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Recommended Citation

Deborah W. Denno, *Physician Participation in Lethal Injection*, 380 *New Eng. J. Med.* 1790 (2019)

Available at: https://ir.lawnet.fordham.edu/faculty_scholarship/1000

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Physician Participation in Lethal Injection

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Deborah W. Denno, *Physician Participation in Lethal Injection*,
380 New England Journal of Medicine 1790-91 (May 9, 2019), at
<https://www.nejm.org/doi/full/10.1056/NEJMp1814786>

On April 1, 2019, the U.S. Supreme Court rejected a Missouri death-row inmate's claim that executing him using the state's lethal-injection protocol would violate the Eighth Amendment's ban on "cruel and unusual punishment" because blood-filled tumors in his head, neck, and throat could rupture and cause him to choke and suffer "excruciating" and "prolonged pain."¹ Many commentators found the 5-to-4 decision in *Bucklew v. Precythe* shocking — a stunning rebuke of Eighth Amendment precedent that shows divisions in the Court over the use of the death penalty. Although it's difficult to predict the extent of *Bucklew's* constitutional footprint, the opinion's unusual facts and circumstances throw into sharp relief the pervasiveness of physician participation in lethal injection despite the medical community's professed condemnation of such involvement. The role of doctors in all forms of execution during the past century has been thoroughly documented,² and in *Bucklew* the Court confronted a case regarding execution methods that was built almost entirely on medical input.

Russell Bucklew, who is scheduled to be executed by lethal injection in Missouri, has congenital cavernous hemangioma, a rare condition that causes clusters of blood vessels and tumors to grow on his face and neck and in his mouth and throat. Assuming that executioners could successfully insert an intravenous (IV) line into his compromised veins, Bucklew argued, Missouri's lethal-injection protocol could cause a tumor to bleed, and the bleeding could impair his breathing and suffocate him for minutes before the protocol's 5g of pentobarbital could kill him. The need for physician involvement in this case was clear from the start, given that Bucklew's challenge to the lethal-injection protocol was based on a medical diagnosis. Yet *Bucklew* also reveals to an unprecedented degree the extent and complexity of the medical community's role in guiding and carrying out executions.

The Court has set forth requirements for challenges to execution methods in two cases during the past decade. In 2008, the Court held in *Baze v. Rees* that petitioners relying on the Eighth Amendment to challenge a state's execution method must demonstrate that the method poses a "substantial" or "objectively intolerable" risk of "serious harm" as compared with "known and available alternatives."³ Seven years later, in *Glossip v. Gross*, the Court broadened the *Baze*

¹ *Bucklew v. Precythe*, 139 S. Ct. 1112 (2019).

² Denno DW. The lethal injection quandary: how medicine has dismantled the death penalty. *Fordham Law Rev* 2007;76: 49-128.

³ *Baze v. Rees*, 553 U.S. 35 (2008).

standard by suggesting a two-pronged test in which the petitioner must both prove that the planned method of execution poses a “substantial risk of severe pain” and “identify a known and available alternative method of execution that entails a lesser risk of pain.”⁴ In other words, inmates have the burden of finding another way the state can execute them — one that would be substantially less problematic and painful than the planned method.

Although Bucklew identified nitrogen gas as an alternative method of execution, his prevailing argument was that he should not have to identify an alternative method at all, given his particular medical condition. Bucklew’s position was that inmates are required to suggest an alternative method of execution only when they are contending that the planned method is unconstitutional for all inmates (a “facial” challenge), and Bucklew was instead proposing that the planned method is unconstitutional specifically in his case because of the potential interaction between his condition and Missouri’s execution protocol (an “as-applied” challenge). Bucklew was therefore challenging not the state’s lethal-injection procedure per se, but rather the protocol as it applies to people with unusual medical conditions that would create a “substantial risk of severe pain.” Bucklew was also concerned about the experience, training, and qualifications of the medical team that would be instrumental in his execution, particularly about how much they had been told about his condition and whether they would be able to accommodate it and control his pain.

Indeed, Bucklew introduced extensive testimony by a physician expert regarding his rare medical condition and the resulting risk posed by lethal injection. He also provided thorough documentation for a series of botched executions or attempted executions — in particular the execution of Dennis McGuire in Ohio in 2014 and the attempted executions of Alva Campbell in Ohio in 2017 and Doyle Lee Hamm in Alabama in 2018.

Even more notable was the state’s heavy reliance on medical involvement in its assurances that Bucklew would not face a “substantial risk of severe pain” during the execution and that his death would proceed as intended. The state argued that it would accommodate Bucklew’s condition by using experienced medical personnel, including a board-certified anesthesiologist who would insert the IV line. Similarly, much of the justices’ initial discussion during oral arguments and nearly a third of the Court’s decision focused on medical details.

Ultimately, the Supreme Court affirmed the decisions of the district court and the Eighth Circuit and rejected Bucklew’s arguments. It held that the *Baze–Glossip* test pertains to all Eighth Amendment challenges to the constitutionality of an execution method, whether facial or applied, and that Bucklew’s distinction between the two types “invites pleading games” that only delay an inmate’s execution. In addition, the Court found that Bucklew failed to establish “a feasible and readily implemented alternative method of execution” because he provided so few facts about nitrogen gas. As the Court stressed, “the Eighth Amendment does not guarantee a prisoner a painless death — something that, of course, isn’t guaranteed to many people, including most victims of capital crimes.” Rather, prohibited punishments are those that “superadd terror, pain, or disgrace to their executions.” Although the Court did not detail how this standard would be

⁴ *Glossip v. Gross*, 135 S. Ct. 2726 (2015).

measured, it's quite possible that such assessments would require the involvement of medical experts.

Bucklew is far from the first capital case to rely on physicians' contributions. Physicians have participated in executions for more than a century and continue to do so, yet the American Medical Association (AMA) and other physician organizations gloss over this reality. Physician involvement is particularly problematic given the wide range of unresolved problems created by lethal injection, many of which were described in the amicus briefs filed in *Bucklew*. Shortages of drugs to be used for lethal injection have led to a scenario in which departments of corrections desperately seek to use untested drugs and protocols, which results in a random and unreliable process that is almost certainly unconstitutional — but also seemingly unfixable without the benefit of physicians' expertise.⁵ Although national medical associations, at least in theory, strongly discourage members from providing guidance regarding lethal injection, these ethical guidelines are not binding, and only a small number of state medical boards have adopted the AMA's guidelines into their own ethical codes.

For the most part, then, the medical community does not fully acknowledge physician participation in executions or turns a blind eye altogether. As Orin Guidry, then-president of the American Society of Anesthesiologists, insisted in 2006, the legal system's predicament with lethal injection is not medicine's fault: "The legal system has painted itself into this corner and it is not [the medical profession's] obligation to get it out."

The Supreme Court clearly did not take on this obligation in *Bucklew*. But the facts of the case make it difficult for either the legal or the medical profession to deny that doctors do indeed take part in executions and therefore share in the responsibility of addressing the shortcomings of execution methods. I believe that whatever moral or professional credibility the medical community fears it will lose by engaging in a discussion of physician involvement in lethal-injection executions is already imperiled by the increasingly apparent divergence between the community's words and its actions.

⁵ Denno DW. Lethal injection chaos post-*Baze*. *Georgetown Law J* 2014;102:1331-82.