

HEALTH LAW, ETHICS, AND HUMAN RIGHTS

Toxic Tinkering — Lethal-Injection Execution and the Constitution

George J. Annas, J.D., M.P.H.

Michel Foucault opened his 1975 book *Discipline and Punish* with a particularly gruesome account of a French execution in 1757 that involved tearing the flesh away with hot pincers and applying boiling oil to what remained, followed by drawing and quartering of the body by four horses.¹ In the 18th century, the goals of torturing to death were retribution and deterrence by spectacle. Executions slowly moved away from violent torture to methods that were seen as being more humane, such as hanging, shooting by a firing squad, electrocution, and lethal gassing. Executions also became much less public.

In the United States, a recurring question has been whether particular methods of execution are consistent with the Eighth Amendment to the Constitution, which states: “Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted.” The most recent new execution technique to raise this question is lethal injection. In 1977, Oklahoma became the first state to adopt lethal injection, and today it is used in 36 states and by the federal government. Deborah Denno has argued that in adopting lethal-injection executions, “The law turned to medicine to rescue the death penalty.”²

After a number of statutes regarding lethal injection were passed, but before the country’s first execution by lethal injection in 1982, William Curran and Ward Casscells wrote an influential article in the *Journal* arguing that physicians should not participate in executions by lethal injection.³ They wrote that lethal injection, unlike other methods, “presents the most serious and intimate challenge in modern American history to active medical participation in state-ordered killing of human beings . . . [since] this procedure requires the direct application of biomedical knowledge and skills in a corruption and exploitation of the healing profession’s role in society.”³ The American Medical Association (AMA) and other medical societies quickly fol-

lowed their advice, declaring the participation of physicians in executions by lethal injection unethical. Ethics, of course, is critical to the medical profession. But as Robert Veatch noted at the time, no principle of medical ethics itself defines or sets legal limits to the physician’s role in executions⁴; this helps explain why some physicians still participate in executions by lethal injection.^{5,6}

Much of this year’s decision of the U.S. Supreme Court regarding lethal injection, *Baze v. Rees*, reads like Foucault’s *Discipline and Punish*. Foucault, for example, analyzed torture in execution as well as the contemporary movement to replace the vicious executioner with “a whole army of technicians . . . warders, doctors, chaplains, psychiatrists, [and] psychologists.” Likewise, in *Baze*, the Supreme Court highlighted not only past uses of torture, but also issues of contemporary medical practice and medical ethics, including the drugs used, their method of delivery, the qualifications of the persons involved, and the similarities and differences between veterinary euthanasia practices and the Dutch protocols for euthanasia.⁷ The decision, which did not address the constitutionality of the death penalty itself, is fragmented and fractured, consisting of opinions written by seven different justices. Seven of the nine justices agreed that Kentucky’s protocol for lethal injection, which was at issue in this case, is constitutional as is, but no more than three justices — Chief Justice John Roberts and two justices who signed on his plurality opinion — could agree on a specific standard that executions by lethal injection must meet.

THE PLURALITY OPINION OF CHIEF JUSTICE ROBERTS

In an opinion joined by Justices Anthony Kennedy and Samuel Alito, Chief Justice Roberts reviewed the previous use of hanging, electrocution,

firing squad, and lethal gas in executions, and he concluded that the motivation for adopting lethal injection as the exclusive or primary means of execution was “a desire to find a more humane alternative.”⁷ Thirty of the 36 states (including Kentucky) that have adopted lethal injection use a three-drug combination in their protocols:

The first drug, sodium thiopental is a fast-acting barbiturate sedative that induces a deep, comalike unconsciousness. . . . The second drug, pancuronium bromide is a paralytic agent that inhibits all muscular-skeletal movements and . . . stops respiration. Potassium chloride, the third drug, interferes with the electrical signals that stimulate the contractions of the heart, inducing cardiac arrest. The proper administration of the first drug ensures that the prisoner does not experience any pain associated with the paralysis and cardiac arrest caused by the second and third drugs.⁷

Kentucky’s written protocol provides, among other things, that 3 g of the first drug, 50 mg of the second drug, and 240 mmol of the third drug be used. The intravenous catheters are placed by either a certified phlebotomist or an emergency medical technician with at least 1 year of experience. Other personnel mix the solutions and load them into syringes. The execution team administers the drugs from a control room, and the warden and deputy warden keep the prisoner under visual inspection. “A physician is present to assist in any effort to revive the prisoner in the event of a last-minute stay of execution” but by statute is prohibited from participating in the “conduct of an execution,” except to certify the cause of death.⁷

The petitioners, who were sentenced to death, sought to have the Kentucky protocol for lethal injection declared unconstitutional. A trial court concluded that the risk of improper administration of the drugs was minimal. The Kentucky Supreme Court agreed, holding that a method of execution violates the Eighth Amendment only if it “creates a substantial risk of wanton and unnecessary infliction of pain, torture or a lingering death.”⁸ This is the opinion that was appealed to the Supreme Court.

Chief Justice Roberts reviewed previous U.S. Supreme Court opinions, noting an 1879 case in

which the Court said simply, “it is safe to affirm that punishment of torture . . . and all others in the same line of unnecessary cruelty, are forbidden by the Eighth Amendment.” That opinion provided examples from England in which “terror, pain or disgrace” were added to execution itself; these forms of punishment included being “emboweled alive, beheaded, and quartered” and sentenced to “public dissection . . . and burning alive.”⁷ Chief Justice Roberts concluded that “What each of the forbidden punishments had in common was the deliberate infliction of pain for the sake of pain.” In his words, the test of constitutionality must present more than a simple risk of needless suffering. To prevail, the condemned prisoner must “establish that the State’s lethal injection protocol creates a demonstrated risk of severe pain . . . that is substantial when compared to the known and available alternatives.”⁷

The petitioners alleged that there was a risk that the dose of thiopental would be inadequate to render the prisoner unconscious, thus causing cruel suffering. Chief Justice Roberts, however, found that this risk was not substantial. Roberts also concluded that the state had no constitutional obligation to adopt an alternative method, to adopt methods used to euthanize animals in the United States, or to assist in the suicide of terminally ill patients, which is legal in Oregon. The euthanasia of animals and assisted suicide both involve the use of a single overdose of a barbiturate.

THE OPINION OF JUSTICE ALITO

Justice Alito wrote a concurring opinion because he was concerned that the plurality opinion might be read as an invitation to litigants to suggest alternative methods of lethal injection that would “significantly reduce a substantial risk of severe pain.”⁷ Alito noted that the majority of justices (including Alito himself) proceed from two assumptions: the death penalty is constitutional, and lethal injection is a constitutional means of execution. Therefore, he argued, the use of lethal injection “must not be blocked by procedural requirements that cannot practicably be satisfied.”⁷ The major practical constraint, he noted, is the ethics of the medical profession.

Physicians could, for example, make lethal injections even less risky, “But the ethics rules of medical professionals — for reasons that I cer-

tainly do not question here — prohibit their participation in executions.”⁷ Justice Alito went on to cite the rulings of the AMA, as well as those of the American Nurses Association and the National Association of Emergency Medical Technicians, opposing participation in executions. He did this to make a point: objections to current methods of lethal injection that can be remedied by medical participation cannot be regarded as being either “feasible” or “readily” available, and therefore cannot be constitutionally required. Moreover, he concluded, the Court should not get involved with micromanaging how executions by lethal injection are carried out, because this could “produce a de facto ban on capital punishment by adopting method-of-execution rules that lead to litigation gridlock.”⁷

THE OPINION OF JUSTICE THOMAS

Justice Clarence Thomas suggested his own constitutional standard, and Justice Antonin Scalia signed on to that opinion. Thomas wrote that the method of execution “violates the Eighth Amendment only if it is deliberately designed to inflict pain.” He listed examples that would be unconstitutional under his standard: burning at the stake, gibbeting (“hanging the condemned in an iron cage so that his body would decompose in public view”), public dissection, emboweling alive, breaking on the wheel, flaying alive, crucifixion, “rendering asunder with horses,” and mutilating and scourging to death.⁷

The following penalty, pronounced on seven men convicted in England of high treason, would, he said, be unconstitutional:

That you and each of you, be taken to the place . . . of execution, where you shall be hanged by the necks, not till you are dead; that you will be severally taken down, while yet alive, and your bowels be taken out and burnt before your faces — that your heads be then cut off, and your bodies cut in four quarters. . . .⁷

Justice Thomas argued that the purpose of these “aggravated forms” of execution was to “terrorize the criminal,” thereby deterring crime. He wrote that the “evil the Eighth Amendment targets is intentional infliction of gratuitous pain.” Since lethal injection was adopted by the state legislatures and the federal government to

make execution more humane, it could not be unconstitutional. The fact that the method might involve a risk of pain does not, in his view, raise a constitutional issue. If it did, Thomas expressed concern that the review of acceptable risks would require the Court “to resolve medical and scientific controversies that are largely beyond judicial ken.”⁷

THE OPINION OF JUSTICE BREYER

Justice Stephen Breyer began his opinion by adopting Justice Ruth Bader Ginsburg’s test of constitutionality: does the method create “an untoward, readily avoidable risk of inflicting severe and unnecessary suffering”?⁷ He said he believes that the key to making such a determination is found in the “facts and evidence” presented in the legal record of the case and in the medical literature. His reading of these sources did not persuade him that there was sufficient evidence to find that the Kentucky protocol poses a “significant and unnecessary risk of inflicting severe pain.”⁷ A 2005 article in the *Lancet* by Leonidas Koniaris and others received wide attention in the courts in the United States, yet it was not relied on by the litigants in this case.⁹ Justice Breyer reviewed the study, which concluded that toxicologic testing at autopsy suggested that the amount of barbiturate could leave the inmate conscious enough to suffer during the execution. He noted that others have criticized the study for relying on blood levels of thiopental taken hours to days after death (which may not indicate the level at the time of execution) and for a lack of scientific evidence of the person’s actual awareness during the execution. Because of these criticisms and because no one used the study in the case, Breyer concluded that “a judge, nonexpert in these matters, cannot give the *Lancet* study significant weight.”⁷

Breyer also noted that the paralytic agent, pancuronium bromide, is used in the Netherlands for assisted suicide and euthanasia. He concluded that the call for better trained executioners is not likely to be met by physicians who oppose participation in executions, so that even “finding better trained personnel may be more difficult than might, at first blush, appear.”⁷

THE OPINION OF JUSTICE GINSBURG

Justice Ginsburg wrote the sole dissenting opinion, joined by Justice David Souter. She believes

that the constitutionality of the Kentucky execution method turns exclusively “on whether inmates are adequately anesthetized by the first drug in the protocol, sodium thiopental. . . .”⁷ In her view, the Kentucky protocol fails to ensure unconsciousness because it “lacks basic safeguards used by other States to confirm that an inmate is unconscious before injection of the second and third drugs.”⁷ She would have remanded the case for the trial court to determine whether the failure to use these safeguards “poses an untoward, readily avoidable risk of inflicting severe and unnecessary pain.”⁷ In terms of simple safeguards adopted by other states, she noted that in Kentucky, “No one calls the inmate’s name, shakes him, brushes his eyelashes to test for a reflex, or applies a noxious stimulus to gauge his response.”⁷

THE OPINION OF JUSTICES STEVENS AND SCALIA

Justice John Paul Stevens used his concurring opinion to argue that the death penalty itself is unconstitutional, primarily for the reasons set forth in *Furman v. Georgia* (i.e., the risk of error, the risk of discrimination, and the excessiveness of the penalty).¹⁰ But Stevens added a new reason: in attempting to adopt a more humane method of execution, society has actually undermined its remaining primary purpose — retribution. In his words, by making execution less painful, “we necessarily [and appropriately] protect the inmate from enduring any punishment that is comparable to the suffering inflicted on his victim.”⁷ Thus, the costs to society of the death penalty are not outweighed by any benefits. In addition, Stevens argued provocatively that Kentucky has outlawed the use of pancuronium bromide for animal euthanasia because of the risk of suffering and that “It is unseemly — to say the least — that Kentucky may well kill petitioners using a drug that it would not permit to be used on their pets.”⁷

Justice Scalia wrote separately solely to refute what he characterized as Stevens’s “astounding position that a criminal sanction expressly mentioned in the Constitution violates the Constitution.”⁷ He argued that Stevens’s position is based solely on “judicial fiat” and that it is not for individual justices but for state legislatures to decide whether the death penalty serves a public purpose such as retribution. Scalia opined, “I would

think it difficult indeed to prove that a criminal sanction fails to serve a retributive purpose — a judgment that strikes me as inherently subjective and unsusceptible of judicial review.”⁷

TORTURE, INTENT, AND PHYSICIAN PARTICIPATION

Fragmented as they are, the opinions speak pretty well for themselves. However, there are at least two points — the primary ones made by Justices Thomas and Alito — that are dubious. Justice Thomas’s insistence that it is only the “intentional” infliction of torture that is prohibited by the Eighth Amendment is almost the identical argument (although one made in the context of a statute, not the Constitution) that his former law clerk, John Yoo, made in the now infamous Department of Justice “torture memos.” In one of these memos, Yoo wrote that to constitute torture under federal law, “severe pain must be inflicted with specific intent . . . [and] knowledge alone that a particular result is certain to occur does not constitute specific intent.”¹¹

Justice Alito’s point is similarly overstated. It is the role of the Court to determine what is and what is not constitutional. If the Court requires that procedures be followed to make the death penalty constitutional, and a state cannot follow them, then the state must stop executing convicted criminals. This is the teaching of the major death-penalty case (*Furman*), in which all nine justices wrote separate opinions. In this case, the justices held, among other things, that if procedures could not be put in place to minimize the risk of arbitrary and capricious death sentences, the death penalty simply could not be imposed.¹⁰ Thus, in the highly unlikely event that a future Court requires physician participation, and physicians refuse, the lethal-injection methods could not be used.

THE FUTURE OF PHYSICIAN PARTICIPATION IN LETHAL-INJECTION PROTOCOLS

Before this year’s Supreme Court opinion on *Baze v. Rees*, Atul Gawande had suggested that a fundamental question raised by the case was “whether physicians should take charge to make [lethal injection] deaths less painful.”¹² Robert Truog argued that if the inmate requests the involvement of a physician to prevent suffering, he could

not think “of any principle of medical ethics that would say that this is an unethical thing for the physician to do.”^{5,12} Truog’s position seems to rest on the proposition that the Hippocratic principle, “first, do no harm,” is an insufficient guide, since it begs the question of whether it is proper to help in the prevention or alleviation of suffering in this context. He is not alone in this view.¹³ But as ethicist Arthur Caplan has noted, this argument rings hollow in the context of medical care in prison. On the one hand, in his words, “It seems a bit late for physicians to step forward in the context of an execution and say they are motivated by a duty of mercy given that many prisoners suffer miserably because of the poor state of prison-based medicine without eliciting any involvement from these same physicians.”¹⁴ On the other hand, one of the physicians interviewed by Gawande appeared to have provided continuous medical treatment to the death-row prisoners before their execution, and in such a circumstance a more principled argument for physician participation at the request of the condemned prisoner could be made.⁶

The more central principle at stake here, however, is that it is a violation of medical ethics for physicians to put their medical skills at the service of the state to facilitate the commission of crimes against humanity. Such crimes include murder and torture as well as harmful experimentation without consent. Under the principles of the World Medical Association and the Geneva Conventions, these crimes also include cruel, inhumane, and degrading treatment.^{15,16}

The majority of the Supreme Court does not believe that as currently practiced, with or without the participation of physicians, executions by lethal injection are “cruel” as that term is used in the Eighth Amendment. Medical ethics is, of course, not synonymous with U.S. constitutional law, and physicians may reject this categorization and refuse to participate on the grounds that even if it is not cruel or tortuous, execution by lethal injection is nonetheless inhumane and degrading to such an extent that it is unethical for physicians to participate by using their medical skills to kill in the service of the state. Nonetheless, at least some physicians would find it ethically acceptable to try to lessen the risk of suffering by improving on the existing protocols generally or even by changing them from a three-

drug protocol to a one-drug protocol that produces death quickly and painlessly.^{2,5,17}

The arguments for improving the methods of lethal injection are not entirely new. More than 20 years ago, for example, the Court heard a challenge to the three-drug protocol that argued that the Food and Drug Administration (FDA) should be required to certify these drugs as being “safe and effective” for the purpose of execution.¹⁸ The petition to the FDA noted that the FDA has certified drugs used to euthanize animals for the prevention of pain and discomfort, and it argued that humans should be treated at least as well as animals. This argument persists. Specifically, the petition alleged that even a slight error in dosage could leave prisoners conscious but paralyzed while dying, a witness to their own slow, painful, and lingering asphyxiation. The FDA rejected the petition, and the Supreme Court ruled unanimously that it was “solely in the FDA’s discretion whether or not to exercise its enforcement authority over the use of drugs in interstate commerce.”¹⁹

After *Baze*, it has also been suggested that states that have been trying to “improve” their methods of lethal injection are performing human experimentation involving prisoners and are performing these experiments without either protocol review or informed consent, contrary to both medical ethics and federal and state regulations regarding human experimentation.^{20,21} This is another way to recast the earlier argument that the FDA should have had to approve the drugs used for lethal injection as being “safe and effective” for this purpose — by conducting research to demonstrate safety and efficacy. The FDA declined to do this, most likely because it did not want to get into the controversy regarding the death penalty and because it is difficult to see how any such study could be ethically conducted. This remains the case today when modifications of current protocols are proposed. Nonetheless, with or without physicians, courts and state legislatures may move to adopt single-drug protocols that are associated with less risk of inflicting pain. An Ohio trial court did this, citing an Ohio law that requires that the drugs used “quickly and painlessly cause death.”²²

Curran and Casscells were correct in observing that lethal injection is not any part of “normal medical practice . . . but a corruption and

exploitation of the health profession's role in society."³ Conducting medical research, even to achieve a more humane or less painful way of performing lethal injections, would be a similar perversion of the practice of medicine. Permitting a physician to administer the lethal injection at the prisoner's request to help reassure the prisoner that the process is likely to be painless would be another perversion. Consent cannot be voluntary in the execution chamber, and even if it could, consent cannot render an unethical act — such as torture, direct killing, or even physician-assisted suicide — ethical.

MEDICAL ETHICS AND LETHAL-INJECTION EXECUTIONS

The Supreme Court did not and cannot solve this medical-ethics problem for America's physicians. State legislatures continue to have the authority under the Constitution to determine whether or not to require executions by lethal injection, and physicians continue to have the legal freedom to determine whether placing their medical skills at the service of the state to execute condemned prisoners is consistent with medical ethics. In this regard, physicians could again come to the rescue of the law by helping corrections officials make executions by lethal injection less risky, less cruel, and more medicalized, routinized, and sanitized. This form of physician participation would follow Foucault's view of the "double process" of modern rituals of execution: "the disappearance of the spectacle and the elimination of pain."¹

None of the justices even suggested that physicians should be required to participate in or be present during executions by lethal injection. All the justices who mentioned medical ethics supported medicine's ethical stand against physician participation.⁷ The bottom line for physicians is clear: the law does not require physicians to be involved in administering the death penalty, and the future "involvement of physicians in executions will [continue to be] up to the medical profession."²³ To the extent that executions by lethal injection without physician participation could ultimately turn the public away from supporting capital punishment, this seems to be a much better outcome than medicalizing the death penalty in order to save it. The relationship between capital punishment and more humane

forms of execution is complicated. For example, like Gawande, one can be for the death penalty and yet be opposed to physician participation in it.⁶ Similarly, one can, like Human Rights Watch, be opposed to the death penalty but still insist that until it is abolished, states must use the method that risks the "least possible pain and suffering of the inmate."¹⁶

Physicians should not lend their medical expertise to the state to make executions more palatable to the public, even by advising on drug protocols, doses, and routes of administration. Even physicians who support the death penalty should stay out of its execution, because the problem that the state seeks to solve by using physicians is one of the state's own making by its refusal to abolish capital punishment and its insistence on execution by lethal injection.^{16,24,25} For physicians who oppose capital punishment, more than medical ethics is involved in refusing to participate in executions. Basic fairness in applying the death penalty is also at stake. By rejecting even a role of expert adviser in redesigning drug protocols, physicians will be joining Justice Harry Blackmun. After more than 20 years of attempting to fairly apply the death penalty, he abandoned his support for it, saying that it was wrong for the Court to substitute "mere aesthetics" for principles and that he would no longer "tinker with the machinery of death."²⁶

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From the Department of Health Law, Bioethics, and Human Rights, Boston University School of Public Health, Boston.

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