RETHINKING the Ethics of Physician Participation in Lethal Injection EXECUTION

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Though there are good arguments against physician participation in executions, physicians should be allowed to make their own decisions about whether they will participate, and professional medical organizations should not flatly destroy the careers of those who do.

The ethical propriety of physician participation in lethal injection executions in the United States stands in serious question, despite organized medicine's longstanding and absolute prohibition of it. Since lethal injection executions involving physicians will continue, it is time both to revisit the substantive moral grounds for a ban on physician participation and to reach a more definitive public resolution of the conflict between professional ethics and the state's desire to impose this punishment in a humane manner. We contend that, though the traditional ethical arguments against physician participation are not without merit, they are not persuasive enough to justify a total ban on physician involvement. When principled and morally serious arguments lead to different conclusions about what physicians as medical professionals may do, individual physicians typically are allowed by their colleagues to make their own decisions about the proper use of their medical knowledge and skills. Hence, professional medical organizations should allow physicians to participate in executions on the basis of their own consciences; and although we do not oppose other forms of sanction, we believe they should not impose organizational sanctions that significantly impede or destroy physicians' ability to practice medicine.

As recently as 1994, Robert Truog and Troyen Brennan wrote that they were "unaware of any published reasoned ethical justification for [physician participation in executions]."[1] Recently, however, the well-accepted, mainstream view forbidding physician participation has been publicly challenged by several commentators. David Waisel has claimed that "organized medicine has an obligation to *permit* physician participation in legal execution,"[2] while Kenneth Baum has concluded that "condemned death row inmates are, for all practical purposes, terminally ill patients, albeit under a nontraditional definition of the term, and deserve to be treated as such [by physicians]."[3] Ty Alper has argued that "the widely repeated refrain that medical ethics 'prohibits' physician participation is misleading at best and disingenuous at worst," in large part because the "ethical guidelines of the AMA and similar associations are not binding or enforceable."[4] We disagree with

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Waisel that organized medical groups have a moral obligation to permit physician participation and with Baum that the arguments opposed to a ban definitively decide the question. We agree with Alper that the profession's ethical objections do not constitute an insurmountable barrier to participation.

As far as we can determine, no physician has lost his or her ability to practice medicine or been dismissed from a professional medical organization as a result of participation in executions. But recently the practical and professional consequences for those who participate in an execution, in defiance of the traditional ban, have significantly changed for some physicians—and may change for many more. In February 2010, the American Board of Anesthesiology ruled that no anesthesiologists may "participate in capital punishment if they wish to be certified by the ABA."[5] Other specialty boards may follow suit.

Individual physicians and private medical groups (such as the AMA and state and local medical societies) are presumptively entitled to oppose physician participation as unethical and to censure or dismiss their members who violate their ban, but the ABA's policy of revoking board certification of anesthesiologists who participate in executions constitutes a far harsher and more socially significant penalty than loss of membership in a medical society that likely means little to patients, health care institutions, or insurers. Loss of board certification directly affects a physician's ability to practice medicine and attract patients, given that many institutions and patients will not enter into a relationship with a physician lacking this credential of professional competence and accomplishment. In addition, the threat of losing board certification could prevent states from securing the physician services that are thought necessary for administering capital punishment humanely, which might lead states to prohibit medical organizations from taking that action.

The ABA's action creates a significant conflict between the important interest of professional certifying boards in enforcing ethical standards and the commitment of the state to the effective, humane, and just administration of the criminal law. If a profession's ethical standards ought to emerge out of a dialogue between the profession and the larger community it serves, then organized medicine, individual physicians, and the people in the thirty-four states that allow or require physician participation in executions ought to engage in public debate aimed at reaching a practical and principled resolution of this chronic conflict.

The debate about the ethics of physician participation in executions has been thrown into confusion by the failure to separate this issue from the ethical propriety of the death penalty itself.

Threshold Matters

Some ground must be cleared before arguments about the ethics of physician participation can be properly examined. First, prisoners *will* continue to be executed by lethal injection: forty such executions occurred in the United States in 2010 and eight during the first two months of 2011. Over twenty executions are scheduled for the remainder of 2011. Thirty-four states, the federal government, and the U.S. military authorize capital punishment solely or primarily by lethal injection for certain heinous crimes, but only one of these jurisdictions (Kentucky) forbids physicians from participating in executions. The remainder allow or require physician involvement.[6] Alper writes, "doctors routinely *are* involved in . . . executions and have been since states first started using lethal injection."[7]

California provides an illuminating example. This state, which has nearly seven hundred prisoners condemned to death, intends to continue executing prisoners by lethal injection despite a five-year moratorium. It has recently opened a facility costing over $800,000 that was designed solely for performing executions efficiently, humanely, and in accordance with constitutional requirements. The state has regulations that allow Department of Corrections and Rehabilitation officials to retain physicians either to participate in executions as members of the "Lethal Injection Team" or "to serve as the physician attending the execution" who "monitors an electronic device(s) showing the inmate's vital signs and determines when the inmate has expired."[8] All of these activities are expressly barred by the AMA's Code of Ethics.[9]

Unfortunately, the debate about the ethics of physician participation in executions has been thrown into confusion by the failure to separate this issue from the ethical propriety of the death penalty itself. Several commentators argue that because the death penalty is unethical, physicians should not participate in its administration. Margaret Wentz calls the death penalty an "act of injustice" and urges physicians "to focus their time and influence on eradicating the root causes of crime . . . rather than on making an unjust and barbaric act less conspicuous to soothe our consciences."[10] Richard Van Dellen calls for "doing away with capital punishment" and contends that "it is not possible to discuss the ethics of physician involvement without addressing the ethics of capital punishment."[11] However, none of these arguments reach the underlying moral dispute over *physician* participation specifically.

The arguments against physician participation cannot be reduced to those showing that the death penalty is inherently unethical and unjust. If Wentz and Van Dellen are right, then *no one* should participate in executions—judges, lawyers, corrections officers, or anyone else—and all criminal laws that authorize imposition of the death penalty ought to be repealed without delay. As these two issues should be kept distinct, we will follow the direction that the editors of the *Mayo Clinic Proceedings* gave to those who would respond to Waisel's endorsement of physician participation: "focus specifically on physician involvement in capital punishment and not on the broader (and unmanageable) discussion of capital punishment itself."[12]

Similarly, reaching the foundations of the ethical permissibility of physician participation in the death penalty is obstructed by invoking the analogy to physician involvement in torture or the outrages of Nazi physicians in the death camps. William Curran and Ward Casscells claim that physician involvement in "torture or other forms of cruel, inhumane or degrading treatment" (including "the presence by physicians at the administration of torture") is morally equivalent to participation in capital punishment by lethal injection.[13] Steven Miles's book on medical complicity in torture documents physician participation in the torture of prisoners outside the United States in the same section (entitled "Illicit Torture") in which he discusses the American employment of "medical knowledge to refine capital punishment."[14] However, torture is "wrong under all circumstances, because it is cruel and degrading to humans and an extreme violation of human rights under international law."[15] If capital punishment is in the same moral category of human rights violation as torture, then no one should ever become involved in it, and the question of the propriety of physician participation, primarily to make execution neither cruel nor degrading, is never engaged.

Other arguments against physician participation seem to reach the underlying question but actually do not. Truog and Brennan object to physician participation because it "offends the sense of [the moral community of medicine] by prostituting medical knowledge and skills to serve the purposes of the state and its criminal justice system."[16] An American College of Physicians report decried physician participation because it "serves to give an aura of medical legitimacy to the procedure" and has physicians acting "under control of the state, doing harm."[17]

These objections beg the question, by assuming that the state is acting unjustly and harmfully when it executes convicted criminals who have received due process of law and that anyone participating in the practice is likewise acting unjustly. A need for "medical legitimacy" or for "whitewashing" an immoral practice exists only if execution is actually an unjust, wrongful punishment, which we must assume—and many Americans ardently believe—it is not. Moreover, the activities of physicians who are agents of the state are not by that fact alone rendered morally wrong. For example, military physicians plainly are state agents and serve its purpose of protecting the collective welfare of its citizens by the use of armed force. Yet this does not make physicians' behavior necessarily unethical, given that a more than plausible, if still controversial, case can be made that, in times of genuine military necessity, they should not honor conventional medical ethics by, for example, treating soldiers without their consent so that they may be returned to combat, or by conducting triage structured by military ends rather than by the best medical interests of the soldiers.[18]

If state-sanctioned execution is inherently unethical or violates human rights, then the distinct question of the moral propriety of physician participation never arises. Therefore, in order to reach the distinctive merits of the ethical controversy over physician participation, we will assume that the imposition of capital punishment following due process of law is at least ethically permissible, but we nevertheless also recognize that "reasonable people of good faith disagree on the morality and efficacy of capital punishment."[19]

Arguments over Participation

The overwhelming majority of states have used three drugs for execution—sodium thiopental, pancuronium bromide, and potassium chloride—which are administered intravenously and in that sequence. The intended functions of the drugs are to anesthetize, paralyze, and kill the condemned, respectively. Improper venous access can make multiple, painful needle sticks necessary; cause infiltration of the drugs into the surrounding tissues, resulting in chemical burns; prolong the dying process; and result in inadequate anesthesia. When appropriate venous access is achieved, the correct administration of the first drug should make the prisoner unconscious before he receives the other drugs, and death should follow promptly, before consciousness is regained. If the prisoner is not rendered unconscious by the thiopental, however, he likely would experience asphyxiation from the paralysis of respiratory muscles caused by the pancuronium, a severe burning sensation and massive muscle cramping caused by the potassium, and then death from cardiac arrest.

The "recipe" for drugs used in executions is currently undergoing significant change. The only American manufacturer of thiopental, Hospira, no longer produces the drug in the United States and will not import it from its Italian plant since the government there threatened legal action against the company if the drug was used in executions. Last year, California and Arizona obtained thiopental manufactured in Austria from a U.K. wholesaler that had obtained it from the British license holder, but

the British government has now imposed export controls to prevent its use in executions. Attorney General Eric Holder has announced that the federal government has no supplies of thiopental and is facing the same problem as the states.

Ohio recently executed a prisoner using only pentobarbital, a short-acting barbiturate that has Food and Drug Administration approval for use in humans as, inter alia, a sedative (preoperative and otherwise), a short-term hypnotic, and a treatment for seizures. It is used in physician-assisted suicides in Oregon and by Dignitas, the Swiss group involved in assisted dying. Curiously, it is also used for animal euthanasia. Recently, Oklahoma and Texas have decided to use pentobarbital in place of thiopental. At a federal court hearing in November contesting Oklahoma's use of pentobarbital, an anesthesiologist testified on video that the planned dosage was enough to cause unconsciousness and death within minutes, and a defense expert agreed. Other states—such as Washington, which had intended to use only thiopental[20]—may well have to follow their lead. In any event, these developments are unlikely by themselves to seriously affect the essential elements of the case for physician participation.

Waisel and Baum claim that physician participation is ethically justifiable because it can greatly reduce or eliminate the risk of pain and suffering being inflicted on prisoners. Waisel argues that "poorly done executions needlessly hurt the condemned and . . . the problems [with lethal injection] center not on the specific drugs chosen but on establishing and maintaining intravenous access and assessing for anesthetic depth. . . . it is honorable for physicians to minimize the harm to these condemned individuals."[21] Baum compares condemned prisoners to terminally ill patients and states that "physicians should do what any compassionate physician would do for a dying patient—preside over the condemned's final moments to minimize complications and suffering, and maximize the patient's comfort until the end of his life."[22] Specifically, physicians can establish venous access efficiently, "so that the condemned will not suffer the pain and humiliation of multiple needle punctures by inept technicians" and monitor drug administration to minimize the "chance that the condemned will regain consciousness during the lethal injection and suffer the unimaginable horror of conscious asphyxiation."[23]

Extensive evidence demonstrates that lethal injection executions are frequently botched and that prisoners suffer significantly as a result of a variety of mistakes—improper placement of intravenous lines, administration of the wrong drugs or of the right drugs in the wrong manner, and inadequate anesthesia.[24] Consider just two examples. After a difficult insertion of an intravenous line, the usual drugs were injected into an Ohio prisoner, and he appeared to be unconscious with shallow breathing. But shortly thereafter, he "raised his head and, frustrated, shook it back and forth, repeatedly declaring 'it don't work.'" The execution team created a second venous access site, but mistakenly administered a second round of drugs into the first line that had failed. After figuring out what had gone wrong, they administered a third round. The prisoner "raised his head about a dozen times and appeared to try to speak" before dying.[25] An Arkansas execution team spent more than fifty minutes sticking a prisoner with needles before resorting to a surgical cut-down to create venous access, all of which resulted in much pain and numerous loud moans from the prisoner.[26] It seems nearly unimaginable that a patient in surgery, attended by an anesthesiologist or other well-trained physician, would suffer these mishaps.

The number of botched executions indicate that the skills required to achieve and maintain intravenous lines, place central lines if necessary, and properly mix and administer the various drugs used in lethal injection are too frequently beyond the ken of corrections officers. Yet these skills are routine parts of many physicians' daily practices. While some states, such as California, have taken the firestorm of legal challenges to lethal injection practices as an incentive to reform the training of corrections officers, no training schedule can feasibly emulate the level of skill many physicians have acquired by virtue of clinical training and simply going about their daily work. Consequently, a space exists within the death chamber for physicians to mitigate the risk of executions being botched by unskilled corrections officers—a risk the Constitution tolerates as long as it does not rise to the level of a "substantial risk of serious harm" and as long as the state has reasonable safeguards for minimizing it.[27]

Even if a training program could raise the skill level of corrections officers to roughly that of physicians, though, the question remains of who will train them. Given the rarefied nature of these skills, particularly those related to assessing anesthetic depth, the most apt candidates would be physicians. Yet if it is unethical for physicians to participate in lethal injection, then it will also be unethical for them to train corrections officers (the AMA forbids "consulting with or supervising lethal injection personnel"). One could argue that there is no need for physicians to train corrections officers, since the skills needed to perform lethal injections and to teach lay people how to perform them are possessed by other health care professionals, such as nurses, paramedics, and EMTs. But this argument is morally disingenuous. The traditional moral arguments that apply to physicians are equally applicable to all others who care for the sick; their professional organizations likewise condemn participation.[28] Something has gone badly haywire when sharp moral outrage and apocalyptic fears of disastrous consequences are expressed only if physicians, but not other clinicians, help a condemned murderer to die.

While it is surely true that the death chamber resides far outside the mainstream of medical practice, this does not dissolve the compassionate space the physician can occupy within the death chamber. Yet Baum's claim that by taking an active role in lethal injection physicians "will further the fundamental ethical ideals of the practice of medicine" goes too far.[29] Given that only an attenuated relationship exists between physicians working in the death chamber and those engaging in everyday therapeutic medical practice, yet acknowledging the ability of physicians to reduce needless risk to the condemned, we believe the most that can be fairly said is that physician participation neither fully advances the ethical ideals of medicine nor is strictly anathema to them.

The most fundamental objection to physician participation rests on its inconsistency with the morally legitimate goals of medicine, although it is articulated in different ways. Lee Black and Robert Sade state that the "central thread running through the AMA's *Code of Medical Ethics* is the physician's obligation to help and not to harm people. The result of an execution . . . clearly harms the executed person without offsetting benefit—no rationale can justify a different conclusion—so physician participation in executions is manifestly unethical."[30] Other commentators make the same point by referring to the supposed first principle of medical ethics, "above all, do no harm" or by invoking the Hippocratic Oath ("I will not give a drug that is deadly to anyone if asked, nor will I suggest the way to such a counsel").[31] Atul Gawande phrases the objection more lyrically: "The hand of comfort that more gently places the IV, more carefully times the bolus of potassium, is also the hand of death. We cannot escape this truth. The ethics codes seem right."[32]

The clearest argument here is that physicians should never intentionally and directly take a human life or assist someone else in doing so. However, the validity of this argument has been seriously questioned by a substantial literature ethically defending physicians who, under certain conditions, assist in a person's suicide[33] or perform voluntary active euthanasia.[34] Others have persuasively argued that the conventional view in medical ethics forbidding physicians to intend to cause or hasten death rests upon an insupportable moral fiction.[35]

The ethical case for the acceptability of physician participation in assisted suicide and voluntary euthanasia typically rests both on the principle that physicians should intervene in persons' lives only with their consent and on the fact that the person involved has voluntarily agreed to have the physician be involved in ending his or her life. Consequently, the issue of physicians offering aid in dying can be easily distinguished from that of physicians aiding in executions because the prisoner does not consent. But the objection to participation based on the absence of the prisoner's consent is neither conclusive nor unambiguous. First, some prisoners (like Westley Dodd, a serial killer of children) consent to their execution. Second, a physician could easily (and understandably) condition his or her participation on the prisoner's consent to his participation—something both Waisel and Baum endorse—and it would be a very odd, indeed irrational, prisoner who, faced with certain death, would refuse physician participation and expose himself to the much greater risk of pain associated with a botched execution at the hands of less skilled individuals.

Third, if the objection based on lack of consent is understood to mean that the prisoner has not consented to execution itself, then it is misplaced. Assuming due process has been served, a prisoner's consent to a justly imposed punishment of execution is not morally required for *anyone* to assist in carrying out the punishment. Similarly, an unjust attacker's consent is not morally required before the person being attacked (or someone else coming to his aid) uses appropriate force to inflict pain or injury (even death) on the wrongdoer if such is necessary to thwart the attack. Kant has even argued that in executing murderers we are "complying with his own decision" to treat others badly: "His own evil deed draws the punishment upon himself."[36]

The talismanic invocation of the Hippocratic Oath (which does not actually contain the injunction to "do no harm") certainly does not constitute a strong argument against physician participation. By and large, American physicians do not take this oath. Only one U.S. medical school administers it;[37] the remainder of the 98 percent of schools that administer a professional oath use dozens of different texts.[38] Furthermore, the evidence in ancient Greek history makes it unlikely that the Hippocratic Oath's injunction against giving a deadly drug "refers to anything like" our concept of physician aid in dying or forgoing life-sustaining treatment, and the historical record is silent on whether ancient Greek physicians "were asked to participate in executions or offer technical advice to make execution more effective or humane."[39] Instead, the passage "addresses the fear that physicians would collaborate with murder by poisoning."[40]

Several opponents of physician participation claim that it should be prohibited because it will result in a loss of public trust in physicians. Jonathan Groner asserts that "when doctors enter the death chamber, they harm not only their relationship with their own patients but the relationships of all doctors with their patients."[41] Lee Black and Mark Levine also raise the issue of trust: "If physicians are viewed as facilitators of death, patients might not believe that their physicians are always acting in their best interests."[42]

These claims are speculative on their face and lack supporting evidence. A California appellate court has expressly rejected the notion "that physician participation in executions is likely to erode trust between individual physicians and patients . . . or

undermine public confidence in physicians or the medical profession as a whole"; the court noted that "physicians have long participated in . . . gas chamber executions," and yet no evidence shows that "such conduct has in any way affected the trusting quality of the physician-patient relationship in the population at large."[43] The citizens of Oregon and Washington who voted to legalize physician-assisted suicide were apparently not worried about losing trust in physicians. No empirical evidence demonstrates that people in either state have in fact lost trust in the physicians who write prescriptions for lethal medications, or in the profession as a whole. Moreover, no evidence exists that people have lost trust in veterinarians to preserve the lives and health of their animal patients, even though they routinely perform euthanasia.

Finally, other opponents have argued that physician participation is morally objectionable because it will lead to physician involvement in other kinds of wrongful killing. Truog and Brennan, for example, assert that just as the development of medicalized killing in the Nazi's T4 program led to the atrocities at Auschwitz, so, too, will physician participation in lethal injection lead them to participation in even worse killings: "Although the Nazi analogy is often overused and inappropriately applied, we believe it is on the mark in this case."[44]

This objection is both unfounded and inflammatory. "There is nothing new about medical participation in state executions. Doctors have been present at and have had roles in official executions for centuries."[45] No evidence exists linking individual physicians who participate to other, presumably wrongful, types of killing. Many California physicians have participated in lethal gas executions since 1937 and lethal injection executions since 1996, and yet they have not been subsequently involved in small- or large-scale killing. The same argument has been applied to physicians who perform abortions: once they start killing very young human beings, they will start killing older ones. However, no evidence exists that this has in fact happened despite the fact that many more physicians perform abortions than would ever participate in executions and that U.S. physicians have performed millions of legal abortions over the thirty-eight years since *Roe v. Wade*. The physicians interviewed by Gawande who actually participated in executions do not appear to be indiscriminate killers, either.[46]

Profession, Private Action, and Public Values

In light of the at least prima facie plausibility of the case supporting physician participation in executions and the problems with the arguments supposedly mandating a complete ban, what conclusions might be drawn about how this controversy could be resolved? First, the arguments against participation should not be considered wholly insubstantial. Indeed, they are sufficiently serious and weighty that no physician (or other health care professional), whether an independent contractor or an employee of a state's corrections system, has an ethical duty to participate. Baum is wrong to suggest the contrary: "It is the physician who abandons his or her patient by failing to provide [comforting care to the condemned] who truly violates the ethical code of the profession."[47] No physician should be required to participate in executions and violate his conscience. Yet the only survey on the subject shows that a significant number of physicians approve of some physician participation in execution,[48] and other evidence demonstrates that many are actually willing to do so.[49] To dismiss all of these physicians as "morally confused" is both simplistic and presumptuous.[50]

Second, private action to curtail or end physician participation can and should be taken by those who strongly object to the violation of important professional ethical norms. Medicine is a venerable profession, and one of the most important (if not *the* most important) features of a profession is "the acceptance by its members of a set of ethical standards of professional practice" that go beyond marketplace obligations not to coerce, cheat, or defraud others.[51] Consequently, those engaged in the professional practice of medicine should be deeply concerned about the content of the ethical standards that constitute their profession's integrity, and they should be actively involved in advocating adherence to those standards.

We believe that the most that can be fairly said is that physician participation neither fully advances the ethical ideals of medicine nor is strictly anathema to them.

Whatever the legal status of physician participation, individual physicians and private medical organizations seem to be presumptively entitled to express their moral disapproval of it by dissuading their colleagues from participating and disassociating themselves from those who participate. The AMA and the American Society of Anesthesiologists could expel participating members, and individual physicians could choose not to refer to them or practice with them. For those who consider the proscription of physician participation to be "settled and widely accepted," based on "mature ethical principles of medical practice," and comparable to the strict ethical requirement to represent "one's professional qualifications honestly," such action seems nothing short of morally obligatory.[52]

Waisel has argued that "organized medicine has an obligation to *permit* physician participation in legal

execution."[53] Similarly, Baum contends that it is "imperative" for "the medical establishment, especially the AMA, [to] reconsider its position on the ethics of physician participation in lethal injections."[54] We disagree that the case justifying physician participation is so strong and convincing as to impose a moral obligation on professional organizations (and professionals themselves) to abandon their objections. While we certainly believe the AMA and other opponents have good reason to reconsider their views in light of the countervailing arguments, they are not morally blameworthy to decline our invitation to do so and furthermore have no obligation to abandon public condemnation of what they take to be immoral and unprofessional behavior.

Some opponents of participation have pursued litigation to force state medical licensing boards to take disciplinary action against physicians who assist in executions, but no physician has ever been disciplined for this reason, and "every court that has considered the matter has concluded that state medical boards cannot impose discipline where, as in most states, the governing death penalty statute appears to contemplate some form of physician participation."[55] For instance, the physician litigants in *Thorburn v. Department of Corrections* petitioned the court to enjoin physician participation as "unprofessional conduct" in violation of the medical practice act because it "breaches the rules or ethical code of a profession." The court concluded that "there is nothing about physician participation in executions which automatically constitutes 'unprofessional conduct' or renders a participating physician 'unfit' to practice medicine," and it noted that the legislation governing execution contemplates "direct participation by physicians in the execution process."[56] If physicians are to be kept out of the death chamber by the state, then this should be accomplished directly by legislation, not collaterally by litigation targeting their licensure.

Finally, the controversy over physician participation in executions raises the important question of who has control over the content of professional ethical standards and how they are to be enforced. The AMA, the American College of Physicians, and other professional organizations share a code of ethics that uniformly condemns physician participation. However, their statements on the norms of professional practice

> are never complete or fully authoritative. They are, at best, good partial representations of the content of the profession's norms and obligations. The full content of these norms is the fruit of an ongoing dialogue between the expert group and the larger community, on whose recognition of expertise and grant of professional autonomy the expert group depends for its status as a profession. Therefore, the effort to answer such questions as "What professional norms apply in this situation?" and "What is a member of this profession obligated to do in this situation?" must include asking what the larger community understands those norms and obligations to be, rather than looking only at the views of the professional group or some organization(s) within it.[57]

While the "larger community" grants the expert group the status of profession, its members are also the patients, clients, or customers of the professionals who ultimately receive and pay for the profession's services directly or indirectly, through insurance premiums and taxes. War is too important to be left to the generals and banking too important to be left to the bankers because the conduct of professionals seriously affects a much larger class of individuals—indeed, the common good itself. Consequently, professional ethical norms are not just the dominion of the professionals themselves.

Physician participation in executions implicates important social values and ends as well as the professional ethics of medicine. Although the Supreme Court in *Baze v. Rees* cleared the way for lethal injections to proceed without physician involvement, the protocols for almost all states still leave a place for physicians, apparently on grounds that physicians have the special ability to help the prisoner die swiftly and quietly, making the execution more humane for the prisoner, more efficient overall, and (to be frank) less disturbing for everyone who witnesses or has a hand in it. The public also has a strong interest in the fair and humane administration of the criminal justice system, and currently a majority of Americans endorse capital punishment by lethal injection as a legally and ethically just punishment for heinous crimes. Botched executions and numerous lawsuits claiming that lethal injection execution is unconstitutionally cruel frustrate this interest.

Executions are governed by statutes and public policy that are created by state legislatures and Congress. Individual physicians, their professional organizations, and others opposed on ethical and professional grounds to physician involvement in the imposition of the death penalty should take their case to the political process and lobby legislators to ban the practice. If the ethical arguments against physician participation are as obviously irrefutable as many proponents hold, then conscientious legislators ought to concur. To date, the overwhelming majority of them—thirty-three of thirty-four state jurisdictions, plus the federal government and the military—do not agree, but in the face of a concerted campaign from the profession (absent to date, to our knowledge), they might well change their minds. Furthermore, it should be clear even to skittish politicians that opposition to physician involvement is not the equivalent of opposition to the death penalty itself, and the Supreme Court's ruling in *Baze* expressly authorizes lethal injection

executions to continue despite the absence of physician involvement.

In any event, organized medicine and individual physicians with convictions on this complex, ethically charged subject should engage the (admittedly imperfect) political process and find out how persuasive their ethical arguments are, rather than make their case largely in the professional literature. The public and the profession ought to conduct their dialogue about the ethics of physician participation in open legislative hearings, with the goal of airing the diverse views on this matter and arriving at some practical resolution through statutes and governmental regulations. The ABA's board of directors (physicians all) and the AMA's Council of Ethical and Judicial Affairs (physicians and one medical student) cannot substitute for the variety of voices that would be heard if legislatures held public hearings.

One fundamental issue that the public dialogue must address is whether the state, in pursuit of the public interest, should intervene if the action of private medical organizations to enforce their views on professional ethics interferes unacceptably with the conduct of executions. Early last year, the ABA amended its "Professional Standing Policy" to forbid participation in executions as defined by the AMA's *Code of Medical Ethics* (that is, doing anything as a professional in an execution other than certifying the prisoner's death when another has declared him dead). Anesthesiologists with board certification who participate in executions "may be subject to disciplinary action, including revocation of their ABA diplomate status," because physicians should not "act in ways that violate the ethics of medical practice, even if these acts are legal."[58]

The ABA claims that "patients, physicians, healthcare providers, insurers and quality organizations look for Board certification as *the best measure* of a physician's knowledge, experience and skills to provide quality healthcare within a given specialty."[59] The value of board certification is also demonstrated by the hospitals and other health care organizations that make it a central qualification for medical staff privileges. No one claims AMA or local medical society membership is any measure, much less the best measure, of a physician's professional abilities. The loss of such membership very likely would be inconsequential to a physician's career; the loss of board certification most certainly would not.

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Given that nearly 90 percent of anesthesiologists are board certified, and given the importance of board certification, the ABA's action will very likely keep nearly all these physicians—certainly among the most qualified to prevent botched executions—out of the death chamber. If other specialty boards take similar action, states may be hard pressed to find any physicians to assist in executions. Many states prevent public disclosure of the identity of physicians who participate in executions,[60] but those policies will not protect them from disciplinary action by a specialty board. A board could require all applicants to sign a document, under penalty of perjury, that they never have or will assist in executions, forcing those who have assisted either to commit perjury or to acknowledge their involvement and lose certification. If a state does not shield physician identity, participants would have no cause of action against the state if their identities became public in an otherwise lawful manner.

How can jurisdictions that allow or require physicians to participate in executions respond to a specialty board action that could prevent physicians from assisting? Two states have enacted legislation, both by direct ballot of their citizens, allowing another controversial practice that organized medicine likewise flatly prohibits as unethical: Oregon and Washington have both legalized physician-assisted suicide under certain conditions for terminally ill patients, despite the view of professional medical organizations that physician-assisted suicide runs counter to the standards of professional ethics. The AMA condemns physician-assisted suicide as "fundamentally incompatible with the physician's role as healer,"[61] and the American College of Physicians argues that it undermines the patient–physician relationship and the trust necessary to sustain it, alters the medical profession's role in society as healer, and involves physicians intentionally and wrongfully in bringing about the death of a patient.[62] These are essentially the same reasons that the AMA and ACP cite in opposition to physician participation in executions.

Both states have passed legislation to prevent organized medicine from sanctioning physicians who engage in physician-assisted suicide, and they likewise protect physicians who refuse to participate. Oregon law provides that "no professional organization or association, or health care provider, may subject a person to censure, discipline, suspension, loss of license, loss of privileges, loss of membership or other penalty for participating or refusing to participate in good faith compliance with [the Oregon Death with Dignity Act]."[63] The Washington Death with Dignity Act has a nearly identical provision.[64] In short, both of these states determined not only that organized medicine's ethical opposition to physician-assisted suicide was insufficiently persuasive

to deter them from legalizing it in the first place, but also that the public interest (in autonomy, freedom from suffering and loss of meaningful life, and privacy) advanced by physician participation in assisted suicide requires that these professionals be protected from sanctions levied by their colleagues.

States could pass similar laws to protect physicians involved in the administration of capital punishment. Nevertheless, laws that require private organizations to accept unwanted members are subject to constitutional challenge under the expressive association doctrine of the First Amendment. The Supreme Court has held that implicit in the right to free speech is "a corresponding right to associate with others in pursuit of a wide variety of political, social, economic, educational, religious, and cultural ends."[65] This right prevents "the majority from imposing its views on groups that would rather express other, perhaps unpopular, ideas."[66] Government action requiring a group to accept members it does not desire can unconstitutionally burden the right of expressive association: "Forcing a group to accept certain members may impair the ability of the group to express those views, and only those views, that it intends to express."[67] However, this right is not absolute and may be overridden by laws that serve "compelling state interests, unrelated to the suppression of ideas, that cannot be achieved through means significantly less restrictive of associational freedoms."[68]

Professional medical organizations like specialty boards are surely groups entitled to expressive association, especially on matters of professional ethics and integrity. When the state forces organizations to accept members who espouse values that violate basic norms of proper professional practice, as evidenced by assisting in executions (or patient suicides), then the organization's ability to express its distinctive values on these matters is compromised. Consequently, the constitutional acceptability of a state law preventing professional medical organizations from sanctioning its members for involvement in executions turns on whether the state can establish that (1) physician involvement in the administration of capital punishment serves a compelling public interest that cannot be achieved through means significantly less restrictive of the organization's freedom of association, and (2) this interest is unrelated to the suppression of ideas.

States can almost surely show that their interests in the effective administration of the criminal justice system and in imposing just punishment on heinous criminals in a humane manner are compelling and unrelated to the suppression of anyone's ideas. But they could have much more difficulty demonstrating that they cannot achieve these ends except by denying the freedom of medical organizations to eject members thought to be acting unethically. On the one hand, *Baze* establishes that lethal injection executions can constitutionally go forward without physician involvement. The Supreme Court has also recognized that the "State also has an interest in protecting the integrity and ethics of the medical profession,"[69] and some—perhaps most—executions performed without physician involvement have been successful. On the other hand, states can argue that the unfortunately long list of mishandled executions shows their need for physician involvement. The ABA itself has admitted that anesthesiologists "can assuredly provide effective anesthesia" to condemned prisoners,[70] and the long history of physicians' involvement in executions, during which professional medical groups failed to deny membership to such individuals or otherwise sanction them, shows that the groups' values in this regard are not very important to them.

It is difficult to predict how a court would rule on a constitutional challenge to a statute forbidding medical organizations from sanctioning physicians who have worked on an execution. The factual, ethical, legal, and political issues at the heart of the controversy over physicians in the death chamber have not been publicly and vigorously explored to date. But given that lethal injection involving physicians will continue, organized medicine's ethical justification for its absolute prohibition of physician participation and the states' choice for it should be put to the test of open public debate. Legislators must participate in this debate and then make a considered judgment not only about whether to allow physicians in the death chamber, but also about whether to permit professional organizations like the ABA to enforce their views on professional ethics despite the public's interest in conducting humane executions.

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