Baze v. Rees, Execution by Lethal Injection, and the Role of the Medical Profession

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Introduction

The United States remains alone among Western nations in its acceptance of the death penalty. Thirty-seven states in the United States allow the execution of inmates, and the preferred method of execution in thirty-six states as well as in the military and in the federal prison system is by lethal injection. Since 1976, 83% of executions in the United States have been carried out in this manner.

Aside from the general question now actively being debated of whether the death penalty, however administered, is inherently cruel and never constitutional, the more specific issue of whether execution by lethal injection constitutes cruel and unusual punishment is now before the United States Supreme Court.

This is not the first time in recent history that the Court has agreed to review a death penalty case in response to what is perceived to be a shift in public opinion and state legislatures on the issue of execution of prisoners. In 2002 in Atkins v. Virginia, the Court reversed its 1989 Penry decision on the constitutionality of execution of the mentally handicapped, now holding that a Virginia law allowing the execution of mentally handicapped individuals violated the 8th Amendment’s prohibition against cruel and unusual punishment. Although the Court has indicated willingness to deal with the constitutionality of the death penalty for broad “classes” of individuals, such as the mentally handicapped in Penry and Atkins, it has rarely shown any interest in reviewing the constitutionality of specific methods of execution since its 19th century decisions upholding the use of a firing squad and the electric chair.

The Current Controversy

The impetus for the United States Supreme Court’s current decision to review execution by lethal injection arises from concern over whether the generally accepted “cocktail” of three drugs used to sequentially induce sleep, paralyze muscles, and stop the heart might create a situation in which there is inadequate sedation and thus pain from the lethal potassium chloride injection. The scientific evidence supporting the currently preferred

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1 John Gibeaut, Tinkering with Lethal Injection. An Eighth Amendment challenge comes before the court, ABA JOURNAL, January 2008 at 18. Nebraska still uses the electric chair.
6 Wilkerson v. Utah, 99 U.S. 130 (1878).
7 In re Kimmler, 135 U.S. 436 (1890).
regimen of drugs and their doses in humans is sparse at best, and several instances of overt suffering by inmates during botched attempts at lethal injection have been reported. Several states now have a moratorium on executions pending the Court’s resolution of the issue of pain and suffering during execution by lethal injection. In December 2007, New Jersey became the first state in over 40 years to abolish the death penalty, in part due to these concerns.

The Case Before the United States Supreme Court

The case of *Baze v. Rees* now before the Supreme Court is specifically centered on the precise formula of drugs currently used for lethal injection. This appeal arose out of a failed challenge to the three-drug protocol in Kentucky state court in 2004 brought by two Kentucky death row inmates (Ralph Baze and Thomas C. Bowling), neither of whom were facing an imminent execution date. The lower court decision was upheld by the Kentucky Supreme Court and a petition for certiorari was filed with the Supreme Court.

The defendants in *Baze v. Rees* do not challenge either murder conviction, nor do they seek either a constitutional ban on the death penalty itself or on the use of lethal injection per se. Rather, they ask the Court to rule only on the narrow question of setting “standards for lethal injections to avoid ‘an unnecessary risk of pain and suffering’” by focusing on the specific chemical protocol used in Kentucky and thirty-five other states. Three questions were posed to the court for review: (1) does the particular protocol used for lethal injection violate the cruel and unusual punishment ban in the 8th Amendment; (2) does the protocol do so because there are alternative procedures with less risk of pain and suffering; and (3) does continued use of the protocol itself violate the 8th Amendment, given what is known about the potential problems with the protocol?

A fourth question also posed to the Court was whether a state had a duty to have a medical team present to keep the inmate alive should the execution process start but be interrupted by a court before it was completed. Although the U.S. Supreme Court indicated that it would limit its review to only the first three questions, the fourth question is equally serious and revolves around the realization that in some instances the training of personnel involved in carrying out lethal injection execution is haphazard and not standardized. Indeed, the fourth question is intimately linked to the other three questions; the Petition for the Writ of Certiorari specifically states that “even an

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11 The state of Illinois has had a moratorium on executions since 2000 and debate in the legislature is still on-going.
12 *Baze, supra* note 3.
14 *Baze, supra* note 3.
15 *Id.*
16 *Id.*
17 *Id.*
18 *Id.*
execution method such as lethal injection that is humane in theory can be carried out by means of flawed or haphazard procedures that create a foreseeable danger of inflicting severe pain in actual practice.”\(^{19}\) This question posed to the Court raises the issue of involvement of the medical profession in general, and physicians in particular, in execution by lethal injection.\(^{20}\)

There is no consensus among the thirty-seven states administering the death penalty by lethal injection on the precise role the medical profession should play. Eighteen states permit physician involvement, and seventeen states, including Texas, mandate physician involvement.\(^{21}\) The actual degree to which physicians must be involved, and what constitutes “involvement,” varies a great deal from state to state, but the real question is whether physicians should be involved at all.\(^{22}\)

**Primim No Nocere\(^{23}\) vs. Statutory Sleight of Hand**

Even if a state were to require that a physician directly participate in the administration of a lethal injection by measuring chemicals, inserting intravenous lines, or assisting in the injection of drugs, the American Medical Association’s Code of Medical Ethics specifically prohibits the direct involvement of physicians in executions,\(^{24}\) although there is some ambiguity in the AMA’s statement as to what degree of involvement, if any, is permissible. Physician involvement may be limited to only being asked to enter the death chamber to affirm the inmate’s death (as in Texas), or inserting of intravenous lines and mixing the chemicals to be administered. The Hippocratic Oath, at least in its presently accepted version,\(^{25}\) would also seem to preclude physician participation in an execution.”\(^{26}\) By any standard, an execution of an individual constitutes a direct harm.

Some states have attempted to circumvent the apparent direct conflict between a physician’s duty to do no harm and preserve patient trust with the obvious harm of participating in the taking of a human life by stating that physician participation in an execution is not the practice of medicine.\(^{27}\) The language of such laws notwithstanding, it is clear that but for being a physician with specialized training, the physician would normally not be at the execution at all.\(^{28}\) Hence, there can be no question that the physician is acting in a medical capacity. What is not clear from the AMA’s position


\(^{20}\) Black, *supra* note 8.

\(^{21}\) *Id*. A state cannot require that any physician do this, but it can mandate that execution not be carried out without physician assistance, e.g. to pronounce the patient.

\(^{22}\) Gawande, *supra* note 2.

\(^{23}\) “First, do no harm.” A Latin phrase. It does not appear in the Hippocratic Oath although it is something all medical students are taught.


\(^{25}\) *Id*.

\(^{26}\) *Id*.

\(^{27}\) Black, *supra* note 8.

\(^{28}\) *Id*. 

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statement is whether limiting the role of a physician in an execution to one of only pronouncing the patient dead would constitute an ethics violation.\textsuperscript{29}

The Role of State Medical Boards and Professional Medical Societies

Individual state medical boards have also weighed in on the issue of willing physician participation in state sanctioned executions (by lethal injection or otherwise), and here the situation gets more interesting.\textsuperscript{30} By virtue of their ability to take direct action against a physician’s medical license, state medical board rulings concerning the acceptable degree of physician participation in any death penalty procedure potentially have more clout. Not surprisingly, individual state medical board decisions on permissible involvement of physicians in death by lethal injection runs the entire spectrum from inaction (New Jersey, Texas)\textsuperscript{31} to the threat of sanctions and medical license revocation for any participation (North Carolina).\textsuperscript{32}

There is the potential for conflict between state law and a state medical board. If execution is legal and physician involvement mandated in a given state, a state medical board cannot address physician participation in an execution as illegal conduct or poor patient care. However, a state medical board could, if sufficiently motivated, investigate the behavior of the involved physician and take action against his or her medical license if it felt the conduct were unprofessional. A position statement to this effect by both a state medical society and appropriate specialty medical societies on physician conduct could provide guidance for potential disciplinary action against a physician. Unfortunately, there is little evidence that this ever happens. The actions of North Carolina aside, it would appear that state medical boards have little interest in pursuing physicians when they comply with the level of participation mandated by the state, even if such participation conflicts with ethical standards.\textsuperscript{33}

Medical professional societies other than the AMA have also gone on record opposed to any participation of their members. In particular, the American Society of Anesthesiologists has endorsed the AMA’s position on physician participation in execution by lethal injection and noted that although it mimics some aspects of the administration of anesthesia, it is not the practice of medicine.\textsuperscript{34} Even the Association of Emergency Medical Technicians has issued a public statement reminding its members of their ethical obligation not to participate in legal execution by lethal injection.\textsuperscript{35} This is no minor concern: in the state of Texas all of the mechanics of administering lethal

\begin{itemize}
  \item \textsuperscript{29} American Medical Association \textit{supra} note 17.
  \item \textsuperscript{30} \textit{Id.}
  \item \textsuperscript{32} Black, \textit{supra} note 8.
  \item \textsuperscript{33} \textit{Id.}
\end{itemize}
injections (inserting IV lines, mixing and administering drugs) have been contracted out to a non-physician group whose members are only noted to have “prior medical training.”

**Conclusion**

In the potential conflict between medical ethical duties and the obligation to follow the recommendations of one’s medical and professional societies on the one hand, and the laws of the state and individual physician preferences on the other, the winner appears to be the state and the preference of select individual physicians to participate in execution by lethal injection. This is true even when the activity the physician might participate in is a role specifically disallowed by the AMA.⁶⁶ A 2001 survey of 1000 randomly selected physicians from rosters provided by the AMA revealed that more than forty percent were willing to participate in ten aspects of lethal injection even when eight of the aspects clearly violated the AMA Code of Ethics.⁶⁷ Absent bold action from state medical boards such as that in North Carolina, it is unlikely that physician participation in execution by lethal injection will end before the procedure itself is outlawed.


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⁶⁶ Neil Farber, Elizabeth B. Davis, Joan Weiner, Janine Jordan, E. Gil Boyer, and Peter A. Ubel, *Physicians’ Attitudes About Involvement in Lethal Injection for Capital Punishment*, 160 ARCH. INT. MED. 2912 (2000). The authors suggested that one possible explanation for physicians’ favorable attitudes towards involvement in lethal injection for capital punishment was the lack of stigmatization by colleagues. Given the effort to protect physician anonymity for those involved in capital punishment, it is hard to imagine how an individual physician might be stigmatized absent publicly proclaiming active participation in an execution.