LEGAL EXECUTION BY LETHAL INJECTION HAS MADE NATIONAL HEADLINES DURING THE PAST 2 YEARS BECAUSE PRISONERS HAVE ARGUED THAT IT POSES AN UNNECESSARY RISK OF PAIN AS CURRENTLY PERFORMED AND THEREFORE CONSTITUTES UNCONSTITUTIONAL CRUEL AND UNUSUAL PUNISHMENT. THE MOST WIDELY USED METHOD OF LETHAL INJECTION, DEVELOPED BY A PHYSICIAN, INVOlVES THE INTRAVENOUS INFUSION OF LARGE Doses OF SODIUM THIOPENTAL TO INDUCE DEEP SLEEP, PANCRUronium Bromide AS A PARALYZING AGENT, AND POTASSIUM CHLORIDE FOR CARDIOPLegIA. LETHAL INJECTION WAS ADOPTED AS A MEANS OF EXECUTION BECAUSE IT SEEMED MORE HUMANE THAN OTHER METHODS, BUT IT IS UNCLEAR WHAT CONSIDERATION WAS GIVEN TO THE SELECTION OF EXECUTION PERSONNEL, THE SKILLS THEY NEEDED, AND THE TRAINING THEY MIGHT REQUIRE. RECENT COURT CHALLENGES HAVE REVEALED THAT DRUG DOSAGES ARE NOT UNIFORM AMONG THE STATES, SO WIDE DISPARITIES IN LEVELS OF SEDATION MAY OCCUR, AND SOME INMATES MAY HAVE EXPERIENCED CONSIDERABLE PAIN AFTER POTASSIUM CHLORIDE INFUSION.

The legal challenges have also publicly exposed the participation of physicians in executions. A number of states suspended executions to reexamine their methods and have considered escalating the role of physicians to meet constitutional challenges. These events have raised questions about the effect of professional ethical standards on physician participation in capital punishment and about the response of the medical profession to known instances of physician involvement in executions.

**Lethal Injection and Medical Ethics**

Currently 38 states allow the death penalty and, of those, 35 either require (n=17) or permit (n=18) physician participation in executions. Lethal injection is the preferred method for execution in all 38 states and has accounted for 83% of executions since 1976. Georgia law stipulates that physicians who participate in executions are not practicing medicine and therefore cannot be disciplined by the Georgia Composite State Board of Medical Examiners. California and Missouri have attempted unsuccessfully to recruit physicians to assist in lethal injection. In California, 2 anesthesiologists offered to assist but later withdrew their offer; in Missouri, after questions were raised about the competence of the physician who had been assisting, appeals for additional help went unanswered. North Carolina requires the presence of a physician at executions, but the North Carolina Medical Board recently adopted a policy of disciplining physicians for any verbal or physical assistance in an execution. The North Carolina Department of Corrections challenged this policy, asking a court to declare that participation in an execution is not the practice of medicine, even though it clearly requires medical knowledge and skills. Although the medical board is empowered to discipline physicians for violating ethical standards, the court concurred with the Department of Corrections and enjoined the medical board from enforcing its policy.

The inclusion of physicians in lethal injection medicalizes capital punishment by moving a process that has always been a function of the penal system into the domain of medicine. Other methods of execution do not require direct physician participation: hanging, firing squad, and electrocution have no medically related elements. Lethal injection, however, certainly has elements of medical practice: insertion of intravenous lines, intravenous injection of medicinal drugs, and monitoring vital signs. The chronology of lethal injection suggests that it was intended merely to supplant other methods of execution and that involvement of physicians was not originally contemplated. Some have suggested, however, that physician involvement was intentional—their presence may make executions palatable and appear humane, reassuring observers and others that the inmate will die with minimal suffering.

The American Medical Association’s (AMA’s) Code of Medical Ethics prohibits involvement of physicians in executions, permitting only certification of death after someone else has declared it. State laws and regulations requiring the participation of a physician imply much more extensive involvement, including measuring chemicals, inserting intravenous lines, injecting drugs, monitoring sedation, and intervening if the prisoner does not die after injection.

Author Affiliations: Ethics Group, American Medical Association, Chicago, Illinois (Mr Black); and Institute of Human Values in Health Care, Medical University of South Carolina, Charleston (Dr Sade). Dr Sade is a former chairman of the AMA Council on Ethical and Judicial Affairs.

Corresponding Author: Lee Black, JD, LLM, Ethics Group, American Medical Association, 515 N State St, Chicago, IL 60610 (lee.black@ama-assn.org).

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Healing the sick and alleviating suffering is the primary role of physicians in US society. The central thread running through the AMA’s Code of Medical Ethics is the physician’s obligations to help and not to harm people. The result of an execution, however, clearly harms the executed person without offsetting benefit—no rationale can justify a different conclusion—so physician participation in executions is manifestly unethical. Even if not practicing medicine, physicians are bound by medical ethics when using medical knowledge and skills and therefore must not participate in executions, whether or not participation is deemed medical practice.17

Some physicians who have participated in executions do not agree with this conclusion; they view their role in capital punishment as consistent with their role as physicians—preventing needless pain or suffering at the end of life.4 Although this argument is logical and may seem compelling, it cannot override the reality that lethal injection unambiguously causes the death of a human being. According to ethical standards, physicians have no place in such proceedings, even if their intent is to provide comfort.

Active Participation of Physicians in Executions

The identity of physicians who participate in executions is typically held confidential by state authorities. Nevertheless, a few such physicians have been publicly identified. A Missouri physician admits having participated in many executions. His testimony in the case of Taylor v Crawford clearly demonstrated that the presence and involvement of a physician does not ensure a trouble-free execution.2 The doses of drugs he used were inconsistent from case to case and were not always recorded. He admitted that he was dyslexic and that he sometimes confused the names of drugs.2 Most states will not disclose the names of physicians who participate in executions; in this case, the physician’s identity was revealed through investigation by the media, although the physician denied participation when directly confronted.3 After this disclosure, Missouri enacted a law to protect the identity of executioners, including allowing civil suits against those who disclose.18

Not all physicians have been reluctant to reveal their identities. A Georgia physician permitted the use of his name in a medical journal article and freely admitted his involvement in executions, expressing his belief that it was his duty to ensure as painless an execution as possible, even when he knew he was violating ethical standards.4

In recent revelations in North Carolina, an identified physician claimed that he was present at an execution but did not participate, a role specifically allowed by the North Carolina Medical Board.19 However, a court required the prison system to have a physician in attendance to monitor the inmate’s level of consciousness. If the physician’s claims were true, the state may have violated the judicially sanctioned agreement that permitted it to reinstate executions, or the Department of Corrections may have exaggerated the physician’s involvement to create the appearance of compliance with the court order.20 This case illustrates the difficulties that states may face in complying with mandated physician participation when physicians limit their roles based on ethical standards.

The 3 physicians mentioned above in Missouri, Georgia, and North Carolina have publicly admitted their involvement in lethal injections. Other physicians have also apparently assisted in executions, but state laws and policies have hidden their identities from public view. Presumably, these unnamed physicians fear public recrimination for their roles. Do they have cause to fear punitive consequences from other sources?

Medical Self-regulation

The medical profession polices itself through licensing boards and professional organizations, such as medical societies and hospital medical staffs. Disciplinary actions by these groups may be reported to the National Practitioner Data Bank (NPDB), which could have serious consequences for a physician’s ability to practice medicine. Information from the NPDB can lead hospital medical staffs to deny practice privileges, medical societies to take action against membership, and licensing boards to take action against medical license.

Medical licensing boards ordinarily address illegal activities of physicians and complaints relating to patient care. Transgressions of other kinds, including ethics violations, usually do not trigger disciplinary proceedings. Executions are legal; therefore, in states that require the presence of physicians at executions, licensing boards—established by state law and quasi-legal—are unlikely to take action against the licenses of physicians who participate. North Carolina is an exception, as noted above.

Medical societies are less constrained than licensing boards. Societies that have incorporated ethical standards into their rules or bylaws have wide latitude to take action against a physician’s membership. Although certain procedural standards must be met, medical societies are generally free to act on ethical violations and may be less hesitant to speak out publicly. In August 2006, for example, the American Society of Anesthesiologists released a statement detailing the current status of lethal injection. In the statement, the president of the society encouraged anesthesiologists to “steer clear” of participation.21

AMA policy has prohibited physician participation in capital punishment for nearly 3 decades, and the AMA has periodically reaffirmed, revised, and publicly spoken out against violation of this policy. The AMA has gone beyond exhortation, however, by enforcing its long-established policy prohibiting participation in capital punishment. The AMA’s bylaws empower its Council on Ethical and Judicial Affairs (CEJA) to act on ethical trans-
gressions. The Council on Ethical and Judicial Affairs generally relies on the findings and decisions of courts and of state licensing boards as the basis for its disciplinary actions. However, because no court or board has taken action against physicians who have violated the prohibition against participating in capital punishment, the AMA appointed an investigating committee to seek evidence of unethical conduct and to determine if further action was warranted. The investigating committee found such evidence and reported its findings to CEJA. After receiving the committee’s report, CEJA initiated disciplinary proceedings, observing strict procedural due process, including confidentiality of the proceedings and findings, and developed new evidence under its own procedural rules. At the conclusion of the process, CEJA revoked one physician’s membership in the AMA for participation in execution by lethal injection.

Conclusion
Legislatures and courts may consider ethical standards when deliberating on various issues and usually look upon them favorably, but sometimes do not take them seriously. For example, courts have relied in part on the ethical standards articulated in the AMA’s Code of Medical Ethics when determining the propriety of physician-assisted suicide and restrictive covenants in practice contracts, but have usually disregarded medical ethics when permitting or requiring physician participation in executions.

During policy deliberations, all participants in regulating the medical profession—federal and state government, licensing authorities, professional societies, and individual physicians—should consider the specific role of physicians in society, which is preventing and healing illness and relieving suffering. The core requirement for that role is trust in the profession, which is advanced and preserved by ethical principles. Any form of participation in causing death by lethal injection is unethical because it violates the physician’s role, thereby undermining trust. Courts and legislatures should not ask physicians to violate ethical standards to solve problems raised by legal challenges. The penal system, not the medical profession, is responsible for finding a way to perform executions. Physicians who are asked to assist in capital punishment should remember that transgressions against ethical obligations may evoke sanctions against their licenses by state medical boards and elicit disciplinary actions against membership by their medical societies.

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