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DOCTORS, DISCIPLINE, AND THE DEATH PENALTY: PROFESSIONAL IMPLICATIONS OF SAFE HARBOR POLICIES

Nadia N. Sawicki*

State capital punishment statutes generally contemplate the involvement of medical providers, and courts have acknowledged that the qualifications of lethal injection personnel have a constitutionally relevant dimension. However, the American Medical Association has consistently voiced its opposition to any medical involvement in executions. In recent years, some states have responded to this conflict by adopting statutory mechanisms to encourage medical participation in lethal injections. Foremost among these are safe harbor policies, which prohibit state medical boards from taking disciplinary action against licensed medical personnel who participate in executions.

This Article posits that safe harbor policies, as limitations on medical board autonomy, must be viewed not merely as artifacts of the political discourse on capital punishment, but as part of the historical narrative of American medical regulation. As a matter of policy, safe harbors cannot be defended by reference to the three traditional justifications for regulating medical professionals -- they are not necessary to keep the profession from exceeding the scope of its delegated powers; they do not promote traditional medical goals; and they do not satisfy the criteria for promotion of important state goals unrelated to medicine. This Article suggests that safe harbors and other restrictions on board autonomy, if not adequately justified, may weaken public confidence in the authority and independence of the medical profession. Because the loss of systemic medical trust tends to have a corrosive effect on the medical profession's ability to promote patient interests and public health, policymakers should be wary of adopting safe harbors without first considering their trust implications in the professional sphere.

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I. INTRODUCTION

Of the thirty-seven U.S. jurisdictions that authorize the use of capital punishment, all but one use lethal injection as an execution method.[1] Nearly every jurisdiction's lethal injection procedures permit or require the presence or participation of a physician or other licensed medical provider.[2] Moreover, courts throughout the country have recognized the Eighth Amendment implications of lethal injections administered by personnel without adequate medical training.[3] A prisoner may suffer pain so

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[1] Thirty-six states and the federal government use lethal injection as a primary or permitted method of capital punishment. Baze v. Rees, 553 U.S. __ (2008) (slip op., at 14); Deborah W. Denno, *The Lethal Injection Quandary: How Medicine Has Dismantled the Death Penalty*, 76 FORDHAM L. REV. 49, 59 (2007) (citing, prior to New Jersey's December 2007 repeal of the death penalty, thirty-seven lethal injection states) [hereinafter, Denno 2007]; 28 C.F.R. 26.2 (2008) (authorizing execution by lethal injection in federal death penalty cases); 18 U.S.C. 3596 (a) (2007) (authorizing execution "in the manner prescribed by the law of the State in which the sentence is imposed" in death penalty cases under the Violent Crime Control Act of 1994). Only Nebraska's death penalty statute relies exclusively on a different method, electrocution. NEB. REV. STAT. § 29-2532 (2007); *but see* State v. Mata, 745 N.W. 2d 229 (Neb. 2008) (holding that electrocution is cruel and unusual punishment).

[2] See Section II-B, *infra*.

[3] *See, e.g.*, Baze v. Rees, 553 U.S. __ (2008) (slip op., at 14) (finding that the "most significant" of the safeguards in place to protect against Eighth Amendment violations during Kentucky lethal injections is the requirement that IV team members have at least one year's experience as certified medical assistants, phlebotomists, EMTs, paramedics, or military corpsmen); Taylor v. Crawford, 487 F.3d 1072, 1084 (8th Cir. 2007) (finding that, because of the risk that prisoners subject to Missouri's lethal injection procedures might suffer extreme pain, "it is imperative for the State to employ personnel who are properly trained to competently carry out each medical step of the procedure," but recognizing that such personnel need not be physicians); Brown v. Beck, 2006 U.S. Dist. LEXIS 60084, at *24-25 (E.D. N.C. 2006), *aff'd*, 445 F.3d 752 (4th Cir. 2006) (holding that questions raised about the constitutionality of North Carolina's lethal injection procedures "could be resolved by the presence of medical personnel" qualified to ensure that the prisoner is unconscious); Morales v. Tilton, 465 F.Supp.2d 972 (N.D. Cal. 2006) (holding that the administration of California's lethal injection protocol by an execution team with little or no training or knowledge regarding the necessary drugs creates an undue risk that an inmate will suffer pain so extreme that it offends the Eighth Amendment); Morales v. Hickman, 415 F.Supp.2d 1037 (N.D.Cal. 2006), *aff'd*, 438 F.3d 926 (9th Cir. 2006) (permitting the State of California to proceed with Plaintiff's execution by retaining the services of a qualified expert with training and experience in general anesthesia); Abdur'Rahman v. Bredesen, 181 S.W. 3d 292 (Tenn. 2005) (recognizing that "the experience, training, and qualifications of persons involved in the lethal injection process" are relevant to the question of whether the procedure constitutes cruel and unusual punishment); State v. Webb, 252 Conn. 128 (2000) (finding that because the "state intends to employ either emergency medical technicians, paramedics, or nurses, all trained to insert the intravenous catheter," Connecticut's lethal injection procedures do not pose an unacceptably high risk of suffering).

excruciating as to constitute cruel and unusual punishment if execution technicians encounter any one of a number of potential problems – if they have difficulty placing the intravenous line by which the necessary drugs are delivered; improperly prepare the drugs, modify their quantities, or administer them in the wrong order; fail to accurately assess the prisoner's anesthetic depth; or are faced with any medical anomaly or emergency that necessitates a deviation from standard procedures.

While no court has yet held that lethal injection procedures are unconstitutional *per se* without physician involvement, and the Supreme Court in *Baze v. Rees* recently limited the availability of challenges to the qualifications of execution personnel,[4] states have grown increasingly concerned that a shortage of qualified medical personnel would make it difficult or impossible to conduct executions in accordance with the Eighth Amendment. Indeed, there is legitimate reason for concern about the availability of willing personnel – the ethical codes applicable to physicians, nurses, emergency medical technicians, and physician assistants uniformly denounce participation in executions.

In an effort to circumvent this potential conflict, some state legislatures have taken an unusual step to facilitate the involvement of medical personnel in lethal injections. They have adopted statutory provisions that strip state medical boards of the authority to take disciplinary action against medical providers who participate in executions, effectively immunizing those providers from licensure challenges ("safe harbor provisions"). Many have also adopted provisions that exclude the procedures involved in lethal injection from the scope of state medical practice acts, effectively ensuring that execution participants will not be deemed to be engaged in the practice of medicine ("exclusionary provisions"). Even in the absence of such explicit legislative directives, some state courts have held that the existence of criminal procedure statutes contemplating medical involvement in lethal injection indicates a legislative intent to prohibit boards from disciplining medical participants.[5]

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[4] In *Baze v. Rees*, the Supreme Court upheld Kentucky's lethal injection procedure, which required IV team members to be certified medical assistants, phlebotomists, EMTs, paramedics, or military corpsmen with one year of professional medical experience, but prohibited participation by physicians in the execution process. *Baze*, 553 U.S. __ (slip op., at 6-7, 16). In upholding the Kentucky procedure against a challenge to the qualifications and training of the execution personnel, the Court set a very high standard for future challenges to lethal injection procedures in states with more stringent medical personnel requirements than those imposed by Kentucky, and effectively shut down future lines of argument grounded in the constitutional necessity of physician participation. *Id.* (slip op., at 15-17, 20-21).

[5] *See, e.g.*, N.C. Dep't of Corrections et al v. N.C. Med. Bd., Civ. No. 07-003574 (N.C. Super. Ct., Sept. 21, 2007) (holding that judicial executions are outside the scope of the

Despite the wealth of literature examining the ethical underpinnings and practical ramifications of the medical profession's position against involvement in executions, legal scholars have not yet examined the history, theoretical foundation, or likely consequences of disciplinary safe harbor policies.[6] Even the most recent articles about physician participation in capital punishment mention these policies only in passing.[7] Given the Supreme Court's recent resolution of the Eighth Amendment challenge in *Baze v. Rees*, states may soon be re-evaluating the constitutionality of their lethal injection procedures as well as their strategies for encouraging medical involvement in executions. Thus, it is imperative that the academic community take the lead in understanding and critically evaluating existing safe harbor provisions, with the goal of providing policy guidance to states that may be considering similar legislation. This Article is the first commentary in what should become a broad academic exchange on the merits of legislative interventions designed to eliminate barriers to medical participation in lethal injection.

Section II provides the historical context for understanding safe harbors and other mechanisms for facilitating medical involvement in executions. Section III situates safe harbor policies in the context of traditional medical regulation and identifies three justifiable reasons for limiting the disciplinary discretion of state medical boards: (1) if the boards are exceeding the scope of their delegated powers, (2) if the limitations are necessary to promote the state's traditional medical interests in patient welfare and public health, and (3) if the limitations satisfy the criteria necessary to secure demonstrably compelling state goals unrelated to medicine. In Section IV, both existing and potential disciplinary safe harbors are evaluated with respect to these three justifications and found to

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Medical Practice Act and do not constitute medical procedures subject to board review); Thorburn v. Dep't of Corrections, 66 Cal. App. 4th 1284 (Cal. App. 1998) (holding that the California legislature did not intend to include physician participation in executions within the ambit of unprofessional conduct subject to injunction by the court).

[6] Moreover, discussions by legal scholars of the contentious issue of physician participation in executions tend to focus on the extent to which medical ethics have hampered the implementation of a constitutional system of capital punishment. *See, e.g.*, Denno 2007, *supra* note 1 (addressing how "medicine has dismantled the death penalty"). The inquiry posed in this Article instead examines the effect of safe harbor statutes on the practice of medicine as a whole.

[7] For brief references to disciplinary safe harbors in the context of capital punishment, see Denno 2007, *supra* note 1, at 89-90; Daniel N. Lerman, *Second Opinion: Inconsistent Deference to Medical Ethics in Death Penalty Jurisprudence*, 95 GEO. L.J. 1941, 1951, note 56 (2007); Joan M. LeGraw and Michael A. Grodin, *Health Professionals and Lethal Injection Execution in the United States*, 24:2 HUMAN RIGHTS QTLY. 382, 416 (2002); Cary Federman and Dave Holmes, *Caring to Death: Health Care Professionals and Capital Punishment*, 2 PUNISHMENT & SOC'Y 441, 442 (2000).

be lacking.

Section V argues that disciplinary safe harbors and other limitations on board authority, if not adequately defended as a matter of policy, may have dangerous implications for the medical profession and for society at large. Unjustified state interventions in medical board decision-making may erode public trust in the independence and authority of the medical profession, in turn implicating the profession's effectiveness in achieving the public goals with which it has been tasked. Given the significance of these potential consequences, states should be wary of adopting safe harbors without first considering their trust implications in the professional sphere.

Section VI concludes with two recommendations for policymakers evaluating strategies for facilitating medical involvement in executions. First, as a matter of health care policy, policymakers should ensure that such strategies are justified by reference to compelling state interests beyond the merely expressive and do not have unintended effects on systemic medical trust. Second, as a matter of capital punishment policy, policymakers ought to consider whether maintaining medical involvement in a quasi-clinical execution procedure serves constitutional or merely cosmetic values.

The analysis set forth in this Article by no means presupposes opposition to capital punishment in general or to physician participation in lethal injection in particular.[8] Rather, the relevant inquiry is whether, if we as a society believe that capital punishment is a worthwhile endeavor, states should facilitate medical involvement in lethal injection by restricting the disciplinary discretion of state medical boards. This Article concludes that, given the open questions about the trust implications of such legislative interventions, they should not.

[8] I expressly reserve the question of whether the medical community's opposition to participation in lethal injection is, as a normative matter, the best interpretation of the profession's ethical principles. That said, I also recognize that there is a "danger in discussing the morality of methods when it is the ends themselves that must be resisted." Gerald Dworkin, *Patients and Prisoners: The Ethics of Legal Injection*, 62 ANALYSIS 181, 189 (2002).

II. TRACING THE HISTORY OF CAPITAL PUNISHMENT SAFE HARBORS

Austin Sarat writes of capital punishment, "It is only in and through its claims to legitimacy that what law does is privileged and distinguished from 'the violence that one always deems unjust.'"[9] Since the origins of the death penalty, its claims to legitimacy have been grounded in ritualistic formalities and simulacra of humane treatment, in which physicians have taken a historically significant role. Nowhere is the link between the medical profession and the technology of capital punishment more apparent than in the 1977 development of the modern lethal injection protocol by an Oklahoma medical examiner. Although state lethal injection statutes generally require only limited participation by medical personnel, states in recent years have developed policies granting execution participants immunity from medical board discipline in an effort to encourage medical participation beyond the statutory requirements. This Section explores the history of these disciplinary safe harbor policies.

A. Historical Perspectives on Medicine and Capital Punishment

Early executions were conducted publicly, before crowds of spectators eager to take part in a communal ritual of punishment.[10] In Michel Foucault's words, "In the ceremonies of the public execution, the main character was the people, whose real and immediate presence was required for the performance."[11] While similar attitudes prevailed in the early stages of the American republic, support for public executions began to wane in the late nineteenth century.[12] In the past century, capital punishment has become one of the most concealed parts of the American penal process – carried out behind prison walls, witnessed by only a select few, and designed to separate the condemned from even the executioner himself by a physical barrier.[13] As public observation, which had long

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[9] Austin Sarat, *Capital Punishment as a Fact of Legal, Political, and Cultural Life: An Introduction*, *in* THE KILLING STATE: CAPITAL PUNISHMENT IN LAW, POLITICS, AND CULTURE, 7 (Austin Sarat, ed., 1999).

[10] John Laurence, A HISTORY OF CAPITAL PUNISHMENT, 183 (The Citadel Press 1960); John D. Bessler, DEATH IN THE DARK: PUBLIC EXECUTIONS IN AMERICA, 23-27 (1997).

[11] Michel Foucault, DISCIPLINE AND PUNISH; THE BIRTH OF THE PRISON, 58 (2nd ed. 1995); *see also* Louis P. Masur, RITES OF EXECUTION: CAPITAL PUNISHMENT AND THE TRANSFORMATION OF AMERICAN CULTURE, 1776-1865, 103 (1989) (writing, of public executions in eighteenth century America: "Assembled as one, the spectators provide a reminder that the public execution is designed for the crowd, an image that the community is united … The criminal seems hardly to matter at all.").

[12] Masur, *supra* note 11, at 93-116; Robert Johnson, DEATH WORK: A STUDY OF THE MODERN EXECUTION PROCESS, 262 (1998); Bessler, *supra* note 10, at 40-44.

[13] Austin Sarat, *The Cultural Life of Capital Punishment*, *in* THE KILLING STATE,

served as a check on the legitimacy of the execution process, became less common, greater emphasis was placed on formal procedures that could serve to standardize and legitimize the process in the absence of direct public oversight.[14] The most significant of these procedures (which include the selection of witnesses and the incorporation of humanizing rituals such as the last cigarette) is the technology of capital punishment itself, which has developed over the years to satisfy evolving societal standards.[15]

While the medical community as a whole has taken no formal role in the advancement of capital punishment, individual physicians have played significant parts in the development of execution technologies. Historians have concluded that even the techniques used in hanging, one of the most frequently used execution methods in modern history,[16] were perfected by early executioners only after consultation with "medical men."[17] One of the most prominent historical examples of the ties between medicine and capital punishment is the development of the guillotine by Drs. Antoine Louis and Joseph Guillotin at the start of the French Revolution.[18]

Medical professionals had similarly significant roles in developing and implementing the technology of capital punishment in modern America. As early as 1848, writers suggested that the United States, as a civilized and refined society, should use advances in medical and scientific technology to spare condemned prisoners excessive pain and mental anguish.[19] When New York State created a Commission on Capital

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supra note 9, at 227-28; Masur, *supra* note 11, at 162-63; *see also* Foucault, *supra* note 11, at 9-10 ("[T]he execution itself is like an additional shame that justice is ashamed to impose on the condemned man; so it keeps its distance from the act, tending always to entrust it to others, under the seal of secrecy.").

[14] *But see* Sarat, *supra* note 9, at 6 (positing that the primary benefit of such practices is to obfuscate, by way of fetishization, an underlying recognition that "law's violence" ultimately "bears substantial traces of the violence it is designed to deter and punish").

[15] The dissemination of information about executions by the press has also served as an additional means of public oversight. *See* Masur, *supra* note 11, at 110, 115-16 (addressing the media's impact on public conceptions of executions).

[16] *See* Laurence, *supra* note 10, at 41-42; Commission Report, *infra* note 20, at 34-35.

[17] Laurence, *supra* note 10, at 44-48 (identifying a "medical man's" suggestion that nooses be tied "beneath the ear and pulled fairly tight" as one of the more important changes in "the hangman's art").

[18] Advocates of the guillotine hoped that this "simple mechanism" (operated without discretion by an impartial and respected agent of the government) would be an improvement over earlier methods of execution, such as hanging, which were criticized as inhumane and disgraceful to victims and their families. *See generally*, Daniel Arasse, THE GUILLOTINE AND THE TERROR, 11-29 (1987); Arthur Isak Applbaum, *Professional Detachment: The Executioner of Paris*, 109 HARV. L. REV. 458 (1995) (examining the role morality of the profession of executioner).

[19] *See* G. W. Peck, *On the Use of Chloroform in Hanging*, 8 AM. WHIG REV. 283, 296

Punishment in the late nineteenth century to evaluate alternatives to hanging, it surveyed "a large number of the members of the medical profession" on the physiology of various execution methods and their attendant challenges.[20] The surveyed physicians typically favored electrocution over the other alternatives considered, including lethal injection, the guillotine and shooting.[21] The conclusions in the Commission's comprehensive 1888 report were based largely on these professional opinions; indeed, the Commission cited as its sole reason for rejecting lethal injection as an execution technique the medical profession's opposition to the practice.[22]

Ultimately, the Commission recommended that electrocution, a method initially proposed by a Buffalo dentist,[23] be adopted as New York's

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(Sept. 1848). Peck writes:

> Our ancestors abolished torture. . . ; why should we not, now that science has found a means of alleviating extreme physical suffering, follow their example by allowing the benefit of it to the miserable wretches whom we simply wish to cast contemptuously out of existence? If we have a right to hang a man at noon-day . . . then it follows that we have a right to give him Chloroform at noon-day, and hang him immediately afterwards, while under its operation . . . By this means we avoid for him, not only the pain of the actual killing, but the agonizing instant of certain apprehension.

[20] New York State Commission on Capital Punishment, Report of the Commission to Investigate and Report the Most Humane and Practical Method of Carrying Into Effect the Sentence of Death in Capital Cases: Transmitted to the Legislature, January 17, 1888, at 86 (1888) [hereinafter, Commission Report].

[21] *Id*. Consider, for example, the response of one New York physician, who opined of electrocution, "It is a most admirable substitute [to hanging], probably the best known to science, fulfilling all the indications in the most humane, practical and painless manner." *Id*. at 89.

[22] The Commission noted:

> [T]he injection of a violent and sudden poison, such as prussic acid, by means of the hypodermic needle, into the body of the condemned . . . is open to the very serious objection that the use of that instrument is so associated with the practice of medicine, and as a legitimate means of alleviating human suffering, that it is hardly deemed advisable to urge its application for the purposes of legal executions against the almost unanimous protest of the medical profession.

Id. at 78. Similar objections were cited by the British Royal Commission on Capital Punishment in 1953. Melvin V. Wingersky, *Report of the Royal Commission on Capital Punishment (1949-1953): A Review*, 44 J. CRIM. L. & CRIMINOLOGY 695, 714 (1954) (noting that the British Medical Association "vigorously protested any member performing [lethal injection] or instructing lay persons in the techniques.")

[23] After witnessing the death of a man who accidentally touched a live electrical generator, Dr. Alfred Southwick, a former engineer, reportedly described the episode to a state senator; the Commission was appointed shortly thereafter. Arden G. Christen and Joan A. Christen, *Alfred P. Southwick, MDS, DDS: Dental Practitioner, Educator and Originator of Electrical Executions*, 48 J. HIST. DENTISTRY 117, 118-19 (Nov. 2000).

primary method of capital punishment.[24] More than ten physicians attended the first electrocution to observe the workings of the new technology,[25] one of whom later opined that electrocution is "the most humane, decent, and scientific method of inflicting the death penalty because of its efficiency, quickness, and painlessness," and recommended that it be adopted by "every state in the Union."[26]

The execution of prisoners by lethal gas was first proposed by a physician in 1878,[27] but it was not until forty years later, when a major in the U.S. Army Medical Corps developed the technology for use in prison populations,[28] that Nevada became the first state to adopt it as an execution method.[29] When a prisoner challenged Nevada's lethal gas statute on constitutional grounds, the Nevada Supreme Court upheld it, citing the fact that gas had already been in use "for many years" by dentists and veterinarians, and finding that the legislature adopted the statute so as to "provide a method of inflicting the death penalty in the most humane

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[24] Commission Report, *supra* note 20, at 95. The new law went into effect in 1889, and required the presence of two physicians at each execution by electrocution. Laurence, *supra* note 10, at 64. The first prisoner subject to the law's provisions challenged his punishment on Eighth Amendment grounds, but was unsuccessful. In re Kemmler, 10 S.Ct. 930, 933 (1890) (refusing to reexamine the New York court's holding in favor of the electrocution statute).

[25] One news report of the time identified eleven physician witnesses by name. *Far Worse than Hanging – Kemmler's Death Proves an Awful Spectacle – The Electric Current Had to be Turned on Twice Before the Deed was Fully Accomplished*, N.Y. TIMES, Aug. 7, 1890, at 1 [hereinafter, Far Worse than Hanging]. However, modern accounts report that at least fourteen physicians attended. The American College of Physicians et al., BREACH OF TRUST: PHYSICIAN PARTICIPATION IN EXECUTIONS IN THE UNITED STATES, at 9-10 (1994) [hereinafter, Breach of Trust].

[26] Edward Anthony Spitzka, *Observations Regarding the Infliction of the Death Penalty by Electricity*, Proc. Am. Phil. Soc'y (Jan.-Apr. 1908), at 46; *See also, The Kemmler Execution – Dr. C.E. Spitzka Tells Doctors and Lawyers All About It – A Paper Read Before the Society of Medical Jurisprudence Last Night – Death Instantaneous*, N.Y. TIMES, Nov. 11, 1890, at 2 [hereinafter, The Kemmler Execution]. Note that Dr. Spitzka was more than a mere observer during the Kemmler execution. According to his own statements and contemporaneous reports, Dr. Spitzka examined Kemmler after the initial current was applied, instructed that that the current be turned on again quickly after the first current failed to execute him, and pronounced Kemmler's death. The Kemmler Execution; Far Worse than Hanging, *supra* note 25, at 1.

[27] Annulla Linders, *The Execution Spectacle and State Legitimacy: The Changing Nature of the American Execution Audience, 1833-1937*, 36 LAW & SOC'Y REV. 607, 636, n. 17 (2002).

[28] *See* Anne Krueger and David Hasemyer, *Debate Rages Anew Over Gas Chamber*, SAN DIEGO UNION-TRIBUNE, April 17, 1992, at A3; Jacob Weisberg, *This Is Your Death -- Capital Punishment: What Really Happens*, THE NEW REPUBLIC, July 1, 1991, at 26.

[29] Raymond Hartmann, *The Use of Lethal Gas in Nevada Executions*, 8 ST. LOUIS L. REV. 164, 165-66 (1922-23).

manner known to modern science."[30] The physicians and scientists who attended the prisoner's 1924 execution unanimously pronounced the use of lethal gas to be "a swift and painless method" of execution, perhaps the "most merciful form yet devised."[31]

B. Developing and Legislating the Lethal Injection Procedure

Like the guillotine and electric chair, lethal injection – a method of capital punishment that relies on intravenous injection of one or more lethal drugs – was developed by a medical professional. The first steps were taken in 1976, when Bill Wiseman, an Oklahoma legislator, began researching the possibility of a more humane method of execution than the current standard, electrocution.[32] Although both Wiseman's personal physician[33] and the Oklahoma Medical Association[34] declined to provide guidance, citing ethical concerns, Oklahoma's state medical examiner, Dr. Jay Chapman, offered technical assistance.[35] Dr. Chapman suggested "a lethal injection consisting of an ultra-short-acting barbiturate in combination with a chemical paralytic."[36] Dr. Stanley Deutsch, chair of the Oklahoma Medical School Anesthesiology Department, who later reviewed Dr. Chapman's proposal, concluded that the method would be a "rapidly pleasant way of producing unconsciousness" leading to death.[37]

In 1977, the Oklahoma legislature adopted lethal injection as the state's execution method. The statute, which mirrored the language used by Dr. Chapman in his initial recommendation, provided that "the punishment of death . . . be inflicted by continuous, intravenous administration of a lethal quantity of an ultrashort-acting barbiturate in combination with a chemical paralytic agent until death is pronounced by a licensed physician according to accepted standards of medical practice."[38] There is no evidence to suggest that legislators consulted any other medical experts

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[30] State v. Gee Jon, 211 P. 676, 681-82 (Nev. 1923).

[31] *Gas Kills Convict Almost Instantly*, N.Y. TIMES, Feb. 9, 1924, at 15 (identifying Drs. A. Huftaker, E.E. Hamer, and Major D.A. Turner of Army Medical Reserve Corps as the official physician witnesses to the execution); *see also*, *Nevada Will Execute Slayer by Gas Today*, N.Y. TIMES, Feb. 8, 1924, at 4 (noting that several physicians and "chemical experts" first tested Nevada's gas chamber on two cats).

[32] Don Oldenburg, *Poison Penalty: Bill Wiseman Drafted the Law Allowing Lethal Injections, Then Lived to Regret It*, WASHINGTON POST, Dec. 7, 2003, at D1.

[33] *Id*. at D1.

[34] *So Long as They Die: Lethal Injections in the United States*, 18 HUMAN RIGHTS WATCH 1, 14 (2006) [hereinafter, So Long as They Die].

[35] *Id*. at 14; Oldenburg, *supra* note 32, at D1;

[36] So Long as They Die, *supra* note 34, at 14.

[37] *Id.*

[38] *Id.* at 14; 22 OKL. STAT. ANN. §1014(A) (1991) (enacted as Laws 1977, c. 41, § 1).

besides Drs. Chapman and Deutch before adopting either the Oklahoma statute or the Department of Corrections protocols, which later included the addition of a third drug, potassium chloride, pursuant to Dr. Chapman's recommendation.[39] Nearly every state that subsequently approved lethal injection as an execution method modeled its protocol after Oklahoma's without further research or inquiry, leading Deborah Denno, a leading scholar in this area, to suggest that in developing the three-drug protocol, Dr. Chapman "effectively set the final drug framework for all future lethal injection executions."[40]

In designing the modern lethal injection procedure, Dr. Chapman had imagined that the process "would be carried out by people with enough medical training to start intravenous lines, mix and measure the drugs, and give them in the right order."[41] Given that these skills, unlike the skills necessary for earlier execution methods, have traditionally been ascribed to the medical domain, Dr. Chapman's expectations as to the executioners' qualifications were by no means unreasonable.[42] However, when state criminal procedure statutes and department of corrections procedures were revised to reflect the adoption of lethal injection, they were surprisingly vague about the expected level of participation by medical personnel. Nevertheless, it is possible to reach some general conclusions about how legislators envisioned the process by parsing some of the more common

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[39] *Id.* at 14-15; Denno 2007, *supra* note 1, at 74. The three-drug protocol that was ultimately adopted by the Oklahoma Department of Corrections is still in use throughout the country today. The first drug, sodium thiopental (Pentothal), is a short-acting barbiturate used in the clinical setting for general anesthesia; depending on the dosage, its effects range from mild sedation to medically induced coma. The second drug, pancuronium bromide (Pavulon), is a paralytic agent traditionally used in surgery to lower blood pressure, induce muscle flaccidity, and facilitate insertion of a breathing tube. Experts agree that if a prisoner is not fully anesthetized during the lethal injection process, administration of pancuronium bromide would result in paralysis and the sensation of asphyxiation, although the prisoner would still be able to feel pain and other sensations. The third drug, potassium chloride, stops the heart. When administered at full strength, it causes excruciating pain as it travels through the bloodstream; accordingly, in clinical settings, it is only used in a dilute form. *See generally*, Mark Heath, *The Medicalization of Execution*, in PUBLIC HEALTH BEHIND BARS (Robert B. Greifinger, ed. 2007); *see also* Leonidas G. Koniaris et al., *Inadequate Anaesthesia in Lethal Injection for Execution*, 365 THE LANCET 1412 (April 16, 2005) (analyzing the implications of post-mortem sodium thiopental concentrations from prisoner toxicology reports).

[40] Denno 2007, *supra* note 1, at 74, 78-79.

[41] Denise Grady, *Doctors See Way to Cut Suffering in Executions*, N.Y. TIMES, June 23, 2006.

[42] Compare the skills involved in lethal injection (securing venous access, preparing prescription drugs, administering drugs, and monitoring anesthetic depth) with those involved in other execution methods, such as hanging (knot-tying), electrocution (electrical expertise, application of electrodes), and firing squad (marksmanship).

statutory language. In particular, three common statutory elements suggest an expectation on the part of legislators that physicians, though present at executions to observe or provide indirect support and supervision, would not actually be the ones to prescribe or prepare medications, secure venous access, or administer the injections.

First, while lethal injection statutes permitted or required that one or more physicians attend the execution as witnesses, they generally did not impose upon those physicians any direct responsibilities beyond declaring or certifying death.[43] Most statutes granted great discretion to correctional directors in selecting an execution team with appropriate qualifications and training to administer the injection,[44] and none required that the execution team include licensed medical personnel.[45] The specific details of any direct involvement by medical personnel (including physicians, nurses, and medical technicians) were delineated, if at all, in internal Department of Corrections procedures.[46] To the extent that physicians did participate in

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[43] *See generally*, Breach of Trust, *supra* note 25, at 17-21 and 49-72; Christopher J. Levy, *Conflict of Duty: Capital Punishment Regulations and AMA Medical Ethics*, 26 J. LEG. MED. 261, 265-66 (2005).

[44] However, many statutes were silent as to the medical qualifications of executioners and attendees. *See* Breach of Trust, *supra* note 25, at 17-21 and 49-72; Levy, *supra* note 43, at 166; Deborah W. Denno, *When Legislatures Delegate Death: The Troubling Paradox Behind State Uses of Electrocution and Lethal Injection and What It Says About Us*, 63 OHIO ST. L.J. 63, 121-23, 156-68 (2002) [hereinafter, Denno 2002] (noting that only 39% of states' lethal injection protocols mention executioner "training," "competency," "practice," or "preparation").

[45] *Id. See, e.g.*, MONT. CODE ANN., § 46-19-103(5), (6) (2007) (providing that executions must be performed by someone "selected by the warden and trained to administer a lethal injection;" that person "need not be" a licensed medical practitioner); S.D. Codified Laws § 23A-27A-32 (2007) (same); N.H. REV. STAT. § 630:5(XV) (2007) (same). In fact, three states explicitly prohibited direct medical involvement in the execution process. *See* KY. REV. STAT. § 431.220(3) (2008) ("No physician shall be involved in the conduct of an execution except to certify cause of death provided that the condemned is declared dead by another person."); 725 ILL. COMP. STAT. 5/119-5(d)(5) (2008) (providing that the Department of Corrections "shall not request, require, or allow a health care practitioner licensed in Illinois" to participate in an execution); N.J. STAT. ANN 2C:49-3(b) (repealed Dec. 17, 2007) ("The commissioner shall designate persons who are qualified to administer injections and who are familiar with medical procedures, other than licensed physicians, as execution technicians[.]").

[46] *See* Denno 2002, *supra* note 44, at 121-23, 156-68. Oklahoma's statute, for example, merely provides that a physician be "invited" to an execution, but its correctional procedures require that the physician order the necessary prescriptions and inspect the catheter and monitoring equipment. Breach of Trust, *supra* note 25, at 18. Note, however, that increasingly restricted public access to lethal injection procedures makes it difficult to determine the extent of any required medical involvement. Denno 2007, *supra* note 1, at 95-96 (reporting that states surveyed about their lethal injection procedures "provided as little information about their protocols as possible.").

the lethal injection process, it was typically on an *ad hoc* basis rather than as a result of planned procedures or legal requirements.[47]

Second, many of the statutes include exclusionary clauses providing that lethal injection procedures do not constitute the practice of medicine as defined by state professional practice acts. The Delaware statute, for example, specifies that administration of lethal substances in accordance with the act "shall not be construed to be the practice of medicine."[48] Other states further extended this exclusion to the "prescription, preparation, compounding, dispensing, and administration" of lethal substances, providing that such activities fell outside the practice of not only medicine, but also nursing, pharmacy, and other licensed medical professions.[49] In all, more than a dozen states formally exempted direct involvement in lethal injection from the scope of medical practice, suggesting a legislative intent to mark a clear distinction between the practice of medicine and the practice of capital punishment.[50]

Finally, many statutes authorize pharmacists to dispense the drugs used in the lethal injection process to correctional facility directors and

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[47] Indeed, this seems to have been the case at the first execution by lethal injection, which took place in Texas in 1982. Before the execution, prison authorities stated that, apart from pronouncing the death of the prisoner, no physicians would be involved in the execution. *See* Robert Reinhold, *Technician Executes Murderer in Texas by Lethal Injection*, N.Y. TIMES, Dec. 7, 1982. Although a "medical technician" was the one to actually administer the lethal injection, Dr. Ralph Gray, the Texas Department of Correction medical director, played a more direct role than initially anticipated. Dr. Gray admitted that he and his staff "had assisted in preparations for the execution," and that the medical technicians and drug supplies used during the procedure were under his control. *Id.* According to his own account, Dr. Gray examined the prisoner on the morning of the execution to determine if his veins were large enough to accommodate the catheter needle that would be used during the execution. Robert Reinhold, *Technician Executes Murderer in Texas by Lethal Injection*, N.Y. TIMES, Dec. 7, 1982. Finally, when called to pronounce death, Dr. Gray found that the prisoner was still alive, and suggested waiting longer for the drugs to take effect. Elizabeth Weil, *The Needle and the Damage Done*, N.Y. TIMES, February 11, 2007; Breach of Trust, *supra* note 25, at 10.

[48] 11 Del. Code § 4209(f) (2007).

[49] *See, e.g.*, ALA. CODE § 15-18-82.1(f) (2007).

[50] *See* MISS. CODE ANN. § 99-19-53 (2007); 11 DEL. CODE § 4209(f) (2007); IDAHO CODE § 19-2716 (2007); OREG. REV. STAT. § 137.473(2) (2005); N.H. REV. STAT. ANN. 630:5(XVI) (2008); S.D. CODIFIED. LAWS § 23A-27A-32 (2007); WYO. STAT. § 7-13-904(a) (2007); NEV. REV. STAT. ANN. § 453.377(6) (2007); MD. CORRECTIONAL SERVICES CODE ANN. § 3-905(b)(1) (2008); ARK. CODE ANN. § 17-80-108(b) (2007); FLA. STAT. ANN. § 922.105(6) (2007); Ga. Code. Ann. § 17-10-38(c) (2007); ALA. CODE § 15-18-82.1(f) (2007); 725 ILL. COMP. STAT. 5/119-5(g) (repealed July 24, 2003); N.J. STAT. ANN 2C:49-3(a) (repealed Dec. 17, 2007); *see also* Abdur'Rahman v. Bredesen et al, 2004 WL 2246227 (Tenn. Ct. App. 2004) (holding that the state's lethal injection protocols are exceptions to and fall outside of state medical licensing statutes and drug and pharmacy acts); *aff'd*, 181 S.W. 3d 292 (Tenn. 2005); *cert denied*, 126 S.Ct. 2288 (2006).

executioners without a prescription.[51] Delaware's statute, for example, provides that "any pharmacist or pharmaceutical supplier is authorized to dispense drugs to the Commissioner or the Commissioner's designee, without prescription" for the purpose of carrying out a lethal injection.[52] Such language suggests an understanding on the part of legislators that prison directors and officers, rather than licensed physicians, would be obtaining and preparing the lethal drugs.[53]

Reading these statutory provisions as a whole suggests an expectation on the part of legislators that physician participation would not be necessary to accomplish the most essential elements of the lethal injection procedure. Rather, prison officials and unlicensed personnel would be responsible for obtaining the necessary drugs, inserting the intravenous lines, and administering the injections. A physician, however, would generally be in attendance to determine the time of death, and, presumably, provide indirect support or oversight if needed. While limited legislative history makes it difficult to determine precisely why legislators envisioned the process in this manner, one reason may be because they were reluctant to make significant changes to existing personnel requirements. Executions by hanging, lethal gas, and electrocution were generally conducted by prison wardens and guards, and the continued use of such unlicensed personnel for lethal injection would certainly offer greater flexibility than requiring the involvement of physicians or other licensed medical providers.[54] It is possible that legislators, while perhaps unaware of the early ethical guidance against physician participation, sought to forestall the possibility that executions might be delayed if physicians were unable or unwilling to participate. Alternatively, perhaps legislators hoped to preempt concerns that unlicensed prison personnel, in selecting injection sites, starting intravenous lines, or preparing and administering the lethal drug

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[51] *See, e.g.*, Miss. Code Ann. § 99-19-53 (2007); 11 DEL. CODE § 4209(f) (2007); IDAHO CODE § 19-2716 (2007); OREG. REV. STAT. § 137.473(3) (2005); N.H. REV. STAT. ANN. 630:5(XVI) (2008); S.D. CODIFIED LAWS § 23A-27A-32 (2007); NEV. REV. STAT. ANN. § 453.377(6) (2007); MD. CORRECTIONAL SERVICES CODE ANN. § 3-905(b)(2) (2008); 61 PA. STAT. § 3004(b) (2007); 725 ILL. COMP. STAT. 5/119-5(h) (2008); N.C. GEN. STAT. § 15-187 (2007); N.J. STAT. ANN. 2C:49-3(a) (repealed Dec. 17, 2007).

[52] 11 DEL. CODE § 4209(f) (2007).

[53] Indeed, at the first execution by lethal injection, the prison warden was responsible for preparing the lethal drugs; it was as a result of his error in preparation that the drugs precipitated into a thick sludge, rendering the first catheter unusable. *See* Weil, *supra* note 47; Breach of Trust, *supra* note 25, at 10; *see also* John Kifner, *Man Who Killed 33 Is Executed in Illinois*, N.Y. TIMES, May 10, 2004 (reporting that John Wayne Gacy's execution was delayed "because gelling prevented the chemicals from flowing through a delivery tube.")

[54] *See generally*, Johnson, *supra* note 12, at 125-139.

cocktail, might be engaged in the unlicensed practice of medicine.[55]

C. Responses to Threats of Professional Discipline

In 1980, just three years after Oklahoma and Texas adopted the first lethal injection statutes (but still two years before the first execution by lethal injection), the Judicial Council of the American Medical Association ("AMA") proposed a policy on physician participation in capital punishment. Prompted by inquiries from its membership about permissible involvement in the process of lethal injection, the Judicial Council recommended adoption of a policy that, while an individual's opinion on capital punishment is her "personal moral decision," physicians, as members of "a profession dedicated to preserving life where there is hope of doing so," should not participate in legally authorized executions.[56] This policy was formalized in the AMA's Code of Medical Ethics and has been periodically updated based on recommendations by the Council for Ethical and Judicial Affairs.[57]

The AMA defines physician participation in capital punishment as any action that would "directly cause the death of the condemned," would "assist, supervise, or contribute to the ability of another individual to directly cause the death of the condemned," or could "automatically cause an execution to be carried out on a condemned prisoner."[58] Prohibited actions include prescribing, preparing, or administering drugs that are part of the execution process; selecting injection sites; starting intravenous lines; monitoring vital signs; providing technical advice; consulting with or supervising lethal injection personnel; and "attending or observing an execution as a physician."[59] A physician is, however, permitted to attend an execution in a "totally nonprofessional capacity" (for example, as a community witness) and may certify the prisoner's death if death has

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[55] Though exclusionary statutes effectively immunize unlicensed personnel from being charged with the unlicensed practice of medicine, they do not speak to the disciplinary implications, if any, of physician involvement. While some have argued that exclusionary statutes effectively prohibit physician discipline, Lerman, *supra* note 7, at 1950-52, this is not the case. Medical boards have the authority to discipline physicians for a variety of activities falling outside the scope of medical practice, including, among others, sexual contact with patients, fraud, substance abuse, and criminal activity. *See* Barry Furrow *et al*, HEALTH LAW, at 82-83 (2nd ed. 2000).

[56] American Medical Association Judicial Council, *Capital Punishment* (1980), reported in House of Delegates Proceedings (Chicago, IL, July 20-24, 1980), 129th Annual Convention, pp. 85-86 [hereinafter, AMA Report 1980].

[57] American Medical Association Opinion 2.06, *Capital Punishment* (issued July 1980; updated June 1994, June 1996, December 1999, and June 2000).

[58] *Id.*

[59] *Id.*

already been declared by a third party.[60] Nearly every major medical association and human rights organization in the U.S. and abroad has an analogous policy.[61]

In brief, the AMA's ethical arguments[62] against physician participation in capital punishment are grounded in concerns that it violates the Hippocratic Oath and undermines the credibility and legitimacy of the practice of medicine in the eyes of the public.[63] The principle of primum

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[60] *Id.*

[61] The American Society of Anesthesiologists has one of the most carefully drafted such policies, which provides:

> Execution by lethal injection has resulted in the incorrect association of capital punishment with the practice of medicine, particularly anesthesiology. Although lethal injection mimics certain technical aspects of the practice of anesthesia, *capital punishment in any form is not the practice of medicine.* Because of ancient and modern principles of medical ethics, legal execution should not necessitate participation by an anesthesiologist or any other physician. ASA continues to agree with the position of the American Medical Association on physician involvement in capital punishment. ASA strongly discourages participation by anesthesiologists in executions.

STATEMENT ON PHYSICIAN NONPARTICIPATION IN LEGALLY AUTHORIZED EXECUTIONS (2006) [hereinafter, ASA Policy]. *See also* American Psychiatric Association Position Statement No. 200125, *Medical Participation in Capital Punishment* (1980); American College of Physicians, *Relation of the Physician to the Government*, in its *Ethics Manual* (5th Ed. 2005); Society of Correctional Physicians, *Code of Ethics* (adopted 1997, amended 1998); American Public Health Association, *Participation of Health Professionals in Capital Punishment*, 91 AM J. PUB. HEALTH 520 (2001) (reaffirming Position Statement No. 8521 (1985)); National Association of Emergency Medical Technicians, *Position Statement on EMT and Paramedic Participation in Capital Punishment* (June 9, 2006); American Academy of Physician Assistants, *Guidelines For Ethical Conduct for the Physician Assistant Profession*, at 9 (adopted 2000, amended 2004, 2006, and 2007); American Nurses Association, *Position Statement: Nurses' Participation in Capital Punishment* (1999); International Council of Nurses, *Position Statement: Death Penalty and Participation by Nurses in Execution* (1998, revised 2003 and 2006); UN International Code of Medical Ethics, *Proposed Guidelines for Practice in Difficult Settings: Guideline No. 10*; World Medical Association, *Resolution on Physician Participation in Capital Punishment*, Adopted by the 34th World Medical Assembly Lisbon, Portugal.

[62] The AMA has also challenged physician participation on purely logistical grounds, arguing that nurses, technicians, physician assistants, and even unlicensed prison personnel may in fact be able to perform executions procedures safely and effectively. AMA 1980, *supra* note 56. *See also* Baum, *infra* note 154, at 57-58; Caplan, *infra* note 209; Lanier, *infra* note 209. However, this position does not acknowledge that the codes of professional ethics applicable to nurses, emergency medical technicians, and physician assistants all include prohibitions on participation in executions similar to those made by the AMA. See *supra* note 61.

[63] Most of the AMA's ethical arguments opposing physician participation in capital punishment are not dependent on opposition by AMA delegates or the profession generally to capital punishment. Even those physicians who support the death penalty may believe that, as a professional matter, it is inappropriate for medical providers to be involved. For

non nocere ("First, do no harm") and the standards set forth in the Hippocratic Oath require that physicians use their medical skills and training to alleviate pain and prolong life.[64] According to the AMA, physician participation in executions causes harm, rather than alleviating suffering, and so "contradicts the dictates of the profession."[65] Moreover, the use of medical skills and technology in the context of an execution procedure that mimics clinical practice presents the public with a conceptual contradiction.[66] Such a "perversion" of the physician's role allegedly distorts societal understandings of the medical profession, undermines professional credibility, and leads to a loss of public trust.[67]

Although the AMA's opinions and policies are merely advisory, most state medical practice acts authorize board discipline of physicians who engage in unprofessional conduct or violate ethical norms,[68] terms which are defined in part by reference to the AMA's policies. Consider, for

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articles citing professional norms as grounds for opposition, see, e.g., William J. Curran & Ward Casscells, *The Ethics of Medical Participation in Capital Punishment by Intravenous Drug Injection*, 302 NEW ENGL. J. MED. 226 (Jan. 24, 1980); Peter A. Clark, *Physician Participation in Executions: Care Giver or Executioner?*, 34 J. L., MED. & ETHICS 95 (2006); Michael K. Gottlieb, *Executions and Torture: The Consequences of Overriding Professional Ethics*, 6 YALE J. OF HEALTH POL'Y, L. & ETHICS 351 (2006). However, at least some physicians who have spoke out against the practice do so on the basis of opposition to the death penalty generally. Consider, for example, Dr. Arthur Zitrin, the self-described "death penalty abolitionist" who initiated a Georgia inquiry into physician involvement in executions. Carlos Campos, *Doctors' Role in Executions Debated*, ATLANTA J.-CONST., Feb. 1, 2005, at A1. *See infra* notes 94-98, and accompanying text.

[64] However, physicians are generally not prohibited from taking harmful actions that do not involve medical training or expertise – for example, sitting as jurors in capital sentencing cases, or acting as public officials. Consider, for example, Kentucky governor Ernie Fletcher, a licensed physician, who in 2004 signed a death warrant for a convicted killer and was challenged before the state medical board. The board determined that he did not violate ethical standards because he was acting as a governor, rather than a physician, when he signed the warrant. Deborah Yetter, *Ethics Complaint is Dismissed; Foes of Execution Challenged Fletcher*, COURIER-J., Jan. 14, 2005, at 1B.

[65] AMA Council on Ethical and Judicial Affairs, *Physician Participation in Capital Punishment (adopted December 1992)*, 270 JAMA 365 (July 21, 1993) [hereinafter AMA CEJA Policy]; *see also* Dworkin, *supra* note 8, at 182-3; Washington v. Glucksberg, 521 U.S. 702, 731 (1997) (noting that physician-assisted suicide could "undermine the trust that is essential to the doctor-patient relationship by blurring the time-honored line between healing and harming").

[66] ASA Policy, *supra* note 61.

[67] AMA CEJA Policy, *supra* note 65. *See also* M. Gregg Bloche, *Clinical Loyalties and the Social Purposes of Medicine*, 281 JAMA: 268, 272 (Jan. 20, 1999); Edmund D. Pellegrino, *Societal Duty and Moral Complicity: the Physician's Dilemma of Divided Loyalty*, 16 INT'L J. L. & PSYCHIATRY 371, 373 (1993); Breach of Trust, *supra* note 25, at 38; Dworkin, *supra* note 8, at 185 (referring to the impermissibility of "the healing hand acting as the hurting hand").

[68] *See* Furrow, *supra* note 55, at 82-83.

example, Ohio's Medical Practice Act, which requires that the state medical board "keep on file current copies of the codes of ethics of the various national professional organizations" and provides that the board "shall" discipline or limit the right to practice of a medical provider for "violation of any provision of a code of ethics of the American [M]edical [A]ssociation . . . or any other national professional organizations that the board specifies by rule."[69] It is on the basis of the AMA's policies that, starting in the mid-1990's, medical providers and human rights organizations began petitioning state medical boards to take disciplinary action against physician participants in executions.[70]

Evidence suggests that, until the late 1990's, state corrections departments had little difficulty finding qualified personnel to participate in executions. Physicians and nurses were routinely involved in the process of lethal injection, though their participation was generally kept out of the public eye and under the AMA's radar. In March of 1994, the American College of Physicians released a report titled *Breach of Trust: Physician Participation in Executions in the Unites States*, which documented the fact that physicians are "often directly involved" in executions by lethal injection and electrocution, "in violation of ethical and professional codes of conduct."[71] The *Breach of Trust* report also provided recommendations intended to "eliminate [the] conflict between medical ethics and the law" and "allow the medical profession to enforce its ethical guidelines" in the context of capital punishment.[72] Among other things, the report recommended that state medical boards "define physician participation [in executions] as unethical conduct, and take appropriate action against physicians who violate ethical standards."[73] That same month, the

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[69] OHIO REV. STAT. 4731.22(B)(18) (2008).

[70] *See, e.g.*, Gibbons et al v. Peters et al., No. 1-94-4453 (Ill. App. Mar. 16, 1996); Thorburn v. Dep't of Corrections, 66 Cal. App. 4th 1284 (Cal. App. 1998); Zitrin v. Georgia Composite State Board of Medical Examiners, Civ. No 2005–103905 (Ga. Super. Ct., July 28, 2006); N.C. Dep't of Corrections et al v. N.C. Med. Board, Civ. No. 07-003574 (N.C. Super. Ct. Sept. 21, 2007).

[71] Breach of Trust, *supra* note 25, at 3. The report cited examples of physicians attending preparatory briefings with the execution team, determining venous access, prescribing lethal drugs, observing the prisoner during the execution process, monitoring the EKG, assessing the prisoner's level of consciousness with "medically accepted tests for reaction to pain," determining whether death had occurred, and pronouncing death. *Id.* at 21-25. A more recent study of physician and nurse participants in executions confirmed their involvement in these activities and others, including placing IV and central lines, instructing that more drugs be given, and doing "dry runs" with the execution technicians. Atul Gawande, *When Law and Ethics Collide - Why Physicians Participate in Executions*, 354 NEW. ENG. J. MED. 1221, 1223-27 (2006).

[72] Breach of Trust, *supra* note 25, at 45.

[73] *Id.* at 46.

American Public Health Association ("APHA"), American College of Physicians, American Nurses Association, and AMA issued a joint statement calling upon state licensing and disciplinary boards to treat participation in executions as grounds for disciplinary action.[74]

Just two months later, in May of 1994, four physicians and Physicians for Human Rights (one of the organizations that authored the *Breach of Trust* report) filed a complaint with the Illinois State Medical Disciplinary Board (the "Illinois Board"), requesting that the board investigate and discipline the physicians who were planning to participate in the scheduled execution of John Wayne Gacy.[75] At the time the complaint was filed, the Illinois Execution of Death Statute required that a physician pronounce death at an execution.[76] The complainants contended that any physician who did so at Gacy's execution would be violating the Medical Practice Act by virtue of his "unethical conduct" and "involvement" in the administration of drugs "for other than a medically accepted therapeutic purpose."[77] Ultimately, the Illinois Board concluded that it had no authority to take disciplinary action, finding that the Execution of Death Statute evidenced the Illinois legislature's policy determination "that there is no violation of the Medical Practice Act for a physician to pronounce the death of a defendant at an execution."[78]

Illinois was among the first states to adopt a statutory safe harbor amendment to its lethal injection statute.[79] Proposed just one year after the Gibbons complaint was filed with the Illinois Board, the amendment provided that Section 22 of the Medical Practice Act, relating to discipline, "does not apply to persons who carry out or assist in the implementation of

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[74] APHA et al., "Health care professional participation in capital punishment: statement from professional societies regarding disciplinary action" (March 23, 1994), reprinted in *APHA, Other Groups, Sign Letter Against Participation in Executions*, 24 NATION'S HEALTH 9 (1994).

[75] *See* Petition for Leave to Appeal, Gibbons v. Peters, No 95-78777 (Ill. Mar. 13, 1995).

[76] 725 ILL. COMP. STAT. 5/119-5(a)(1) (1994).

[77] *See* Petition for Leave to Appeal, Gibbons v. Peters, *supra* note 75.

[78] *Id.* The complainants then filed suit, seeking administrative review of the Illinois Board's decision, as well as declarative and injunctive relief. While the trial court initially remanded to the board for review and recommendation, the appeals court reversed without comment, leaving unchallenged the board's decision not to investigate or initiate disciplinary action. Gibbons et al v. Peters et al., No. 1-94-4453 (Ill. App. Mar. 16, 1996). Although an opinion was supposed to follow the appellate court's March 16 order, the passage of Illinois' safe harbor statute on March 21 rendered the matter moot, and no opinion was issued. Gacy's execution took place as scheduled on May 10, 1994.

[79] The first state to create a safe harbor, albeit not by way of legislation, was Virginia. *See* 1994 VA. OP. ATTY. GEN. 85 (Apr. 26, 1994).

a court order effecting the provisions of [the Execution of Death Statute]."[80] Reportedly, the amendment was adopted "to head off attempts by opponents of the death penalty to delay executions."[81] However, because the amendment was passed hurriedly as part of a sweeping crime bill, there is no record of legislative debate or public discussion of the proposed safe harbor provision.[82] It is perhaps for this reason that the safe harbor provision was challenged, albeit unsuccessfully, immediately after its passage by both physicians and legislators as an improper intrusion upon medical professionals' autonomy.[83]

During the same month that the Illinois statute was passed, Arkansas adopted similar legislation.[84] While there had yet been no reported efforts in Arkansas to instigate disciplinary action against participants, board members of the Arkansas Department of Corrections were aware that professional and ethical concerns might limit the pool of physicians willing to assist in executions. Although no official legislative history is available,[85] news reports indicate that the safe harbor provision was proposed at a 1994 Department of Corrections board meeting during which a board member, Mary Parker (a professor of criminal justice at the University of Arkansas), informed the department of the AMA policy opposing physician participation.[86] Prof. Parker raised the possibility that

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[80] P.A. 89-8, effective March 21, 1995 (adopted as 225 ILL. COMP. STAT. 60/4(b)).

[81] Anita Srikameswaran and Christi Parsons, *Doctors Assail Role In Execution*, CHI. TRIB., June 20, 1995, at 3.

[82] *Id.* The bill was introduced on January 13, 1994, and signed by the governor on March 21. *See* Westlaw 1995 IL H.B. 204 (SN). There were no public hearings, and legislative debates did not address disciplinary immunity for medical providers.

[83] *See* Srikameswaran and Parsons, *supra* note 81 (reporting that physicians at the 1995 AMA meeting challenged the recently enacted statute); Sue Ellen Christian, *Legislator Seeks to Bar Role for Doctors in Executions*, CHI. TRIB., Oct. 24, 1995 at 7 (reporting on a later bill to repeal the safe harbor). The statute containing the safe harbor provision was ultimately repealed in 2003; however, based on the legislative history of the 2003 amendments, legislators were not aware that repealing the statute might subject physicians to discipline for participating in executions. *See generally*, Illinois 93 G.A. SENATE TRANSCRIPTS, March 19, 2003, at 75-78; May 9, 2003, at 117-119; Illinois 93 G.A. House Transcript, March 13, 2003, at 74-79 .

[84] As adopted, the legislation provided that infliction of the death penalty pursuant to Arkansas' lethal injection statute "shall not be construed to be the practice of medicine" and that a licensed medical professional's assistance with an execution "shall not be cause for any disciplinary or corrective measures" by any state board or commission that oversees the practice of health professionals. Act 651, effective March 16, 1995 (adopted as ARK. CODE ANN. § 17-80-108(a) and (b)).

[85] Arkansas does not publish committee reports, committee prints, floor debate, or minutes of senate and house proceedings.

[86] Ray Pierce, *Panel Delays Vote On Execution Methods*, ARK. DEMOCRAT-GAZETTE, January 18, 1995, at 10B [hereinafter, Pierce, Panel Delays Vote].

physicians, in light of AMA policy and the professional oath to "do no harm," might be unwilling to participate in lethal injections.[87] In response to this concern, the Department initially considered abandoning lethal injection altogether in favor of electrocution, the state's previous execution method,[88] but ultimately drafted safe harbor legislation based on the language of a proposed Pennsylvania bill.[89] Arizona[90] and Oregon[91] followed suit, adopting safe harbor provisions in 1998 and 1999, respectively.[92]

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[87] *Id.* (reporting the state's concern that it "could find itself unable to execute convicts in the future because of the reluctance of the medical community to participate in lethal injections"); Ray Pierce, *Privatizing Moves State's Prison System Into New Era*, ARK. DEMOCRAT-GAZETTE, May 14, 1995, at 6B [hereinafter, Pierce, Privatizing].

[88] Pierce, Privatizing, *supra* note 87, at 6B (reporting that the Department considered the electrocution proposal to be "taking a step backward," since lethal injection was considered by some to be "more humane").

[89] Pierce, Panel Delays Vote, *supra* note 86, at 10B. *See also* Frank Reeves, *Bill Would Exclude Doctors From Executions*, PITTSBURG POST-GAZETTE, July 10, 1994, at A1 (reporting that the Pennsylvania Department of Corrections hoped to propose a bill containing exclusionary, safe harbor, and anonymity provisions). The Pennsylvania bill appears never to have been introduced.

[90] Arizona's safe harbor, which was proposed as part of a larger bill addressing various correctional and education issues, provides, "If a person who participates or performs ancillary functions in an execution is licensed by a board, the licensing board shall not suspend or revoke the person's license as a result of the person's participation in an execution." Legis. Serv. Ch. 232 (H.B. 2144), effective March 16, 1995 (adopted as ARIZ. REV. STAT. ANN § 13-704).

[91] Oregon's safe harbor, which was proposed as part of a larger crime bill addressing post-conviction appeals, provides, "Any assistance rendered in an execution" carried out pursuant to law, whether by licensed or nonlicensed personnel, "is not cause for disciplinary measures or regulatory oversight by any board, commission or agency . . . that oversees or regulates the practice of health care professionals[.]" 1999 Oregon Laws Ch. 1055 (S.B. 392), effective Oct. 23, 1999 (adopted as OR. REV. STAT. § 137.476(2)).

[92] While there is no formal record of what triggered these legislative actions on the West Coast, the timing suggests they may have been prompted by a 1998 California challenge. In *Thorburn v. Department of Corrections*, a group of California physicians sought an injunction against physician participation in executions on the grounds that such participation violates the unprofessional conduct provisions of the California Business and Professional Code. The trial court entered judgment in favor of the respondents, medical and correctional officers at California Department of Corrections and San Quentin State Prison, and the appeals court affirmed, concluding that the California legislature did not intend to include physician participation in executions within the ambit of statutorily prohibited unprofessional conduct. Thorburn v. Dep't of Corrections, 66 Cal. App. 4th 1284 (Cal. App. 1998). In 2001, California enacted a law providing that a physician's refusal to participate in an execution would not subject him to disciplinary action; however, the sponsor was clear to point out that the bill "does not seek to establish that such participation by a physician constitutes unprofessional conduct." Senate Committee on Public Safety, Bill Analysis 2001-2002 Regular Session, S.B. 129 (Westlaw CA B.An., S.B. 129 Sen., 3/20/2001).

Although the APHA publicly reaffirmed its 1994 position statement in 2001,[93] there appear to have been no further efforts at board discipline until several years later. In 2004, a group of physicians in Georgia petitioned the state medical board to revoke the license of a Georgia physician who had testified as to his participation in state executions.[94] Though the board refused to sanction the physician, a decision which was upheld by a Georgia court,[95] the Georgia Department of Corrections nevertheless proposed that the legislature adopt a safe harbor provision.[96] According to its sponsor, the bill was introduced because "there ha[d] been challenges to the licensure of people who participate" in executions since Georgia adopted its lethal injection protocol in 2001.[97] In 2006, after passing 157-1 in the House and 46-1 in the Senate with no debate, the bill was signed into law.[98]

That same year, Oklahoma legislators, concerned by the medical profession's response to the California ruling in Morales v. Hickman,[99] passed a safe harbor statute of their own.[100] Said the author of the Oklahoma statute, "This legislation will ensure activists cannot target doctors and nurses who participate in state-ordered executions" and will allow medical professionals to "participate in an execution without fear of retaliation by a medical board or organization."[101]

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[93] APHA, *Participation of Health Professionals in Capital Punishment*, Policy No. 200125 (Jan. 1, 2001).

[94] *See* Zitrin v. Georgia Composite State Board of Medical Examiners, Civ. No 2005–103905 (Ga. Super. Ct., July 28, 2006); Campos, *supra* note 51, at A1.

[95] *Id.* Despite not being sanctioned by the board, the physician stopped participating in executions, citing "harassment."

[96] Nancy Badertscher, *Legislature 2006: Bill would shield doctors at executions*, ATLANTA J.-CONST, Feb. 17, 2006, at 12D.

[97] *Id.*

[98] The safe harbor bill had originally been proposed in 2005 but did not pass. Campos, *Doctors' Execution Role Targeted*, ATLANTA J.-CONST, June 2, 2005, at 1C; Campos, *supra* note 63, at A1.

[99] In Morales, the U.S. District Court for the Northern District of California denied an inmate's request for a stay of execution on the condition that a qualified anesthesiologist be present during the course of the execution. Morales v. Hickman, 06-219, 06-926 (N.D. Ca., Feb. 14 2006), *aff'd*, 438 F.3d 926 (9th Cir. 2006). The two anesthesiologists who initially volunteered ultimately withdrew from involvement on ethical grounds shortly before the execution was to take place; when no colleagues stepped forward to take their place, the execution was effectively stayed pending a ruling on the constitutionality of California's lethal injection procedures. *See* Bob Egelko, *Lethal Injection Hearing*, SAN FRANCISCO CHRON. (Sept. 30, 2006).

[100] Oklahoma House News Releases, Feb. 23, 2006 and May 3, 2006 (noting that the bill was authored following the California "fiasco"). The bill was signed by the governor only three months after its introduction. 2006 Bill Tracking OK H.B.2660.

[101] Oklahoma House News Release, Feb. 23, 2006 and May 3, 2006 (quoting State Rep. Paul Roan).

Professional responses to a similar court ruling in Missouri[102] prompted the 2007 passage of a Missouri statute that not only created a safe harbor from professional discipline for participation in a lawful execution but also provided execution team members with coverage under the state legal expense fund for any legal challenges to their conduct.[103] Legislators expressed the hope that the safe harbor and anonymity provisions in the statute would protect "members of the execution team and their families from retaliation and ridicule" and from professional disciplinary action.[104]

North Carolina is the most recent state to have created a disciplinary safe harbor policy. In January 2007, the North Carolina Medical Board adopted a policy supporting discipline of physician participants in executions.[105] In direct response to this policy, legislators from the House and the Senate proposed a bill that would have included both safe harbor and exclusionary provisions.[106] While the legislative attempt ultimately failed, a ruling by the North Carolina Superior Court effectively created the same kind of safe harbor legislators sought. In North Carolina Department of Corrections et al v. North Carolina Medical Board, the North Carolina Department of Corrections petitioned for declaratory and injunctive relief against the Medical Board, arguing that the Board had no authority to enforce its position statement on physician participation in executions.[107] The court concluded that the Board, in promulgating its position statement and declaring physician conduct "specifically authorized and required by law" to be unethical and subject to discipline, "improperly exceeded the

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[102] After a federal district court ordered Missouri to hire an anesthesiologist to oversee a scheduled execution, Taylor v. Crawford**,** No. 05-4173-CV-C-FJG2006 (W.D. Mo. Sept. 12, 2006), *rev'd*, Taylor v. Crawford, 487 F.3d 1072 (8th Cir. 2007), state officials reported that they were unable to find one. Derek Kravitz, *Bill Would Shield Execution Doctors' Names*, ST. LOUIS POST-DISPATCH, Feb. 28, 2007, at B4; *Editorial*, ST. LOUIS POST-DISPATCH, May 29, 2007, at p. B6.

[103] MISSOURI STAT. § 546.720(4) (2007).

[104] Note that much of the legislative debate in Missouri addressed concerns about retaliation by prisoners, rather than medical boards. For example, Department of Corrections spokesman Brian Hauswirth said that members of the execution team need to be protected from possible acts of retribution by the prisoners on death row, some of whom "are murderers who have committed heinous acts." Kravitz, *supra* note 102, at B4.

[105] The board took the position that "any physician who engages in any verbal or physical activity … that facilitates the execution," beyond those activities specifically required by the criminal procedure statute, "may be subject to disciplinary action by this Board." North Carolina Board Position Statement, *Capital Punishment* (adopted Jan. 2007).

[106] Andrea Weigl, *Execution Impasse Unlikely to End Until Courts Rule*, NEWS & OBSERVER, Apr. 6, 2007, at A1.

[107] N.C. Dep't of Corrections et al v. N.C. Med. Board, Civ. No. 07- 003574 (N.C. Super. Ct. Sept. 21, 2007).

authority bestowed upon it to regulate the practice of medicine."[108] Holding that a "judicial execution is not a medical event or medical procedure and is outside the scope of [the Medical Practices Act]," the court granted the requested relief and rejected the Board's claim to disciplinary authority.[109] The Supreme Court of North Carolina has recently granted a petition for discretionary review of this matter.[110]

The groundswell of safe harbor legislation and litigation over the past three years[111] has brought to at least nine the number of states that effectively prohibit state medical boards from taking disciplinary action on the grounds of participation in lethal injection.[112] Yet public and academic discussion of these safe harbor policies has been limited. Before policymakers increase their reliance on safe harbors as mechanisms for facilitating medical involvement in executions, they ought to evaluate critically the justifications for and the implications of disciplinary safe harbor policies.

III. PRINCIPLES OF PROFESSIONAL REGULATION

An informed policy analysis of capital punishment safe harbors must begin with an understanding of where in the legal landscape they are situated. Fundamentally, safe harbor policies act as limitations on the scope of medical board authority in matters of discipline. As such, their strength as a policy matter should be evaluated by reference to general principles of

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[108] *Id.*

[109] *Id.*

[110] N.C. Dep't of Corr. v. N.C. Med. Bd., 661 S.E. 2d 736 (N.C. 2008).

[111] In 2006 and 2007, safe harbor legislation was proposed in four states (Georgia, Oklahoma, Missouri, North Carolina). For relevant litigation, see Bowling et al v. Haas et al, Civ No. 3:07-cv-32 (E.D. Ky. June 7. 2007) (issuing order to show cause why prisoners' complaint that lethal injection violates the FCSA and FDCA should not be dismissed); N.C. Dep't of Corrections et al v. N.C. Med. Board, Civ. No. 07-003574 (N.C. Super. Ct., Sept. 21, 2007) (holding that judicial executions are outside the scope of the Medical Practices Act and do not constitute medical procedures subject to Board review); Zitrin v. Georgia Composite State Board of Medical Examiners, Civ. No 2005–103905 (Ga. Super. Ct., July 28, 2006) (holding that Georgia law excludes execution from the practice of medicine and the Board was within its authority in refusing to open an investigation), *aff'd*, 2007 WL 3025835 (Ga. Ct. App., Oct. 17, 2007).

[112] See Virginia (1994 VA. OP. ATTY. GEN. 85, Apr. 26, 1994), Arkansas (Ark. Code Ann. § 17-80-108, effective March 16, 1995), California (Thorburn v. Dep't of Corrections, 66 Cal. App. 4th 1284 (Cal. App. 1998)), Arizona (ARIZ. REV. STAT. ANN. § 13-704, effective Dec. 31, 1998), Oregon (OR. REV. STAT. § 137.476, effective Oct. 23, 1999), Georgia (*see* GA. CODE ANN. § 17-10-42.1, effective July 1, 2006), Oklahoma (59 OKL. STAT. ANN. § 4001, effective Nov. 1, 2006), Missouri (MISSOURI STAT. § 546.720, approved June 30, 2007), and North Carolina (N.C. Dep't of Corrections, Civ. No. 07-003574).

medical regulation. That is, safe harbors should be viewed not just as artifacts of the political discourse on capital punishment, but also as part of a historical narrative in which American states have traditionally delegated a great deal of autonomy to the medical profession -- and, more importantly, have granted state medical boards wide latitude in matters of licensure and discipline.

A. Self-Regulation and Professional Autonomy

The principle of professional autonomy largely defines modern theories of professionalism.[113] In a kind of social contract,[114] the professions, on the basis of their members' collective expertise and organized commitment to public service, are privileged with the authority to self-define and self-regulate in exchange for taking on responsibility for the provision of important social goods.[115] The American approach towards the regulation of medicine is consistent with this understanding of professionalism.

Regulation of the medical profession is justified by reference to the states' police powers, which authorize state actions aimed at protecting the public's health and welfare.[116] While the modern system of American medical regulation can be most accurately described as a hybrid scheme that incorporates elements of self-regulation, private oversight, as well as administrative, statutory, and common law,[117] direct government oversight

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[113] *See generally*, Wilbert E. Moore, THE PROFESSIONS: ROLES AND RULES, 6 (1970); Michael D. Bayles, PROFESSIONAL ETHICS, 9 (1988); William M. Sullivan, WORK AND INTEGRITY: THE CRISIS AND PROMISE OF PROFESSIONALISM IN AMERICA, 4-5 (2004); Richard L. Abel, AMERICAN LAWYERS, 37 (1989); Eliot Freidson, PROFESSION OF MEDICINE, 71-72 (1988).

[114] *See* Sullivan, *supra* note 113, at 2; William M. Sullivan, *What Is Left of Professionalism after Managed Care?*, 29 HASTINGS CENTER REPORT 7, at 10-11 (Apr. 13, 1999).

[115] *See generally*, Moore, *supra* note 113, at 6; Bayles, *supra* note 113, at 8-9; Sullivan, *supra* note 113, at 4-5, 9-10; Corinne Lathrop Gilb, HIDDEN HIERARCHIES: THE PROFESSIONS AND GOVERNMENT, 53-54 (1966).

[116] U.S. Const. amend. X. S*ee also* Hawker v. New York, 170 U.S. 189, 191-94 (1898) (noting that "within the acknowledged reach of the police power, a State may prescribe the qualifications of one engaged in any business so directly affecting the lives and health of the people as the practice of medicine."); Dent v. West Virginia, 129 U.S. 114, 122-23 (1889) ("The power of the State to provide for the general welfare of its people authorizes it to prescribe all such regulations as, in its judgment, will secure or tend to secure them against the consequences of ignorance and incapacity as well as of deception and fraud.").

[117] *See, e.g*, Theodore W. Ruger, *Health Law's Coherence Anxiety*, 96 GEO. L. J. 625, 634-35 (2008) (noting that the "interests and relationships that health law centers on are protected by a myriad of legal forms and institutions," including contract law, tort, federal

is rare in matters of licensing, credentialing, and discipline. Instead, medical practice acts aimed at protecting the public from the "unprofessional, improper, incompetent, unlawful, fraudulent and/or deceptive" practice of medicine vest adjudicative and rulemaking authority in state medical boards.[118] These boards, which are composed primarily of licensed medical professionals (and some public members),[119] are responsible for imposing standards for entry into the profession, establishing guidelines for ethical and competent practice, and enforcing those guidelines by way of discipline.[120] Ultimately, the medical profession is given a significant degree of autonomy in determining how best to achieve the state's interests in patient welfare and public health.

There exists no reason why states could not oversee the details of professional practice more directly. Indeed, given the importance of the goals with which the professions have been tasked (improving public health, for medicine; promoting justice, for law), one might question whether the delegation of professional regulation to autonomous or quasi-autonomous administrative or private entities is a wise approach. Though a full defense of this position is beyond the scope of this Article, three justifications are generally offered in support of this approach.

First, professional self-regulation is likely to be, on the whole, more effective than direct government oversight in achieving the state's patient welfare and public health goals. Many scholars contend that professionals

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and state statutes, and administrative regulations); Furrow, *supra* note 55, at 59 (noting that medical boards, while described as self-regulating, include lay members, are governed by procedures set by the legislature, and make decisions subject to judicial review); Thomas L. Greaney, *Public Licensure, Private Certification, and Credentialing of Medical Professionals: An Antitrust Perspective*, in REGULATION OF THE HEALTHCARE PROFESSIONS, at 153-54 (discussing the "ubiquitous and influential role played by private entities" in the process of medical quality assurance), Mark A. Hall, *Law, Medicine, and Trust*, 55 STAN. L. REV. 463 (2002) (seeking to unify the disparate elements of medical regulation by reference to themes of therapeutic jurisprudence and trust).

[118] *See generally*, Furrow, *supra* note 55, at 59-60; Guide to the Essentials of a Modern Medical Practice Act, Tenth Edition, Approved by the House of Delegates of the Federation of State Medical Boards (April 2003); Elements of a Modern State Medical Board, Approved by the House of Delegates of the Federation of State Medical Boards (May 1998).

[119] Furrow, *supra* note 55, at 59-60; Carl F. Ameringer, STATE MEDICAL BOARDS AND THE POLITICS OF PUBLIC PROTECTION, 8 (1999). While the members of the medical board are formally appointed by the governor, private medical associations have historically held significant power in the appointment process. *See* Ronald L. Akers, The Professional Association and the Legal Regulation of Practice, 2 LAW & SOC'Y REV. 463, 471-72 (1967).

[120] *See generally*, Timothy S. Jost, *Oversight of the Competence of Healthcare Professionals*, in REGULATION OF THE HEALTHCARE PROFESSIONS (Timothy S. Jost ed. 1997).

with specialized training and expertise are more qualified than state legislators or administrators to weigh in on issues of technical competence within the profession.[121] Although there is some question as to whether a self-regulated profession's achievement of public goods is merely incidental to its focus on professional well-being, there is intuitive appeal to the idea that a profession's specialized knowledge is valuable in setting professional regulation.[122]

Second, professional self-regulation is typically more efficient than the alternative of direct state oversight. It is generally far less burdensome for the state to delegate its regulatory powers to an administrative agency, particularly one with close ties to private professional associations, than to oversee the details of professional practice directly.[123] Indeed, in the administrative law context, it is well-recognized that, for reasons of both efficacy and efficiency, a legislature in an increasingly complex society "simply cannot do its job absent an ability to delegate power under broad general directives."[124]

There is also a third, somewhat more nuanced, justification for professional self-regulation – namely, that only a profession with a reasonable degree of independence and authority will be able to engender the public trust necessary for it to achieve its goals.[125]

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[121] *See, e.g.*, Bayles, *supra* note 113, at 193; David Orentlicher, *The Role of Professional Self-Regulation*, in REGULATION OF THE HEALTHCARE PROFESSIONS, at 131, *supra* note 120. Some also argue that professionals, by virtue of their specialized knowledge, are likewise more qualified to speak on matters of professional ethics. *See* Robert M. Veatch, "Who Should Control the Scope and Nature of Medical Ethics?," in Robert B. Baker et al., THE AMERICAN MEDICAL ETHICS REVOLUTION: HOW THE AMA'S CODE OF ETHICS HAS TRANSFORMED PHYSICIANS' RELATIONSHIPS TO PATIENTS, PROFESSIONALS, AND SOCIETY, 162-63 (1999) (describing the epistemological claim that while the ethical norms of a profession have their roots in a centralized morality, only members of the professional group can understand and articulate them); *but see infra*, note 134.

[122] *See* Ronald L. Akers, The Professional Association and the Legal Regulation of Practice, 2 Law & Soc'y Rev. 463, 477-78 (1967) (noting that, while laws regulating medical practice "are not so much legislated *against* as *for* and *by* the professions," it would be a mistake to say that their primary goal is self-beneficial rather than of benefit to the public); Gilb, *supra* note 115, at 62 (discussing the dual goals of public and private protection); Abel, *supra* note 113, at 38.

[123] *See* Akers, *supra* note 122, at 467-71 (noting that a "close relationship between the statutorily created boards and the private professional associations" facilitates, and sometimes finances, the activities of medical boards); Gilb, *supra* note 115, at 63 (describing the development of state boards of bar examiners as a means of relieving state courts of the burden of handling bar admission).

[124] Mistretta v. United States, 488 U.S. 361, 372 (1989).

[125] This justification is most clearly explicated in Mark Hall's work on law, trust, and medical profession, which is discussed in greater detail in Section V. *See generally*, Hall, *supra* note 120; Mark A. Hall et al., *Trust in Physicians and Medical Institutions: What Is*

B. Justifications for Overriding Professional Self-Regulation

Regardless of which justification for state delegation of authority to the professions is most compelling, a state that overrides professional self-regulation should, as a matter of policy, have good reasons for doing so if its actions are to win public approval.[126] There are three legitimate reasons for a legislature to override or reclaim powers that were previously delegated to a profession. These reasons are conceptually consistent with general understandings of the rule of law, as well as the more specific justifications for state delegation of professional authority.[127]

First, a state may legitimately reclaim regulatory authority if a self-regulating profession has overstepped the authority granted to it by the state and is acting beyond the scope of its delegated powers.[128] In the health care context, one example would be a state's decision to grant its Health Care Cost Containment Board ("HCCCB") statutory jurisdiction over hospitals and nursing homes. If the HCCCB later adopts a rule pertaining to freestanding ambulatory surgery centers, such a rule would be deemed to exceed the board's statutory authority.[129] Generally, however, the determination of whether an agency has overstepped its statutory authority is left to the judiciary.[130]

Second, a state may reclaim direct regulatory authority over a profession if doing so is necessary to achieve the goals for which the profession was initially established. In the context of medicine, for

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It, Can It Be Measured, and Does It Matter?, 79 MILBANK Q. 613, 614 (2002).

[126] I emphasize that there is likely no legal impediment to such a reclamation of previously delegated powers, only that there are good policy reasons for legislatures to exercise restraint in taking such action. *See, e.g.*, Missouri Coalition for the Env't v. Joint Commission on Admin. Rules, 948 S.W.2d 125, 134 (Mo. 1997) (holding that, while a legislature "may not unilaterally control execution of rulemaking authority" after delegating such authority to an administrative agency, it may "attempt to control the executive branch by passing amendatory or supplemental legislation"); In re Adoption of Regs. Governing the State Health Plan, 135 N.J. 24, 27-28 (1994) (upholding the state legislature's adoption of a statutory amendment prohibiting the state Department of Health from adopting conflicting regulations).

[127] See Section V, *infra*, for a more thorough discussion of why unjustified legislative overrides of professional powers previously delegated pursuant to the state's police powers are problematic as a policy matter.

[128] *See* United States v. Mead Corp., 533 U.S. 218, 226-227 (2001) (holding that an administrative agency's action qualifies for Chevron deference when the action was promulgated in the exercise of authority specifically delegated to the agency by a legislature)

[129] Cataract Surgery Center v. Health Care Cost Containment Bd., 581 So. 2d 1359 (Fla. Dist. Ct. App. 1991).

[130] Chevron v. National Res. Defense Council, 467 U.S. 837, 843 n.9 (1984).

example, direct state regulation may be appropriate if it is a more effective means for securing the welfare of individual patients and the health of the public. This can occur if, for example, the conditions necessary for achieving the state's medical goals have changed, and the profession's existing authority under these changed circumstances is no longer adequate. Consider a public health emergency during which there is a shortage of licensed medical personnel; a state might reasonably suspend licensing requirements for out-of-state medical providers if doing so were deemed necessary to secure medical care for its population.[131]

Finally, a state may reclaim professional authority when doing so is necessary to achieve other compelling public interests unrelated to its interests in medical care, provided that adequate safeguards are in place to protect patient welfare and public health. Occasionally, the state's action itself, though aimed at non-medical goals, may have a secondary effect of supporting the state's medical goals. Consider, for example, the Federal Trade Commission's ("FTC") 1979 antitrust ruling against the AMA, which prohibited medical associations and state medical boards from enforcing their ethical guidelines regarding advertisement and price fixing.[132] In that case, the FTC interfered with medical boards' autonomy in an effort to prohibit anticompetitive behavior. Although the FTC's primary motives were economic in nature (rather than aimed at improving public health), they were sufficiently important to warrant intrusion in the professional sphere. Moreover, the FTC's intervention did not harm patients seeking medical care; arguably, it had a secondary effect of protecting patient welfare and public health. In fact, in finding that the AMA's prohibition on advertising constituted an unfair and anti-competitive practice, the FTC recognized the policy's deleterious effects on public health, noting that restrictions on advertising have "a disproportionate effect on the poor, the sick, and the aged," and that ensuring the availability of information about treatment costs "could mean the alleviation of physical pain or the enjoyment of basic necessities."[133]

If a state can point to one of these three justifications for intervention in the medical sphere, it will be on firm theoretical footing in

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[131] See, for example, § 507(a)(2) of the Model State Emergency Health Powers Act, which authorizes the waiver of all state licensing requirements in the event of a public health emergency as necessary for health care providers licensed in other jurisdictions to practice in the state. This provision has been adopted as, among others, S.C. Code Ann. § 44-4-570(b)(2) (2007); 20 DEL. C. § 3140(2)(b) (2008); N.J. STAT. § 26:13-18(b)(2) (2008); and 63 OKL. ST. § 6602(2)(b) (2008).

[132] Matter of the Am. Med. Ass'n., 94 F.T.C. 701 (1979).

[133] *Id. See also* Wilk v. Am. Med. Ass'n, 895 F.2d 352, 360 (7th Cir. 1990) (upholding district court's finding that the AMA violated federal antitrust laws by conspiring to eliminate the chiropractic profession).

choosing to reclaim regulatory authority that has been historically delegated to the profession. Even if the state's goals in adopting such a policy are unrelated to its traditional interests in professional regulation, the policy should nevertheless be evaluated with these factors in mind.

IV. EVALUATING THE JUSTIFICATIONS FOR SAFE HARBOR POLICIES

For disciplinary safe harbors in the context of capital punishment to be defensible as a matter of public policy, proponents should be able to justify them on at least one of the three grounds set forth in Section III-B. This Section demonstrates that even the most compelling arguments in support of safe harbor policies do not demonstrate that they are necessary to prevent board action beyond the scope of delegated powers, to serve the state's interests in public health and patient welfare, or to serve important state interests beyond the realm of medicine. Moreover, even narrowly drafted safe harbor policies that emphasize the importance of patient welfare and tie disciplinary immunity to good faith physician participation requirements could not be justified on the grounds set forth herein.

A. Reinforcing the Scope of Authority Delegated to the Profession

Capital punishment safe harbors cannot be justified by arguments that they are necessary to prevent the medical profession from overstepping the disciplinary authority delegated to it by the state. First, the profession has always had the power to sanction medical providers for unprofessional and unethical conduct. Furthermore, even if board discipline of execution participants were beyond the scope of the profession's self-regulatory authority, in the thirty years that providers have been participating in lethal injections in contravention of the AMA's ethical norms, not a single state medical board has ever initiated disciplinary action on these grounds. Regardless of the reasons for the unwillingness of medical boards to discipline execution participants, safe harbors policies are not necessary to correct or reinforce the scope of disciplinary authority delegated to the profession.

The disciplinary powers granted to state medical licensing boards have long been broader than necessary to ensure that medical providers are technically competent to provide clinical care. Since the beginning of the twentieth century, boards have been authorized to take disciplinary action against physicians who engage in unprofessional or unethical conduct broadly defined.[134] Some medical practice acts specifically enumerate those

[134] Furrow, *supra* note 55, at 82-83. *See also* Hawker v. New York, 170 U.S. 189, 194 (1898) (holding that character is as important a qualification for professional practice as

activities that constitute unprofessional conduct, while others rely on unprofessional conduct as a "catch-all when a board is convinced that disciplinary action should be taken but that the crime does not fit neatly into another category."[135] Whether or not specifically identified under the rubric of "unprofessional conduct," statutes permit and courts regularly uphold professional discipline for a variety of behaviors that do not directly implicate clinical competence or patient safety – including being convicted of a felony or a crime of moral turpitude,[136] failing to comply with a child support order,[137] providing expert opinion to a court without reasonable investigation,[138] ordering unnecessary laboratory tests,[139] engaging in conduct that brings the medical profession into disrepute,[140] or violating a professional code of ethics.[141]

However, even if professional discipline for participation in capital punishment were deemed to be beyond the scope of medical boards' authority,[142] it is important to recognize that, in the nearly thirty years that

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technical knowledge, and that a legislature that imposes educational requirements for medical licensure "may with equal propriety prescribe what evidence of good character shall be furnished."). Some critics argue that medical professionals have no greater moral authority than laypersons or legislators and ought not be responsible for determining what constitutes unprofessional or unethical conduct subject to discipline, particularly if such determinations are made based on the profession's stance on social policy. *See, e.g.*, Veatch, in Baker, *supra* note 121, at 165-66 (challenging the notion that "only those in a role can have knowledge of the [ethical] duties that attach to that role"); Stephen R. Latham, Linda L. Emanuel, "Who Needs Physicians' Professional Ethics?," in Baker, *supra* note 121, at 193-94. A full defense of the existing system of professional licensure, which clearly authorizes sanctions for unprofessional conduct that does not implicate clinical competence, is far beyond the scope of this Article. Suffice it to say that as a matter of both history and current practice, the American system of medical discipline, in giving medical boards discretion to sanction unprofessional and unethical conduct, implicitly recognizes that professional boards are in a better position than legislatures to determine how and when to enforce the profession's ethical norms. For a more thorough discussion of this issue, see Nadia N. Sawicki, *A Theory of Discipline for Professional Misconduct*, U. of Penn. L. Sch., Public Law Research Paper No. 08-36, available at http://ssrn.com/abstract=1204642.

[135] Robert Cushing Derbyshire, MEDICAL LICENSURE AND DISCIPLINE IN THE UNITED STATES, 85-86 (1978). *See, e.g.*, Forman v. State Board of Health, 157 Ky. 123, 127 (Ky. 1914) (interpreting a statute providing for sanction for "other grossly unprofessional or dishonorable conduct of a character likely to deceive or defraud the public.")

[136] Derbyshire, *supra* note 135, at 85; Furrow, *supra* note 55, at 82-83.

[137] *See, e.g.*, TEX. FAM. CODE. ANN. § 232 (2007).

[138] *See, e.g.*, Deatherage v. Board. of Psychology, 134 Wash.2d 131 (Wash. 1997); Huhta v. State Bd. Of Med., 706 A.2d 1275 (Pa. Comm. 1998).

[139] *See, e.g.*, COLO. REV. STAT. 12-36-117(bb) (2007).

[140] *See, e.g.*, KY. REV, STAT. § 311.597(4).

[141] *See, e.g.*, OHIO REV. STAT. § 4731.22(B)(18) (2008).

[142] This is the position that was taken (erroneously, I argue) by the North Carolina Superior Court in N.C. Dep't of Corrections et al v. N.C. Med. Board. It held that the

medical providers have been participating in lethal injections contrary to the ethical directives of the AMA, not a single medical board has taken disciplinary action against a provider on this basis, and only one board has even suggested a willingness to investigate or discipline these providers.[143] Thus, to the extent that existing safe harbor policies were justified by reference to the threat of board discipline, that threat appears to have been vague, at best.[144]

Were boards to dramatically increase their rate of discipline against execution participants, states might be more justified in enacting safe harbor policies. There is, however, no indication that this is likely to occur. For a variety of reasons, state medical boards have historically been extremely cautious in exercising their disciplinary discretion.[145] Though occasionally

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medical board, in promulgating its position statement, "improperly exceeded the authority bestowed upon it to regulate the practice of medicine," despite the fact that its policy specifically exempted from discipline those physicians who are merely present at an execution in compliance with the statutory requirements for lethal injection, and the fact that North Carolina's medical practice act authorizes discipline for "unprofessional conduct," including a "departure from … the ethics of the medical profession." *See generally, supra* notes 107-110.

[143] *See generally,* Section II-C.

[144] Admittedly in the early 1990's, when the first safe harbors were adopted, the prospect of board discipline loomed large and legislators were unsure how great the risk might actually be. However, by the late 1990's and early 2000's, it was abundantly clear that the threat of successful disciplinary action against participating physicians had not materialized, and that legislative action would not be necessary to prevent an imminent crisis. Moreover, by the mid-1990's, there was ample precedent from analogous pharmaceutical regulation cases that courts would be unwilling to recognize claims challenging an agency's discretion not to investigate the improper use of prescription drugs in capital punishment proceedings. See, e.g., O'Bryan v. McKaskle, 729 F.2d 991, 993 (5th Cir. 1984) (rejecting as "insubstantial" and "unlikely to succeed" petitioner's claim that defendants violated the FDCA by using drugs for lethal injection without demonstrating their safety and effectiveness for this use"); Del. v. Deputy, 644 A.2d 411 (Del. Super. 1994) (holding that a Delaware statute allowing correctional officers to obtain and use controlled substances without a prescription is not preempted by federal drug laws because it is not an obstacle to the execution of Congress' goals); Abdur'Rahman v. Bredesen et al, 2004 WL 2246227, No. M2003-01767-COA-R3-CV (Tenn. Ct. App. 2004), *aff'd* 181 S.W. 3d 292 (Tenn. 2005) (holding that state lethal injection protocols are exempt from drug and pharmacy acts). In fact, as early as 1985, the Supreme Court held, in *Heckler v. Chaney*, that the FDA's decision not to take enforcement action against persons using prescription drugs for purposes of lethal injection was presumptively unreviewable under the Administrative Procedures Act. Heckler v. Chaney, 470 U.S. 821 (1985)**.**

[145] Until the mid- to late-20th century, medical boards were reluctant to initiate disciplinary actions against all but the most egregious violators of medical standards. Ameringer, *supra* note 119, at 2. It was only in the 1970's and 1980's that, facing increased criticism of their passive stance on professional misconduct, boards became more active in disciplining medical providers, increasing eightfold the number of actions against physicians. Jost, *supra* note 120, at 21-22; Ameringer, *supra* note 119, at 5. Overall,

explained by reference to medical boards' alleged impotence,[146] a more compelling interpretation construes their caution as a matter of prudence and discretion.[147] Because boards lack the resources to take disciplinary action against every provider who is alleged to have breached professional standards,[148] they necessarily maintain a system of triage and ultimately pursue only the most fruitful claims.[149] Moreover, in tracking a complaint through the disciplinary process, boards take into account a variety of countervailing practical and policy concerns, including the cost of prosecution, the potential effect of a disciplinary action on patient access, the political and professional implications of a disciplinary action, due process implications, and, most importantly, professional disagreements as to ethical practice and standards of care.[150] Thus, the fact that medical boards exercise their disciplinary authority relatively infrequently does not necessarily suggest that they are negligent or unwilling to take action but rather reflects a prudent determination of which cases are worthy of action when competing values are at stake.[151]

In the case of capital punishment, the reluctance of many boards to discipline participating physicians likely stems from the balancing of factors described above. One of the most relevant considerations may be the fact that, despite the AMA's formal imprimatur against physician participation,

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however, the nationwide rate of board discipline continues to be low. Ameringer, *supra* note 119, at vi, 2; *but see* Jost, *supra* note 120, at 25 (noting that medical boards are no worse than other professional licensing boards in addressing disciplinary problems).

[146] *See* Jost, *supra* note 120, at 22 ("The licensure boards are often criticized as bungling and inept, or, worse, as corrupted by a desire to protect peer professionals from discipline and from public exposure.").

[147] Consider an analogy – the relevance of the Supreme Court's decisions to the American judicial system is not undermined by the fact that the Court ultimately resolves only a miniscule percentage of legal wrongs. Numerous factors affect whether a claim is brought before the legal system in the first place and brought to a substantive resolution in the second, but these do not impact the Courts' authority to resolve legal challenges and set important precedent.

[148] One reason why rates of board discipline are low is the systemic problem of underfunding. Due to their limited budgets, state medical boards are faced with impediments including inadequate staffing, poor information technology services, and problems obtaining necessary expertise and evidence. *See* Randall R. Bovbjerg, Pablo Aliaga & Josephine Gittler, STATE DISCIPLINE OF PHYSICIANS: ASSESSING STATE MEDICAL BOARDS THROUGH CASE STUDIES, 9-10 (2006) [hereinafter, State Discipline of Physicians]; Jost, *supra* note 120, at 24.

[149] Because patients and their families are the primary sources of disciplinary complaints, boards see an extremely high volume of cases, many of which are nonactionable. State Discipline of Physicians, *supra* note 148 at 21.

[150] *Id.* at 38-46.

[151] While this may be a rational approach in light of the practical necessity of triage, this Article does not address the broader question of what kinds of discipline medical boards should pursue if they had fewer financial constraints.

there is genuine dissent among the members of the medical profession as to whether individual physicians should participate in executions and, if they do, whether they should be disciplined.[152] Thus, although the AMA deems participation in executions a violation of medical ethics, individual physicians have made good faith arguments in support of participation that are grounded in traditional principles of medical ethics – for example, that beneficence towards the prisoner-patient requires ensuring a humane death.[153] Given that reasonable interpretations of professional norms have led to legitimate disagreement within the profession, it is very unlikely that boards charged with the legal enforcement of ethical norms would, absent other grounds, be willing to adopt a policy of disciplining execution participants. Unless and until such a change occurs (an unlikely possibility, given medical boards' disinclination to act on this issue thus far), safe harbors appear to be an unduly restrictive mechanism for protecting against the vaguest of threats.

B. Serving the Traditional Goals of Medical Regulation

A more compelling justification of capital punishment safe harbor policies might be the argument that they are consistent with and necessary to achieve one of the traditional goals of medical regulation – namely, the promotion of patient welfare, defined narrowly in this case as the welfare of the condemned prisoner during the process of lethal injection. If prisoner suffering can be minimized by having a physician present to ensure that the drugs are correctly administered and the prisoner is adequately anesthetized, then safe harbors policies might be justified as a means to this end. However, this position, while compelling in theory, has never been advanced by legislative proponents of safe harbor statutes, who instead emphasize the state's interests in criminal punishment. Moreover, even if legislators were to ground safe harbor policies in traditional medical goals, they would have difficulty justifying this position to the extent it is inconsistent with prevailing legal and professional norms.

Some scholarly proponents of physician participation in capital punishment have argued that it is consistent with both state and professional interests in patient protection because it helps to ensure that the prisoner experiences a painless death. Moreover, a vocal minority of physicians has taken the position that medical ethics may in fact obligate physicians to

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[152] Compare *supra* notes 61-67 and *infra* note 154. *See also*, *Commentaries and Letters to the Editor*, 83 MAYO CLINIC PROC. 113-123 (Jan. 2008) (reactions from the medical community to Waisel's commentary promoting physician involvement in executions).

[153] *See infra* note 154.

intervene in the execution process to render it more humane; these practitioners generally compare the death row inmate to the terminally ill patient for whom physician beneficence offers the best hope of a "good death."[154] However, the legislative history of the safe harbor provisions reveals that no legislative proponent of safe harbor provisions has taken this position.[155] The widely acknowledged legislative justification for safe harbors in the context of capital punishment is the pragmatic one of facilitating the implementation of lethal injection, rather than clarifying any theoretical concerns about the goals of medical practice.[156] While issues of patient welfare may be at the heart of some of the unspoken constitutional concerns, nothing in the legislative history indicates that safe harbor policies are being implemented because they are consistent with the traditional goals of medical regulation.[157] Granted, a state seeking to adopt a safe harbor policy could strengthen its position by making legislative findings about the link between medical participation in lethal injections and prisoner welfare, positioning the safe harbor as nothing more than a traditional regulation of medical practice. This, however, would raise larger issues about how states ought to determine what constitutes patient welfare and how the goals of medicine are best achieved.

A state that adopts a safe harbor policy with the express goal of promoting condemned prisoners' medical welfare would have to confront head-on the conflict between its own interpretation of medical welfare and the interpretation offered by the AMA and the medical community (which, with few exceptions, considers the administration of lethal injection a harm to the prisoner-patient's medical interests).[158] Particularly in light of how deferential American law has traditionally been to the opinions of the

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[154] *See, e.g.*, Kenneth Baum, T*o Comfort Always: Physician Participation in Executions*, 5 N.Y.U. J. LEG. & PUB. POL'Y 47 (2002) (supporting physician participation in capital punishment; suggesting that legislation explicitly sanction participation); David Waisel, *Physician Participation in Capital Punishment*, 82 MAYO CLINIC PROC. 1073, 1073, 1079-80 (2007) (arguing that medicine has an obligation to permit participation in executions to minimize harm to the condemned). In fact, 41% of respondents in a recent survey of practicing physicians reported a willingness, at least in theory, to participate in a lethal injection by performing at least one action considered impermissible by the AMA. Neil H. Farber et al., *Physicians' Willingness to Participate in the Process of Lethal Injection for Capital Punishment*, 135(10) ANNALS OF INTERNAL MED. 884, at 887 (2001) [hereinafter, Farber 2001].

[155] *See generally*, Section II-C.

[156] *See, e.g.*, *supra* notes 81, 85-89, 92, 96-98, 100-104, 101 and accompanying text.

[157] Indeed, the fact that most safe harbor and exclusionary provisions are located in state criminal procedure statutes, rather than medical practice acts, further supports this conclusion.

[158] *See generally*, *supra* notes 64-67 and accompanying text.

medical profession in technical matters as well as matters of discipline,[159] the state must make a strong argument for why its interpretation of patient welfare should prevail.[160] One way in which the state could seek to discredit the medical profession's conception of patient welfare is by suggesting that the profession's opinion on this issue is driven more by political opposition to capital punishment than true concern about what is best for patients. In other words, while a state may be willing to defer to medical opinions in matters relating to medical practice, it will not do so in matters of public policy where the medical profession's stance is based on ideology rather than public welfare.

While the political leanings of the medical profession may have some impact on AMA policy,[161] their relevance seems limited in the case of capital punishment safe harbors. In this context and others, the AMA has taken a clear and consistent position opposing medical facilitation of death, even if done for humanitarian purposes. Consider, for example, the AMA's policy on physician assisted suicide, which, while recognizing that some terminally ill patients may prefer death over life, nevertheless holds that physician-assisted suicide "would cause more harm than good" because it is "fundamentally incompatible with the physician's role as healer."[162] In contrast, any state that seeks to make a patient welfare argument in support of safe harbors for execution participants would have to reconcile its position on this issue with the precedent set in *Washington v. Glucksberg* and *Vacco v. Quill*, in which the Supreme Court rejected patient welfare-based arguments in support of physician assisted suicide.[163] Moreover, in

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[159] *See generally*, Section III, *supra*. Consider also the numerous precedents where, rather than allowing legislatures to reach their own conclusions about what patient welfare requires, courts have deferred to the determinations of individual medical providers and the judgment of the medical profession as a whole. See, for example, *Washington v. Harper*, *Riggins v. Nevada*, and *Sell v. Unites States*, which reinforce the principle that the involuntary medical treatment of prisoners is constitutionally permissible only if deemed medically appropriate by the treating physician, regardless of what prison policy requires. While recognizing "the fallibility of medical and psychiatric diagnosis," the Supreme Court refused to accept the notion that "the shortcomings of specialists can always be avoided by shifting the decision from a trained specialist using the traditional tools of medical science to an untrained judge or administrative hearing officer[.]" Washington v. Harper, 494 U.S. 210, 232 (1990) (quoting Parham v. J.R., 442 U.S. 584, at 607-609). Similarly, in *Roe v. Wade*, the Supreme Court identified the first-trimester abortion decision as "inherently, and primarily, a medical decision," the basic responsibility for which "must rest with the physician," rather than the legislature. Roe v. Wade, 410 U.S. 113, 165-166 (1973).

[160] *See generally*, Lerman, *supra* note 7, at 1973-77 (proposing a model of judicial deference to medical ethics).

[161] *But see*, *supra* note 63.

[162] American Medical Association Opinion 2.211, *Physician-Assisted Suicide* (issued June 1994, updated June 1996).

[163] Washington v. Glucksberg, 521 U.S. 702 (1997); Vacco v. Quill, 521 U.S. 793

these cases, the Supreme Court recognized that one of the traditional purposes of medical regulation, beyond promoting patient welfare and public health, is safeguarding the "ethics and integrity of the medical profession."[164] The Court objected to physician assisted suicide in part because it could "undermine the trust that is essential to the doctor-patient relationship by blurring the time-honored line between healing and harming."[165] Given that the Supreme Court has cited the states' interests in preserving public trust in the medical profession as a reason for rejecting a right to physician assisted suicide, the adoption of safe harbor policies in the context of capital punishment without reference to this principle seems ill-advised.

If a state were truly interested in serving the traditional goals of medical regulation, then it would focus not only on basic notions of patients' welfare as understood by the medical profession, but also on preserving the "trust that is essential to the doctor-patient relationship." It is not clear that safe harbor policies adequately serve either of these two goals.[166]

C. Serving State Interests Unrelated to Medical Regulation

If one can draw any general conclusion about the legislative justifications for safe harbor provisions from the history set forth in Section II, it is that they were adopted in response to concerns that state executions might be delayed or even halted altogether if medical professionals were unwilling to participate. In their extremely limited public discussions of the

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(1997). If anything, patient welfare arguments would be stronger in the case of physician assisted suicide, which involves a competent and consenting patient's right to end his own life, as opposed to physician assistance in capital punishment, which involves patients who are involuntarily imprisoned and have not consented to treatment or execution.

[164] *See also* Gonzales v. Carhart, 127 S. Ct. 1610, 1633 (2007) (citing Washington, 521 U.S. 702); In re Conroy, 98 N.J. 321, 352 (1985) (recognizing the state's interest in "safeguarding the integrity of the medical profession" as a countervailing interest to a competent patient's right to refuse medical treatment); Barsky v. Board of Regents of Univ. of N.Y., 347 U.S. 442, 451 (1954) (noting the state's "legitimate concern for maintaining high standards of professional conduct" in the practice of medicine); Haley v. Med. Discip. Bd., 117 Wash. 2d 720, 732 (1991) (describing one of the purposes of medical discipline as protecting the medical profession's standing in the public eye).

[165] Washington, 521 U.S. at 731.

[166] Note that the arguments in this Section regarding how states should define their medical interests could also be used to oppose medical involvement in executions generally. I do not intend to blur the distinction between physician participation requirements and safe harbor policies, but merely to point out the inconsistencies that might arise were states to justify safe harbors on patient welfare grounds. *See also* note 193, *infra*.

merits of the disciplinary safe harbors, legislators expressed hope that the policies would prevent delays in scheduled executions that might otherwise result from challenges by physicians opposing medical participation, constitutional challenges by prisoners, and practical delays resulting from an inability on the part of prison wardens to find adequate personnel to assist in executions.[167] Ultimately, then, the purpose of the safe harbor policies was to ensure that capital punishment, deemed by most states to be a necessary and important feature of the American criminal justice system, could proceed without impediment.[168]

For a medical regulation to be justified on grounds unrelated to the states' traditional medical interests, at least two conditions must be satisfied. First, the state should demonstrate that the regulation is necessary to achieve the non-medical interest in question (in this case, effective implementation of capital punishment). Second, the state should either ensure that alternate safeguards are in place to protect medical interests, or demonstrate that its non-medical interests are so compelling as to warrant intervention without providing additional protections for patient welfare and public health. Arguments for disciplinary safe harbors for lethal injection participants satisfy neither of these conditions.

1. Demonstrating Necessity and Efficacy

Proponents of disciplinary safe harbors cannot justify them on the grounds that they are necessary to support the states' compelling interest in criminal punishment. Safe harbor policies are neither required as a matter of statutory nor constitutional law, and there is no evidence to suggest that they are likely to have a significant impact on states' ability to conduct lawful executions.

a. Statutory Necessity

The most straightforward argument that can be made in support of safe harbor policies is that they are necessary and logical corollaries to state criminal procedure statutes requiring medical participation in executions.[169] If a state legislature has determined that legal executions cannot proceed without the presence of a physician or other licensed provider, then permitting a state medical board to discipline providers for doing what is

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[167] *See generally*, Section II-C, *supra*.

[168] This, of course, serves the states' interests in criminal punishment generally, including deterrence, public safety, and retribution.

[169] *See, e.g.*, Baum, *supra* note 154, at 72-75 (noting that statutes requiring medical involvement take precedence over medical practice acts that merely permit discipline).

required of them by law would directly frustrate the legislature's intent.

While this argument could be used to defend narrow safe harbors in states with explicit medical participation requirements, it is of limited practical value in defending existing safe harbors. Few, if any, of the safe harbor policies currently in force are narrowly tailored to protect only those physicians whose involvement in executions is specifically required by state law. Of the thirty-seven jurisdictions that authorize the use of lethal injection as an execution method, physician attendance is statutorily required in sixteen.[170] Of those sixteen state statutes, none explicitly requires or contemplates that the physician take any specific action beyond being present as a witness, declaring death, or certifying that the execution has taken place,[171] arguably among the least controversial forms of medical participation otherwise prohibited by the AMA. In some states, Department of Corrections regulations may impose more specific participation requirements for physicians or other medical providers, but the secrecy surrounding these regulations make it impossible to determine how often this may be the case.[172]

Indeed, medical providers who admit to having participated in executions typically acknowledge that when their actions have gone beyond the boundaries of what is considered acceptable by the AMA, it is not as a result of any explicit legal requirement. Instead, the role just "crept up on them."[173] If we accept the fact that many (if not most) cases of medical involvement in executions involve activities that are not explicitly required by state law, then we must also recognize that many (if not most) cases could conceivably be subject to medical board discipline without frustrating legislative intent. Because there is no inherent contradiction if a state medical board takes disciplinary action against a physician for doing something that is neither legally required nor prohibited, existing safe harbors are unnecessary to facilitate the legislative goals set forth in lethal injection statutes.

Consider, for example, the legislative mandate in Ohio, where the criminal procedure statute permitting medical involvement in executions is

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[170] *See* Levy, *supra* note 43, at 265 (citing, prior to New Jersey's 2007 repeal of the death penalty, seventeen states).

[171] *Id.* at 265; *but see* N.J. STAT. ANN. § 2C:49-2 (2006) (repealed Dec. 17, 2007) (providing that, prior to lethal injection, the inmate "shall be sedated by a licensed physician, registered nurse, or other qualified personnel"); N.J. STAT. ANN. § 2C:49-8 (2006) (repealed Dec. 17, 2007) (providing that the physician present at the execution shall examine the body and make a written report as to the same).

[172] See *supra* note 46. Moreover, unlike statutory participation requirements, Department of Corrections regulations take no precedence over regulations or adjudications by state medical licensing boards.

[173] Gawande, *supra* note 71, at 1223.

much less explicit than the medical practice act authorizing board discipline. Ohio's medical practice act requires that the state medical board "keep on file current copies of the codes of ethics of the various national professional organizations" and provides that the board "shall" discipline or limit the right to practice of a medical provider for "violation of any provision of a code of ethics of the American [M]edical [A]ssociation … or any other national professional organizations that the board specifies by rule."[174] In contrast, Ohio's criminal procedure statute specifies, with respect to involvement in executions, only that a prison physician "may" be present.[175] Were the Ohio medical board to sanction a physician for participating in an execution, a court reviewing the board's decision could reasonably conclude that the board's authority to discipline physicians for ethical violations has been more clearly established by the legislature than any authority the department of corrections might have to require physician participation.

Turning to the nine safe harbors that have been created in recent years, only one is drafted as a narrow corollary to the state's lethal injection statute. Virginia law requires that a Department of Corrections physician be present at an execution by lethal injection, and that he "perform an examination to determine that death has occurred."[176] By way of a 1994 Attorney General opinion, Virginia established a limited safe harbor for physicians who comply with these specific statutory requirements. Responding to an inquiry by the Director of the Department of Corrections, the Attorney General acknowledged in a carefully-worded opinion that "it would be an obvious absurdity" to permit medical board discipline of a physician who complies with the statutory requirements.[177] "Whatever discretion the Board may otherwise have in the context of a disciplinary proceeding to adopt the ethical standards of the AMA or any other professional group," the Attorney General wrote, "it has no such discretion *when applicable state statutes require that a physician perform the acts in question*."[178] The opinion did not, however, extend this safe harbor to physicians engaged in execution-related activities not expressly required by statute.

Of the remaining eight states with safe harbor policies, four –

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[174] OHIO REV. STAT. 4731.22(B)(18) (2008).

[175] OHIO REV. STAT. 2949.25(A)(4) (2008).

[176] VA. CODE ANN. § 53.1-234, 235 (2007).

[177] 1994 VA. OP. ATTY. GEN. 85 (Apr. 26, 1994).

[178] Emphasis added. See 1994 VA. OP. ATTY. GEN. 85 (Apr. 26, 1994), providing,"[A] physician may not be disciplined by the Board for attending or observing an execution, for making a determination that death has occurred, for issuing a certificate of death, or for performing any other function that applicable state statutes lawfully *require to be performed by a physician* in connection with an execution." [Emphasis added]

Georgia,[179] North Carolina,[180] Oregon,[181] and Oklahoma[182] – have statutory participation requirements but protect physicians from discipline even if they engage in actions beyond those explicitly required by statute. For example, North Carolina's lethal injection statutes require that the prison physician or surgeon attend the execution and certify the fact of execution; they also require that "qualified personnel" administer the injections and perform other relevant tasks.[183] In establishing a judicial safe harbor, however, the North Carolina Supreme Court concluded that these statutes indicate a legislative intent that a physician "be present to perform medical tasks for which he is uniquely qualified" and held that physicians participating in executions, "even if engaged in medical evaluations, examinations, assessments and procedures" beyond the scope of the statutory requirements, are not subject to review or discipline by the state medical board.[184] In its brief to the Supreme Court of North Carolina, the North Carolina Medical Board highlighted this inconsistency, arguing that the Superior Court's conclusion that "the legislature clearly intended that a physician attend and provide professional medical assessment, assistance and oversight in every judicial execution" contradicts both the plain language of the lethal injection statutes and their legislative history.[185]

The remaining four states – Arkansas,[186] Arizona,[187] Missouri,[188]

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[179] Georgia's lethal injection statute, GA. CODE ANN. § 17-10-41, 38(d) (2007), requires the presence of "two physicians to determine when death supervenes." Its safe harbor, GA. CODE ANN. § 17-10-42.1 (2007), arguably goes beyond the express requirements of the lethal injection statute, providing that "[p]articipation in any execution of any convicted person . . . shall not be the subject of any licensure challenge, suspension, or revocation."

[180] N.C. GEN. STAT. § 15-190, 188, 192 (2007).

[181] Oregon's lethal injection statute, OR. REV. STAT. § 137.473 (2005) provides that the prison superintendent "shall invite" the presence of a physician or nurse. Its safe harbor, OR. REV. STAT. § 137.476 (2005), provides that a licensed medical professional "may assist" with the execution and that "any assistance rendered" will not be cause for discipline.

[182] Oklahoma's lethal injection statute, 22 OKLA. STAT. § 1014, 1015 (2007), requires that the prison warden invite a physician to be present at an execution, and that a physician be the one to pronounce the prisoner's death. Its safe harbor statute, 59 OKLA. STAT. § 4001 (2007), however, protects physicians from a much broader range of activities, providing that no disciplinary action will be taken by a medical board against a person "for the reason that the person participated *in any manner* in the execution of a judgment of death." (emphasis added).

[183] N.C. GEN. STAT. § 15-190, 188, 192 (2007).

[184] N.C. Dep't of Corrections v. N.C. Med. Bd., Civ. No. 07- 003574 (N.C. Super. Ct. Sept. 21, 2007).

[185] Brief of North Carolina Medical Board, at 22, N.C. Dep't of Corrections et al v. N.C. Med. Bd. , No. 51PA08 (N.C. 2008), filed July 26, 2008.

[186] Arkansas' lethal injection statute, Ark. Code Ann. § 5-4-617 (2008), requires that the prisoner's death be pronounced "according to accepted standards of medical practice,"

and California[189] – offer similarly broad safe harbors, even in the absence of statutory participation requirements. Consider, for example, Arizona, which does not require physician attendance[190] but nevertheless provides disciplinary immunity for persons who perform "ancillary functions" at executions.[191] Indeed, even the use of the word "ancillary" in the safe harbor statute suggests that licensed medical personnel are not, as a statutory matter, necessary participants in a lethal injection.

Legislatures could, of course, modify existing safe harbor policies to protect execution participants from discipline only if they engage in conduct expressly required by law. Such narrowly tailored safe harbors would be a step in the right direction but would still be subject to challenge on a variety of grounds, including lack of efficacy and inadequate protection of patient interests.[192] Moreover, the underlying physician participation requirements might also be subject to challenges on similar grounds.[193]

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but does not expressly require that a licensed medical provider be the one to do so. Its safe harbor, Ark. Code Ann. § 17-80-108 (2008), protects licensed personnel from discipline for "[a]ny assistance rendered with any execution."

[187] ARIZ. REV. STAT. § 13-704, 705 (2007).

[188] Missouri's lethal injection statute does not require physician involvement, but provides that the execution team shall include, among others, "those persons, such as medical personnel, who provide direct support for the administration of … lethal chemicals." MO. REV. STAT. § 546.720(2) (2007). Its safe harbor is broader, however, protecting execution team members from discipline by a "licensing board or department" as a result of their "participation in a lawful execution." MO. REV. STAT. § 546.720(4) (2007).

[189] At the time that the California Court of Appeal decided in *Thorburn* that the legislature did not intend to include physician participation in capital punishment within the ambit of "unprofessional conduct" prohibited by the Business and Professional Code, California's lethal injection statute, CAL. PEN. CODE § 3605 (1998) required the warden to "invite the presence of two physicians" to executions. However, given that the lethal injection statute was amended in 2001 to eliminate reference to physicians, instead providing that "no physician or any other person … shall be compelled to attend the execution," CAL. PEN. CODE § 3605(c) (2007), it is an open question as to whether *Thorburn*'s broad common law safe harbor is still in force.

[190] ARIZ. REV. STAT. § 13-704, 705 (2007).

[191] ARIZ. REV. STAT. § 13-704(D) (2007).

[192] *See* Sections IV-C-1-c and IV-C-2.

[193] While this Article does not challenge the legitimacy of physician participation requirements generally, a number of the arguments expressed herein could also be used to oppose participation requirements, which may have similar effects on public trust in the medical profession. See, for example, Sections IV-B (regarding professional support of state definitions of patient welfare), IV-C-1-b (regarding constitutional necessity), and IV-C-2 (regarding inadequacy of patient protections).

b. Constitutional Necessity

A more compelling justification for safe harbor statutes, though one that was left conspicuously unspoken by legislators, is that they are necessary for the constitutional implementation of capital punishment. Legislators might have seen the adoption of safe harbors as necessary to preempt the possibility, no matter how remote, that the American execution process might grind to a halt as a result of medical opposition. This justification assumes that medical participation is required as a constitutional matter. As has been widely recognized by physicians and courts alike, the three-drug cocktail currently used for lethal injection involves a risk that a prisoner will suffer cruel and unusual punishment during the execution process if he is inadequately anesthetized and prison personnel proceed with the execution nevertheless.[194] No court, however, has yet held that the Eighth Amendment requires physician participation in lethal injection as a matter of course.[195] Indeed, as demonstrated in this Section, the Supreme Court's recent decision in *Baze v. Rees* only weakens the argument from constitutional necessity.

In *Baze v. Rees*, two death row prisoners brought an Eight Amendment challenge to Kentucky's lethal injection protocol.[196] While conceding that the protocol would be humane if properly administered, the petitioners alleged that the risk of improper administration was unnecessarily high because the lethal injection personnel are not qualified to mix the correct dose of anesthetic, establish intravenous ("IV") access, identify IV problems, or monitor anesthetic depth.[197] The Kentucky protocol requires that IV team members "have at least one year of professional experience as a certified medical assistant, phlebotomist, EMT, paramedic, or military corpsman" but prohibits physician participation except as necessary to certify the cause of death or to "revive the prisoner in the event of last-minute stay of execution."[198]

The Supreme Court rejected the petitioners' challenge, holding that a successful Eighth Amendment claim must establish that the state's lethal injection protocol "creates a demonstrated risk of severe pain," and that this risk is "substantial when compared to the known and available alternatives."[199] In other words, even if Kentucky's lethal injection protocol did create a risk of severe pain, it would not be struck down unless the

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[194] *See supra* notes 3 and 39.
[195] *But see supra* notes 99 and 102.
[196] Baze v. Rees, 553 U.S. __ (2008) (slip op., at 1-2).
[197] *Id.* (slip op., at 10, 15-17, 20-21).
[198] *Id.* (slip op., at 6).
[199] *Id.* (slip op., at 22).

petitioners could identify an alternative protocol that would be substantially less dangerous.[200] While leaving open the possibility that another state's execution protocol might be successfully challenged if it satisfied these standards, the Supreme Court held that the petitioners in *Baze* had not demonstrated a "substantial" or "objectively intolerable" risk that the Kentucky protocol would lead to improper administration of anesthetic.[201] With respect to dosage, the Court upheld the lower court's finding that there is minimal risk of improperly mixing the anesthetic if the manufacturers' instructions are followed (even by a layperson).[202] The Court likewise noted that problems with IV insertion or infiltration were unlikely given the training requirements for IV team members and the presence of the warden, who could watch for signs of infiltration.[203] Finally, with respect to monitoring anesthetic depth, the Court found that "a proper dose of thiopental obviates the concern that the prisoner will not be sufficiently sedated," concluding that the risk posed by Kentucky's failure to adopt additional monitoring procedures was "even more . . . attenuated" than the risk of improper administration of anesthetic.[204]

Given that the only medical personnel involved in Kentucky's execution procedure are a phlebotomist and an EMT,[205] neither of whom are licensed by the state,[206] and that their sole responsibility during the execution is insertion of an IV, after which they leave the execution chamber,[207] the Supreme Court's decision in *Baze* effectively preempted future arguments that the involvement of physicians or other licensed medical personnel in lethal injections is required as a matter of constitutional law.[208]

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[200] The petitioners suggested that a one-drug protocol using only a lethal dose of anesthetic was a "known and available alternative" posing substantially less risk than Kentucky's three-drug protocol. However, the Supreme Court rejected this claim on evidentiary grounds. *Id.* (slip op., at 17-21).

[201] *Id.* (slip op., at 15).

[202] *Id.* (slip op., at 15).

[203] *Id.* (slip op., at 16-17).

[204] *Id.* (slip op., at 20-22).

[205] *Id.* (slip op., at 6, 16).

[206] Kentucky does not license EMTs, but they are required by the Kentucky Board of Emergency Medical Services to be certified pursuant to 202 Ky. Admin. Reg. 7:301 (2007). Kentucky does not license or certify phlebotomists; however, phlebotomists can be privately certified by the National Phlebotomy Association. http://www.nationalphlebotomy.org/.

[207] Baze v. Rees, 553 U.S. ___ (slip op., Ginsburg dissent at 6).

[208] A more striking blow to medical participation was delivered by Justice Alito, whose concurrence elaborated on the possibility of involving additional medical personnel. While agreeing that the risk of unconstitutional pain would be minimized if medical professionals such as anesthesiologists participated in the execution process, Alito rejected this alternative by pointing to the fact that professional rules of ethics and traditions prohibit it.

Though implicitly calling into question the judicial orders in cases like *Morales* and *Taylor*, the reasoning in *Baze* is consistent with earlier scholarly arguments questioning the necessity of medical licensure for execution participants. Even before the Supreme Court accepted certiorari in *Baze v. Rees*, many scholars argued that the benefits of medical participation in executions could be achieved through the use of unlicensed personnel with adequate training in lethal injection procedures.[209] "An argument from technical expertise," noted bioethicist Art Caplan, "simply requires that appropriate training be given by the state to a person who can then competently handle the job. It is difficult to believe that the only persons capable of administering lethal injections are graduates of medical schools and residency programs."[210] In other words, if the presumption that prison personnel can substitute for licensed medical personnel in the context of capital punishment has "proven inaccurate time and time again,"[211] this has resulted from a lack of training, not a lack of licensure. Accordingly, commentators argued, concerns about the qualifications of lethal injection personnel might be adequately addressed simply by improving the training and oversight provided by state departments of corrections.[212]

Alito wrote, "[T]he ethics rules of medical professionals – for reasons that I certainly do not question here – prohibit their participation in executions." From this, he concluded that "[o]bjections to features of a lethal injection protocol must be considered against the backdrop of the ethics rules of medical professionals and related practical constraints." *See generally*, *Id.* (slip op., Alito concurrence at 2-5). This language, while not binding, seems to accurately reflect the presumption made by many justices (and by the parties) during oral arguments that, as a result of the AMA's ethical prohibition, medical personnel would simply be unwilling to participate in Kentucky lethal injections. *See* Transcript, at 12-13, 39, Baze v. Rees, U.S. Supreme Court No. 07-5439 (Jan. 7, 2008) [hereinafter, Baze Transcript]. Justice Scalia, for example, noted during oral arguments that "medical doctors, according to the Code of Ethics of the American Medical Association, can't participate" in lethal injections. Baze Transcript, at 6.

[209] *See, e.g.*, Arthur L. Caplan, *Should Physicians Participate in Capital Punishment?*, 82 MAYO CLINIC PROC. 1047, 1048 (Sept. 2007); William L. Lanier, *Physician Participation in Capital Punishment: Simplifying a Complex Calculus*, 82 MAYO CLINIC PROC. 1043, 1045-46 (Sept. 2007).

[210] Caplan, *supra* note 209, at 1048.

[211] Denno 2007, *supra* note 1, at 91.

[212] A more controversial possibility would be to create a new category of professional under a state's licensing statute – for example, a Licensed Practitioner of Execution ("LPE"). Like other licensed professionals, LPEs would be required to complete a course of training and education before beginning their professional practice and would then be subject to regulation by a state agency independent of the state medical board. In fact, the credentialing program required of LPEs might even be administered by the state Department of Corrections, their likely employer, much in the same way that early nursing diploma programs were administered within individual hospitals seeking to train nurses for their own patient populations. For more on the topic of role morality and practice positivism, see Arthur Isak Applbaum, *Doctor, Schmoctor: Practice Positivism and Its*

Moreover, even if the Supreme Court's decision in *Baze* had left greater leeway for constitutional objections to the administration of lethal injections by non-medical personnel, the defense of safe harbor policies would be far from complete. While the threatened abolition of capital punishment may be an effective rallying cry for safe harbor proponents, it is hardly a realistic threat. Historically, each rejection of execution technology has resulted not in an abandonment of the practice of capital punishment altogether but in an improvement in methodology to satisfy evolving constitutional norms.[213] From improving training for lethal injection personnel to modifying the injection procedure so as to minimize the necessity of medical expertise, a constitutional method of lethal injection could likely exist even in the absence of medical involvement. Although the Supreme Court in *Baze* ultimately rejected on evidentiary grounds the petitioners' suggestion to replace the three-drug protocol with a single-drug protocol,[214] it left open the possibility that alternative procedures might be considered in future cases if their feasibility and effectiveness were adequately documented.[215] Modifications to lethal injection protocols that minimize or eliminate the need for licensed personnel would make it possible for states to proceed with executions even in the event of an absolute boycott by physicians and nurses.

Finally, yet another solution might be to eliminate lethal injection entirely in favor of an alternative execution protocol. Some scholars have suggested that execution by firing squad or at gunpoint poses no more than a minimal risk of violating the Eighth Amendment,[216] and as recently as 1994, the Ninth Circuit, sitting en banc, refused to find hanging

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Complications, in Baker, *supra* note 121, at 144-48 (accepting that, under a theory of practice positivism, physicians may use their expertise for a wide variety of purposes; labeling the use of medical skills in such contexts "schmoctoring," to distinguish it from "doctoring").

Such a system, however, would likely face opposition by the medical profession, which has historically opposed the establishment of independent regulatory schemes for professionals such as midwives, chiropractors, and osteopaths. *See generally*, PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE, 223 (1984). Furthermore, to the extent that licensed medical personnel were involved in training LPEs, they might be subject to disciplinary action for indirect participation in the lethal injection process. *See* Dworkin, *supra* note 8, at 187-88. Moreover, because such a system of alternative licensing would still have the effect of limiting the scope of medical board authority without adequate justification, it would not adequately address the argument of declining professional trust set forth herein.

[213] *See* Section II-A.

[214] Baze v. Rees, 553 U.S. ___ (slip op., at 12).

[215] *Id.* (slip op., at 12).

[216] *See, e.g.*, Denno 2007, *supra* note 1, at 63 (noting that execution by firing squad, though it "carrie[s] with it the baggage of its brutal image and roots," may in fact be "the most humane of all methods.").

unconstitutional.[217] Furthermore, given the level of technical ingenuity exhibited in the past century, it is possible that other constitutional execution methods may yet be discovered.[218]

c. Efficacy

Even if physician participation were required as a statutory or constitutional matter, policymakers have failed to demonstrate that the adoption of disciplinary safe harbor policies would be an effective means of increasing medical participation in executions. Because there is no evidence to suggest that the actual or perceived threat of disciplinary action is a significant factor driving physician behavior in this context, it is unlikely that elimination of board discipline would make medical providers significantly more likely to participate.

First, as noted earlier, in the nearly thirty years that medical providers have been participating in lethal injections contrary to the ethical directives of the AMA, only one state medical board has ever independently taken any steps that suggests a willingness to investigate or discipline those providers.[219] Every disciplinary challenge that was brought before the courts, whether in the medical or pharmaceutical contexts, was raised by individuals critical of the medical boards' allegedly lax approaches to disciplining participants in capital punishment. Given how infrequent and unsuccessful these disciplinary inquiries have been, it would be difficult for proponents of modern safe harbor policies to argue in good faith that medical providers' behavior is likely to be chilled by threats of board discipline.

Second, there is little evidence to suggest that states, including those that adopted or considered adopting safe harbor statutes, have had trouble finding willing medical providers to assist, as necessary, in lethal injections.[220] In Pennsylvania, for example, where safe harbor legislation

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[217] Campbell v. Wood, 18 F.3d 662, 682 (9th Cir. 1994) ("The number of states using hanging is evidence of public perception, but sheds no light on the actual pain that may or may not attend the practice."). *But see* Campbell v. Wood, 511 U.S. 1119 (1994) (J. Blackmun, dissent) (concluding that hanging is a practice offensive to civilized society and therefore unconstitutional).

[218] With few exceptions, however, the pursuit of alternate methods of capital punishment has not been explored. *See, e.g.*, Deborah Denno, *Getting to Death: Are Executions Constitutional?*, 82 IOWA L. REV. 318 (1997); Kristina E. Beard, Comment, *Five Under the Eighth: Methodology Review and the Cruel and Unusual Punishments Clause*, 51 U. MIAMI L. REV. 445 (1997).

[219] *See* Section II-C and *supra* notes 105-110 and accompanying text.

[220] See, for example, Arkansas, which executed five prisoners in 1994 (the year before its safe harbor was adopted); Arizona, which executed four prisoners in 1998 (before the safe harbor's Dec. 31, 1998 effective date); California, which executed one prisoner in

was being considered in 1994, officials had anticipated problems finding physicians to participate in scheduled executions, but later reported that several offered their services.[221] Reports of licensed medical providers participating in executions abound, most notably in Atul Gawande's 2006 study, which reinforced the fact that physicians who choose to participate do so in reliance on their personal ethic of care and sense of civic duty, regardless of the potential disciplinary consequences.[222] If threats of board discipline were as imminent as safe harbor proponents feared, one would expect to find far more dramatic shortages of execution personnel.[223]

Finally, there is no evidence that medical providers who refuse to participate in executions generally do so as a result of consequentialist concerns about professional discipline; rather, their motivations appear to be deontological in nature. Indeed, evidence of physicians' attitudes about participation in capital punishment suggests that actual or perceived threats of board discipline are not a significant motivating factor in their behavior. Consider, for example, that only three percent of physicians surveyed in 1999 were even aware that the AMA had any guidelines on physician participation in capital punishment, making it unlikely that their participation decisions were driven by the risk of medical board enforcement of this policy.[224] Consider also that the vast majority of

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1998 (before *Thorburn*); Georgia, which executed three prisoners in 2005 (the year before its safe harbor was adopted); and Oklahoma, which executed four prisoners in each of 2005 and 2006 (before the safe harbor's Nov. 1, 2006 effective date). All data collected from the Death Penalty Information Center, www.deathpenaltyinfo.org. Note that the number of executions per year may not be an adequate metric for determining the extent of physician participation, as it does not take into account the number of participating physicians, their level of involvement, or other relevant factors (success of appeals, pardons, moratoria, national trends, etc.). However, in the absence of any quantitative study, it may be a useful metric, because if medical participation were necessary for executions, a state unable to find willing medical providers would necessarily be unable to effectuate executions.

[221] Beth Wagner, *Death by Lethal Injection Brings its Own Problems For Corrections Officials*, PITTSBURGH POST-GAZETTE, July 17, 1994, at D2.

[222] Gawande, *supra* note 71. *See also* Neil Farber et al., *Physicians' Attitudes About Involvement in Lethal Injection for Capital Punishment*, 160 ARCHIVES OF INTERNAL MED. 2912, 2913-15 (Oct. 23, 2000) [hereinafter, Farber 2000] (finding that physician willingness to participate in lethal injection was associated with personal factors unrelated to professional discipline – including support for the death penalty, belief in the effectiveness of the death penalty in reducing the murder rate, support for assisted suicide, and a belief that physicians have a "duty to society" to participate in executions).

[223] There is, however, some evidence that the threat of discipline may have increased the costs of executions. *See* Michael Mears, *Lethal Injection and the Georgia Supreme Court's New Millennium*, CHAMPION (Jan/Feb 2004) (noting that, after *Zitrin*, the cost per execution in Georgia rose from $850 to $18,000).

[224] Neil H. Farber *et al*, *Physicians' Willingness to Participate in the Process of Lethal Injection for Capital Punishment*, 135(10) ANNALS OF INTERNAL MED. 884, at 886-7 (2001) [hereinafter, Farber 2001]. In fact, those physicians who were members of the

professional opposition to physician participation in capital punishment, as reflected in the medical literature, is grounded in normative understandings of personal or professional ethics, rather than any threat of disciplinary consequences.[225]

In fact, there have been only two cases in which medical providers' unwillingness to participate has actually halted the progress of executions. In both cases, the specific circumstances of each case suggest that the threat of board discipline was not a significant factor. Though neither California nor Missouri law require that physicians attend or participate in executions,[226] district court judges in both states recently resolved two prisoners' Eighth Amendment challenges by ordering that a board-certified anesthesiologist attend and supervise the prisoners' executions.[227] When qualified anesthesiologists could not be found, executions in both states were stayed.[228]

In California, two anesthesiologists initially volunteered their services; they later changed their minds only after they were told they would have to intervene in the execution if there were any problems. While active intervention in an execution is arguably a greater reason for discipline than mere attendance and oversight, both are prohibited under the AMA's policy. The fact that the anesthesiologists volunteered in the first place, in itself a violation of medical ethics, suggests that the threat of board discipline was not a significant motivating factor in their decisions.[229]

Though there were no volunteers in Missouri,[230] there is evidence that the lack of executioner confidentiality was perceived to be a much more important factor in the anesthesiologists' refusals than the prospect of

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AMA were more likely to report a willingness to participate. *Id.*

[225] *See supra* note 63.

[226] Missouri's lethal injection statute does not explicitly require physician involvement, but provides that the execution team shall include, among others, "those persons, such as medical personnel, who provide direct support for the administration of … lethal chemicals." Mo. Rev. Stat. § 546.720 (2007).

[227] *See generally*, *supra* notes 99 and 102.

[228] At the time that the Supreme Court's grant of certiorari in *Baze v. Rees* imposed a de facto moratorium on executions throughout the country, California's stay was being reevaluated in light of changes to the state's lethal injection procedures. *See* Bob Egelko, *Execution Moratorium Extended Until Fall at Least*, SAN FRANCISCO CHRONICLE, June 2, 2007, at B2. In Missouri, however, the Eighth Circuit soon reversed the district court's judgment and lifted the stay. Taylor v. Crawford, 487 F.3d 1072 (8th Cir. 2007).

[229] *See Editorial*, ST. LOUIS POST-DISPATCH, May 29, 2007, at B6 (opining of the Missouri physicians, "Perhaps it's not retribution that doctors fear, but the concept of violating the first tenet of the Hippocratic Oath.").

[230] Monica Davey, *Missouri Says It Can't Hire Doctor for Executions*, N.Y. TIMES, July 15, 2006 (reporting that Missouri state officials sent letters to 298 anesthesiologists residing near the state prison, and were turned down by all).

formal board discipline. Consider, for example, the Missouri Governor's public message regarding House Bill 820, which he succinctly described as a bill that "keeps the identities of members of the execution team confidential."[231] Only after a thorough description of the confidentiality provisions does the governor's statement note, "The law also protects execution team members who are licensed by a board or department from being censured, reprimanded or suspended."[232] Indeed, a representative of the Missouri State Medical Association stated that while the state medical association did not take a formal position on the bill, its "principal controversy involved the confidentiality of the execution team."[233]

2. Establishing Safeguards to Protect Medical Interests

Even if safe harbors were justified on the grounds of necessity and efficacy, they cannot be defended without first analyzing their impact on the state's interests in medical regulation generally. When a state chooses to enact a medical regulation for purposes unrelated to traditional medical goals, care must be taken to ensure that the regulation is not ultimately harmful to those medical goals. In the case of disciplinary safe harbor policies enacted to support the state's interests in criminal justice, states must ensure that the policies do not run to the detriment of prisoner-patient welfare (or, if they do, states must ensure that alternative mechanisms are in place to protect patient interests). If there are no safeguards in place to protect medical interests, then a medical regulation ought to be adopted only if the state can demonstrate that its chosen purpose is demonstrably more compelling than its interest in patient health and welfare.

a. Adequate Safeguards

Though enacted to facilitate the involvement of licensed medical providers in executions, existing safe harbor statutes fail to provide adequate safeguards for the protection of prisoner-patient welfare. They do nothing to ensure that execution participants act in good faith and cannot protect condemned prisoners from negligence or malice on the part of execution personnel.

Consider, for example, the following hypothetical. Imagine that the

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[231] Missouri Governor Matt Blunt News Release, *Blunt Signs Bill to Protect Safety of Missourians Who Carry Out Death Penalty Law* (July 2, 2007) (available at http://governor.mo.gov/press/DeathPenalty070207.htm).

[232] *Id.*

[233] E-mail from Tom Holloway, Missouri State Medical Association, to Ronald E. Day, Head of Reference Services, Biddle Law Library (Jan. 29, 2008) (on file with author).

state of Georgia has selected, from a group of physician volunteers, Dr. Jones, a graduate of a top medical school with excellent credentials and no history of malpractice or misconduct. During his first execution, however, Dr. Jones performs a venous cut-down with no anesthetic, modifies the amount of drugs in the lethal injection cocktail (specifically, he decreases the amount of sodium thiopental, decreases the amount of pancuronium bromide, and increases the amount of potassium chloride), and instructs the technicians administering the injections to proceed even though the prisoner has not been properly anesthetized.[234] The prisoner experiences pain during the venous cut-down and suffers unbearably during the lethal injection process because the sodium thiopental is insufficient to fully anesthetize him.[235] Because the amount of pancuronium bromide is inadequate, the prisoner is not fully paralyzed and witnesses observe him straining against his restraints, grimacing, and crying out in pain before his death.[236] After the procedure, Dr. Jones is asked why he deviated from standard medical procedures in a way that apparently resulted in a more painful death for the prisoner. He explains that he believes the death penalty's deterrent effects can only be realized if prisoners visibly suffer during the procedure. Moreover, Dr. Jones thinks that the prisoner, who was sentenced to death for torturing and murdering a child, "deserves to suffer."[237]

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[234] Such last-minute procedural changes are by no means uncommon. Correctional procedures rarely specify the amounts of drugs to be used, and the attending physician and warden generally have great latitude in modifying procedures during the execution. In Taylor v. Crawford, 487 F.3d 1072 (8th Cir. 2007), for example, the physician who was in charge of mixing chemicals and inserting IVs for six executions (later identified as Dr. Alan Doerhoff) admitted that he had "independent authority to alter the chemical doses at will based on his medical judgment, and that in fact, there were occasions when he chose to give a dose of only 2.5 grams of thiopental without notifying the director" of the Department of Corrections, despite the fact that Missouri's unwritten execution protocol called for the administration of a 5-gram dose. *Id*. at 1075. Dr. Doerhoff, who is dyslexic and often transposes letters and numbers, also testified that he does not record the amount of the dose actually administered to inmates, and that "the chemical amounts listed in the execution logs are not always accurate as they represent only 'an approximation' of the chemicals used." *Id.;* Weil, *supra* note 47 (quoting Dr. Doerhoff as saying, "[I]t's not unusual for me to make mistakes [as a result of my dyslexia]"). The Eighth Circuit in *Taylor* was careful to note, however, that there was no evidence to indicate that the prisoners executed under Dr. Doerhoff's watch experienced any significant pain. Taylor, 487 F.3d at 1075. While there have been no reported cases of malicious behavior as egregious as in the above hypothetical, examples of lethal injections that have been "botched" due to negligence or professional incompetence abound. See *infra* note 243.

[235] *See* Heath, *supra* note 39, at 93; Koniaris, *supra* note 39, at 1412.

[236] *Id.*

[237] For a real-life parallel to this perspective, see the interview in Gawande, *supra* note 71, at 1224, with "Dr. A," a physician who has participated in a number of executions. While admitting that he does not have a strong opinion about the death penalty, Dr. A. responded to inquiries about his motivations by stating, "I knew something about the past

In this hypothetical, Georgia's medical board would have no authority to discipline Dr. Jones for his unprofessional behavior. Georgia's safe harbor statute provides that "[p]articipation in any execution" pursuant to the lethal injection procedures "shall not be the subject of any licensure challenge, suspension, or revocation" for any licensed Georgia medical professional.[238] Indeed, the safe harbor provisions in other states are just as broadly drafted, generally providing that any assistance or participation in an execution may not be "the cause of" or "the subject of" any disciplinary challenge and that boards may not take action "because of" or "as a result of" a person's participation in an execution.[239] Effectively, such overbroad language prohibits boards from disciplining physicians even for gross malpractice that takes place during the course of an execution.

Because Georgia's exclusionary statute prohibits a civil action for medical malpractice,[240] the only apparent remedy for the scenario described above would be a civil action by the family of the deceased prisoner for deliberate indifference by prison personnel during the course of an execution. Given the procedural limitations on such an action, the narrowness of the deliberate indifference doctrine, and the difficulties families would face in obtaining evidence to support such a claim, it is extremely unlikely that a Section 1983 action could be used successfully as a post facto evaluation of execution personnel.[241]

Ultimately, both safe harbor statutes, which prohibit medical boards from disciplining licensed personnel who act unprofessionally while participating in executions, and exclusionary statutes, which immunize

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of these killers … [M]orally, if you think about the animal behavior of some of these people…" There is no evidence, however, that Dr. A's conduct during executions reflected his motivations in any way.

[238] GA. CODE ANN. § 17-10-42.1 (2007).

[239] *See* ARK. CODE ANN. § 17-80-108 (2007) ("any assistance" shall not be cause for discipline); ARIZ. REV. STAT. ANN § 13-704 (2007) (the board shall not discipline "as a result of" participation); Ga. Code Ann. § 17-10-42.1 (2007) (participation "shall not be the subject of any" disciplinary challenge); MISSOURI STAT. § 546.720 (2007) (the board shall not discipline a person "because of his … participation"); 59 Okl. Stat. Ann. § 4001 (2007) (no board shall take action "for the reason that the person participated in any manner"); OR. REV. STAT. § 137.476 (2007) ("any assistance" is not cause for discipline).

[240] GA. CODE. ANN. § 17-10-38(c) (2007).

[241] *See generally*, 42 U.S.C. 1983, 1988(a); Robertson v. Wegmann, 436 U.S. 584, 588-90 (1978) (holding that survival of a Section 1983 action is governed by state law); Owens v. Okure, 488 U.S. 235, 236 (1989) (holding that state law statutes of limitations for personal injury actions govern Section 1983 claims); Estelle v. Gamble, 429 U.S. 97, 106 (1976) (holding that, in order to state a cognizable Section 1983 claim in the context of medical care, a prisoner must demonstrate prison authorities' deliberate indifference to his serious medical needs); Farmer v. Brennan, 511 U.S. 825, 828-29 (1994) (holding that claims for deliberate indifference require a showing that prison officials were subjectively aware of the risk to a prisoner and nevertheless failed to act).

physicians from malpractice liability and prohibit medical boards from charging laypersons with the unlicensed practice of medicine, make it impossible or impractical for prisoners, their families, correctional officers, and the public to challenge the qualifications of execution participants. While a state may rightly conclude that, as a general matter, executions overseen by physicians are likely to be more humane than those conducted by unlicensed personnel, an absolute bar on board discipline assumes that physician involvement will, without exception, result in a more humane execution, and that board oversight will never be necessary – assumptions that, as shown herein, are untenable. Given that there is already a serious lack of oversight in a national prison medical system that has been described as "inadequate ... and sometimes shockingly poor,"[242] that our society has already been witness to a number of "botched" lethal injections,[243] and that state and federal prisons continue to employ execution personnel whose professional competence is dubious,[244] it is disconcerting that legislatures throughout the country are attempting to eliminate even the most unlikely mechanisms for post facto evaluation of execution personnel.[245]

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[242] John V. Jacobi, *Prison Health Public Health: Obligations and Opportunities*, 31 AM. J. L. AND MED. 447 (2005).

[243] Even the first execution by lethal injection, in 1982, was plagued with errors. Due to the prisoner's history of intravenous drug use, execution technicians had difficulty finding a usable vein, and their repeated attempts left the prisoner bleeding. Reinhold, *supra* note 47; Denno 2007, *supra* note 1, at 84. The prison warden incorrectly mixed the thiopental and pancuronium bromide, obstructing the catheter used for injection. *See supra* note 53. Finally, when called to pronounce death, the prison physician found that the prisoner was still alive. *See supra* note 53. Commenting in 2007 on how the first lethal injection actually played out, Dr. Chapman, the architect of the procedure, said, "It never occurred to me when we set this up that we'd have complete idiots administering the drugs." Weil, *supra* note 47. *See also* Denno 2002, *supra* note 44, at 139-41 (describing lethal injection errors between 1983 and 2001); Weil, *supra* note 47 (reporting on errors during executions resulting from incompetence and negligence); Heath, *supra* note 39 (describing recent botched executions in Ohio, Florida, and Oklahoma).

[244] Dr. Alan Doerhoff, the Missouri doctor whose qualifications and competence were challenged in *Taylor*, had been sued for malpractice more than twenty times, had his privileges revoked at two hospitals, and was ultimately barred by the District Court from "participating in any manner, at any level, in the State of Missouri's lethal injection process." Taylor v. Crawford, No. 05-4173-CV-C-FJG (W.D. Mo. Sept. 12, 2006). *See also For Hire: Executioner*, ST. LOUIS POST-DISPATCH (MO.), B2 (January 20, 2008) [hereinafter, For Hire]; Weil, *supra* note 47 (citing testimony of an expert witness in *Taylor* who opined that a medical resident who practiced as Dr. Doerhoff admitted to practicing "wouldn't be allowed to continue through a residency."). Nevertheless, Dr. Doerhoff was later hired to assist with federal executions. For Hire, at B2.

[245] Admittedly, post-facto discipline by professional boards is an imperfect and unlikely means of ensuring the constitutionality of lethal injections. This is in part because of boards' traditionally cautious approach towards discipline, but also because of the

There are ways in which states could address some of these concerns about prisoner-patient welfare. The simplest would be to craft a narrower safe harbor that protects only those execution participants who act in good faith and in compliance with procedural requirements.[246] While such policies would likely be sufficient to protect against malicious actions, they would not address cases of negligence or incompetence. Moreover, even these narrowly tailored safe harbors would be subject to the concerns set forth in Sections IV-B and IV-C-1. Another method might be to incorporate additional procedural protections for prisoner-patients within the lethal injection protocols.[247] However, no state department of corrections has publicly indicated that it has done so; moreover, because lethal injection procedures are generally adopted outside the normal administrative rulemaking process and kept confidential, it would be extremely difficult to determine whether they provide adequate safeguards.

b. Compelling State Interests and Patient Protection

Some state interests may be so compelling that they demand intervention in the medical sphere even if safeguards for individual patients are impossible or impractical. In other words, a state may be justified in imposing a medical regulation that limits the autonomy of medical boards if its interests in enacting such a policy are so compelling that they outweigh

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profession's repeated assertions that physician participation in capital punishment is not the practice of medicine and thus presumably not subject to review on the basis of poor performance. *See, e.g.*, ASA Policy, *supra* note 61; Curran & Casscells, supra note 63, 228-29. That said, if boards were able to discipline only for poor performance (rather than participation), it is possible that some might use the means available to them.

[246] Disciplinary safe harbors that have been established in other medical contexts (including withdrawal of futile care, withdrawal of life-sustaining treatment pursuant to a DNR order, harvesting of organs in accordance with a patient's wishes, and prescription of opiates for pain management) generally offer immunity only to those physicians who act in good faith or otherwise comply with procedural and substantive requirements. *See, e.g.*, Thaddeus Mason Pope, *Medical Futility Statutes: No Safe Harbor to Unilaterally Refuse Life-Sustaining Treatment*, 75 TENN. L. REV. 1, at 54, 58 (2007) (describing the "good faith" requirement for withdrawal of futile care).

[247] Traditional safe harbors, such as the ones described in note 246, *supra*, immunize physicians from discipline for certain unilateral actions but impose clear statutory requirements as to when and how physicians can take those actions. In the end-of-life context, for example, statutory requirements for valid DNR orders and organ donation requests help to assure that patient wishes will be followed. *See, e.g.*, Charles P. Sabatino, *Survey of State EMS-DNR Laws and Protocols*, 27 J.L. Med. & Ethics 297, 302-04 (Winter 1999) (discussing statutory safe harbors for emergency medical providers complying with do not resuscitate orders); Uniform Anatomical Gift Act §18(a) (providing that a person who attempts in good faith to comply with the Act shall be immune from liability in civil, criminal, and administrative proceedings).

its traditional interests in protecting patient welfare.

Consider, for example, a massive public health emergency during which a state suspends its medical licensing statutes.[248] Such intervention might be necessary if there were a shortage of in-state medical providers and the only way to secure medical treatment for the state's population were to use the services of out-of-state providers and unlicensed individuals with medical training (such as medical students and volunteers with CPR certification). While state medical licensing statutes are clearly aimed at protecting patient welfare and there is a risk that patients treated by unlicensed and potentially negligent providers will suffer harm, the state's interest in minimizing a statewide catastrophe outweighs these concerns. By contrast, it is by no means clear that states with disciplinary safe harbors for execution participants would be able to demonstrate that their interests in executing condemned criminals by way of lethal injection are so strong that they outweigh the state's traditional medical interests in prisoner-patient welfare. It is important to note that this requirement does not demand a comprehensive defense of capital punishment generally; those states that allow capital punishment do so because their citizens have already determined that it is an essential mechanism of the criminal justice system. Rather, states need only show that their interests in administering capital punishment – at this time and in this particular manner – are so strong as to outweigh their interests in traditional medical regulation.

Even this model, however, may be problematic in extreme cases. Consider, for example, a disciplinary safe harbor that protects physicians who facilitate the interrogation, abuse, or torture of alleged terrorists in criminal or military contexts.[249] If a terroristic threat were real and imminent enough that the state could reasonably declare an interest in protecting the public from immediate catastrophic harm, this interest might outweigh the state's interests in protecting medical professionalism and the welfare of patients in its custody. There may be no easy solution to this problem, except to call on the distinction between cases such as these (and the public health emergency described above), where imminent harm is likely to occur, and that of capital punishment, where the public threat posed by an unexecuted criminal is far less severe.

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[248] *See supra* note 131.

[249] For articles citing evidence of medical participation in interrogations at Guantanamo Bay, see, e.g., M. Gregg Bloche & Jonathan H. Marks, *When Doctors Go to War*, 352 NEW ENG. J. MED. 3 (Jan. 6, 2005); Jane Mayer, *The Experiment*, NEW YORKER, 60-71 (July 11, 2005).

V. PROFESSIONAL IMPLICATIONS OF SAFE HARBOR POLICIES

As important as it is to recognize that most safe harbor policies cannot be supported by reference to the three justifications described above, this conclusion, on its own, is not likely to significantly further the academic discourse. While courts are generally considered immune from the vagaries of inconsistent jurisprudence, state legislatures regularly adopt statutes that are poorly tailored, targeted at uncertain goals, or lacking in theoretical support. Often, such statutes exist to satisfy the expressive function of law -- that is, to make a political or social statement, even if that statement is unlikely to have any immediate practical effect.[250] However, even primarily expressive laws must be evaluated in light of their potential (even unintended) consequences.[251]

Judging by the history in Section II and the analysis in Section IV, disciplinary safe harbors and similar policies for facilitating medical involvement in executions are more likely to serve expressive functions than to have significant practical effects on the implementation of capital punishment. This Section considers whether safe harbors may instead have unintended consequences outside the realm of capital punishment – in the realm of medical practice. A preliminary analysis suggests that disciplinary safe harbors and other unjustified limitations on medical board autonomy may negatively affect public trust in the medical profession. Because public trust is a key determinant of medicine's ability to achieve the public interests it has been charged with protecting – namely, patient welfare and public health – policymakers would be remiss in adopting safe harbors without first considering these potential consequences. Though further empirical inquiries into the likelihood of such effects should be pursued, simply introducing theories of medical trust into the public discourse about medical involvement in lethal injections will surely help elevate the quality of debate.

A. Trust, Medicine, and the Pursuit of Public Interests

Although much has been written about the importance of trust in medical practice, Mark Hall's comprehensive work on law and medical trust is most instructive in this regard.[252] Hall asserts that trust has both

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[250] Cass R. Sunstein, *On the Expressive Function of Law*, 144 U. PA. L. REV. 2021, 2031-33 (1995).

[251] *Id.* at 2044-2048.

[252] *See generally*, Hall, *supra* note 120; Hall, *supra* note 125; Mark A. Hall et al., *Trust in the Medical Profession: Conceptual and Measurement Issues*, 37 HEALTH SERVICES RES. 1419 (2002).

intrinsic and instrumental value in the physician-patient relationship[253] and posits that the conditions of intense vulnerability inherent in serious illness and even routine medical care "magnify the role that trust plays in medical relationships.[254] Without some minimal level of trust in medical professionals and institutions, patients would not be willing to "seek care, submit to treatment, disclose necessary information, or follow treatment recommendations."[255] Moreover, nonspecific healing effects, such as the placebo effect, are dependent on the intervention of a trusted healer, rather than any particular therapeutic agent.[256] Ultimately, Hall concludes, trust is "essential for activating the charismatic or emotive dimension of healing that is fundamental to effective treatment relationships."[257] Perhaps more importantly, once lost, this trust (whether systemic or individual) is extremely difficult to regain.[258]

Though Hall's work focuses on the connection between trust and effective clinical practice, it is also important to recognize that the medical profession is often called upon to serve public goals beyond the realm of patient care. Because a variety of social institutions rely on the authority and credibility of the medical profession,[259] promotion of medical trust is likely to further not only the state's interests in patient welfare and public health, but also its interests in other non-medical goals. Consider, for example, judicial and legislative reliance on the testimony of medical experts; the cooperation between public health authorities and medical providers that is necessary to identify, contain, and treat public health threats; or, most relevant to this discussion, the state's dependence on medical technology and professionals to implement the process of capital punishment. In each of these contexts, society has sought guidance from the medical profession not merely because of its technical expertise but also because of the legitimacy that medical involvement brings.[260] If this sense

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[253] Hall, *supra* note 120, at 477-482; Hall, *supra* note 125, at 614.

[254] Hall, *supra* note 120, at 471.

[255] *Id.* at 478. *See also* Hall, *supra* note 125, at 614; Starr, *supra* note 212, at 5 (addressing the importance of clinical authority to the therapeutic process); David Mechanic, *The Functions and Limitations of Trust in the Provision of Medical Care*, 23 J. HEALTH POL. POL'Y & L. 661 (1998) (describing the effects of erosion of trust on the effectiveness of medical interventions).

[256] Hall, *supra* note 120, at 479-80.

[257] *Id.* at 480.

[258] *Id.* at 508-09.

[259] *See generally*, Starr, *supra* note 212, at 14-15 (addressing medical authority as a "resource for social order").

[260] As noted in Section II, *supra*, lethal injection technology was so quickly and widely accepted after its 1977 adoption in Oklahoma not because of its demonstrated effectiveness (after all, the first execution by lethal injection did not take place until 1982) but because there was something intrinsically reassuring about the introduction of medicine into the

of legitimacy and respectability is lost, many of the perceived benefits of reliance on medicine in these various realms would likewise be lost.[261]

Given these "psychological realities of trust,"[262] Hall hypothesizes three different stances that the law could take with respect to trust in medicine: a predicated stance, which "takes the existence of trust as a factual premise" for the imposition of legal rules; a supportive stance, which uses the law as a mechanism for sustaining or promoting trust; and a skeptical stance, which crafts legal alternatives to trust where trust is nonexistent or undeserved.[263] While Hall makes no normative conclusions about the comparative validity of these approaches, he notes that the supportive approach has found purchase among scholars in the field. Hall recognizes a "widespread agreement" that trust in the medical profession is desirable and should be promoted,[264] and describes the preservation and enhancement of trust as prominent objectives of health care law.[265]

There is indeed strong support among scholars for some iteration of a supportive stance towards trust broadly defined.[266] One of the

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execution chamber. Who better to push the plunger than Marcus Welby, M.D.? *See* Federman and Holmes, *supra* note 7, at 446 (noting that the use of a "therapeutic discourse" regarding the death penalty evidences a "sanitization of the capital punishment process"); Johnson, *supra* note 12, at 46 (describing society's attempts to develop a method of execution that is "the most tame and reliable method of killing made possible by existing technology").

[261] Consider, for example, a member of Missouri's lethal injection team whose name was disclosed on the front page of the St. Louis Post-Dispatch despite a recently enacted state law prohibiting the public identification of execution team members. Jeremy Kohler, *Execution Nurse had Criminal Past*, ST. LOUIS POST-DISPATCH (MO.), A1, Jan. 13, 2008. Although his nursing license was "unblemished," his "special knowledge, skills, and abilities" were described as "one of a kind," and there was no evidence that he had committed any negligence or misconduct during an execution, *Id.*, the editors deemed it "crucial" to disclose his identity because, at the time he was performing executions in Missouri, he was on probation after pleading no contest to two misdemeanors. For Hire, *supra* note 244. While not condoning the newspaper's disclosure, I use this case as an example of how a medical provider's lapse of moral judgment may be judged just as harshly, if not more, than a lapse of clinical competence.

[262] Hall, *supra* note 120, at 472.

[263] *Id.* at 486.

[264] *Id.* at 504-05. Hall notes that this "widespread agreement" exists despite a lack of empirical support for the assumption that trust needs support and that legal mechanisms are effective in providing such support. *Id. See generally, infra* note 270.

[265] *Id.* at 470-71. This is consistent with Friedson's sociological view, which posits that the medical profession sustains and maintains its special status in society "by its persuasive profession of the extraordinary trustworthiness of its members." Eliot Freidson, PROFESSION OF MEDICINE: A STUDY OF THE SOCIOLOGY OF APPLIED KNOWLEDGE, xv (1988).

[266] *See, e.g.*, Robert Gatter, Faith, *Confidence and Health Care: Fostering Trust in Medicine Through Law*, 39 WAKE FOREST L. REV. 395, 402-403, n. 36 (2004) (identifying

foundational principles of modern health law scholarship is the recognition that something unique about illness and the doctor-patient relationship – alternatively called vulnerability, trust, or fiduciary duty – warrants differential and protective treatment under the law.[267] Skeptical attitudes towards medical trust, which hold that patients are merely medical consumers and that the law should not encourage irrational trust founded on overly optimistic archetypes, go directly against this founding principle of health law scholarship. While not everyone may be willing to defend a strong supportive stance, those who acknowledge the existence of medical trust and recognize its importance to the achievement of state goals ought to agree that the trust implications of medical regulations warrant consideration by policymakers.[268]

B. Law as a Mechanism for Supporting Systemic Trust

Any view of the law as a mechanism for producing, maintaining, or increasing medical trust is based on the presumption that trust in the professions is contingent on and can be affected by legal rules and attitudes.[269] Though there is little empirical evidence to suggest that changes in health care law affect trust in individual physicians,[270] Hall suggests that the apparent robustness of trust in physicians is tied to "diffuse" or "systemic" medical trust, which in turn is "fostered by

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the author as a proponent of the position that medical trust or confidence "should be preserved, if not promoted, as a matter of policy"); Mechanic, *supra* note 255, at 683 ("Regulation provides a counterpoint to distrust by controlling its most apparent causes. If such regulation can be appropriately targeted, it will provide a stronger basis for trust.").

[267] *See, e.g.*, Mark A. Hall, *The Legal and Historical Foundations of Patients as Medical Consumers*, 96 GEO. L. J. 583, 594-96 (2008) (exploring the special features of medical relationships by reference to the law's approach to imposing payment obligations on patients who have received medical care); Ruger, *supra* note 117, at 645 (describing how health law coalesced around the conception of patient rights to impose an obligation to care for patients in emergencies even absent any preexisting treatment relationship). *See also* Norman Daniels, *Health Care Needs and Distributive Justice*, 10:2 PHIL AND PUB. AFFAIRS 146 (Spring 1981) (arguing that health care needs are special and distinctive because of their impact on equality of human opportunity).

[268] While promotion of medical trust alone may not be an adequate justification for the adoption of medical regulations, a regulation that is justified on police power grounds and otherwise satisfies constitutional scrutiny ought to be evaluated by policymakers with respect to its likely impact on medical trust.

[269] Hall, *supra* note 120, at 496-98.

[270] *Id.* at 505-507 (surveying the limited scholarship in this area and concluding that trust in physicians "may be more resilient than we often suppose"). However, Hall warns against relying too much on this apparent resilience, emphasizing that "threats to trust are real and should be taken seriously." *Id.* at 508.

institutional and social mechanisms such as licensure or peer review."[271] Indeed, studies have shown that patient trust in individual medical providers is distinct from trust in medical organizations and the profession as a whole,[272] and that systemic trust has a strong influence on interpersonal trust.[273] Hall describes licensure and certification laws as among the most obvious examples of laws crafted to bolster public trust,[274] and notes that the stability of such standard-setting laws may serve to protect systemic trust even in the face of misconduct by individual physicians.[275]

Though further empirical work certainly needs to be done in this area, Hall's suggestion that licensure and other standard-setting laws play a role in establishing systemic medical trust is consistent with the system of professionalism described in Section III. Medical board licensure, peer review, and other self-regulatory mechanisms are embodiments of professional autonomy, one of the key elements of modern theories of professionalism. Thus, it is only a short step from Hall's argument that licensure and peer review are key to maintaining systemic medical trust to the broader argument that medical trust is driven in large part by the special self-regulatory authority granted to the professions under American law, including the authority to discipline providers who fall short of professional standards.[276] In other words, the trust that is required for the medical profession to effectively achieve social goals does not arise exclusively from public perceptions of individual physicians. Rather, the legal delegation of regulatory power to the medical profession itself engenders trust in the profession.[277]

Indeed, evidence suggests that public perceptions of medicine's

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[271] *Id.* at 508.

[272] Hall, *supra* note 125, at 619-20; *see also* David Mechanic, *Changing Medical Organization and the Erosion of Trust*, 74 Milbank Q. 171, 173-74 (1996) (describing the distinctions and correlations between interpersonal and systemic trust).

[273] Hall, *supra* note 125, at 620; Mechanic, *supra* note 272, at 173-74.

[274] Hall, *supra* note 120, at 501.

[275] *Id.* at 508.

[276] *See also*, Starr, *supra* note 212, at 19-20 (identifying professional authority as "built into the structure of institutions" such as the law; noting that the "authority that inheres in the status of physician" does so "because it has been institutionalized in a system of standardized education and licensing").

[277] Beyond its effect on systemic medical trust, professional autonomy in matters of self-regulation may also impact the profession's effectiveness by affecting physicians' own perceptions of their role. *See, e.g.*, David Orentlicher, *The Role of Professional Self-Regulation*, in REG. OF HEALTHCARE PROFS., *supra* note 120, at 130-32 (noting that the internal development of guidelines leads to greater physician satisfaction); Robert D. Troug and Troyen A. Brennan, *Participation of Physicians in Capital Punishment*, 329 NEW ENGL. J. MED. 1346 (Oct. 28, 1993) (describing "[e]fforts to ensure ethical behavior from within the profession" as preferable to legislation attempting to "enforce such behavior from without.").

accountability and respectability are, now more than ever, tied to the profession's ability to independently and effectively police its members. A recent Gallup poll concluded that a majority of consumers of medical care believe that the oversight authority granted to independent medical boards is "very important" as a formal check on physician behavior.[278] Moreover, recent public criticism of medical boards' alleged impotence suggests that the public favors an even greater disciplinary role for boards and will voice its concern if it appears that the medical profession cannot or will not act in the interests of patients, whether as a result of professional self-protection,[279] state intervention,[280] or other reasons.[281] Most recently, some state legislatures are responding to these concerns by enacting

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[278] The Gallup Organization (for The American Board of Internal Medicine), *Awareness of and Attitudes Toward Board-Certification of Physicians* (Aug. 2003) (64% feel that it is "very important" for physicians to be evaluated on an ongoing basis by an independent board; 81% know what state licensing is and report that their personal physicians are licensed).

[279] Much criticism directed towards the medical profession in recent years has arisen in connection with allegations that the medical profession is more sensitive to its own economic interests than to the health interests of patients. Consider, for example, the AMA's 1997 agreement to endorse a line of health-related products made by Sunbeam, which was widely criticized once it became clear that the AMA would not be testing the quality of the endorsed products. Glenn Collins, *Look Who's Doing Endorsements*, N.Y. TIMES, Aug. 17, 1997. Within a week of its announcement, the AMA abandoned the Sunbeam deal, citing widespread "public doubt" about its "motives" and "credibility." Glenn Collins, *AMA Seeks to Dismantle Sunbeam Deal*, N.Y. TIMES, Aug. 22, 1997.

[280] Independence from political influences has long been recognized as a key factor in facilitating effective medical board function. State Discipline of Physicians, *supra* note 148, at 9. Historically, policies that have modified the scope of medical authority for political reasons unrelated to patient welfare – for example, to facilitate criminal prosecution or to protect prevailing moral norms – have been criticized as inappropriate political intrusions upon professional practice. *See, e.g.*, Ferguson v. City of Charleston, 532 U.S. 67, 84-86 (U.S. 2001) (holding that a hospital policy of using diagnostic tests to incriminate drug-abusing patients was unconstitutional because its immediate objective was to generate evidence for law enforcement purposes, rather than treatment); Griswold v. Connecticut, 381 U.S. 479, 498 (U.S. 1965) (Goldburg, Harlan, White concurrence) (noting that the legitimate government interest of discouraging extra-marital relations can be served by a statute more tailored than one criminalizing medical assistance in procuring birth control). *See generally*, Richard H. Shryock, *Freedom and Interference in Medicine*, 200 ANNALS AM. ACAD. POL. & SOC. SCI. 32, 39-41 (November 1938) (describing public criticism of state laws grounded in religious and moral concerns).

[281] *See, e.g.*, David Mechanic, *Changing Medical Organization and the Erosion of Trust*, 74 MILBANK Q. 171, 172-73, 178 (1996) (discussing the effects of managed care organization gag rules that prohibit physicians from discussing incentives for withholding care); Stephen M. Shortell et al., *Physicians as Double Agents: Maintaining Trust in an Era of Multiple Accountabilities*, 280 J. AM. MED. ASS'N. 1102, 1102-04 (Sept. 23, 1998) (addressing the potential for managed care arrangements to undermine public confidence in physicians' willingness to act in patients' interests).

legislation to strengthen their medical boards' oversight authority.[282] In other words, Americans believe that medical boards have an important role to play in discipline and professional self-regulation, even if the boards may not currently be living up to public expectations in this regard.[283]

The theory that public trust in the medical profession is linked to the legal mandate for professional self-regulation is consistent with Hall's conclusions regarding the possible effects of state regulation. Under the supportive approach to health care law described by Hall, excessive or unjustified state regulation of the medical profession ought to be avoided on the grounds that it is likely to diminish trust in the profession and, consequently, diminish the profession's effectiveness in achieving public goals.[284] For example, Hall writes, legal mandates to improve physician performance can, in some cases, "backfire by conveying to the public an attitude of distrust and by reducing medical actors' motivations to behave in a trustworthy fashion."[285] While this risk is hardly a *per se* argument against state regulation, it does give us reason to seek out strong justifications for laws regulating the medical profession.

C. Safe Harbors and their Implications for Medical Trust

If the current system of licensure, discipline, and self-regulation is indeed supportive of systemic medical trust, then policymakers considering changes to this system ought to first evaluate their potential trust implications. In the case of disciplinary safe harbor policies, which limit medical boards' disciplinary discretion without adequate justification, the potential consequences for systemic medical trust are significant.

As recounted in Section III, the professions enjoy a privileged status under American law. Laws regulating professional practice must be

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[282] Kevin B. O'Reilly, *Doctor Disciplinary Actions Down for Third Year*, AM. MED. NEWS (May 12, 2008) (reporting that Indiana, New Mexico, and Washington enacted legislation in 2008 to "beef[] up board authority," and that nine other states are considering similar changes). See, for example, N.M. Stat. Ann. § 61-6-15.1 (2008), a New Mexico law enacted in 2008 that grants the state medical board authority to summarily suspend a physician's license without a hearing upon commission of certain crimes.

[283] *See generally*, Stephen R. Latham, *Medical Professionalism: A Parsonian View*, 69 MT. SINAI J. MED. 363, 365 (Nov. 2002) (noting that although the Parsonian model of professional motivations may fail as a factual description, it should be viewed as a normative description of what professionalism ought to be); Eliot Freidson, "Professionalism and Institutional Ethics," in Baker, *supra* note 121, at 139 (arguing that if medical ethics are to be more than "mere window dressing," the medical profession must undertake vigorous legal enforcement and "defend … the institutional circumstances which encourage ethical practice.").

[284] Hall, *supra* note 120, at 486.

[285] *Id.* at 509-11.

justified under the state's police powers, and restrictions on medical licensure must comply with substantive and procedural due process requirements.[286] Moreover, state medical board decisions are reviewed under a deferential standard; they are overturned only if they are not supported by substantial evidence.[287] Accordingly, as a matter of both law and public policy, a state that abandons its deferential stance towards medical boards in matters of professional licensing and discipline must offer compelling reasons for doing so.

When a state limits the powers previously delegated to a professional board without adequate justification, its actions suggest to the public that traditional understandings of professionalism offer no more than an illusory protection of professional autonomy, and that the profession is no more able to withstand state intrusion than any skilled or unskilled trade. If the state demonstrates a dismissive attitude towards medical self-regulation, the public may well follow suit, becoming less willing to recognize professional authority and more likely to adopt the role of skeptical consumer. This public skepticism, in turn, threatens the effectiveness of the American medical system, which, according to Hall and others, operates on a foundation of systematic and interpersonal medical trust. Moreover, if, as scholars have noted, professionalism in self-regulation is the basis of every profession's contract with society, then medicine's inability to enforce its collective standards, even in a limited context, may lead to a weakening of this social contract. Trust in individual physicians is grounded in their membership in "a community that has objectively validated their competence" and monitors them on an ongoing basis by sanctioning those whose professional or technical qualifications are inadequate.[288] Absent some assurance that practicing physicians satisfy the standards set by the profession, patients will have little reason to ascribe value to their independent exercise of medical judgment.[289]

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[286] Dent v. State of W.Va., 129 U.S. 114, 121-22 (1889).

[287] Furrow, *supra* note 55, at 79-80.

[288] Starr, *supra* note 212, at 12-13 (noting that the medical professional "offers judgments and advice, not as a personal act based on . . . idiosyncratic criteria, but as a representative of a community" of shared standards and values).

[289] It is important to distinguish the traditional argument from interpersonal trust that has been made by many critics of physician participation in capital punishment from the argument from systemic trust emphasized in this Article. I posit the threat posed by state interference in medicine's ability to discipline physicians who deviate from professional norms is entirely distinct from, and much more problematic than, the threat posed by the individual physicians themselves. Consider the distinction between statutes requiring physician participation in lethal injection and statutes establishing disciplinary safe harbors for participants. Physician participation statutes do not impose an affirmative obligation on any particular provider; rather, they allow each physician to choose for himself whether assisting in an execution is consistent with his personal norms. In contrast, disciplinary

Two challenges are likely to be raised against the argument that unjustified limitations on medical board disciplinary authority may negatively impact trust in the profession. First, for any policy to have an impact on public trust, the public must be aware of the policy and possibly the circumstances surrounding its adoption. While there was little public discussion of existing safe harbor policies at the time of their passage,[290] a number of factors suggest that proposals to adopt new safe harbors will garner greater public attention in the future. Capital punishment has always been a highly visible issue, provoking strong emotional and political opinions, and the Supreme Court's recent decision in *Baze* has once again brought it to the forefront. Press coverage of "botched" lethal injections and scandals surrounding execution personnel abounds.[291] Medical and law journals are flooded with academic research about medical involvement in lethal injections.[292] At least one state's medical board and department of corrections are engaged in a well-publicized legal dispute over the discipline of execution personnel.[293] In this environment, and particularly given the modern trend toward increasing the powers of medical boards,[294] any state that suddenly chooses to limit board authority by adopting a safe harbor is likely to draw the notice of its citizens.

Second, some may argue that unjustified legislative interventions are likely to have a greater impact on public trust in the legislature than trust in the regulated profession, and therefore that concerns about safe harbors' effects on medical trust are overblown. While there is no question that regulations adopted without compelling justifications cast doubt on the legislature's ability to adopt sound and well-reasoned laws, these

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safe harbors are likely to be far more pernicious, because they call into question not the moral agency of individual physicians, but the regulatory ability and authority of the profession as a whole. For an analogous example, see Massachussetts v. EPA, 549 U.S. 497 (2007), in which petitioners opposed an argument by the EPA that it lacked statutory authority to regulate emissions of greenhouse gases because they did not fall within the definition of "air pollution" under the Act. The contested issue was the EPA's alleged inability to enforce its guidelines, not the fact that individual manufacturers were operating in a manner that violated emissions requirements.

[290] See Section II-C, *supra*.

[291] *See, e.g.*, Weil, *supra* note 47; For Hire, *supra* note 244.

[292] *See, e.g.*, Denno 2007, *supra* note 1; Waisel, *supra* note 154; Gawande, *supra* note 71.

[293] N.C. Dep't of Corrections et al v. N.C. Med. Board, Civ. No. 07- 003574 (N.C. Super. Ct. Sept. 21, 2007), petition granted, 661 S.E. 2d 736 (N.C. 2008). For press coverage of this dispute, see Sarah Avery, *Executions Pose Dilemma for Doctors*, NEWS & OBSERVER, July 31, 2008, at B4; Titan Barksdale, *Board to Appeal Execution Ruling*, NEWS & OBSERVER, Oct. 10, 2007, at B5; *Editorial: Death Docs?*, NEWS & OBSERVER, Sept. 25, 2007, at A8.

[294] *See supra* note 282 and accompanying text.

regulations, when they act to restrict board authority, undoubtedly cast similar doubt on the medical profession's ability to act in the public interest. Perhaps the relevant distinction, then, is one of authority – a legislature that adopts a safe harbor statute has full authority to act but demonstrates a failure in reasoning, whereas a medical board that refrains from disciplining execution participants may have a well-reasoned theory of discipline but simply lacks the legal authority to implement it.

Further empirical research is necessary to determine whether this hypothesis about the trust effects of unjustified limitations on medical board authority is valid. However, though current evidence has not yet provided a definitive answer, policymakers considering the adoption of safe harbors would be remiss if they failed to consider their potential impact on medical practice and public trust in addition to their potential impact on the practice of lethal injection. In bringing to light these considerations regarding systemic medical trust, this Article will help further public debate by ensuring that future policies designed to encourage medical participation in executions are evaluated no differently than traditional regulations on the practice of medicine – that is, by reference to their potential consequences in the professional sphere.

VI. CONCLUDING THOUGHTS

The analysis set forth in this Article leads to two relevant conclusions for those policymakers considering the adoption of policies for facilitating medical involvement in executions. The first has broad implications for health care law generally; the second, for theories of capital punishment.

This Article's primary contribution to the field of health law is the connection it draws between the adoption of regulations on the practice of medicine that lack adequate policy support and the medical profession's ability to effectively serve public interests. Because unjustified medical regulations may lead to a loss of confidence in the authority and independence of the medical profession – and because public confidence is essential for effective medical practice – it is particularly important that policymakers seek strong justifications before enacting laws that limit medical board discretion. Even if disciplinary safe harbors serve important expressive functions, they should not be adopted if further empirical inquiry demonstrates that they are likely to erode systemic medical trust.[295]

In the realm of capital punishment, this Article suggests that the

[295] This conclusion, however, is based on the principle that medical boards have legitimate authority over matters relating to professional ethics, which, although widely accepted in the legal literature, still needs a more thorough defense. *See supra* note 134.

constitutional justifications for disciplinary safe harbors are weak and have been weakened even further by the Supreme Court's recent decision in *Baze v. Rees*. As a result, it is important to understand why legislatures have sought and still seek to facilitate medical involvement in executions. Recall that when Arkansas first learned that physicians might be unwilling to participate in lethal injections, the state initially considered a return to electrocution; however, this option was rejected as "taking a step backward" to a less humane era.[296] This response was understandable, given that the historical development of capital punishment technologies demonstrates a societal preference for clinical detachment over prejudice, technology over brutality, and silence over clamor. However, given the very real problems that have arisen in using the modern lethal injection protocol, one wonders whether this preference is founded more on cosmetic than constitutional concerns.[297] Assuming that the practice of capital punishment is indeed valuable enough to preserve, perhaps, rather than asking the medical profession to abandon its ethical principles to facilitate a quasi-clinical execution protocol, we should instead ask society to come to terms with its own moral qualms about a process it has long sought to conceal.

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[296] *See supra* note 88 and accompanying text.

[297] As much was implied by Justice Stevens during the oral argument in *Baze v. Rees*. When the respondents' attorney justified the use of pancuronium bromide, a paralytic, in Kentucky's lethal injection protocol as a means to bringing about a "more dignified death." Justice Stevens asked him whether the "dignity" of the current process outweighs the "risk of excruciating pain." If a prisoner were offered a single-drug protocol that posed no risk of pain but involved the appearance of indignity, Justice Stevens asked, "Would he prefer to say, I want to die in a dignified way?" Baze Transcript, at 33-34. *See also* Leigh Buchanan Bienen, *Anomalies: Ritual and Language in Lethal Injection Regulations*, 35 FORDHAM URB. L.J. __ (2008), *available at* SSRN, http://ssrn.com/abstract=1116662 (arguing that state lethal injection protocols are little more than public relations documents describing "hypothetical rituals meant to reassure [observers] that a controlled and orderly process, in accordance with the rule of law, will take place").