committee, *American College of Physicians Ethics Manual 6th Edition*, *Annals of Internal Medicine* 156, no. 1 (part 2) (2012): 73-101, at 90; *Participation of Health Professionals in Capital Punishment: Policy no. 200125*, American Public Health Association, January 1, 2001, <<http://www.apha.org/advocacy/policy/policysearch/default.htm?id=264>> (last visited February 25, 2013); "Anesthesiologists Advised to Avoid Lethal Injection," Death Penalty Information Center (July 2, 2006), available at <<http://www.deathpenaltyinfo.org/node/297>> (last visited February 25, 2013) (citing Message from Orin F. Guidry, President, American Society of Anesthesiologists, "Observations Regarding Lethal Injection," June 30, 2006).

31. "Position Statement: Nurses' Role in Capital Punishment," American Nurses Association, January 28, 2010, available at <<http://gm6.nursingworld.org/MainMenuCategories/Policy-Advocacy/Positions-and-Resolutions/ANAPositionStatements/Position-Statements-Alphabetically/prtetcpt114447.pdf>> (last visited February 25, 2013); American Academy of Physician Assistants, "Guidelines for Ethical Conduct for the Physician Assistant Profession," available at <<http://www.aapa.org/uploadedFiles/content/Common/Files/19-EthicalConduct.doc>> (last visited February 25, 2013); National Association of Emergency Medical Technicians, "NAEMT Position Statement: EMT or Paramedic Participation in Capital Punishment," adopted January 26, 2010, available at <<http://www.naemt.org/Libraries/Advocacy%20Documents/1-26-10%20EMT%20or%20Paramedic%20Participation%20in%20Capital%20Punishment.sflb>> (last visited February 25, 2013).

32. See AMA Council on Ethical and Judicial Affairs, *supra* note 30 .33. D.W. Denno, "The Lethal Injection Quandary: How Medicine Has Dismantled the Death Penalty," *Fordham Law Review* 76, no. 1 (2007): 49-124, at 88-89.

34. *Id.*, at 88-89.

35. *Id.*

36. T. A. Zimmers and D. A. Lubarsky, "Physician Participation in Lethal Injection Executions," *Current Opinion in Anaesthesiology* 20, no. 2 (2007): 147-151.

37. In addition, empirical research published at the beginning of last decade asked physicians about eight actions prohibited by the AMA's ethical stance. The research revealed that a majority of doctors surveyed found it acceptable for a physician to engage in most of those actions. Thirty-four percent found all eight acceptable. N. Farber et al., "Physicians' Attitudes about Involvement in Lethal Injection for Capital Punishment," *Archives of Internal Medicine* 160, no. 19 (2000): 2912-2916. In another study, forty-one percent of physicians surveyed said they would perform at least one of the actions prohibited by the AMA code. N. J. Farber, "Physicians'

Willingness to Participate in the Process of Lethal Injection for Capital Punishment,” *Annals of Internal Medicine* 135, no. 10 (2001): 884-888.

38. *Clemons v. Crawford*, No. 07-4129-CV-C-FJG, 2008 WL2783233, at *1 (W.D. Mo. 2008); T. Rizzo, “Anesthesiologist Joins Missouri’s Execution Team, Violating Ethical Guidelines,” *Kansas City Star*, May 24, 2008. 39. *Arthur v. Thomas*, Case no: 2:11-cv-438-MEF-TFM, Defendant’s Motion to Dismiss and, in the Alternative, Motion for Summary Judgment, Exhibit E (Affidavit of Warden Anthony Patterson) (August 15, 2011).

40. A. Gawande, “When Law and Ethics Collide – Why Physicians Participate in Executions,” *New England Journal of Medicine* 354, no. 12 (2006): 1221-1229; see also J. I. Groner, “Lethal Injection: A Stain on the Face of Medicine,” *British Medical Journal* 325, no. 7371 (2002): 1026-1028 (reporting that after a nurse failed in trying to insert a peripheral IV line into the condemned, a physician inserted a central venous catheter into the prisoner’s subclavian vein).

41. P. Mazzei, “Doctors Testify on New Use of Drug in Florida’s Lethal Injections,” *Miami Herald*, August 3, 2011; see also *Arthur v. Thomas*, *supra* note 39, at Exhibit D.

42. See AMA, “Code of Ethics,” *supra* note 30. See also W. L. Lanier and K. H. Berge, “In Reply,” *Mayo Clinic Proceedings* 83, no. 1 (2008): 122-123 (2008) (noting that after writing on physician participation, they had been contacted by two physicians, “both self-identified as board-certified specialists,” who admitted participation). 43. See AMA Council on Ethical and Judicial Affairs, *supra* note 30.

44. American College of Physicians et al., *Breach of Trust*, 1994. See also *State v. Deputy*, 644 A.2d 411 (De. Super. 1994) (“ . . . the official statement which explains these organizations’ position does not cite opposition to the death penalty as the basis for their position.”).

45. See *Id.* (*Breach of Trust*), at 1.

46. O. F. Guidry, “Message from the President: Observations Regarding Lethal Injection,” June 30, 2006, available at <<http://www.yesmagazine.org/issues/go-local/1561>> (last visited Feb. 28, 2013)

47. R. D. Truog and T. A. Brennan, “Participation of Physicians in Capital Punishment,” *New England Journal of Medicine* 329, no. 18 (1993): 1346-1350, at 1348. 48. See Waisel, *supra* note 3, at 1073

49. L. Nelson and B. Ashby, “Rethinking the Ethics of Physician Participation in Lethal Injection Execution,” *Hastings Center Report* 41, no. 3 (2011): 28-37, at 29.

50. R. M. Veatch, “The Impossibility of a Morality Internal to Medicine,” *Journal of Medicine and Philosophy* 26, no. 6 (2001): 621-642, at 634. 51. A. L. Caplan, “Should Physicians Participate in Capital Punishment?” *Mayo Clinic Proceedings* 82, no. 10 (2007): 1047-1048 (“Despite the possible cost of suffering to individuals who undergo crude modes of or a poorly administered execution, physician involvement in moderating suffering in the final minutes of the lives of the condemned is too high a price for medicine to bear relative to the harms caused by legitimizing the practice of execution through physician involvement.”).

52. *World Medical Association, Handbook of Declarations* (1985): at 22 (quoted in P.A. Clark, *supra* note __, at 99).

53. P. A. Clark, “Physician Participation in Executions: Care Giver or Executioner?” *Journal of Law, Medicine & Ethics* 34, no. 1 (2006): 95-104, at 99.

54. W. C. Jones, “Anti-Death-Penalty Group Files Complaint Against Execution Doctor,” *Bluffton News*, June 20, 2011, available at <<http://www.blufftontoday.com/bluffton-news/2011->

06-21/anti-death-penalty-group-files-complaint-against-execution-doctor> (last visited February 25, 2013).

55. See Gawande, *supra* note 40.

56. An analogous conflict could arise for physicians where punishments include torture. Physicians, like everyone else, have a *prima facie* obligation not to inflict torture on anyone. But, as Lepora and Millum persuasively point out, the ethics of physician participation in such cruel punishment is not always clear. C. Lepora and J. Millum, "The Tortured Patient: A Medical Dilemma," *Hastings Center Report* 41, no. 3 (2011): 38-47, at 40. 57. L. Black and H. Fairbrother, "The Ethics of the Elephant: Why Physician Participation in Executions Remains Unethical," *American Journal of Bioethics* 8, no. 10 (2008): 59-61, 61. 58. See AMA Council of Judicial and Ethical Affairs, *supra* note 30. Peter Clark endorses these arguments, claiming that they "negate" the pro-physician-participation arguments. See Clark, *supra* note 53, at 99.

59. Black and Fairbrother argue that it is wrong for a physician to *directly* cause another's death. The notion of a "direct" cause will fail to resolve these ethical matters for the same reasons, given above, why the notion of "primary cause" will fail.

60. J. Dressler, *Understanding Criminal Law*, 5th ed. (Newark, NJ: Matthew Bender & Co., Inc., 2009): at 189. T. A. Street, *The Foundations of Legal Liability*, vol. I (Long Island, NY: Edward Thompson Co., 1906): at 110 (quoted in R. A. Epstein, *Cases and Materials on Torts* 8th ed. (New York: Aspen Publishers, 2004): at 436 ("[Proximate causation] is always to be determined on the facts of each case upon mixed considerations of logic, common sense, justice, policy, and precedent.")).

61. See M. G. Bloche, "Clinical Loyalties and the Social Purposes of Medicine," *JAMA* 281, no. 3 (1999): 268-274 (discussing the view of the AMA's Council on Ethical and Judicial Affairs regarding psychiatry and death row inmates).

62. See Denno, *supra* note 33, at 69 (citing A. J. Chapman, "Lethal Injections Not Practice of Medicine," *American Medical News*, April 22-29, 1991, at 45).

63. See Bloche and Marks, *supra* note 7, at 3. Paul Appelbaum made a similar argument with respect to forensic psychiatry. P. S. Appelbaum, "The Parable of the Forensic Psychiatrist: Ethics and the Problem of Doing Harm," *International Journal of Law and Psychiatry* 13, no. 4 (1990): 249-259, at 258. 64. See *Breach of Trust*, *supra* note 44, at 3.

65. L. L. Emanuel and L. B. Bienen, "Physician Participation in Executions: Time to Eliminate Anonymity Provisions and Protest the Practice," *Annals of Internal Medicine* 135, no. 10 (2001): 922-924, at 923. 66. See Truog and Brennan, *supra* note 47, at 1348.

67. See Bloche and Marks, *supra* note 7, at 5 (discussing physicians involved in military interrogations).

68. E. D. Pellegrino, "The Internal Morality of Medicine: A Paradigm for the Ethics of the Helping and Healing Professions," *Journal of Medicine and Philosophy* 26, no. 6 (2001): 559-579, at 566.

69. *Id.*, at 566.

70. E. D. Pellegrino, "Societal Duty and Moral Complicity: The Physician's Dilemma of Divided Loyalty," *International Journal of Law and Psychiatry* 16, no. 3-4 (1993): 371-391, at 376.

71. L. Black and H. Fairbrother, *supra* note 57 at 6072. J. Arras, "A Method in Search of a Purpose: The Internal Morality of Medicine," *Journal of Medicine and Philosophy* 26, no. 6 (2001): 643-662; see Lepora and Millum, *supra* note 56.

73. *Id.* (Arras).

74. See Lepora and Millum, *supra* note 56, at 44.

75. For an excellent discussion, see Bloche, *The Hippocratic Myth*, *supra* note 4.

76. P. S. Appelbaum et al., “False Hopes and Best Data: Consent to Research and the Therapeutic Misconception,” *Hastings Center Report* 17, no. 2 (1987): 20-24, at 20 (describing the therapeutic misconception); F. G. Miller and D. L. Rosenstein, “The Therapeutic Orientation to Clinical Trials,” *New England Journal of Medicine* 348, no. 14 (2003): 1383-1386, at 1383-84 (describing how the setting of medical research, with its similarity to the clinical setting, “may make it especially difficult to appreciate how clinical trials differ from personalized medical care”).

77. See, e.g., *State v. Nelson*, 803 A.2d 1, 15 (N.J. 2002) (reporting testimony of Dr. Robert Sadoff, in conflict with more favorable testimony of defendant’s psychiatrist).

78. E. D. Pellegrino, “The Moral Foundations of the Patient-Physician Relationship: The Essence of Medical Ethics,” in E. D. Pellegrino et al., eds., *Military Medical Ethics*, vol. I (Washington, D.C.: Office of the Surgeon General at TMM Publications, 2004): 3-22, at 10 (stating that coherence theories based on commonly accepted moral beliefs and principles cannot provide the foundation for medical ethics).

79. *Id.*, at 10 (stating that deontological, utilitarian, and virtue-centered moral theories cannot provide a foundation for medical ethics because they “leave a gap between ethical theory and the realities of the moral world of physician and patient”).

80. See Pellegrino, *supra* note 68, at 560. See Arras, *supra* note 72, at 645 (attributing to Pellegrino an “essentialist” view, “according to which a morality for medicine is derived from reflection on its ‘proper’ nature, goals or ends”).

81. See Pellegrino, *supra* note 78, at 13.

82. See Truog and T.A. Brennan, *supra* note 47.

83. See Pellegrino, *supra* note 70, at 376.

84. D. Wendler, “Are Physicians Obligated Always To Act in the Patient’s Best Interests?” *Journal of Medical Ethics* 36, no. 2 (2010): 66-70, at 67. See Bloche, *supra* note 4, at 10.

85. T. Gottlieb and G. R. Nimmo, “Antibiotic Resistance is an Emerging Threat to Public Health: An Urgent Call to Action at the Antimicrobial Resistance Summit 2011,” *Medical Journal of Australia* 194, no. 6 (2011): 281-283.; see Bloche (*Clinical Loyalties and the Social Purposes of Medicine*), *supra* note 4, at 268.

86. See, e.g., *Tarasoff v. Regents of the University of California*, 17 Cal. 3d 425 (1976); C. P. Leeman, M. A. Cohen, and V. Parkas, “Should a Psychiatrist Report a Bus Driver’s Alcohol and Drug Abuse? An Ethical Dilemma,” *General Hospital Psychiatry* 23, no. 6 (2001): 333-336.

87. S. R. Benatar and R. E. G. Upshur, “Dual Loyalty of Physicians in Military and Civilian Life,” *American Journal of Public Health* 98, no. 12 (2008): 2161-2167.

88. See Wendler, *supra* note 84, at 67.

89. 45 C.F.R. § 46.102(d) (2007) (“Research means a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge.”). E. J. Emanuel et al., “Scandals and Tragedies of Research with Human Participants: Nuremberg, the Jewish Chronic Disease Hospital, Beecher, and Tuskegee,” in E. J. Emanuel et al., eds., *Ethical and Regulatory Aspects of Clinical Research: Readings and Commentary* (Baltimore, MD: Johns Hopkins University Press, 2003).

90. F. G. Miller and H. Brody, “What Makes Placebo-Controlled Trials Unethical?”

American Journal of Bioethics 2, no. 2 (2002): 3-9, at 4. T. Lemmens and P. B. Miller, "Avoiding a Jekyll-and-Hyde Approach to the Ethics of Clinical Research and Practice," *American Journal of Bioethics* 2, no. 2 (2002): at 14.

91. C. Coleman, "Duties to Subjects in Clinical Research," *Vanderbilt Law Review* 58, no. 2 (2005): 387-452, at 398. J. W. Berg et al., *Informed Consent: Legal Theory and Clinical Practice*, 2d ed. (New York, NY: Oxford University Press, 2001): at 282.

92. *Id.*

93. See Coleman, *supra* note 91, at 399. D. T. Chen et al., "Clinical Research and the Physician-Patient Relationship," *Annals of Internal Medicine* 138, no. 8 (2003): 669-672, at 669.

94. 45 C.F.R. § 46.111(a)(2) (1991).

95. The discussion here tracks many of the arguments provided in P. Litton and F. G. Miller, "A Normative Justification for Distinguishing the Ethics of Clinical Research from the Ethics of Medical Care," *Journal of Law, Medicine & Ethics* 33, no. 3 (2005): 566-574. See also P. Litton and F. G. Miller, "What Do Physician-Investigators Owe Patients Who Participate in Research," *JAMA* 304, no. 13 (2010): 1491-1492.

96. The obligations listed are helpfully articulated and discussed in E. J. Emanuel, D. Wendler, and C. Grady, "What Makes Clinical Research Ethical?" *JAMA* 283, no. 20 (2000): 2701-2711. See Litton and Miller, *supra* note 95, at 569.

97. See *Gregg v. Georgia*, 428 U.S. 153, 183 (1976) (plurality opinion) ("The death penalty is said to serve two principal social purposes: retribution and deterrence of capital crimes by prospective offenders.")

98. J. Groner, "Lethal Injection and the Medicalization of Capital Punishment in the United States," *Health and Human Rights* 6, no. 1 (2002): 64-79, at 73.

99. *Id.*

100. *Id.*, at 73 (citing M. Himaka, "Judge Sentences David Lucas to Die for Three Murders," *San Diego Union Tribune*, September 20, 1989, at sec. B-d); see also L. Welborn, "Before Sentenced to Death, Home Depot Killer Shouts: 'I'm Innocent,'" *Orange County Register*, November 29, 2011, 6:34 AM, <http://www.ocregister.com/articles/richardson-328969-egan-death.html>.

101. J. Groner, *supra* note 98, at 73 _____. 102. *Id.*, at 73-74. See also D. L. Lerman, "Second Opinion: Inconsistent Deference to Medical Ethics in Death Penalty Jurisprudence," *Georgetown Law Journal* 95, no. 6 (2007): 1941-1978, at 1946-1947.

103. See Bloche, *The Hippocratic Myth*, *supra* note 4, at 9.

104. Traditionally, criminal law professors teach first-year law students that motive is irrelevant to criminal liability. However, Carissa Byrne Hessick persuasively demonstrates that motive is relevant to the elements of a number of crimes and to sentencing decisions, in addition to being morally relevant to blameworthiness. C. B. Hessick, "Motive's Role in Criminal Punishment," *Southern California Law Review* 80, no. 1 (2006): 89-150.

105. *Id.* See Dressler, *supra* note 60, at 263 (discussing one defendant who intentionally killed his dying father to fulfill a promise and a defendant who unintentionally killed his child through repetitive severe abuse). See *State v. Forrest*, 362 S.E.2d 252 (N.C. 1987); *Midgett v. State*, 729 S.W.2d 410 (Ark. 1987).

106. See Hessick, *supra* note 104.

107. See Dressler, *supra* note 60, at 475; J. Dressler, "Reassessing the Theoretical Underpinnings of Accomplice Liability: New Solutions to an Old Problem," *Hastings Law*

Journal 37, no. 1 (1985): 91-140, at 102 (“The most trivial assistance is sufficient basis to render the secondary actor accountable for the actions of the primary actor.”).

108. See Dressler, *Understanding*, *supra* note 60, at 474 (citing *State v. Doody*, 434 A.2d 523 (Me. 1981) and *Hicks v. State*, 150 U.S. 442 (1893)).

109. A. Caplan, *supra* note 51. 110. See Dressler, *supra* note 60, at 476; J. Dressler (“Reassessing the Theoretical Underpinnings”), *supra* note 107, at 102.

111. K. Baum, “‘To Comfort Always’: Physician Participation in Executions,” *New York University Journal of Legislation and Public Policy* 5, no. 1 (2001-2002): 47-82, at 64.

112. *Id.*

113. *Id.*

114. *Id.*

115. United Nations, “Principles of Medical Ethics, Resolution 37/194,” Article 3, Resolution 37 (1982).

116. *Furman v. Georgia*, 408 U.S. 238, 257-306 (1972) (Brennan, J., concurring); *Furman v. Georgia*, 408 U.S. 238, 314-71 (1972) (Marshall, J., concurring).

117. See, e.g., Groner, *supra*, note 98, at 69-71.

118. A. M. Freedman and A. L. Halpern, “The Erosion of Ethics and Morality in Medicine: Physician Participation in Legal Executions in the United States,” *New York Law School Law Review* 41, no. 1 (1996): 169-188, at 187.

119. See Baum, *supra* note 111, at 70-71.

120. *Id.*

121. Baum states that the arbitrariness in the distribution of the death penalty is problematic. His point is that this moral problem, along with any other moral problem of the American death penalty, does not make the practice the moral equivalent of the Nazi atrocities. But again, arguing that the system is not as evil as the Nazi practices fails to show that the death penalty is not sufficiently unjust and evil as to morally require doctors to refuse to lend their services.

122. *Id.*, at 72.

123. See Veatch, *supra* note 50, at 634-35.

124. O. F. Guidry, *supra* note 46. Groner argues similarly to Guidry, but with respect to all physicians: “When doctors enter the death chamber, they harm not only their relationship with their own patients but the relationships of all doctors with their patients.” Groner, “Lethal Injection: A Stain on the Face of Medicine,” *supra* note 40, at 1028. See also Lerman, *supra* note 102, at 1946.

125. See Bloche and J.H. Marks, *supra* note 7, at 5.

126. L. Black and H. Fairbrother, *supra* note 57, at 60. 127. R. J. Cook and B. M. Dickens, “Hymen Reconstruction: Ethical and Legal Issues,” *International Journal of Gynecology & Obstetrics* 107, no. 3 (2009): 266-269, at 267.

128. *Id.*

129. *Id.*, at 268.

130. Alper, *supra* note 1.

131. For example, let’s say punishment is justified on retributive grounds; the death penalty achieves more retributive justice than life-without-parole when applicable; but moral costs (e.g., racial discrimination in application) and financial costs slightly outweigh its contribution to retributive justice.

132. Perhaps no one deserves death, the death penalty deters no one, and it even causes more

murders because it normalizes revenge.

133. American Medical Association, “AMA Member Benefits,” *available at* <<http://www.ama-assn.org/ama/pub/membership/membership-benefits.page?>> (last visited February 26, 2013).

134. American Medical Association, “AMA Advocacy News,” *available at* <<http://www.ama-assn.org/ama/pub/advocacy.page?>> (last visited February 26, 2013).

135. D. Orentlicher, “The Influence of a Professional Organization on Physician Behavior,” *Albany Law Review* 57, no. 3 (1994): 583-606, at 584-591.

136. *Cf.* Lepora and Millum, *supra* note 56, at 45 (stating that ethical bans on physician participation in torture “constitute a powerful condemnation of torture”).

137. *Id.*, at 45 (ethical bans on physician participation in torture in interrogation settings “provide a defense for doctors who . . . should be able to cite binding rules that forbid them from being involved”).