THE ROLE OF STATE MEDICAL BOARDS IN REGULATING PHYSICIAN PARTICIPATION IN EXECUTIONS

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ABSTRACT

The recent increase in calls for physician participation in lethal injection executions is likely to place a spotlight on state medical boards, the only entities empowered to discipline doctors for ethical violations. This article begins by recounting the history of physician participation in lethal injection executions, as well as the opposition of most medical professional organizations to the practice. The current state of the law suggests, however, that the role of state medical boards is quite circumscribed, at least in the majority of states with death penalty statutes that appear to contemplate some level of physician participation in executions. In order to further determine the legality of medical board action, a comprehensive study was conducted of the statutes and regulations governing state medical boards in all 50 states. The study reveals that only a handful of states – and only seven death-penalty states – explicitly incorporate the AMA's ethical guidelines into their own state ethical codes. The study concludes by suggesting that, where doctors who participate in executions are doing so in order to relieve pain and suffering, it is not clear that a state medical board should intervene even in the rare instance when it would be legally possible to do so.

INTRODUCTION

In recent years, two related phenomena have contributed to the growing debate about physician participation in executions in the United States. First, legal challenges to states' lethal injection practices have raised serious questions about the qualifications of execution team members to perform lethal injections using medical equipment and dangerous controlled substances. Second, a series of high-profile botched executions and one botched execution attempt have further exposed lethal injections as far more problematic and prone to error than most people had previously assumed them to be. These phenomena have contributed to an increased call for the involvement in executions of trained medical professionals, namely physicians.

Indeed, lawyers for death row inmates routinely argue that skilled anesthetic-monitoring is an essential component of a constitutional three-drug execution protocol, particularly where one of the three drugs is a neuromuscular blocking agent that paralyzes the condemned inmate during the execution. Doctors are also necessary when peripheral venous access is too difficult to achieve; gaining intravenous access through a central line in most instances requires a physician. Many states do employ doctors in various capacities, though few, if any, rely on doctors to perform the kind of anesthetic monitoring requested by lawyers for death row inmates. Other states, however, resist calls for physician participation, claiming that doctors are unable to participate and any court order that they do so will lead to a de facto moratorium on the death penalty.

State medical boards find themselves in the middle of this political and legal debate, yet the boards have thus far favored a decidedly hands-off approach. The vast majority have declined to take an explicit public position on the right of doctors to participate in executions and few, if any, have seriously investigated complaints of physician participation that have been brought to their attention.

Recent events, however, suggest that calls for medical board action may increase. Earlier this year, for example, a national abolitionist organization founded by Sister Helen Prejean launched a campaign to persuade medical licensing boards in each state to declare it unethical for doctors to participate in executions. The stated goal of the campaign is to "make it impossible for states to carry out their own protocols for capital punishment."[1]

As calls for medical board involvement increase, the need

for legal clarity on the medical boards' role is apparent. This article begins by recounting the history of physician participation in lethal injection executions, as well as the opposition of most medical professional organizations to the practice. The ethical guidelines of those membership organizations, however, are not themselves enforceable. Only the state medical boards have the power to discipline doctors for alleged ethical violations. The article next studies the current legal landscape with respect to the role of state medical boards in disciplining doctors who participate in executions. The current state of the law suggests that, in most instances, the role of state medical boards is quite circumscribed, at least in the majority of states with death penalty statutes that appear to contemplate some level of physician participation in executions. In those states, courts are likely to conclude that the medical board does not have legal authority to discipline doctors who participate in lawful, state-sanctioned executions. Moreover, a comprehensive study of the statutes and regulations governing state medical boards in all 50 states reveals that only a handful of states – and only seven death-penalty states – explicitly incorporate the AMA's ethical guidelines into their own state ethical codes. Finally, despite the positions of most national medical associations, there are compelling reasons for medical boards to refrain from intervening in this debate. Where doctors who participate in executions are doing so in order to relieve pain and suffering, it is not clear that a state medical board should intervene even in the rare instance when it would be legally possible to do so.

BACKGROUND

States that employ lethal injection typically use a three-drug formula to carry out executions. The first drug in the formula is intended to anesthetize the inmate; the second one paralyzes the inmate; and the third drug stops the inmate's heart, killing him or her.[2] One primary legal challenge to this method rests on the allegation that most states do not employ adequate safeguards to ensure that the person being executed is properly anesthetized before the second and third drugs are administered.[3] Because the second drug in the three-drug formula paralyzes the inmate, the concern is that an inadequately anesthetized person "may have the sensation of paralysis without anesthesia . . . and may feel the burning of the highly concentrated" third drug, potassium chloride.[4] In such a state, the paralyzed inmate is unable to indicate to correctional staff that he or she is experiencing the suffocating effects of the paralyzing drug and the excruciatingly painful effects of the potassium chloride.[5]

States generally do not dispute that an un-anesthetized execution – using these particular drugs – would constitute cruel and unusual punishment under the Eighth Amendment.[6] Lawyers defending states' lethal injection procedures do dispute, however, how likely it is that the delivery of the first drug, the anesthetic, will somehow go awry, and this is typically where the question of the participation of medical professionals enters the equation.

Lawyers for death row inmates have generally taken the position that, given the degree of skill needed to adequately deliver, monitor, and maintain anesthesia, as well as the widely publicized problems with the administration of anesthesia in the lethal injection setting, states that insist on using the three-drug formula must employ the services of highly-trained medical personnel – often, but not always, doctors – in order to ensure that the risk of severe pain to the person being executed does not become "substantial."[7] If the states do not want to employ medical professionals, the argument goes, they should switch to a different protocol for lethal injections that would not require skilled anesthetic monitoring.[8] However, as long as states insist on the three-drug formula, the litigation position taken by lawyers for death row inmates is that only the supervision of qualified medical personnel can reduce the risk of severe pain to a constitutional level.[9]

Lawyers representing states and defending the lethal injection status quo, however, have resisted mandated physician participation on the grounds that doctors are unable to participate. "The goal of death penalty opponents," claimed a spokesman for the California Attorney General in 2006, "is to get a court order that says that lethal injections can only be administered by licensed professionals, because the ethics of medical professionals prohibit them from participating."[10]

The argument that a physician participation requirement would lead to abolition of the death penalty has surface appeal because several national medical associations have expressed their belief that physicians should not participate in executions. The American Medical Association (AMA) has, since 1980, declared the participation of doctors in executions to be a clear violation of medical ethics. The AMA's policy, last updated in 2005, defines "participation" broadly, to include even "consulting with or supervising lethal injection personnel."[11] The American Society of Anesthesiologists (ASA) adopted the AMA position, and its then-president advised members to "steer clear" of participation in lethal injections.[12] The So-

ciety of Correctional Physicians has for years dictated that the "correctional health professional shall . . . not be involved in any aspect of execution of the death penalty."[13] The media has well documented the positions of these national organizations.[14]

The AMA's position on physician participation is not, however, legally enforceable. As a membership organization, the most the AMA could do to discipline a doctor for violating the AMA's ethical guidelines is revoke that doctor's membership, which would have no effect on his or her ability to practice. Indeed, only about 20 percent of doctors in the United States are even members of the association, and, according to the AMA's chief executive officer, "[t]he other 80 percent either do not understand what we do, or they do not value what we do." [15]

The ethical guidelines of the state-based medical associations, many of which mirror those of the AMA,[16] are similarly unenforceable. Although a doctor who participates in an execution may violate the guidelines of his or her state medical association, the most extreme sanction the doctor faces is revocation of membership in the association. Such a sanction would have no effect on a doctor's ability to practice in the state.

The agencies that do have disciplinary authority over physicians are the state medical boards, which award licenses to practice medicine. The study next examines the capacity of the medical boards to discipline doctors for participating in lethal injection executions, beginning with a brief history.

I. LEGAL AUTHORITY OF MEDICAL BOARDS TO DISCIPLINE DOCTORS WHO PARTICIPATE

HISTORY OF PARTICIPATION

Doctors are routinely involved in executions in this country, and have been since states first started using lethal injection almost three decades ago. In fact, doctors have played a key role in the implementation of capital punishment since the eighteenth century, when Dr. Joseph Guillotine developed the machine that bore his name.[17] Two centuries later, it was a doctor who developed the lethal injection procedure that all states but one currently use.[18] And doctors continue to play an active role – a role specifically condemned by the AMA's guidelines – in executions in virtually every state.[19]

It is impossible to report a full accounting of the extent of physician participation in lethal injection executions because of state laws that shield the identities of doctors and restrict public access to lethal injection protocols.[20] As a result of these laws, it is very likely that doctors participate in executions to a far greater extent than is currently known. However, in addition to the anonymous participating doctors interviewed for a *New England Journal of Medicine* article in 2006,[21] recent litigation challenging lethal injection has illuminated the extent of physician participation in certain states.

In Maryland, for example, nursing assistants and paramedics conduct the executions, although a doctor is present, monitors an EKG machine, and pronounces death, all in violation of the AMA guidelines.[22] In Georgia, a doctor supervises executions, and orders the injection of additional chemicals when deemed necessary; during one execution, the doctor inserted a central line when nurses were unable to find a suitable vein.[23] In Oklahoma, a licensed physician is present in the execution chamber, monitoring the inmate's level of consciousness "by whatever means he deems appropriate."[24] In California, doctors have been present in each of the state's eleven lethal injection executions, monitoring heart rate and respiration.[25] In Missouri and Arizona, prison officials recently announced that they have found new doctors to oversee the procedures in those states.[26] And at least two doctors, including regular states' expert Dr. Mark Dershwitz, have assisted states such as Ohio and Tennessee in the development of new lethal injection protocols, including advising on how the drugs work and recommending specific changes to the protocol.[27]

HISTORY OF ACTIVISM AGAINST PHYSICIAN PARTICIPATION

Doctors, human rights groups, and abolitionist groups have expressed strong positions against physician participation in executions and taken direct action in an effort to deter such participation. Amnesty International, for example, has long sought to publicize the fact that physician participation violates the AMA's ethical code. Two other leading abolitionist organizations, the National Coalition to Abolish the Death Penalty (NCADP), and Human Rights Watch, were two of the four organizational authors of a 1994 report exposing the extent of physician participation in executions. Although the report did not take a position on the death penalty, it did take a strong position against physician participation, recommending, among other things, that "[s]tate medical boards . . . should define physician participation as unethical conduct and take appropriate action against physicians who violate ethical standards."[28]

Other, less centralized, efforts have taken similar forms. In Georgia, for example, a group of anti-death penalty doctors, led by Dr. Arthur Zitrin, filed a complaint in 2005 against a doctor who had admitted participating in several Georgia executions. The complaint was ultimately dismissed. Yet newspaper reports noted that it was part of a "recent volley in a campaign to revoke the licenses of doctors who participate in executions."[29] Indeed, the previous year, four death penalty opponents (one lawyer, two doctors, and a chaplain) filed a complaint with the Kentucky Board of Medical Licensure against Governor Ernie Fletcher. The complaint alleged that, because he is a licensed physician, the governor could not sign a death warrant for inmate Thomas Clyde Bowling without violating the AMA guidelines.[30] Dr. Zitrin, also a vocal opponent of the death penalty, followed the complaint filing by publishing an op-ed in the *Los Angeles Times* titled, "Doctor, Reread Your Oath," and arguing that Governor Fletcher's actions violated the AMA ethical guidelines.[31] The Kentucky medical board ultimately dismissed the complaint, ruling unanimously that although he was a physician, Fletcher was acting in his role as governor, not as a doctor, when he signed the warrant.[32]

STUDY OF STATE LAWS GOVERNING MEDICAL BOARDS

The vast majority of state medical boards have taken no position on the specific matter of participation in executions, and few have ever actually considered disciplining a doctor for participating in executions.[33] This is the case despite the fact that, as discussed above, numerous doctors have participated in hundreds of executions in various capacities over the past three decades, and anti-death penalty activists have filed complaints against specific doctors with medical boards on several occasions. The North Carolina Medical Board is the only example of a state board expressing a public interest in disciplining a doctor for participating in an execution; however, as discussed below, the North Carolina Supreme Court prohibited the board from imposing discipline on any doctors.[34] In fact, no doctor in the United States has ever actually been disciplined by a medical board for participation in a lethal injection execution.[35]

In an effort to further determine the relevance of the AMA guidelines in state ethical codes, a comprehensive study was conducted of the governing law in all 50 states.[36] The study reveals that, as of 2009, only two death penalty states, Ohio and Kentucky, have incorporated the AMA ethical guidelines by statute into their state medical ethical code. For example, Ohio's statute provides that, "to the extent permitted by law," the board may "limit, revoke, or suspend an individual's certificate to practice" for violating any provisions of the code of ethics of the AMA.[37] In another five death-penalty states – Maryland, Mississippi, Nebraska, New Hampshire, and Tennessee – the regulations adopted by medical boards explicitly reference the AMA in the local ethical codes. For example, the Tennessee medical board fully adopts the AMA's Code of Medical Ethics as its own code of ethics, at least "to the extent it does not conflict with state law."[38] Maryland regulations allow the medical board to "consider" the ethical guidelines of the AMA, "but these principles are not binding on the Board."[39]

In these few states, it is theoretically possible that a doctor participating in an execution – and thereby violating the AMA's ethical guidelines – could be subject to medical board sanction. But in the vast majority of death-penalty states, a medical board would need to find that a doctor had violated the "catch-all" provision of the state ethics rules in order to impose discipline. Many states have such provisions, allowing, for example, discipline for a "departure from or failure to conform to the standards of acceptable and prevailing practice of a profession or the ethics of the profession." It is highly unlikely that participation in executions would fall within that broad language given that, if anything, the prevailing practice with respect to executions is to include the participation of physicians. In any event, for the reasons discussed below, in those rare instances where a medical board both has the colorable authority to discipline and the desire to do so, it is far from clear that courts will allow such action.

LEGALITY OF POSSIBLE MEDICAL BOARD ACTION

With an anticipated increase in complaints to medical boards, the question arises whether the boards can take action if they are so inclined.[40] There are two reasons to question whether state medical boards have the authority to discipline participating doctors even if the governing ethical statute or regulations appear to allow it. First, courts thus far have refused to allow medical boards to impose discipline where, as in most states, the governing death penalty statute contemplates physician involvement. Second, a growing number of states are passing "shield laws" that explicitly remove medical board jurisdiction over this issue.

1. Governing Death Penalty Statutes

Courts in three states have addressed the question whether

medical boards have the authority to discipline doctors who are participating in the administration of a lawful execution. All three have concluded that the boards do not have the power to discipline doctors who are essentially carrying out state law.

In 2005, Dr. Arthur Zitrin filed a claim with the Georgia Composite State Board of Medical Examiners, seeking an investigation into whether doctors who participated in Georgia's lethal injections were subject to discipline for violating the AMA's ethical guidelines. The board refused to open an investigation. Dr. Zitrin and several other doctors sued in state court, seeking a declaration that Georgia law prohibits physician participation in executions and requiring the Board to open an investigation. The doctors did not receive a warm welcome in court. According to a report in the *Atlanta Journal-Constitution*, the trial judge to whom the case was assigned noted during one hearing that "the AMA is simply a membership organization" and asked counsel for Dr. Zitrin, "How many Georgia physicians belong to the AMA? I'd say less than half. And you want to incorporate an ethical opinion of the AMA into Georgia law?"[41] The judge ruled against the doctors, finding that they had failed to state a claim. The Georgia Court of Appeals affirmed, noting that the medical board's position in the matter "guarantees that no physician [in Georgia] will be subject to disciplinary proceedings as a result of his or her participation in an execution."[42]

When a group of doctors sued in California in 1996 for a declaration that physicians who participated in executions should lose their licenses under state law, the Court of Appeal found highly significant the fact that the state penal code appeared to authorize physician participation in executions. "Surely," the court reasoned, "the Legislature could not have expressly and implicitly provided for physician involvement in executions, and simultaneously subjected participating physicians to discipline or other legal sanctions from engaging in lawful conduct."[43]

Even in the one state in which the medical board publicly expressed a will to consider disciplining participating doctors, the state's supreme court intervened. When the North Carolina Medical Board issued a statement in 2007 warning that doctors who facilitate executions "may be subject to disciplinary action," it was sued by the Department of Corrections, which claimed that the medical board was interfering with its ability to carry out state law, which requires the presence of a physician during executions. The North Carolina Supreme Court sided with the Department of Corrections, noting that the state legislature had both written the state's death penalty law and had created the medical board. Thus, "[t]o allow [the Medical Board] to discipline its licensees for mere participation would elevate the created Medical Board over the creator General Assembly."[44]

With the death penalty statutes in all but two states contemplating some form of physician participation,[45] it is unlikely that courts will be any more sympathetic to medical board attempts to discipline doctors than the courts in Georgia, California, and North Carolina have been. Even in the few states in which state law or regulation incorporates the AMA guidelines, governing death-penalty law is likely to trump the medical board's authority.[46] In Ohio, for example, state law allows medical board discipline for violation of the AMA guidelines, but only to the extent "permitted by" state law. But Ohio law explicitly provides for the presence at an execution of "[p]hysicians of the state correctional institution in which the sentence is executed,"[47] in violation of the AMA guidelines. Under the reasoning of the courts that have thus far addressed this issue, it is unlikely that the Ohio medical board would be able to discipline a doctor for being present at an execution when his or her presence is specifically provided for in the governing death penalty statute.

2. Safe harbor and shield laws

Some states are not taking any chances and have preemptively protected doctors from any medical board action by enacting various laws that are intended to trump any such efforts. These laws, generally referred to as "safe harbor" laws, specifically prevent medical boards from taking disciplinary action against medical providers who opt to participate in executions.[48] In practice, these laws immunize doctors from licensing challenges. Illinois was among the first states to adopt such a provision; it did so in response to a 1994 complaint requesting that the Illinois medical board discipline doctors willing to participate in the execution of John Wayne Gacy.[49] Other states soon followed suit. In addition, at least eight states have adopted "exclusionary" statutes, which provide that lethal injections do not constitute the practice of medicine, thus insulating doctors who participate in executions from medical board sanctions.[50] Finally, many states have various "shield" laws and policies in effect to ensure the anonymity of doctors who do participate in executions. These laws effectively protect such doctors against any licensing challenges by third parties.[51]

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To determine whether a particular state's medical board

can impose discipline, several hurdles must be overcome. First, the state medical board must be empowered to discipline doctors for violating the ethical guidelines of the AMA. As mentioned above, state law in only seven death-penalty states even references the AMA in its ethical code. Second, there must be no safe harbor statute on the books. And third, the state's governing death penalty statute must not explicitly contemplate the participation of physicians. In sum, in the vast majority of states (if not all of them), the medical board has no legal power to discipline doctors for participating in executions.

II. PRACTICAL REASONS FOR MEDICAL BOARDS TO AVOID INTERVENTION

The position of the AMA and others opposed to physician participation is well-publicized. But there is another side. Even if there is a theoretical possibility of imposing discipline in a handful of states, there are compelling reasons for medical boards to refrain from interfering in the execution business. Some doctors have even expressed an obligation on the part of physicians to participate in order to ensure that the execution does not result in unnecessary pain or suffering.

For example, Dr. David Waisel, an anesthesiologist at Children's Hospital in Boston, recently argued that organized medicine has an obligation to permit physician participation in executions "to the extent necessary to ensure a good death."[52] Dr. Waisel rejects the common arguments against physician participation as slippery-slope arguments that have little basis in reality. For example, he finds no evidence to support the arguments that physicians who participate in executions will lack the ability to act with compassion or independence in their normal practice, or that the public trust in the medical profession will be lost as a result. In the end, it is the capacity of the three-drug lethal injection procedure to inflict great suffering on the condemned that has convinced Dr. Waisel that physician participation in the process is necessary. Forbidding physician participation, he writes, "increases the chances of a botched execution. It seems cruel to permit capital punishment but not to permit participation of those who are capable of performing it humanely."[53]

Dr. Atul Gawande, a Harvard medical school professor who is himself opposed to physician participation in lethal injections, interviewed several doctors regarding their decision to participate in executions.[54] Published in the *New England Journal of Medicine*, Dr. Gawande's account provides a rare view into the motivations of doctors who actually conduct executions in the United States. One doctor, anonymously referred to as "Dr. A," originally agreed to assist in an execution with the understanding that his role would be limited to cardiac monitoring. Soon, though, his participation increased by virtue of his presence on the scene, and he began placing IV lines in the men who were set to die and assisting whenever something went wrong during an execution.[55] Another doctor, "Dr. C," worried about being exposed publicly as an executioner, but had no moral qualms about his role. "I think that if I had to face someone I loved being put to death," Dr. C commented, "I would want that done by lethal injection, and I would want to know that it is done competently."[56]

One of the interviewed doctors chose not to remain anonymous. Dr. Carlo Musso, who assists with executions in Georgia, told Dr. Gawande that he participates in spite of the AMA guidelines because he feels an obligation not to abandon inmates in their final moments. As Dr. Musso explained, "[T]his is an end-of-life issue, just as with any other terminal disease. It just happens that it involves a legal process instead of a medical process. [A death penalty] patient is no different from a patient dying of cancer – except his cancer is a court order."[57]

A doctor recently hired by the state of Arizona to oversee executions testified in a recent deposition that he was "surprised" by the number of people who argued that it was "totally inappropriate" for doctors to participate in executions.[58] To the contrary, the doctor testified, "I think as long as it's something that the government thinks is appropriate and it should be done, it should be done correctly. So that's why I'm . . . participating."[59]

Another prominent, and oft-cited, defense of physician participation in lethal injection executions is that offered by Dr. Kenneth Baum, who argues that under the patient-centered conception of medical ethics, physicians are obligated to participate in lethal injections. Dr. Baum echoes Dr. Musso's analogy of a dying cancer patient: "Condemned death row inmates are, for all practical purposes, terminally ill patients, albeit under a nontraditional definition of the term, and deserve to be treated as such."[60] In fact, Dr. Baum notes that doctors generally are thought to have a duty to minimize suffering when a patient is dying, and that "[t]o desert these individuals [condemned inmates] in their most vulnerable hour would be antithetical to the beneficent ideals of medical practice."[61] It is the

doctor who turns his or her back on a dying inmate, and refuses to do what he or she can to relieve suffering, "who truly violates the ethical code of the profession."[62] Or, as another doctor put it in a response letter to Dr. Gawande's article, "the participation of physicians seems more humane than delegating the deed to prison wardens, for by condoning the participation of untrained people who could inflict needless suffering that we physicians might have prevented, we are just as responsible as if we had inflicted the suffering ourselves."[63]

III. CONCLUSION

Medical boards have broad jurisdiction and much to address in the medical profession. It is far from clear, however, that they have the legal authority to impose discipline on doctors who participate in executions. In fact, it is far more likely that they do not have that authority in the vast majority of states. Moreover, while the image of doctors participating in the execution process may spark a viscerally negative reaction in members of a profession dedicated to healing, the reality is that there is a role for doctors to play in the minimization of pain and suffering at the end of a condemned inmate's life. For a medical board to discipline a doctor for playing that role would be, in most instances, legally untenable and a questionable exercise of the board's priorities.

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AUTHOR AFFILIATIONS

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1. Nancy Frazier O'Brien, *Doctors' role in executions part of new tactic against death penalty*, Catholic News Service, Feb. 4, 2009.
2. *See* Deborah W. Denno, *When Legislatures Delegate*

Table A: Incorporation of AMA Ethical Guidelines into State Medical Ethics Statutes

I. Death Penalty States With Statutory or Regulatory Incorporation of AMA Guidelines		
Kentucky*	Maryland	Mississippi
Nebraska	New Hampshire	Ohio*
Tennessee		

II. Death Penalty States Without Statutory or Regulatory Incorporation of AMA Guidelines			
Alabama	Arizona	Arkansas	California
Colorado	Connecticut	Delaware	Florida
Georgia	Idaho	Illinois	Indiana
Kansas	Louisiana	Missouri	Montana
Nevada	North Carolina	Oklahoma	Oregon
Pennsylvania	South Carolina	South Dakota	Texas
Utah	Virginia	Washington	Wyoming

III. Non-Death Penalty States With Statutory or Regulatory Incorporation of AMA Guidelines		
Alaska	Hawaii*	Iowa
New Mexico	West Virginia	

IV. Non-Death Penalty States Without Statutory or Regulatory Incorporation of AMA Guidelines		
Maine	Massachusetts	Michigan
Minnesota	New Jersey	New York
North Dakota	Rhode Island	Vermont
Wisconsin		

* The AMA Guidelines are incorporated by statute in these states.

Table B: Citations to State Ethical Laws

State	Relevant Statutes and Regulations
Alabama	Ala. Code § 34-24-360 (2009)
Alaska	Alaska Stat. § 08.64.326 (2009) Alaska Admin. Code tit. 12, § 40.955(a) (2009)
Arizona	Ariz. Rev. Stat. Ann. § 32-1451 (2009)
Arkansas	Ark. Code Ann. §17-95-409 (West 2009)
California	Cal. Bus. & Prof. Code § 2234 (West 2009)
Colorado	Colo. Rev. Stat. § 12-36-117 (2009)
Connecticut	Conn. Gen. Stat. Ann. § 20-13c (West 2009)
Delaware	Del. Code Ann. tit. 24 § 1731 (2009)
Florida	Fla. Stat. Ann. § 458.331 (West 2009)
Georgia	Ga. Code Ann., § 43-34-8 (2009)
Hawaii	Haw. Rev. Stat. Ann. § 453-8(a)(9) (LexisNexis 2009)
Idaho	Idaho Code Ann. § 54-1814 (2009)
Illinois	225 Ill. Comp. Stat. Ann. 60/22 (LexisNexis 2009)
Indiana	Ind. Code. § 25-22.5-5-2.5 (West 2009)
Iowa	Iowa Code Ann. § 147.55 (West 2009) Iowa Admin. Code r. 653-13.20 (2009)
Kansas	Kan. Stat. Ann. § 65-2836 (2009)
Kentucky	Ky. Rev. Stat. Ann. § 311.597(4) (West 2009) 201 Ky. Admin. Regs. 9:005(1)(a) (2009)
Louisiana	La. Rev. Stat. Ann. § 37:1285 (2009)
Maine	Me. Rev. Stat. Ann. tit. 32 § 3282-A (2009)
Maryland	Md. Code Ann., Health Occ. § 14-404 (West 2009) Md. Code Regs. 10.32.02.10 (2009)
Massachusetts	Mass. Gen. Laws Ann. ch. 112, § 5 (West 2009)
Michigan	Mich. Comp. Laws Ann. § 333.16221 (West 2009)
Minnesota	Minn. Stat. Ann. § 147.091 (West 2009)
Mississippi	Miss. Code Ann. § 73-25-29 (West 2009) 50-013-001 Miss. Code R.§ 22(500)(2)(Weil 2009)
Missouri	Mo. Rev. Stat. § 334.100 (West 2009)
Montana	Mont. Code Ann. § 37-3-323 (2007)
Nebraska	Neb. Rev. Stat. Ann. § 38-178 (2009) 172 Neb. Admin. Code, ch 88, § 013(1) (2009)
Nevada	Nev. Rev. Stat. Ann. § 630.301 (West 2007)
New Hampshire	N.H. Rev. Stat. Ann. § 329:17 (2009) N.H. Code Admin. R. Ann. Med. 501.02(h) (West 2009)
New Jersey	N.J. Stat. Ann. § 45:1-21 (West 2009)
New Mexico	N. M. Stat. Ann. § 61-6-15 (West 2009) N.M. Code R. § 16.10.8.9(A) (Weil 2009)
New York	N.Y. Educ. Law § 6530 (McKinney 2008)
North Carolina	N.C. Gen. Stat. Ann. § 90-14 (West 2009)
North Dakota	N.D. Cent. Code §43-17-31 (2009)

Ohio	Ohio Rev. Code Ann. § 4731.22(B)(18) (West 2009)
Oklahoma	Okla. Stat. Ann. tit. 59, § 509 (West 2009)
Oregon	Or. Rev. Stat. Ann. § 677.190 (West 2009)
Pennsylvania	63 Pa. Stat. Ann. § 422.41 (West 2009)
Rhode Island	R.I. Gen. Laws § 5-37-5.1 (2009)
South Carolina	S.C. Code Ann. § 40-47-110 (2008)
South Dakota	S.D. Codified Laws § 36-4-30 (2009)
Tennessee	Tenn. Code Ann. § 63-6-214 (West 2009) Tenn. Comp. R. & Regs. 0880-02-.14(8) (2009)
Texas	Tex. Occ. Code Ann. § 164.053 (Vernon 2009)
Utah	Utah Code Ann. § 58-1-501 (West 2009)
Vermont	Vt. Stat. Ann. tit. 26 § 1354 (2009)
Virginia	Va. Code Ann. § 54.1-2915 (West 2009)
Washington	Wash. Rev. Code § 18.130.180 (West 2009)
West Virginia	W. Va. Code Ann. § 30-3-14 (West 2009) W. Va. Code R. § 11-1A-12 (12.2)(d) (2009)
Wisconsin	Wis. Stat. § 448.02(3) (West 2009)
Wyoming	Wyo. Stat. Ann. § 33-26-402 (2009)

Death: The Troubling Paradox Behind State Uses of Electrocution and Lethal Injection and What It Says About Us, 63 Ohio St. L.J. 63, 97 (2002). Only Ohio uses a different procedure. *See* Ian Urbina, *Ohio Is First to Change to One Drug in Executions*, N.Y. Times, Nov. 13, 2009.

3. *See* Deborah W. Denno, *The Lethal Injection Quandary: How Medicine Has Dismantled the Death Penalty*, 76 Fordham L. Rev. 49, 54-58 (2007).
4. David Waisel, *Physician Participation in Capital Punishment*, 82 Mayo Clinic Proc. 1073, 1074 (2007).
5. *See* Ty Alper, *Anesthetizing the Public Conscience: Lethal Injection and Animal Euthanasia*, 35 Fordham Urb. L.J. 817, 819 (2008).
6. *See, e.g.*, id., at 819-20 & n.20.
7. Baze v. Rees, 128 S.Ct. 1520, 1532 (2008) (quoting Farmer v. Brennan, 511 U.S. 825, 842 (1994)).
8. Often suggested is that states consider a one-drug, anesthetic-only procedure similar to that used in most animal euthanasia. *See, e.g.*, Alper, *supra* note 5, at 833-39. Ohio recently became the first state to use such a method.
9. Another legal challenge to lethal injection protocols has to do with establishing intravenous access in inmates with compromised veins. In such cases, it is often necessary to place a central line, in, for example, the inmate's groin. Such a procedure almost always necessitates the skill of a trained physician.
10. Emma Harris, *Will Medics' Qualms Kill the Death Penalty?* 441 Nature 8-9 (May 4, 2006).
11. Council on Ethical and Jud. Affairs, AMA, Council Rep., *Physician Participation in Capital Punishment*, 270 JAMA 365, 365 (1993).
12. Message from Orin F. Guidry, M.D., President, Am. Soc'y of Anesthesiologists, *Observations Regarding Lethal Injection* (June 30, 2006), *available at* http://www.asahq.org/news/asanews063006.htm.
13. Society of Correctional Physicians, *Code of Ethics*, (adopted 1997, amended 1998).
14. *See, e.g.*, Henry Weinstein, *Anesthesiologists Advised to Avoid Executions*, L.A. Times, July 2, 2006; Rosanna Ruiz, *Hippocratic Oath Keeps Doctors Out of Death Chambers*, Houston Chron., February 24, 2006; Valerie Reitman, *Doctors Wary of Crossing Line*, L.A. Times, Feb. 22, 2006; Adam Liptak, *Should Doctors Help With Executions? No Easy Ethical Answer*, N.Y. Times, June 10, 2004; Lawrence K. Altman, *Focus on Doctors and Executions*, N.Y. Times, Mar. 20, 1994; Don Colburn, *Lethal Injection: Why Doctors Are Uneasy About the Newest Method of Capital Punishment*, Wash. Post., Dec. 11, 1990.
15. *See* Michael D. Maves, Chief Executive Officer, American Medical Association, *A challenge to the House of Delegates*, *available at* http://www.ama-assn.org/ama/pub/news/speeches/challenge-house-delegates.shtml (Nov. 8, 2008).

16. *See* W. Noel Keyes, *The Choice of Participation by Physicians in Capital Punishment*, 22 Whittier L. Rev. 809, 810 (2001).
17. *See* Kenneth Baum, *"To Comfort Always": Physician Participation in Executions*, 5 N.Y.U. J. LEGIS. & PUB. POL'Y 47, 53 (2001).
18. *See* Denno, *supra* note 3, at 84.
19. *See id.* at 84-88.
20. *See* Nadia N. Sawicki, *Doctors, Discipline, and the Death Penalty: Professional Implications of Safe Harbor Policies*, 27. YALE L. & POL'Y REV. 107 (2008).
21. *See* Atul Gawande, *When Law and Ethics Collide—Why Physicians Participate in Executions*, 354 NEW ENG. J. MED. 1221, 1223-28 (2006).
22. *See* Jennifer McMenamin, *Lethal Practice*, Baltimore Sun, Oct. 22, 2006.
23. *See* Liptak, *supra* note 14.
24. Defendant's Response to Memorandum and Motion to Reactivate Proceedings at 5, Taylor v. Jones, No. 5:05CV00825 (W.D. Okla. Sept. 3, 2008).
25. *See* Teresa A. Zimmers & David A. Lubarsky, *Physician Participation in Lethal Injection Executions*, 20 Current Opinion Anaesthesiology 147, 148-49 (2007).
26. *See* Deposition of Medical Team Member 1 at 11, Dickens v. Napolitano, No. CV07-1770-PHX-NVW (D. Ariz. Oct. 1, 2008); Associated Press, *Missouri Poised to Resume Executions; State Has Added Anesthesiologist To Death Row Team*, St. Louis Post-Dispatch, May 27, 2008.
27. Harbison v. Little, 511 F. Supp.2d 872, 876 (M.D. Tenn. 2007); Ian Urbina, *Ohio Finds Itself Leading the Way to a New Execution Method*, N.Y. Times, Nov. 17, 2009.
28. The Am. Coll. of Physicians et. al., *Breach of Trust: Physician Participation in Executions in the United States* 46 (1994).
29. Carlos Campos, *Doctors' Execution Role Targeted*, Atlanta J.-Const., June 2, 2005.
30. *See* Andis Robeznieks, *Ethics Charges Related to Executions Dropped*, AM News, Jan. 31, 2005.
31. Arthur Zitrkin, *Doctor, Reread Your Oath*, L.A. Times, Dec. 8, 2004.
32. *See* Deborah Yetter, *Ethics Complaint is Dismissed; Foes of Execution Challenged Fletcher*, Courier-J., Jan. 14, 2005.
33. *See* Gawande, *supra* note 21, at 1223.
34. *See* Pauline Vu, *Executions Halted as Doctors Balk*, Stateline.org, Mar. 20, 2007; Kevin B. O'Reilly, *N.C. court overturns ban on doctor participation in executions*, AM News, May 18, 2009.
35. *See* Gawande, *supra* note 21, at 1223.
36. As a result of medical boards operating independently from one another, their governing statutes and regulations are not uniform. Some states, for example, have statutory provisions exclusively addressing medical ethics and/or ethical sanctions, while others do not. States that do not have dedicated "ethics" provisions at times discuss these matters in other provisions of the statute or regulations. The statutory provisions cited in Table B pertain to those provisions that define unprofessional conduct, either generally or specifically. Note that some laws and regulations refer to "unethical" rather than "unprofessional" conduct. To determine whether a state referred to the AMA's ethical standards, key term searches were conducted for the relevant statutes and regulations in all 50 states.
37. Ohio Rev. Code Ann. § 4731.22(B)(18) (West 2009).
38. Tenn. Comp. R. & Regs. 0880-02-.14(8) (2009).
39. Md. Code Regs. 10.32.02.10 (2009).
40. It is quite clear legally that a state medical board's discretion not to pursue discipline against a participating doctor is unreviewable. *See* Sawicki, *supra* note 20, at 138 n. 144.
41. Carlos Campos, *Lawyers: Don't let Doctors Execute*, Atlanta J.-Const., Dec. 21, 2005.
42. *See* Zitrin v. Ga. Composite State Bd. of Med. Examiners, 653 S.E.2d 758, 762 (Ga. Ct. App. 2007).
43. Thorburn v. Dep't. of Corrs., 78 Cal.Rptr.2d 584, 590 (Cal. App. 1998).
44. North Carolina Dept. of Corr. v. North Carolina Medical Bd., 675 S.E.2d. 641, 651 (N.C. 2009).
45. *See* Denno, *supra* note 3, at 88-89.
46. *See* Eric Berger, *Lethal Injection and the Problem of Constitutional Remedies*, 27 Yale Law and Pol'y Rev. 259, 321 (2009).
47. Ohio Rev. Code Ann. § 2949.25 (West 2007).
48. *See* Sawicki, *supra* note 20, at 130.
49. *Id.* at 124-25.
50. *See* Denno, *supra* note 3, at 89 & n.263. It is worth noting that these statutes also serve to insulate non-doctors from discipline for performing tasks during executions that are typically the province of the medical profession.
51. Illinois' statute, for example, provides that "[t]he identity of executioners . . . and information contained in records that would identify those persons shall remain confidential, shall not be subject to disclosure, and shall not be admissible as evidence or be discoverable in any action of any kind in any court or before any tribunal, board, agency, or person." 725 Ill. Comp. Stat. Ann. 5/119-5(e) (West 2009).

52. Waisel, *supra* note 4,at 1073.
53. *Id.* at 1079.
54. *See* Gawande, *supra* note 21.
55. *See id.* at 1225.
56. *Id.*
57. *Id.*
58. Dickens v. Brewer, No. CV07-1770-PHX-NVW (D. Ariz.) (deposition of Medical Team Member 1), at 263.
59. *Id.*
60. *See* Baum, *supra* note 17, at 61.
61. *Id.* at 62.
62. *Id.*
63. Bruce E. Ellerin, Letter to the Editor, *Why Physicians Participate in Executions*, 355 New Eng. J. Med. 99, 99 (2006).

NOTE

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