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Medicine is a Moral Concern:
Rejection of the Partnership with State Killing

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Abstract

This paper will consider the relationship of medical practice, morality, and the state. At the heart of medical professionalism lies a claim that medicine is a moral matter concerned with what is right and what is wrong and a social contract exists between the doctor and the patient. Moral medicine must always be about healing and healing will never be a partner to killing. An examination of medicine and killing will require an understanding of the underpinnings and definition of morality. Moral matters will be understood to be fundamental truths, distinct from notions that ebb and flow. Medical practice is a lawfully regulated activity contained within a complex relationship between state interests and the interests of the medical profession. Physicians have a different social contract with the state and this relationship is a troubled alliance. Here, the state seeks to engage in an exchange of physician self-regulation with filial state loyalty. Within this model, independent physician practice is at the behest of the state to grant or revoke and the state reserves the right to use the power of medicine as it sees fit. Tension between state interests and physician interests are pointedly revealed in the circumstance of death. The medical profession has long sought a relationship with death that will be morally consistent within medical practice. Moral medicine asserts that death is not a treatment. Death occurs naturally and unnaturally and in these unnatural moments, conflicting interests might require state adjudication. Abortion and physician assisted suicide are examples of a public request for death that continues to consume public discourse. For the physician, it appears possible to consider death in these cases as a form of treatment even while recognizing the slipperiness of the moral slope. For the state, physician willingness to participate in these cases created the necessary leap to convert death from treatment to punishment in the form of lethal injection. Capital punishment, masquerading as medicine, confounds the medical profession. In reply, physicians must walk back any hint of physician–state complicity here and reject any part of death as punishment shrouded in a medical face.

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Introduction

Medicine has long been defined by its relationship to life and healing and yet when unchecked by a moral rudder, it can steer itself into treacherous waters. As a moral endeavor, medicine offers a transcendent encounter based on the ultimate trust. Absent morality, medicine is nothing more than butchery. At the heart of medical professionalism lies a claim that medicine is fundamentally a moral matter concerned with what is right and what is wrong. Absent this foundation, medicine runs amok, keeping company with our worst inclinations instead of the angels of our better nature. As the most pointed example, consider the practice of medicine as it grapples with death. Moral medicine must always be about healing and healing will never be a partner to killing. An examination of medicine and killing will require an understanding of the underpinnings and definition of morality. Moral matters will be understood to be fundamental truths, distinct from notions that ebb and flow. Medical practice is a lawfully regulated activity contained within a complex relationship between state interests and the interests of the medical profession. The state-medical relationship is a troubled alliance.

This paper will consider the relationship of medical practice, morality, and the state. Divided into three chapters, chapter I will begin by considering medical practice as a moral concern. It will be necessary to understand how professions such as medicine regulate themselves and how a social contract exists between the doctor and the patient. Within the contract lies the agreement that doctors will conduct themselves morally and that conduct will include self-regulation in

exchange for patient protection. Physicians have a different social contract with the state that also seeks to engage in an exchange of self-regulation with a sort of filial loyalty. The state allows independence but that independence can be granted or revoked. Recognizing the power of medical knowledge and practice, the state reserves the right to claim that power as it sees fit.

Chapter II further explores the sort of power needed by the state by considering the relationship between medical practice and death. The concept of suffering will be considered in relation to the claim that death can relieve suffering. Death itself might be painful and the physician is drawn in with the request to provide a painless death now reimagined as a treatment to relieve suffering. Suicide, or self-killing, blurs its own definition by suggesting that it should be enabled by a doctor. Misnamed as physician assisted suicide, this form of killing will be considered from a moral and ethical perspective. Physician assisted suicide is in reality a form of physician killing as is abortion. The state continues to adjudicate on the abortion question and in certain jurisdictions, seeks to appropriate an aspect of the assertion that physicians can reduce suffering by killing. At some point during fetal development, it might be imagined that the fetus acquires some sort of theory of mind or at least has the neural capacity to register a noxious stimulus. Abortion is a procedure that will produce pain in the pregnant woman. Fetal pain, and how to block it, has become for some, a question worthy of consideration. Doctors are tasked with addressing fetal pain as a thing to blunt during killing but what science lacks, the state provides.

Chapter III finally considers the complex relationship of death as punishment and the appropriation of medical practice and medical practitioners as state agents. Lethal injection, the most common form presently for capital punishment, will be examined in detail. Professional medical societies and state boards attempt to restrict physician participation on the grounds that killing as a method of punishment is entirely outside of the scope of medical practice. Defenders of physician involvement offer categorical and quasi-ethical justification. As a categorical, the state exercises its right to pass laws that serve an interest outside of the medical board thereby disempowering the medical board to regulate the physician during participation in an execution. The state reasons that any lawful act is automatically set beyond the scope of a lesser state agency such as a medical board. The created cannot regulate the creator and the medical board is conceived and maintained at the pleasure and discretion of the state. As a quasi-ethical claim, an inmate facing execution is somehow transformed into a patient now at risk from suffering a painful death. A physician has the power to reduce suffering associated with dying and if a physician refuses to reduce this suffering, it becomes a violation of the medical social contract. The quasi-ethical argument will be shown to fail, as the mere presence of a physician does not confer the title of patient to those within his vicinity. Inmates are questionable moral agents at the best of times and when facing imminent execution, consent of any sort is highly doubtful. The state makes the claim that suffering is relieved in death, physicians are able to kill painlessly, and that killing is a form of healing. This is categorically false, merely false, or un-provable.

I: Doctor, patient, and the interest of the state

Medical Practice is a Moral Endeavor

Medical practice is fundamentally a moral activity based on a fiduciary relationship between doctor and patient. In moral matters, the devil is in the details as even the Hippocratic oath could be regarded as a protest against the more common practice of abortion and euthanasia that was present at that time in history(Ssebunnya 2015). Medical multiculturalism and moral relativism have created a state of practice disarray, far more complex than contemplated by Hippocrates. A physician must be mindful of the moral choices sought by the patient and seek a treatment plan that satisfies the necessities of the healing relationship between doctor and patient(Pellegrino 2006). The real challenge of medical morality is to create a firm moral practice that is still flexible and not brittle. Any moral code must answer real world problems and be useful or risk being set aside as the inconsequential musings of the academy.

Through gritted teeth, current medical practice has reasonably taken up the secular ethics model of a set of four *prima facie* rules of moral conduct as proposed by Beauchamp and Childress(Gillon 1994). These rules are beneficence, non-maleficence, respect for autonomy, and social justice. Necessary to a common morality model is the affirmation of the claim that some belief and certain conduct characterize human civilization fundamentally. A biological argument can be advanced in defense of some sort of common morality. Evolution spawned morality

as a selective advantage and this activity is evident in the biological record and precedes all religious and secular claims to the origins of morality by millions of years(Baschetti 2005). As a counter argument, non-human examples of morality within other biological systems risks anthropomorphic chauvinism as the underpinning of descriptions on what can be observed. The slime mold offers a good analogy. This single celled organism has the capacity to transform itself into a multicellular structure under periods of stress by connecting groups of individual slime molds together. This connected cellular mass can further undergo modifications and launch spores into the air to seek better locations for nutrients. The remaining stalk and base will die, as if by some sort of noble sacrifice for the greater good of the species. A single slime mold cell is a very simple form of life, free of a central nervous system and certainly contains nothing recognizable as a brain. The brainless slime mold appears to make startlingly good choices on what to eat, navigates mazes, remembers and anticipates(Richard Mayne 2015), but it begs the question if any of this is akin to intelligence and certainly it remains unclear if any of this is moral.

For the physician practicing medicine, the absence of an acceptance of a central and robust set of moral rules invites the potential for dangerous mission creep. This reasoning is especially problematic when moral rules are rearranged hierarchically when no such moral hierarchy exists. As a corollary, Judaism lists 613 Mitzvoth (commandments)(Drazi 2009) that seem to range from what would commonly considered to be important to what would commonly considered to be trivial. In one view, each commandment is considered to be as important as every

other commandment and ranking commandments in an imagined moral order would be counter to the intent.

A Doctor's Duty

Moral obligations set in place a doctor's duty that begins when life begins, and ends categorically at the moment of death. As to the post-death experience, doctors are no more authoritative than anyone else. It can be reasonably claimed that an understanding of death requires a theory of mind that includes the corporeal self. Resuscitation is the activity intended to block the occurrence of inevitable death. Common in all examples is a desire to be near enough to glean what can be drawn from the residue of the death experience. In truth, the living will never become expert in death, regardless of physical proximity and death will, by its nature, likely remain the undiscovered country.

Medical practice is an offering of health and whatever is included in the definition of death, it is not a state of health. Death is the end of health and the possibility of the doctor's work. A medical act requires both intention and action and only a physician can simultaneously possess both elements. The practice of medicine is a bounded concept and it is necessary to distinguish who a physician is from what a physician does. Further, certain acts may appear to be medical in nature but the distinction between what constitutes a medical act from an identical act in technique is entirely drawn from what is intended. Actions done by physicians may not be the practice of medicine. This point can be made both obviously and with subtlety. When a physician changes a tire, he is not practicing

medicine but more fundamental is the concept that a physician cannot pretend to not be a doctor when he is acting like one. A physician cannot impersonate himself.

A physician is a person trained in the field of medicine. Medical practice has evolved commensurate with technological innovation but the central moral element of medical practice had remained largely unchanged until the middle of the last century. After physician complicity in Nazi medicine and the holocaust(Wickler 1993), contemporary medical practice has been refined to address concerns neglected or abrogated such as privacy, truthfulness, scarcity, and the use of humans for research(Tom L. Beauchamp 2009). Nazi medicine was central to the degradation of medical practice as it crossed the barrier of the historical restriction on the medicalization of killing by turning killing into healing(Lifton 1986). Examples of misapplication of medical practice plague physician moral discourse on an ongoing basis. During Hurricane Katrina at Memorial Hospital in New Orleans, Dr. Anna Pou chose to administer morphine and midazolam to patients with the intent of killing in the name of mercy. By the available accounts, some of these patients were not close to death nor had they expressed a prior desire to be designated as DNR(Fink 2009). Subsequent to this event, far from expressions of contrition and ethical self-reflection, Dr. Pou has strongly defended her actions. She has since participated in writing legislation that would immunize doctors from civil lawsuits on conduct during mass casualty disasters(Fink 2009).

Advance Directive: The Patient Speaks

The doctor and the patient engage in a social contract, a voluntary arraignment that exchanges some freedom for security. The patient puts trust in the

doctor. The doctor acts in the best interest of the patient. Illness creates vulnerability and the medical social contract may falter. Fear of involuntary treatment or the consequence of the involuntary removal of treatment has necessitated the development of an advanced document or declaration on goals of care. Physicians may honor a request of a patient that no longer desires treatment. This request may be contained within an advance directive or may be determined in the circumstance of ongoing treatment. Advance directives are underpinned by the ethical principle of patient autonomy and, as such, require an extension of a patient's personhood to a point beyond what might otherwise be claimable. An understanding of personhood is fundamental to advance directives as only a person can assert them. We believe that our sense of self extends beyond our capacity to verbally express it and is not necessarily diminished by a loss of personal agency. From the perspective of friends or family, they may be compelled to act against conflicted personal interests when tasked with the responsibility of proxy or surrogate decision maker. From the perspective of the health care provider, all patient treatment directives must be filtered through ethical conduct. The health care provider must use caution against usurping the narrative and be aware of the competing interests of the patient, family, society and themselves.

The rise of patient autonomy and the need for advance directives reflects, to an extent, the perception that physicians have failed to act with non-maleficence and promote beneficence. From the perspective of the physician, the opposite might be claimed, that is, an advance directive cannot be honored if the patient requests the physician to act in a capacity that the physician cannot view as beneficent. The rise

of advance directive is a parallel development to the development of new technology in medical care that can extend life beyond what has traditionally been possible.

The public has concerns that life extension may create lives of low quality as a consequence of pain, disability, or a general incapacity. A further concern is that in this incapacitated state, a loss of the ability to communicate wishes could result in prolonged patient suffering. On its face, suffering of any degree as a result of medical care would seem to clearly conflict with the directive to act with beneficence and not with maleficence. Rigid application of the four prima facie rules of medical ethics can easily generate scenarios that would be otherwise internally incompatible. Placing an intravenous will cause pain to a patient but a much greater good is presumed in the circumstance of that activity. Within the body of an advance directive, patients commonly request no treatment that would lead to a painful life of low quality. Specifically, a request may be made to limit mechanical ventilation, dialysis, or chest compressions, at the point where recovery seems unlikely. When advance directive documents are operationalized, patient families and physicians rapidly realize that a bright boundary line does not exist when some duration of inevitable suffering with the intent to achieve recovery is on one side of the border and on the other is a realistic fear of suffering enduring that is only relieved in death.

Proponents of advance directives often make the true claim that suffering is relieved in death and that sedation reduces or eliminates suffering in life. Medical actions by physicians that attempt to retard death might be regarded as futile. What

are the merits of this claim? All futility arguments are tautological. Absent a religious view of a pleasurable existence after death, the claim that death ends suffering is unverifiable however intuitively appealing.

Advance directive requests may include commentary on various aspects of treatment but as a concept, it is centrally concerned with the initiation of resuscitative efforts. Patients may choose to be designated as Do Not Resuscitate (DNR) or as a "full code", meaning that all resuscitative efforts be initiated if a patient is found to have suffered cardiovascular or respiratory collapse. In this moment, the absence of resuscitative efforts would result in the very near immediate death of the patient. DNR has been in place as a patient expression of autonomy for at least 40 years as a way of designating a patient desire to be allowed to die(Jeffrey Burns 2016). This is not a baseless objection to an intervention that generally succeeds. On the contrary, many resuscitative efforts that require chest compression fail to return circulation to a life sustaining quantity and now death occurs in spite of treatment. DNR is our fear that the act of resuscitation will be painful and that pain will be relieved in death. Though seemingly clear and unambiguous, DNR creates the potential for complex directives for the physician. DNR has further created a shift in treatment culture. Classically, a physician would assume that in the absence of an instruction from the patient to the contrary, resuscitation is the desire. Presently, an assumption for life is now called into question.

Healthcare is a right

Between the moral actions of the physician and the goals of care of the patient lies the assertion that healthcare is a right. If healthcare is a right, a corollary duty must exist to fulfill that right. As a matter of policy, central to the notion that healthcare is a right is the transformation of individuals from beneficiaries to claim holders. Here, the law agrees, and an unfunded mandate to treat patients exists under the Emergency Medical Treatment and Labor Act(Peth 2004). This federal congressional act was first passed in 1986 in order to establish a guarantee for uninsured members of the public to be able to obtain emergency medical care regardless of the ability to pay. Within the Social Security Act, section 1867 puts in place particular obligations on hospitals that receive Medicare funding and offer emergency services. This obligation includes a medical screening examination and treatment of an emergency medical condition, including active labor. Stabilizing treatment must be initiated and a transfer to another hospital can only take place if the treating hospital lacks the capacity to provide the necessary treatment. In the United States, healthcare is considered a right in an additional instance. After Estelle v. Gamble(Conway 2009), prisoners gained a right to healthcare drawn from the 8th amendment ban on cruel punishment. This basic right has 3 provisions, 1) the right to access healthcare, 2) the right to the care that is ordered, 3), the right to a professional medical opinion. For those without health insurance, the notion that prisoners are required by law to receive healthcare may seem unreasonable. Incarceration sets aside a prisoners individuals agency and now that role must be fulfilled by state corrections. The second category of individuals would be those

without the ability to pay for healthcare that present to Emergency Rooms with serious and life threatening medical conditions. In both instances, healthcare must be considered a right and not a privilege.

Absent qualified individuals capable of providing healthcare, rights to access are necessarily meaningless. Hippocrates is largely credited with reimagining the activities related to health and illness as a stand-alone profession now guided by principles(Garrison 1966). As a modern activity, state medical boards grant licensure to physicians, allowing doctors to turn what they know into what they may do. The medical license is the seal of approval that transforms the tapestry of complex medical activity into a service worth buying. It relieves the public's burden of wondering if the offered elixir is merely snake oil. State medical boards are comprised of physicians and members of the lay public who, in exchange for self-regulation, owe a duty to protect the public from harm resulting from improper conduct by doctors(Cruess SR 2005). All self- regulated professions work this way. Within the state board jurisdiction, every licensed physician must be known. Board regulation in concept is more than the mere technical aspects of practice. Medical boards weigh the moral character of the physician and will seek to discipline physician conduct deemed a transgression of turpitude.

Medical boards are granted regulatory authority by a medical practice act. State officials are not schooled in the details of medical practice and are unable to regulate medical practice beyond very broad directives primarily concerned with public safety. However, at times, the state recognizes power in the practice of medicine seeking to usurp or direct that power for its own purpose. When the state

needs the power of medical practice in a circumstance where medical practice will be in a fashion contrary to medical professional conduct, states pass secrecy laws(Cohen 2014) thereby protecting the identity of doctors that perform at the behest of the state. Secrecy here immunizes the doctor from the medical board investigation and now the chief physician of the state is the Governor.

The Interest of the State and the Interest of the Profession

Governments, when acting in their own interest, will set aside medical ethical practice and immunize physicians who will act at the behest of the state. In reply, physicians need to recognize when the medical profession should act under a moral directive in conflict with state interests. Physician moral reasoning requires better bioethics training and to now, such pedagogy has an uneven history. Medical students, residents and practicing physicians have been shown to display gaps in the grasp of basic ethical concepts(N S Wenger 1998, Silverman 2013). To lay the blame exclusively at the feet of physicians for wayward ethical knowledge and conduct would be incorrect. Governments obfuscate on matters of medical ethics and seem to send mixed messages to the physician and the public they serve. Physicians are told to save money and spend money. They are told to shorten life and prolong life. They are told to care for the sickest first and to care for the sickest last. State governments have overridden medical board ethical directives and have successfully prevented the disciplining of physicians who participate in the death penalty(Zivot 2012). As to the question of physician complicity at Abu Ghraib(TF Murphy 2004) the real question is the role of the US Department of Defense by either implicit or explicit encouragement and the overriding of medical ethical

directives against such practices. Physicians will follow orders. According to many physicians in Nazi Germany, apart from commander in chief in a political sense, Hitler was also the highest-ranking physician(Lifton 1986). Taken in context, this should be regarded as a cautionary tale. Physicians may lack ethical certitude or the tools to evaluate ethical dilemmas. Physicians may more likely draw from a moral heuristic than a moral deduction.

Culpability for diminished physician moral knowledge also falls on the bioethics community at large. Bioethics has stubbornly refused to become a profession thereby relegating it to hobbyists that make a living with other work. Clinical bioethics needs to emerge as a discipline that adds value to the care of the patient, and whose practitioners stand behind that promise of added value. In order to do this, it must become a profession by creating core curriculum, pedagogy, and accreditation. It will be subject to the granting and revoking of licensure by its own self-governing body. New legislation will be needed in each state to create these bodies. Hospitals will be empowered to grant privileges to certified individuals. Health Insurance providers will pay for the rendered service at a fair market rate. It will follow that clinical bioethicists will owe a duty to act with reasonable care to avoid foreseeable injury to their clients. If their practice falls below the prevailing standard of care and this causes harm, this harm will be subject to adjudication as a tort with financial remedy. Accordingly, clinical bioethicists, like all healthcare professionals, will be required to have liability insurance coverage, either provided by the hospital or purchased privately.

Physicians as citizens owe duties to their societies. Physicians as physicians

owe duties to the profession that may on occasion collide with society. When the interests of society conflict with the interests of the physician, what is generally at stake is an ethical principle. In these moments, physicians must exercise extreme care and distinguish between personal interest and the fundamental ethical duties that the physician owes to his or her patient. Society, by nature of election or appointment, shall not re-write the ethical rules that the physician must follow. For the physician, the moral lessons drawn from the Nazi doctor's trial must be constantly at hand(Pellegrino 1997). Conflict and confusion around medical practice exists at the intersection of the practice of medicine as a self-regulated profession and the interests of legislative and judicial oversight. Professions define their scope of practice and in exchange for self-regulation pledge to protect the public interest. Self-regulation assumes that only practitioners understand the standard of practice. State officials fulfill their duty by deferring to medical regulatory boards. Professional regulatory organizations certify that members have acquired the necessary knowledge and conduct themselves within the standard of practice. Physician regulatory boards grant licensure and in so doing, set a standard of practice. If that standard is not met and, as a consequence, harm occurs to an individual, that individual may seek a remedy through the courts in the form of a tort or rarely as a criminal matter.

The physician is balanced between the interest of the medical board and the interests of the state. Each entity lays claim to medical practice in order to serve its interests. From the perspective of the medical board, physician practice outside of acceptable standards results in a maximum penalty of loss of licensure. Medical

Boards are not legislating bodies, nor are they within the state or federal judiciary. Nevertheless, they hear complaints and conduct themselves within a judicial framework. In order for medical boards to regulate physician conduct, all physician activity relating to medical practice must be known. In the best interest of patients, physician medical practices would always be conducted according to the professional prevailing standards. Commonly, 'good moral character' is also considered a necessary trait of the physician. As a practical matter, 'good moral character' is hard to define. In this setting, moral character transgressions are referred to as moral turpitude. For the physician accused of moral turpitude, the results can be devastating. Punishment might include a revocation of a medical license and possible public shaming. The following questions therefore need to be answered. For the physician, what are the concerns between private and public life? Why is it difficult to objectively define departures from good moral character when individuals responsible for conduct evaluation believe it is easy to recognize such departures? What concerns are generated by a customary standard doctrine in the determination of the definition of moral turpitude? What evidence supports an assertion that the details of a physician's moral character traits falling outside of customary standards, necessarily leads to direct patient harm?

Physician moral practice reflects an evolving standard and may not be written down as a matter of policy. This strategy is both beneficial and harmful. Lack of a written down rule reflects the absence of agreement over certain moral questions. This same practice can also allow mercurial regulatory conduct on the part of Medical Boards. Medical Board regulation is an imperfect activity and board

membership requires a technical understanding of the job of medical practice. Elected public officials exercise their duty by delegating regulatory authority to medical boards. Each licensed physician within the jurisdiction of the board must be known. Activities done by licensed physicians are broad. Medicine is a profession that once acquired, cannot be easily shed. The obligation to practice medicine is enforced both from a legal standpoint and a moral standpoint.

The Medical Board Strikes and the State Strikes Back

Medical boards seek to regulate physician conduct as a fulfillment of a duty in order to protect the public interest. In January 2007, The State of North Carolina Medical Board released a statement concerning physician involvement in lethal injection. The statement warns that if any licensed physician lends assistance to execution within the state, that physician risks disciplinary action. The only exception would be to certify that an inmate had died as a consequence of that execution(Lippman 2017). Physicians within the state replied by essentially declining to participate in any fashion. North Carolina requires the presence of a physician in the lethal injection procedure and therefore physician refusal resulted in a *de facto* moratorium on lethal injection executions within the state. North Carolina Corrections brought a claim against the Medical Board with plaintiffs, Theodis Beck and Marvin Polk seeking injunctive relief that would prohibit the Medical Board from taking any action against physicians for participation in executions. The claim further sought a declaratory judgment that would delineate the rights and obligations of the plaintiffs and the Medical Board in regard to executions. The North Carolina Department of Corrections prevailed in this claim

compelling the Medical Board to walk back its threat(2007). On appeal to the NC Supreme Court (NCSC) the court reasoned in the fashion of the United States Supreme Court that if lethal injection was legal, physician participation must necessarily be legal as well(2008). The majority of the NCSC upheld the trial decision by drawing a distinction between "participation" and "mere participation". The court ruled that the medical board could not proscribe mere participation by physicians in the execution while at the same time maintaining that the medical board ''would retain disciplinary power over a licensed medical doctor who participates in an execution''. The meaning is rinsed out of "participation" because: ''To allow defendant to discipline its licensees for mere participation would elevate the created Medical Board over the creator General Assembly.''(2009). If the medical profession imagined that it had immunity to state power, decisions such as these demonstrate that real power is at the behest of the state to grant or revoke. It is a bitter realization, and the loser here will be the public good.

II: Medicine, suffering and legal killing

Medicine, death and killing

Above all else, the story of medicine has been the perpetual struggle to understand death. Historically, human civilization served as a documentarian to death; once the process of death began, the narrative became inalterable. Fearful of this force, the practice of medicine toggled between adversary and ally. As adversary, medicine transformed itself into a scientific discipline, seeking to block death by any means. As an ally, medicine sometimes became a killer, although here

killing would need to be reimagined as healing.

Why we die has something to do with biological refreshment. We are not well made and cellular division creates increasingly inferior copies. The capacity of human consciousness allows us the peculiar experience of knowingly witnessing our own gradual destruction. Balanced between the bitterness and suffering of the sense that death is unfair and death as the liberation of an imagined human spirit, these contemplations span the spectrum from catastrophe to ecstasy. The practice of medicine owes its genesis likely to the former, although may be more than casually associated with the latter as it turns killing into healing. Medical associated killing is ambiguous, mixed up in the blender of language about the reduction of suffering; the resulting product has a peculiar after-taste. The medical profession is self-regulated and this means that it must constantly protect itself from itself. The physician creates un-scalable walls to keep safe; he must tie himself to the ethical mast and sail past the tools of killing.

We have always been killers and we have always known death. In acknowledgement of our natural inclinations, we have sought to regulate conduct around killing in the name of human flourishing. Controversy exists around the question on the intentionality of the Neanderthal burial ritual(Pettitt 2002). It is not possible to understand the precise meaning of this activity but we can surmise that Neanderthals understood the difference between life and death and sought to separate them in some manner. In the Abrahamic religions, the first generation born of a man and a woman were the participants in the first intentional homicide. The

struggle for civilization has been the constraining of our killing impulse, ironically through occasional killing. The argument against killing is underpinned by empathy, the likely progeny of the biology of reciprocal altruism(Rodolfo C Barragan 2014) that is perhaps no more than the détente of expedience but perhaps, something more.

As a public activity, our present society holds death at arm's length. We have no shortage of corpses and yet we are advised to shield our eye and in polite society, we cover the body with a sheet to hide its form. After death, the residue of the corporeal self can be a startling imitation of a living person. Our attachment and reverence to our corporeal remains have lead and mislead our way forward. For the doctor or family at the bedside, we wonder if we can catch a glimpse of a death anticipated to further know it's meaning and mute our own anxiety. Death at home affords the comfort of familiar surroundings unconstrained by institutional rules. What to do with the body after death might mute and subdue an imagined benefit. In the hospital, family and friends of the dying have traditionally been excluded from observing the event of death. This practice has recently come under review based on a claim that watching our loved ones die will lead to a more satisfied certainty and closure(Zohar Lederman 2014). A witness to death by execution has a different experience and a different duty. Lawful execution must occur without cruelty according to the 8th amendment of the US constitution. Cruel acts are those that cause unnecessary or excessive pain or suffering. Cruel acts are always a public standard, as what we consider cruel will naturally evolve commensurate with the maturing of civil society. Cruelty can be experienced or observed and is the

necessary circumstance of execution, the condemned can never report afterwards if they experience their own death as cruel. Observers to capital punishment, employing empathy, are the only true guard against cruelty. In current lethal injection practices, the circumstance and staging of death in this form is intended to civilize and make somber what might otherwise be considered as a degraded form of punishment. Here, death is perhaps the reluctant handmaiden of state claimed justice. Lethal injection has the look and feel of a medical act and a doctor in attendance only adds to the deception.

Legalized killing

Death occurs naturally, as a consequence of killing, or unlawfully as the result of murder. All murder is killing but all killing is not murder. Society and the state claim a need for killing and the law needs to immunize our needed killers from a charge of murder. The Canadian experience in doctor-assisted legalized killing offers an examination on the practical applications on physician participants. In 2015, the Supreme Court of Canada decriminalized physician assisted death in Carter v. Canada(2015). The court decision likely reflects an evaluation of public opinion that desired physician assistance in dying and recognized the existing legal impediment faced by physicians. The Government of Canada, needing to reflect the court decision, passed an amendment to the criminal code in 2016 to permit medical assistance in dying in the circumstance where an individual claims to be suffering from a grievous an irremediable medical condition. Within the single-payer healthcare system of Canada, all Canadian citizens have health care insurance guaranteed by the Canada Health Act(Wilson 2004). Citizens seeking healthcare,

trade off universal access with occasional delay. Physicians provide services to all Canadian citizens with an understanding that the federal and provincial government will always be silent on the details of care and will pay for any medical service deemed necessary. Provincial medical colleges, the equivalent of US state medical boards, exchange self-regulation with a promise of public protection. Medical innovation is generally physician-driven and the doctor approaches the single payer government when new services seek a reimbursement mechanism. Carter v. Canada and the subsequent Federal Government amendment to the Canadian Criminal Code reimagines the relationship of the public to the doctor by claiming healthcare innovation can now be akin to the public tail wagging the physician dog. If a Canadian physician is a public servant working at the behest of the government, such a demand for services on behalf of citizen consumers makes some sense. The physician as a public servant model however fails by claiming equivalence between public servant and professional. This failure is not only on the side of the public and might be shared by physicians themselves. The medical profession in Canada has yet to respond to the physician assistance in dying request as if the profession has accepted that physician killing is or is not a medical act. Physician assistance in dying has now occurred in Canada and the experience thus far warrants evaluation. Some doctors that originally came forward to provide assistance with dying now express second thoughts(Kirkey 2017). Proponents of this activity claim it as an expression of care and compassion; it is an alleviation of suffering. If this were so, refusal to participate would be regarded as the actions of those without compassion or in favor of suffering. Such accusations on cruel physician motives neglect to

understand that physician objection here is an affirmation of a claim against cruelty, not a claim in favor of cruelty.

Euthanasia and Physician Assisted Death

Euthanasia in the setting of natural disasters like Hurricane Katrina places the physician on the horns of an ethical dilemma. Killing as healing is a breakdown of the moral imperatives of medicine. Physician assisted suicide (PAS) is another example of an attempt to reframe the killing/healing debate. In the United States, Oregon was the first to legally allow assisted suicide for terminally ill, mentally competent adults. In addition, Washington, Vermont, Montana, and most recently California all have legalized some form of PAS.

In the debate on the rightness or wrongness of PAS, the language frames the debate. Those in favor of PAS claim that the desire to die at the hand of a physician is the moral imperative. Now, suffering is the ultimate harm that only killing will solve. Ending suffering is transformed from an option to a mandate; who would allow suffering to continue? This reasoning needs to be unwound and begins with a rejection of the claim that if one rejects PAS, one supports suffering. A world free of suffering is an idea of great merit but the reasoning here is tautological. Our world is transformed to permit death-loving activity that is shrouded or even celebrated as an action that is laudable. Institutions now give false license to kill people that may still possess valued life.

If suffering is the only criteria necessary to demand death, all suffering, including existential suffering must also be included. Intense suffering can be the consequence of significant or trivial reasons. The intensity of suffering is separate

from the underlying reason for that suffering. PAS is now a possible treatment for depression and loneliness. PAS is not the simple musings of the academy but is an actual policy put in place by legislation that provide for lawful and intentional killing. The devil is in the details as our civil society abides by its rules. In this example, a rule is only valuable if it solves a real world problem and if the exception is the rule, the rule is pointless.

A rule for PAS might apply only is a circumstance where the physician knows with certainty that the requester is a thoughtful moral agent, unfettered by the deductive diminishments associated with pain and depression and still able to freely weigh the risks and benefits of the life or death choice. Further, the requester is suffering from a condition that all would recognize as a non-trivial. From the physician's perspective, it would be necessary to distinguish consequences from motives. If the physician is practicing PAS, as the fee associated with participation was very remunerative, we might judge more harshly his willingness to provide services. It seems paradoxical that a physician might profit from killing. From the requester, such physician motives may be moot, as long as the provided service fits the purpose. If the physician was instead motivated by a desire to reduce suffering, would it be preferred and if so, what test would be put in place to gauge motives separate from consequences? What training would be put in place for the physician in order to evaluate the motives and consequences on the part of the requester? If a requester is refused, what method of appeal should be available and who should sit on such a panel? PAS may dangerously suffer from mission creep, when the best of intentions gathers up many individuals seeking death not contemplated by the

motives of the rule. Acts of omissions and acts of commission can be considered morally equivalent and will be no defense against a too broad application of PAS.

When all else fails and an agreement cannot be reached, the courts will be asked to intervene. If the United States Supreme Court came to the same conclusion as the Supreme Court of Canada, state medical boards would face a serious erosion of their self-regulatory authority. If a state medical board decided that the job of medicine affirms that killing was not healing, that board would now be powerless to prevent physician participation in PAS. Moral and lawful are not necessarily the same. The chief physician of the state is now the court and the physician may be called upon to use medicine at the behest of the court in ways that the profession of medicine would otherwise strongly reject. If the court were tested on this issue, it is uncertain if the idea that killing is not healing would still prevail.

Doctors, Society and Suicide

Oregon's Death with Dignity Act serves as a pointed example of how PAS practice has been employed(Michael Leo LeBlanc 2016). Individuals seeking PAS are largely concerned with autonomy and dignity and not as a consequence of untreated noxious pain. Very few patients seeking death are referred for psychiatric evaluation. In other circumstances, a desire for suicide would be considered an indication for immediate and involuntary hospital admission. How is the seeking of suicide through state legislation different than a threat of suicide in a seemingly more frantic nature? Autonomy permits the former and excludes the latter according to some. Classically, a desire for suicide is assumed to indicate a lack of the necessary moral agency requited to make autonomous claims. Desire for death

by suicide should not necessarily be considered axiomatic of a loss or moral agency. Not everyone who is suicidal can be made incapable under the law. If so, we are complicit in killing by self-murder. While suicide is not necessarily a moral wrong, assisting in suicide is entirely a different moral matter. Suicide is a private concern drawn from a belief that one's life is unendurable. In suicide, you are on your own but your life is only unendurable to me if I feel like killing you. When a physician gives someone pills while looking the other way as that person makes the final decision; this is a weak and thin claim for moral exculpation. Self-murder, perhaps morally allowable at times, when committed by two people is not self-murder but murder.

Consider as an example, suicide as a consequence of jumping from the Golden Gate Bridge in San Francisco, California. At a height of 67 meters, an individual of an average weight of 70 kg would take 3.7 seconds to hit the water after jumping and the speed on impact would be 130 km/hour. The amount of energy in Joules would be 45,962. By comparison, a 45-caliber bullet shot by a gun at the chest from close range will produce 400 joules of energy. The Golden Gate Bridge is the number one most deadly suicide bridge in the world(Mel Blaustein 2009). Since opening in 1937, thousands of people have jumped to their death from the bridge. It is striking to note that in spite of the seemingly fatal inevitability of a fall of such high-energy consequence, a small number of individuals have survived that fall.

Suicide will always be inextricably bound up in the method of death but the notion that the method itself is an enticement for suicide must be considered.

Restricting access to means of suicide has been shown to be effective in delaying or preventing suicide in vulnerable individuals(D Gunnell 2000). In the United Kingdom, this method has been used successfully by repackaging Acetaminophen to small pack sizes, removing carbon monoxide from the gas used to heat houses, and fitting cars with catalytic converters(Amos T 2001, Hawton K 2001, Hawton K 2004). In a review of Golden Gate Bride suicide survivors, four of six survivors claimed that they would not have attempted suicide at any other location and all six favored the placement of a barrier at the bridge that would prevent suicide(Rosen 1975). The second most deadly bridge in North America, with approximately 9 deaths per year, was the Bloor Street Viaduct in Toronto, Canada(Gunnell D 1997). In response, the municipality created a barrier on the bridge known as the Luminous Veil(Kupferman 2015). After the veil was put in place in 2003, the suicide rate from the bridge went to zero but in a natural experiment, the rate of suicide by jumping in the region remained the same(Mark Sinyor 2010). It may be concluded that unlike the Golden Gate Bridge, the Toronto Bridge was not the sort of attractive nuisance that made suicide rather irresistibly or suddenly desirable.

Many individuals do not ultimately use the prescribed lethal medication, once obtained. Lack of usage may indicate second thoughts on a decision to end life once that possibility becomes more immediate. It may also relieve the stress on an individual that fears the future consequence of a lack of control. Knowing that death is available in the drawer of the bedside table allows that option at some other distant moment. When our lives become depleted of quality, for some, death is the solution. Quality of life is the shared concern of the individual and society. Both

must do their part. In consideration of conversations on quality of life, a danger is revealed. Quality of life concerns an interior and private experience; a subjective experience is transformed into something now measurable and capable of being judged by others. The real risk is that quality, now quantified, becomes unattainable to some. Quality of life is not simply exchangeable with a meaningful life, or even a life at all. If an individual experiences their own life as of very low quality, should they necessarily seek death? If death is not in fact sought when that life is judged to be of low quality would that suggest a lack of moral agency, or worse?

Suffering at the End of Life

Medicine, as a moral endeavor employs other methods of adjudication beyond a set of inviolate rules. Care at the end of life provides an opportunity to consider how a physician considers the moral implications of therapeutic choices. End-of-life care represents a departure from a traditional healthcare model. The physician draws on an ethical and therapeutic imperative to restore to heath and life his or her patient to the maximum extent possible. Doctor and patient contract a relationship in this fashion; no provision exists that permits the opposite. That is, a medical contract cannot be struck that directs the doctor to kill the patient. The doctor-patient relationship contract ends if the patient dies and the assumption is that treatment was always directed to restore health. Death may be inevitable in certain situations, though not a failure of the doctor's duty to try to prevent death. Palliative care, drawing from the patient rights movement(Smith 2011), reimagines the doctor-patient contract. Here, restoring health is one option in a hierarchy of

imperatives that places the relief of suffering as the highest priority, and death is now the success of the contract, not the failure.

When death is near, as a consequence of critical illness, the observation of suffering demands a treatment to relieve that suffering(Dyer 2013). Opioids are sometimes used to relieve suffering and, although the treatment goal is singular, opioids blur the line between the relief of suffering and causing death. The truth is shrouded; death by omission and death by commission are morally equivalent. In the classic Trolley Problem(Thomson 1985), we are asked to pull a lever that separates two outcomes that both produce death. The scenario involves a Trolley car proceeding along a track towards a fork. On one fork, 5 people are tied to the track. On the other fork, only one person is tied. The train is heading for the fork with 5 people and if a lever is pulled, the Trolleys' direction will change to the other track with 1 person. Instead of causing the death of 5 people, 1 person is presumably killed. The distinction is drawn between allowing harm and doing harm or between what is intended vs. what is foreseen. A person positioned by the lever may choose to pull, thereby reducing the number of people killed or he may stand by and do nothing but observe. In a medical setting, one treatment may be chosen to reduce suffering. This is the intended choice. Other outcomes may occur as side effects of the intended choice and these effects expedite death. A distinction is drawn between the intended choices and the harmful and foreseen additional outcomes. This doctrine of the double effect also referred to as the rule of the double effect (RDE), traces back to Thomas Aquinas(Klein 2005). The rule claims that when a single act has two possible outcomes, one good and one bad, a bad outcome

is morally permissible if the primary intent was the good outcome. The opioid is the trolley and the doctor pulls the lever. Aquinas equivocates here by placing the goal of the reduction of suffering as the highest value and allowing death as necessary collateral damage. Aquinas could not have known the power over life and death that doctors would one day enjoy. In the time of Aquinas, doctors could do very little beyond bearing witness. The academy ruminates on the rightness or wrongness of the life-death-suffering struggle. All the while, the doctor has his hand on the syringe. Historical ancient knowledge on the practice of medicine was much more familiar with poison and death than with cure and life. Saving a life was more about luck than skill. Our modern care at the end-of-life lacks ethical clarity owing to a lack of consensus on the relationship of death to the relief of suffering.

Moral reasoning within religious traditions all invoke a principle of valuing human life and then creating an exception based on a hierarchy of greater good. Why is life less valued and how did it lose the power to supersede other values? In the biblical tradition, humans are presented with a clear choice: Deuteronomy 30:19 states "I have placed life and death before you, blessing and curse; and you shall choose life so that you will live, you and your offspring". The influence of the church in Europe was forever diminished during the Bubonic Plague, also known as the Black Death. Widespread illness and death, as a consequence of exposure to the bacterium, *Yersina pestis*, killed 30-60% of the world's population between the years 1348-1420(Alchon 2003). The indiscriminate nature of plague death challenged the notion of the connection between piety, virtue, and illness survival. "*Ars Moriendi"(O'Connor 1942)*, Latin for "The Art of Dying," was an assembly of Latin

texts from 1415 and 1450. This book, the first ever printed with movable type, offered advice on the protocols and procedures of a good death. It created a theological justification for death as a benefit. The word "palliate" originates from the Latin, *palliatus*, meaning cloaked or covered. In its current practice, palliative care seeks to lessen symptoms where the possibility of cure is absent. Palliative care maintains a theological connection but also provides a secular justification to the claim that death is a benefit and not a harm.

Doctors at the End of Life

The belief that killing relieves suffering may justify this offering but as a practical matter, what is actual physician decision-making at the end of a life? Bioethics at the bedside is normative and is valued only to the extent that it can solve a real problem. In a review of end of life decision making by intensive care physicians in Europe, it was determined that physician decision making could largely be predicted by knowing the religion of the doctor and the geographic location of the practice(CL Sprung 2003). It has also been reported that doctors withdrew care on brain-injured patients in the absence of supporting medical findings and the pattern of withdrawal changed depending on which doctor was on duty and not based on patient request(David Livingston 2011). Most troubling here is that physician practice is not monolithic and instead of being driven by the cultural or religious imperative of the patient, it is the religion of the physician that guides that care. Common physician staffing practice dictates that a patient in the intensive care unit has no control over which physician will care for them. As a consequence, decisions about the application of care at the end of life will vary from

week to week based on normal physician staff rotation. When the end of life is near, the physician increasingly drives the dialogue. Double effect reasoning at the end of life is ubiquitous and when a patient or family pushes back; physicians cry futility or moral distress(Dzeng 2016). Doctors spin powerfully and patients and families believe that the choice before them is the only one. It is important to recognize that so empowered, some physicians will act to end life. Within this debate, language is critical; the lexicon of death has been greatly expanded to support the "death as benefit" claim. Within this vocabulary, vagueness creates vulnerable populations who are at a risk of harm, and the double effect provides no protection for an impartial rendering on a choice to live or die. The rule of the double effect creates the potential idea that death is a preferred choice over life with suffering.

Abortion and fetal suffering

Abortion is a form of killing although the question on the rightness or wrongness of abortion generally revolves around personhood questions. If a fetus is a person then it enjoys the full rights of personhood including the right to not be killed. If the fetus is not a person, it is subject to a different set of rights. Advocates for and against abortion seek a lexicon favoring their position that linguistically characterizes the opposite view as a negative. The opposite of pro-choice is anti-choice. The opposite of pro-life is pro-death. Physician involvement has generally been confined to the carrying out of abortion as a medical procedure involving dilation of the cervical opening followed by removal of the uterine contents by some method of suction or curettage. Once abortion has passed the ethical test, the physician may participate or refuse. Limited commentary concerns the method of

abortion from the medical perspective. Recently, the State of Utah has taken on abortion via a claim about the fetus as able to experience pain during an abortion. The state passed a law that directs physicians to provide “fetal anesthesia” for abortions beyond 20 weeks gestation(Healy 2016). Central to this law is a claim that the fetus experiences suffering at the time of death. Since the passing of this law, physicians have been at a loss on how to uphold this directive. Seeking clarification from legislators, no specific reply was forthcoming(Golden 2017). The Utah Fetal Anesthesia Law intends to make abortion procurement more difficult by a threat to physicians when they violate this law. From a scientific perspective, fetal capacity to experience anything akin to pain is likely not possible until sufficient neural development occurs at 29 to 30 weeks gestation(Lee 2005). Utah seeks to restrict abortion access under the cover of a claimed medical need. If a physician could somehow provide something like pain relief to a fetus it would necessarily elevate the fetus to some other category of person. Physicians are only professionally obliged to treat persons in a doctor patient relationship. If the fetus is not a person, a physician has no mandate. If the fetus is a person, the physician, in providing pain relief is practicing something akin to involuntary euthanasia, or simply homicide. The rightness or wrongness of abortion is a philosophical question. A law directing physicians to provide fetal anesthesia is a political claim masquerading as a scientific practice.

III: Lethal injection and the physician

The court transforms lethal injection into a medical act

Lethal injection, or death by the administration of chemicals to an individual via an intravenous, is the current most often used method to kill in the setting of capital punishment. Lethal injection has the look and feel of an anesthetic and as such, should be of interest to physician. Lethal injection owes its origins to the contemplations of two physicians in the State of Oklahoma. In 1977, Jay Chapman, Medical Examiner, was asked by Representative Bill Wiseman of the Oklahoma State Legislature to create a method of execution that would be more humane than what had been used previously(Sanburn 2014). Chapman consulted Anesthesiologist Stanley Deutsch, chair of the Department of Anesthesiology at Oklahoma University, to advise on a 3-drug injection protocol that began with a Barbiturate to achieve unresponsiveness, followed by a paralyzing drug to prevent movement and finally, Potassium Chloride to stop the heart. By introducing the tools of medicine to the tools of punishment, a complex alliance was formed.

Baze v. Rees, 553 U.S 35 (2008) is a decision by the Supreme Court of the United States (SCOTUS) that upheld the constitutionality of a method of lethal injection used for capital punishment. The 3-drug protocol referenced in *Baze* consisted of three chemicals injected into the condemned inmate via an intravenous. The three-drug protocol began with Sodium Thiopental, followed by Pancuronim Bromide and lastly Potassium Chloride. The claim that this lethal injection method contemplated by the state would be a violation of the United States Constitution 8th amendment ban on cruel and unusual punishment was made on behalf of two

individuals, Ralph Baze and Thomas Bowling, both sentenced to death in Kentucky. The findings of *Baze v. Rees* had a national impact as the Kentucky method was the same method used in all states practicing lethal injection. Further, at the time of *Baze,* a moratorium on all lethal injection was effectively in place as the US Supreme Court had granted certiorari, a writ seeking judicial review on the subject. In a 7-2 decision, the court held that the method was constitutional and that an isolated error alone would not violate the 8th amendment but that the first drug in the 3 drug method must render the inmate unconscious to avoid an unacceptable risk that the inmate would be aware as they died by suffocation. *Baze* is noteworthy as it claims that if the death penalty is constitutional, then a method of execution must be available that does not violate the 8th amendment. *Baze* therefore finally claims that the 3-drug method for lethal injection is that method. It is not apparent the *Baze* court understood how the drugs involved in the three-drug protocol worked in the body. It is also noteworthy that *Baze* may have underestimated the full implications to the practice of medicine and the ethical dilemma that *Baze* now placed on physicians.

The ethical physician balks at the use of medicine in this way but to simply abdicate an interest here permits the medicine-punishment relationship to proceed, unabated. Medical knowledge is not containable by the medical profession and in spite of a desire to the contrary; no sharp boundary necessarily exists between knowledge and use. Physician practice is regulated by the medical board, which is regulated by the state. Once the state acquires knowledge regarding the aspects of medical practice needed to kill, the profession of medicine can be somewhat

discarded. Physician involvement in execution is ethically problematic. If a physician chooses to be involved then the claim may be made in the name of personal exculpation that during an execution, the physician is not acting in that capacity but is instead using the knowledge of medicine outside of professional practice. For professions such as medicine, it is unclear under what circumstances can a licensed doctor shed that skin. Medical boards consider the conduct of a physician to be germane at all times; a claim of moral turpitude can be made even when the physician is engaged in a non-medical activity.

Lethal injection intends to convey a message of seriousness and safety in the style of medical practice. However, employing the trappings of science and medicine do not create the safety and circumspection of the scientific method. Lethal injection occurs as a protocol and involves personnel. The event is recorded by the state. Occasionally, the execution does not proceed according to plan and it might be referred to as 'botched'. The alarming public failures creates increasing pressure on the state to get it right and the pressure to seek physician involvement, or at least the tools of science and medicine, grows. If science were brought to bear on lethal injection, it would proceed by first generating a hypothesis and then design a method of investigation, free of bias, to determine if the hypothesis is proven or disproven. Science begins with the null hypothesis; the assumption is that the claim is false and must be proven to be true. Consider an experiment that requires subjects to participate. Can a prisoner be a subject in an experiment? Occasionally, prisoners are used in experimentation and past experience on the use of prisoners in this capacity has resulted in documents and directives from the Nuremberg

Trials[1] and the Declaration of Helsinki[2] in order to protect involuntary and harmful subject participation. In the code of federal regulations, any experiment protocol that uses prisoners as research subjects and generated under the Department of Health and Human Services must at a minimum, personally benefit the prisoner[3]. It would be a dangerous claim to suggest that as a rule, prisoners would benefit from their own death.

When lethal injection began, Sodium Thiopental was the first drug in the original three-drug protocol. Hospira, the last company to manufacture Sodium Thiopental, ceased production to avoid European Union (EU) sanctions that were put in place that required all EU members to not support capital punishment in any way. Hospira, an American company, manufactured Sodium Thiopental in Italy. Concern was raised that the company could not guarantee the Italian Sodium Thiopental would not end up being used in lethal injection in the United States. As a consequence, Hospira decided to stop Sodium Thiopental production(McGreal 2011). With the loss of Sodium Thiopental, states have sought alternatives. The question remains on what scientific principle can substitutions occur? Substitution would first require an understanding of the drugs but also a test of the change. If a drug substitution in lethal injection was evaluated according to science, the trial would ideally involve a prospective analysis, employ blinding of all the participants including impartial observers, be subject to a power analysis, establish a p-value,

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[1] *Trials of War Criminals before the Nuremberg Military Tribunals under Control Council Law No. 10, Vol. 2, pp. 181–182.* Washington, D.C.: U.S. Government Printing Office, 1949.
[2] WMA Declaration of Helsinki - Ethical Principles for Medical Research Involving Human Subjects, 64th WMA General Assembly, Fortaleza, Brazil, October 2013
[3] Human Subject Research (45 CFR 46) Subpart C, Section 46.301-6

and be subject to statistical review to eliminate a result attributed to chance alone. An institutional review board, or somebody capable of ethical and methodological evaluation must first approve any experiment. In reality, chemicals are changed up until the last minute before an execution, based on availability more than efficacy. Personnel are changed; facilities lack standardization, post hoc reviews and debriefs are inconsistent and private. Attempts to gain information about the details of lethal injection in order to critically evaluate methodology are met with resistance.

Capital punishment is a kind of killing

Capital punishment is a kind of killing and to be lawfully delivered it must occur without needless cruelty. Cruelty defined, in the setting of punishment will naturally evolve with the maturation of civil society. Cruel punishment will always be a relative standard and punishment cannot exceed what would be considered morally shocking in that contemporary moment. In the setting of public executions, observers and victims share an aspect of the experience of punishment. The inmate has little opportunity to evaluate and report back on cruelty in the moments before death. Once dead, the inmate is necessarily silent on the matter. Empathy allows observers to evaluate punishment as cruel or not. Attempts by the state to block unfettered observation of all aspects of an execution deny 8th amendment protection which stipulates that inflicted punishment shall not be cruel and unusual. Observation necessarily involves more than what a casual observer can surmise. Execution, as a form of killing, is a technical matter and as such, requires more than casual knowledge of the details of that killing. How can the balance be struck

between the benefits of some sort of technical evaluation that would reduce cruelty in executions while failing to instruct the state on how to kill without cruelty?

Physicians in the execution chamber: not a kindness

The United States Supreme Court has never conceded that only doctors decide the extent of medical expertise. Courts have power to adjudicate without medical expert opinion on issues where it feels authoritative. If an issue is held to be outside of the knowledge of the courts, it will rely on experts, in this case physicians, who will compete to instruct the court on the pharmacology of killing with these drugs. Anesthesia is probably not sufficiently understood by the lawyers that argue lethal injection cases brought before the court, or indeed, by anesthesiologists in the context of its use in lethal injection. Medical training does not address the issues that surface in this context. Troubling ambiguity will linger if lethal injection continues to rely on anesthesia to preclude cruelty. Anesthetic agents, when utilized in an anesthetic, provide a qualitative experience that reduces an otherwise negative experience. Anesthesia has never been about blocking cruelty and the sort of cruelty capable in an execution gone wrong is not transposable to any anesthetic.

Lethal injection has been the method of execution claimed to satisfy the 8th amendment and replaced other methods which all had a much different observer experience. As lethal injection seems to approximate a medical act, it becomes the prevue of physicians who now find themselves wittingly or unwittingly cast in the role of execution advisor. The American Medical Association and the American Board of Anesthesiology both have statements condemning physician involvement

in Capital Punishment based on an ethical prohibition, yet some physicians continue to linger around execution activity. Physician participants in capital punishment claim that professional medical societies may be playing at politics more than at ethics when they object to physician involvement by setting aside an ethical imperative to reduce suffering. Lately, lethal injection has somehow gone awry as more states drop the paralyzing drug from the traditional three-drug cocktail and drug shortages lead to suspicious drug substitutions. Lethal injection is increasingly seen for what it actually is, painful and terrifying organ failure caused by chemical suffocation. Increasingly, the public suspects that something is up and instead of forthright and open public debate, capital punishment states respond by placing legal shrouds in the form of secrecy laws over the details of execution.

Capital punishment, like abortion, divides public opinion along two ideological lines. One camp asserts that the condemned showed no mercy in the committing of a crime and so no mercy is owed in the setting of punishment. Crime must be controlled by harsh punishment or anarchy would ensue. The other camp claims that the condemned is them-self a victim, disadvantaged by race, poverty or education. Further, during incarceration the condemned may have undergone a positive character transformation, found religion, or has been reformed. No middle ground exists and all debates on the rightness or wrongness of capital punishment end rather quickly.

For physicians, the cluster of so-called “botched” executions presents a particular sort of ethical dilemma. Secular and religious ethics both direct against standing idly by in the face of suffering. Here, an inmate dying by lethal injection is

compared to a patient dying of a terminal illness. Public concerns about aggressive care at the end of life have led to medical interventions directed to control pain and distress as a primary therapeutic intervention, abandoning any notion of a traditional cure. Now, death is the cure; death has been reimagined as a treatment and lethal injection has been reimagined as another form of physician-assisted death. How sound is the comparison between end-of-life care in the hospital setting and the end of life in the execution chamber? From a distance, the comparison may seem apt and for the physician that participates in the execution, a distant similarity is sufficient. An inmate facing death is not a patient by virtue of being connected to an intra-venous and having a doctor in a lab coat standing by. Physicians can only work with patient consent. A patient can only consent if they are a moral agent and an inmate, about to die against his will, has doubtful agency. If a physician touches a patient without consent, the law regards it as a battery. Circumstance exists where an individual lacks agency and designates a relative to act as a substitute decision maker. In the execution chamber, who would that be? The warden? Lethal injection only impersonates a medical act and in order to be certain that suffering is reduced in a medical setting, much more information in the form of monitoring and testing is required.

With respect to the reduction of suffering, lethal injection has not sought to verify the claim that a doctor makes any difference at all. Medical practice is a highly regulated activity done by a highly trained and licensed individual. When a doctor is standing in the execution chamber, he is not practicing medicine. The question remains, what exactly is the doctor doing? State secrecy laws protect the identity of

doctors that choose to assist the state in execution. The state medical board, charged with regulating all physician activity, including moral turpitude, is rendered blind by state regulation and now the chief physician of the state is the governor. Lethal injection is an impersonation of medicine populated by real doctors who don't realize the deception.

If the medical profession were to accept that physicians should participate in lethal injection, how would such activity be defined? Medical facilities are regulated entities and must be subjected to independent oversight by organizations such as the Joint Commission. This entity is an independent, not-for-profit group in the United States that administers voluntary accreditation programs for hospitals and other healthcare organizations. The Joint Commission is a standard setter for quality of care. The commission provides assurance to patients that the facility providing health services is independently and impartially evaluated as meeting a quality standard for the offered services. If execution is a medical act to the extent that a physician can claim a mandate, the execution chamber becomes a medical facility subject to Joint Commission oversight.

Execution and the rights of the condemned

Consider an execution now as a particular technical act. Executions proceed along a state specific protocol that specifies a timeline, identifies the duties of individuals, identifies the administering of chemicals and evaluates the moment of death. Like all technical acts that involve a sequence of steps, a natural failure rate is anticipated. Failure is generally the result of different scenarios. Broadly, failure may be the result of system or equipment defects. System failures may be the result

of not following a protocol, insufficient training, unanticipated variation, obstacle or barrier. Lethal injection involves the use of several pieces of medical equipment and any of these items can fail as a consequence of mechanical fatigue, misuse or poor quality control. Medical equipment is designed and tested for use in a medical setting and lethal injection is not a contemplated location for product use by medical device companies nor is it likely a target market. Medical device use in a medical setting must also be evaluated and deemed safe for the purpose. State secrecy laws prevent impartial and public evaluation of procedures and devices in lethal injection, all necessary components within the normal practice of medicine. If a physician found themselves in a location offering medical services or using devices for medical treatment and found defects or deficiencies, that physician would be ethically duty bound to correct those deficiencies. Corrections here would include the stopping of services until such deficiencies were rectified. If lethal injection were a medical act involving a physician and the tools of the medical trade, all necessary equipment and necessary chemicals to insure a death free of cruelty would need to be on hand. Lethal injection as practiced does not provide for alternative plans in the circumstance of execution failure.

After *Estelle v. Gamble* 429 U.S. 97 (1976), indifference to prisoner health constitutes cruel and unusual punishment and therefore violates the 8th amendment. We now interpret the meaning here as a prisoner right to health care and the warden is under a legal duty to provide it up until the prisoner dies a natural death. If death occurs as a consequence of execution, at what moment during the execution is this right to healthcare set aside, if ever? Death by execution is not

instantaneous; methods of execution have been set aside as cruel as a result of executions of an uncomfortable duration. In the case of a failed execution, that failure might take several forms. If the chemicals injected cause incomplete physiologic disruption, some states allow for re-dosage. If after the inmate has received the complete chemical dosage and has not been killed, that inmate may be gravely injured but still able to be revived with appropriate medical interventions. Capital punishment cannot be brought about in consequence of withholding necessary healthcare. Nor can it occur by the infliction of sub-lethal injuries that, in the course of time, are expected to worsen and cause death. Prisoners cannot be killed by stealth or neglect. Prisoners cannot be killed by injury or illness.

Botched execution

Clayton Lockett died during an attempt to kill him by execution by the State of Oklahoma on April 29, 2014. On the day of the planned execution, Lockett had cut himself with a razor blade and had attempted to barricade himself into his cell. In order to finally extract him, corrections officers incapacitated him by using a Taser and then were able to remove him. His injuries were evaluated and it was determined that he did not need stitches(Matt Pearce 2014). In consideration of imminent execution, the question of stiches may, on its face, seem rather moot. Instead, the decision to not use stiches to close a wound is a frank acknowledgement of a right to healthcare that was owed to Lockett. In order for the execution of Lockett to take place, intravenous access was necessary. By accounts, vascular access was very difficult and ultimately, a physician was called upon to establish an intravenous(Stern 2015). Multiple attempts failed and ultimately a vein in the groin

was cannulated using a catheter that was considered too short for the location. The execution protocol in Oklahoma uses a three-drug protocol that begins with Midazolam, followed by Vecuronium Bromide and finally, Potassium Chloride. After Midazolam was injected, Locket was observed to be unresponsive. At that moment, the paralyzing drug was injected but shortly thereafter, Locket began to move and thrash and speak. The intravenous site was inspected and it was immediately observed that the catheter was no longer in the vein and the Midazolam and Vecuronium Bromide had likely instead been injected into the surrounding tissue. Frantic attempts were made to re-establish intravenous access, to no avail. As time went by, it became clear that the execution would fail and should be stopped. 10 minutes later, Lockett died having received no attempt at reviving him. In truth, no such reviving capacity was in place and the physician anticipated the sum total of his role to be there to certify death.

Clayton Lockett confessed to a very serious crime of rape and murder. Accounts of the death of Lockett focused on the depravity of the crimes of Lockett as if to justify his death as acceptable, regardless of the clear 8th amendment violation and the clear dereliction of the ethical and professional duty of the physician. In retrospect, the State of Oklahoma did not execute Lockett, the State of Oklahoma murdered him. The ethical physician provides treatment necessary to the patient and does not take into account the character or choices made by the patient that are not germane to treatment. The legal corollary here is the need to test justice on the people that are despised. Absent this conduct, no citizen is truly safe. The physician is a non–combatant and provides care to all in the battlefield. Here, the physician

has abandoned his post and instead is now the agent of the state. The determination that stiches were not necessary to tend to Lockett's self-inflicted wounds was the beginning of upholding Lockett's right to healthcare. Lockett's failed execution should have ethically led to restoration of medical healthcare. Instead, the absence of medical intervention resulted in his death by slow chemical suffocation.

Prisoner lacks moral agency

In lethal injection, the state attempts to turn the inmate into a patient. In so doing, the doctor is drawn in but as a consequence, the doctor-patient relationship is turned upside down. Central to the doctor-patient relationship is the concept of consent. Can an inmate facing his execution be said to have consented? Is execution a treatment to cure a wrongful act? In Missouri, death row inmate Russell Bucklew was asked to sign a Do Not Resuscitate (DNR) order[4]. A valid DNR order must be the request of an individual possessed of moral agency. A prisoner is a person but the physical and psychological constraints of incarceration challenge the capacity of that inmate with respect to the capacity of being able to provide consent. However, this assumption requires further analysis. The mental health toll on incarceration cannot be understated(S Fazel 2002). In the circumstance of depression, doctors routinely weigh requests about treatment choices against that backdrop of patient/inmate affect. If an inmate/patient refuses treatment that by so doing would lead to his death, how can the validity of his agency be considered?

[4] Russell Bucklew, personal communication. May 2014. (Russell Bucklew is an inmate on death row in Missouri).

Consider the case of Charles Lavern Singleton, executed by the State of Arkansas on January 6, 2004(Garasic 2013). Noteworthy in this case is that Mr. Singleton suffered from schizophrenia. The law exculpates individuals whose actions are perpetrated by a person deemed insane. As a corollary, insanity as a mental state excludes an individual from providing consent for medical treatment. Medical practice provides a mechanism for obtaining permission for treatment when an individual is unable to provide consent as a consequence of mental incapacitation. The law recognizes substitute decision makers, either formally named in an advance directive document, or appointed at the bedside based on a relationship to the individual. Bioethics also supports such proxy decision-making individuals. Substitutes, when properly schooled as to the mechanism of proxy consent, are able to provide the necessary permission in both elective and emergency circumstances.

The execution of Charles Singleton requires further analysis. The law requires that a defendant is criminally responsible if it can be shown that he has engaged in a criminal act - *actus reas*, while also in possession of a guilty mind – *mens reas(Uri Maoz 2015).* The concept of a guilty mind arises first from a theory of mind, that is, an ability to attribute mental states to others and understand that such mental states may be different from one's own(Sara Schaafsma 2015). A guilty mind is a deeper concept and requires the ability to understand the difference between right and wrong or what is lawful and what is not and then choose what is wrong while knowing it to be wrong. Mental health is a fundamentally epistemological claim and requires an agreement on what is a normal brain state with respect to the

world at large and what is an abnormal brain state. Whether the voices heard by Joan of Arc were a manifestation of Schizophrenia or Epilepsy(Nicolas Nicastro 2016), in our contemporary period Joan would be labeled and medicated instead of leading a political revolution. Charles Singleton was convicted of stabbing to death a store clerk in 1979. Singleton heard voices all his life and in his most psychotic state, the law would not permit his execution as a consequence of a 1986 SCOUTUS decision that considered execution of the mentally ill to constitute cruel and unusual punishment. The state desired that Singleton be compelled to receive treatment for Schizophrenia and claimed that in his medicated state, Singleton would be sane in the moment and *ex post facto* culpable for the murder. For Singleton, Schizophrenia was not a chosen state and the relationship between Schizophrenia sufferers and treatment is complex. Medication refusal is a not uncommon occurrence in Schizophrenia and this refusal is multifactorial(Kikkert 2006).

Rational refusal of treatment

Health in prison permits the full measure of punishment and mental illness, though an impediment to function when at liberty may in fact be a route to liberty while incarcerated. For the non-incarcerated Schizophrenic, treatment refusal brushes up against fundamental principles within the doctor-patient relationship. Capacity to consent or refuse is a continuum along a mental state. Refusal does not automatically indicate a lack of decisional capacity. Some degree of mental illness or more precisely, a variety of mental states for those at large would permit psychosis as a private experience as long as it did not interfere with the liberty of others. Compelling inmates to conform to punishment is a legal matter. When the state uses

medicine as the strong right arm to transform an inmate into someone that can be punished, a different set of rules and principles apply. Singleton was forced to receive medical treatment for his schizophrenia although his last utterances as he was executed were disconnected ramblings and certainly not an expression of contrition for the murder he committed. Before Singleton died and under forced medical treatment, Singleton instructed his attorneys to cease further legal action that would spare his life. A diagnosis of Schizophrenia carries a short life expectancy and causes of death include suicide(Thomas Laursen 2014). Russell Bucklew, on death row in Missouri, stated that if the state failed to kill him, he would take his own life[5]. The state may believe that Singleton's refusal for legal ongoing legal defense was an acceptance of his crime and a willingness to be subject to the allotted punishment. Singleton may instead have ultimately regarded his execution as a form of liberation. Medical treatment, in this case, might be in effect, physician-assisted suicide.

The physician as a double agent

Corrections healthcare places the physician in a difficult position of dual loyalty. As a state employee, the physician answers to the needs of the state in a circumstance were the inmate-patient is not able to provide consent in a straightforward fashion. Inmates have a constitutionally protected right to healthcare but the delivery of that right is tempered by incarceration and other legal decisions that create a unique and different tension within the doctor-patient

[5] This was a private communication with Russell Bucklew at Potosi Correctional Center, Mineral Point, Missouri.

relationship. Two separate legal decisions permit involuntary treatment of prisoners suffering from mental health disorders. Central to the treatment paradigm is the goal of making the inmate conform to the dictates of trial and punishment and not for the purpose of restoring health(Williams 2015). Now, the physician is cast in the role of the strong right arm of the state and medicine is now untethered from therapeutic beneficence. A new set of ethical principles now subordinate beneficence for the individual and place the greatest good as the need of others and not the inmate. In *Washington v. Harper* 494 U.S. 210 (1990), the court deemed that physicians alone can determine if an inmate needs involuntary treatment based on a concern that without treatment, an inmate risked the serious likelihood of self harm or harm to others. To be clear, these are valued concerns but now the law has co-opted treatment notions and repurposed them for a different goal. When a doctor is practicing this sort of activity, it is not the practice of medicine. When a doctor becomes the jailor, he has left the profession of medicine.

Lethal injection is the current method of capital punishment that falsely copies medical practice. Anesthesiologists may be mistakenly drawn in to assist the state, with the best of intentions. A deeper consideration reveals the full ethical implications of the clear divide between the state's interest in killing and the physician's interest in healing. Capital punishment as a lawful form of punishment is a matter for the adjudication of the courts as an agent of society. Capital punishment does not need lethal injection and physicians are not obliged, nor ethically able, to help solve the problem of how to kill without cruelty.

Conclusion

Civil society is necessary for human flourishing. Violence, and the threat of violence, is a component of our biological origins. Human conduct enjoys some natural controls derived from our biological and anthropological history. Non-genetic inheritance seeks to explain trans-generational phenotype and conduct transmission using an epigenetic model(Szyf 2015). From a matter of policy, such implications are enormous. If the epigenetic model is valid, a treatment imperative exists strongly for the health of the generations to come and not just the patient at hand. Medicine as an arm of state justice might be guilty of downstream treatments for upstream problems based on flawed or incomplete attribution claims about *mens rea.* And yet, the public needs to be protected. From a Skinnerian point of view, a simple operant conditioning model where the threat of punishment exceeds the supposed reward might create some safety in the public space. Some individuals that commit crimes are untroubled by *mens rea* and as such; a fear of punishment is no disincentive to the committing of crimes. In these circumstances, creating effective deterrents have been particularly challenging. Sociopathy may be an applied label to those remorseless individuals brought before the court. Punishment in these individuals is never rehabilitating, nor is retributive justice able to make whole what has been crushed or serve as an opportunity for a noble and contrite enlightenment. Suicide bombers present an even deeper problem as these individuals seek their own death as central to the crime. The threat of loss of one's life is as powerful a disincentive as is naturally available and here the suicide bomber is immune. Recently, the narrative that suicide bombers are ideologues has

been challenged. Suicide bombers may be more the story of suicide than of the story of simple martyrdom(Lankford 2014) and is a mental health story as opposed to a crime story. Criminal sociopathy or weaponizing suicide might be handed over to the physician; now the problem is an abnormal or ill mental state. Mental illness that leads to crime must be managed and if these individuals are at high risk of recidivism, they need to be in a place where they are unable to cause further harm to innocent people. Prison as an institution provides incarceration but has seemingly little ambition to address the serious mental and physical health challenges within the prison population. The public views on crime and punishment reflect the changing views on the prisoner as a moral agent vs. the prisoner as a victim. For the physician, such debates should be moot and the imperative is to always follow the professional ethical dictates of medical practice.

Medicine needs to constantly strengthen and fortify itself as a principled activity that cares for individuals in medical need. Medical practice is powerful, drawn from the knowledge of what can separate life and death. In so knowing, it must first and always reject the notion that death is a treatment capable of reducing suffering. This assertion does not violate the understanding that mortality is a part of human life and that prolonging life might, for some, be contrary to a desire to have one's life unfold and foldup as near a natural experience as possible. The therapeutic imperative is long in place but the capacity to alter the arc of illness in a meaningful way is still a recent capacity. Physicians have only recently acquired this power and may be forgiven if they still don't know how it should be best managed. Flushed with an ever-increasing technical and pharmacological repertoire, the

ethical use of these tools has lagged behind. Ethical discourse, an ancient activity, needs a reformation with respect to bioethical pedagogy and the development of bioethics as a serious independent profession. Lacking this, anyone can claim bioethics expertise simply by showing up and being interested. Medicine as a profession has increasingly recognized the importance of re-discovering the ethical origins of medical conduct and creating new and current ethical applications to the particulars of present medical practice. Patients themselves have also evolved and they demand service in increasingly complex situations. Information technology has created enormous content for the public and fueled conversations and new concerns. Quality of life has become a quantifiable concern and the drive to achieve quality of life has become intertwined with the quality of death. A new lexicon of death and dying has inflamed public debate. Physicians are members of that same public and do not wish to be seen as only relentlessly advocating for another day on a ventilator or another day on dialysis. We are no closer now that we have ever been to a deeper understand of death but it remains undisputed that if we suggest that killing heals suffering, we will be no closer to solving that question by simply more killing. Medical ethical practice is a set of rules to live by and not to die by and practically, rules become a minimum standard, not the maximum. Death, once chosen, cannot be undone and if we permit death it may be chosen much more than intended.

From the perspective of the state, a physician is a desirable partner. Physician knowledge is useful and the physician is generally a person of good moral conduct and good moral character. A physician owes a duty as a physician to the

profession and a duty to the state as a citizen. The physician, however, cannot separate themselves from themselves. As to the states need for citizens, the state might do better to leave the physician out and allow them to contribute through the force of the profession rather than enable them to possibly usurp, or worse, degrade, the power of medicine by using it to persuade, coerce, or punish. The physician can help create a deeper understanding of human conduct in the best and worst sense. Biology, partnered with anthropology, psychology, and sociology, provides an ever increasingly clear picture of human action and human inclination. The physician does best by being an adviser to the state but not an agent. Where the interest of the state and the independent interest of the physician correspond, the physician should affirm that concordance and do so vigorously. When those same interests diverge, the physician must remind the state that medicine is most powerful when it listens to itself and is most useful to the state as a check on state power and never as a multiplier of state power.

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