

No.

IN THE
Supreme Court of the United States

THOMAS D. ARTHUR,
Petitioner,

v.

COMMISSIONER, ALABAMA DEPARTMENT OF
CORRECTIONS, WARDEN,
Respondent.

On Petition for Writ of Certiorari to the United States
Court of Appeals for the Eleventh Circuit

**MOTION FOR LEAVE TO FILE BRIEF OF *AMICI*
CURIAE AND BRIEF OF CERTAIN MEDICAL
PROFESSIONALS AND MEDICAL ETHICISTS
AS *AMICI CURIAE* IN SUPPORT OF PETITIONER**

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Pursuant to Supreme Court Rule 37.2(b), Dr. Robert Truog, Professor Seema K. Shah, Dr. Kenneth W. Goodman, and Professor I. Glenn Cohen hereby move this Court for leave to file the attached brief as *amici curiae* in support of petitioner, Thomas D. Arthur. Petitioner has consented to the filing of the brief. Respondent has not consented to the filing of the brief.

Amici will address whether this Court's decisions in *Baze v. Rees*, 553 U.S. 35 (2008) and *Glossip v. Gross*, 135 S. Ct. 2726 (2015) should be interpreted to allow a district court to require a condemned inmate to offer a revised lethal injection protocol to the one under review, as the district court below required petitioner to provide in support of his challenge to Alabama's current lethal injection protocol, notwithstanding that medical ethics rules would essentially make such expert evidence unavailable to the inmate.

Amici are medical professionals, medical ethicists, and university professors with specialized knowledge in medical ethics, including the ethical issues surrounding the participation of physicians in capital punishment. *Amici* have an interest in ensuring that the long-standing ethical rules governing medical professionals are given proper consideration when courts address the participation of physicians in capital punishment. A clear understanding of the ethical rules that govern physicians and, in particular, those rules that address physicians and capital punishment, is essential to this Court's review of this case, and the specialized knowledge *amici* possess makes them uniquely qualified to assist this Court in gaining that understanding.

For those reasons, *amici curiae* respectfully request that this Court grant them leave to file the attached brief.

November 3, 2016

Respectfully submitted,

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IDENTITY AND INTEREST OF *AMICI CURIAE*¹

Amici curiae are medical professionals, medical ethicists, and university professors with specialized knowledge in medical ethics, including the ethical issues surrounding the participation of physicians in capital punishment. For the reasons stated in this brief, *amici* believe it is important that the Court have a clear understanding of the ethical rules that surround physician participation in executions and that prohibit a physician from designing the sort of detailed lethal injection protocol that the Court of Appeals here required petitioner Thomas Arthur to submit in support of his method-of-execution claim under the Eighth Amendment. *Amici* are particularly well-suited to address those issues.

Amici are each physicians or experts in medical ethics:

Dr. Robert Truog is the Frances Glessner Lee Professor of Medical Ethics, Anaesthesiology & Pediatrics at Harvard Medical School and is a Senior Associate in Critical Care Medicine at Boston Children's

¹ *Amici curiae* certify that no counsel for a party authored this brief in whole or in part, and no person other than *amici* or their counsel made a monetary contribution intended to fund the preparation or submission of this brief. Pursuant to Sup. Ct. R. 37.2(a), counsel of record received the timeliest notice possible given the expedited nature of this case of *amici curiae*'s intent to file this brief. Petitioner has consented to the filing of this brief. Respondent has not consented to the filing of this brief.

Hospital.² Dr. Truog is an expert in the ethical issues that arise in anesthesia and critical care, and is the author of national guidelines for providing end-of-life care in the intensive care unit. Dr. Truog serves as the Director of Clinical Ethics in the Division of Medical Ethics and the Department of Social Medicine at Harvard Medical School; as a member of the Harvard Embryonic Stem Cell Research Oversight Committee; and as a member of the Harvard University Faculty Committee of the Edmond J. Safra Foundation Center for Ethics. Dr. Truog received The Christopher Grenvik Memorial Award from the Society of Critical Care Medicine for his contributions and leadership in the area of ethics.

Seema K. Shah is an Associate Professor in the Division of Bioethics of the Department of Pediatrics at the University of Washington School of Medicine, and is a member of the faculty at the Treuman Katz Center for Pediatric Bioethics in the Seattle Children's Hospital. Among other scholarly articles on medical ethics, Professor Shah has written specifically on ethical issues surrounding capital punishment. *See, e.g.,* S. Shah, *Experimental Execution*, 90 Wash. L. Rev. 147 (2015); S. Shah, *How Lethal Injection Reform Constitutes Impermissible Research on Prisoners*, 45 Am. Crim. L. Rev. 1101 (2008).

Kenneth W. Goodman, Ph.D., FACMI, is a Professor of Medicine and of Philosophy and the Director of the

² Each *amicus curiae* submits this brief in his or her individual capacity. All of the individual *amici curiae*'s organizational and professional affiliations noted in this section are for identification purposes only.

Institute for Bioethics and Health Policy at the University of Miami Miller School of Medicine, and is a Co-Director of Ethics Programs at the University of Miami. He is an expert in several aspects of clinical ethics and research ethics and has argued that, independently of the morality of capital punishment, it is impossible under federal research law to develop an effective lethal injection formula. See L. Koniaris et al., *Ethical Implications of Modifying Lethal Injection Protocols*, PLOS Medicine (June 10, 2008), <http://dx.doi.org/10.1371/journal.pmed.0050126>.³

Professor Goodman served on a special ethics committee of the Florida Department of Corrections' Office of Health Services. It was one of the first ethics committees of its type in the country.

I. Glenn Cohen is a Professor of Law at Harvard Law School, and Faculty Director of the Petrie-Flom Center for Health Law Policy, Biotechnology & Bioethics. Professor Cohen's scholarship focuses on issues at the intersection of medicine, ethics, and the law.

SUMMARY OF THE ARGUMENT

This case presents an issue of critical importance to method-of-execution death penalty litigation nationwide—and the role of expert medical testimony in that litigation—in the wake of this Court's decisions in *Baze v. Rees*, 553 U.S. 35 (2008) and *Glossip v. Gross*, 135 S. Ct. 2726 (2015). *Baze* and *Glossip* require a condemned inmate to show that a feasible and readily implemented alternative method of execution exists to

³ All internet citations in this brief were last visited on September 29, 2016.

the challenged procedure in order to establish a violation of the Eighth Amendment from the use of the state's preferred method. This case presents the question whether a district court can require a condemned inmate to produce evidence that medical ethics rules ensure he will not be able to obtain in order to meet that burden. Below, the Eleventh Circuit affirmed the decision of the district court rejecting petitioner's claim because he could not propose "specific, detailed, and concrete alternatives or modifications to the protocol" for lethal injection used by the State of Alabama, with "precise procedures, amounts, times, and frequencies of implementation." Tab 3 at 11 (quoting Tab 16 at 3–4); *see also* Op. 78-84.⁴ The reason petitioner could not meet that burden is because medical professionals such as physicians—who are the most qualified to offer such proposals—are prohibited by ethical rules of the American Medical Association ("AMA") and most other medical societies from designing lethal injection protocols. That rule flows from the medical profession's longstanding prohibition on physician participation in executions. Petitioner's expert, Dr. Strader, therefore appropriately declined to provide the step-by-step instructions for executing petitioner that the district court required.

Amici submit that this Court should grant review of the decision below because it implicates an issue of exceptional importance to death penalty litigation nationwide in light of *Baze* and *Glossip*. In addressing that issue, the Court must have a clear understanding of

⁴ Citations to "Tab_" are to the Record Excerpts filed by Plaintiff-Appellant in the Eleventh Circuit Court of Appeals on September 30, 2016. "Op. _" refers to the Court of Appeals' opinion below.

the ethical rules that the Court of Appeals' decision implicates when evaluating whether *Baze* and *Glossip* should be interpreted to require the type of evidence the courts below required here. Condemned prisoners will not be able to provide that evidence.

The district court's decision, further, creates a bias in favor of the state in lethal injection cases. This Court has recognized that an inmate cannot meet his burden to show that a feasible alternative method of execution exists by suggesting methods that ethical rules foreclose, such as participation of an anesthesiologist in the execution itself. *Baze*, 553 U.S. at 59-60. In other words, inmates cannot use ethical rules to their tactical advantage. The same principle should apply to the state: the state should not be allowed to defeat an inmate's claim by foisting on the inmate the burden to offer evidence the ethical rules preclude him from obtaining. Yet that is exactly what the Court of Appeals here required.

Amici also believe that this Court should take into account the very real ethical dilemmas that orders like the one issued below will place on physicians and other medical professionals who act as expert witnesses in lethal injection cases. Such orders inherently would require any medical professional serving as an expert to resolve difficult ethical issues surrounding what testimony the expert could appropriately provide. In the face of such orders and the ethical dilemmas to which they give rise, medical professionals may decline to serve as expert witnesses in lethal injection cases in the first place, robbing the courts of appropriate expert testimony that would assist them in accurately

adjudicating the important constitutional issues this and similar cases present.

The Court of Appeals' opinion shows how real this possibility is. The court determined that Dr. Strader "contradicted" his statement that he could not ethically outline a revised lethal objection protocol because he offered some expert testimony on that issue. Op. 82. But the Court of Appeals ignored that *the State's own expert* similarly declined to testify as to alternative procedures. In any event, Dr. Strader simply attempted to draw the difficult ethical line the district court's order required. He determined that he could ethically refer back to prior testimony he gave in the case and could point to the manner in which midazolam is administered in a clinical setting. *See infra* pp. 20-21. But he could not go any further—and the Court of Appeals rejected petitioner's claims for want of that further testimony. The Court of Appeals' decision ensures that physicians will face similar ethical quandaries in future cases—or they will decline to testify at all—a result that *Baze* and *Glossip* did not contemplate.

RELEVANT ETHICAL RULES

AMA Code of Medical Ethics § 9.7.3 (2016) (formerly AMA, Code of Medical Ethics, Opinion 2.06) ("Rule 9.7.3") provides in relevant part:

Debate over capital punishment has occurred for centuries and remains a volatile social, political, and legal issue. An individual's opinion on capital punishment is the personal moral decision of the individual. However, as a member of a profession dedicated to preserving life when

there is hope of doing so, a physician must not participate in a legally authorized execution.

Physician participation in execution is defined as actions that fall into one or more of the following categories:

- (a) Would directly cause the death of the condemned.
- (b) Would assist, supervise, or contribute to the ability of another individual to directly cause the death of the condemned.
- (c) Could automatically cause an execution to be carried out on a condemned prisoner.

These include, but are not limited to:

- (f) Prescribing or administering tranquilizers and other psychotropic agents and medications that are part of the execution procedure.

- (i) Rendering of technical advice regarding execution.

and, when the method of execution is lethal injection:

- (l) Prescribing, preparing, administering, or supervising injection drugs or their doses or types.

- (n) Consulting with or supervising lethal injection personnel.

The following actions do not constitute physician participation in execution:

- (o) Testifying as to the prisoner's medical history and diagnoses or mental state as they relate to competence to stand trial, testifying as to relevant medical evidence during trial, testifying as to medical aspects of aggravating or mitigating circumstances during the penalty phase of a capital case, or testifying as to medical diagnoses as they relate to the legal assessment of competence for execution.
- (p) Certifying death, provided that the condemned has been declared dead by another person.
- (q) Witnessing an execution in a totally nonprofessional capacity.
- (r) Witnessing an execution at the specific voluntary request of the condemned person, provided that the physician observes the execution in a nonprofessional capacity.
- (s) Relieving the acute suffering of a condemned person while awaiting

execution, including providing tranquilizers at the specific voluntary request of the condemned person to help relieve pain or anxiety in anticipation of the execution.

- (t) Providing medical intervention to mitigate suffering when an incompetent prisoner is undergoing extreme suffering as a result of psychosis or any other illness.

ARGUMENT

I. Ethical Rules Prohibit Medical Professionals From Participating In Executions.

1. Ethical rules governing physicians and other medical professionals have long prohibited those individuals from participating in state-sanctioned executions. A number of reasons support this rule.

First, participation in an execution is inconsistent with the Hippocratic Oath. As the AMA’s Judicial Council put it when recommending that the AMA preclude physicians from assisting in capital punishment, “professional standards in medicine always rest on the most fundamental of concepts, ‘primum non nocere,’ above all do no harm. It is harmful to take a life.” AMA Judicial Council: Report to the House of Delegates—129th Annual Convention, Chicago at 85 (1980) (“AMA Judicial Council Report”). “Medicine is at heart a profession of care, compassion, and healing. Physician-assisted capital punishment does not

encompass these virtues.” R. Truog & T. Brennan, *Sounding Board: Participation of Physicians in Capital Punishment*, 329 New Eng. J. Med. 1346, 1348 (1993). Thus, calls for physicians to assist in executions “require[] physicians to abandon historical duties and obligations to patients and become technicians rather than professionals whose primary concern is patient welfare.” A. Sikora & A. Fleischman, *Physician Participation in Capital Punishment: A Question of Professional Integrity*, 76 J. Urban Health: Bull. N.Y. Acad. Med. 400, 401 (1999).

Assisting the state to kill an individual thus is inconsistent with the core ethical aims of the medical profession. The “goals of medicine” are “(1) to save and extend life; (2) to promote, maintain, and restore health; and (3) to ameliorate and relieve suffering.” *Id.* at 402 (discussing Hastings Center Report, *The Goals of Medicine: Setting New Priorities* S9-S14 (1996) (Special Supplement)). In addition to those more general goals, “medical interventions ought to fulfill the following criteria: voluntary and uncoerced consent, reasonable utility, and benefits proportional to the risks and harms.” *Id.*

Medical assistance with carrying out the death penalty cannot meet those requirements. “Physician participation in executions contradicts the dictates of the medical profession by causing harm rather than alleviating pain and suffering.” Council on Ethical & Judicial Affairs, AMA, *Physician Participation in Capital Punishment*, 270 J. Am. Med. Ass’n 365, 365 (1993) (“CEJA Report”). Nor could such participation meet the requirement of “voluntary and uncoerced consent,” even if the prisoner wanted such participation,

because of the inherently coercive fact that the prisoner is under a state-sanctioned execution order when deciding whether to seek medical assistance. *See* Sikora & Fleischman, *supra* p. 10, at 405–06 (“A request by a prisoner for physician assistance in death by capital punishment is coercive inherently and ought not to be confused with a voluntary choice among reasonable options.”); CEJA Report, *supra* p. 10, at 366. Further, the rule against participation applies regardless of the inherently coercive nature of executions and regardless of the prisoner’s wishes because of the distinct interests of the profession and society as a whole: “the physician’s obligation to refrain from causing death is a duty to the profession and to society in general that cannot be waived by individuals.” *Id.*

Second, physician participation distorts the role of the medical profession in service of the state’s distinct goals. “[T]he fundamental reason for regarding the involvement of medical professionals as unethical is grounded in the proper relationship between the state and the medical profession.” R. Truog, et al., *Viewpoint: Physicians, Medical Ethics, and Execution by Lethal Injection*, 311 J. Am. Med. Ass’n 2375, 2375 (2014) (“*Viewpoint*”); *see also* F. Rosner, et al., *Physician Involvement in Capital Punishment*, 91 N.Y. St. J. Med. 15, 15–16 (1991); W. Curran, et al., *Sounding Board: The Ethics of Medical Participation in Capital Punishment by Intravenous Drug Injection*, 302 New Eng. J. Med. 226, 227–28 (1980); T. Murphy, *Physicians, Medical Ethics, and Capital Punishment*, 16 J. Clinical Ethics 160, 163 (2005). The medical profession has determined that participation in capital punishment crosses the line separating state and medical goals: by participating in an execution, “the physician is taking over some of the

responsibility for carrying out the punishment and in this context, becomes the handmaiden of the state as executioner. In return for possible reduction of pain, the physician, in effect, acts under the control of the state, doing harm.” Am. College of Physicians, et al., *Breach of Trust: Physician Participation in Executions in the United States* 38 (1994).

Third, “[t]he image of physician as executioner under circumstances mimicking medical care risks the general trust of the public,” and thereby erodes the foundation of the medical profession in our society and its role in improving health. CEJA Report, *supra* p. 10, at 366. As the AMA has stated, because “[p]hysicians are fundamentally healers, not instruments of death [w]hen they mix these roles, the perception of the profession changes and patient trust erodes,” which in turn means that “the physicians’ ability to care for the patient is diminished.” Brief of *Amicus Curiae* American Medical Ass’n at 5, *N.C. Dep’t Corr. v. N.C. Med. Bd.*, 675 S.E.2d 641 (N.C. 2009) (No. 51PA08), 2008 N.C. Sup. Ct. Briefs LEXIS 238, at *6.

To be sure, not all medical professionals are personally opposed to participation in capital punishment. *See, e.g.*, Murphy, *supra* p. 11, at 164–65 (summarizing the pro-involvement position). A number of physicians have in fact participated in executions, notwithstanding the ethical rules. A. Gawande, *When Law and Ethics Collide-Why Physicians Participate in Executions*, 354 New Eng. J. Med. 1221, 1223–27 (2006). Nonetheless, “[t]here is a consensus among most medical societies that physician participation in executions is unethical,” CEJA Report, *supra* p. 10, at 366, and “individual disagreements do nothing to call the

professional consensus into question.” R. Truog et al., *In Reply to Letter to the Editor*, 312 J. Am. Med. Ass’n 1804, 1805 (2014).

The ethical prohibition against medical professionals participating in executions is not limited to physicians. Professional associations for psychiatrists, pharmacists, nurses, emergency medical technicians, correctional health officials, and public health officials have all stated that their members should not participate in capital punishment, either by incorporating the AMA rule or adopting their own similar policy.⁵

⁵ See Am. Psych. Ass’n, Position Statement on Capital Punishment: Adoption of AMA Statements on Capital Punishment (May 2008), available at www.psychiatry.org/File%20Library/About-APA/Organization-Documents-Policies/Policies/Position-2008-Capital-Punishment.pdf; Am. Pharm. Ass’n, *APhA House of Delegates Adopts Policy Discouraging Pharmacist Participation in Execution* (Mar. 30, 2015), <https://www.pharmacist.com/apha-house-delegates-adopts-policy-discouraging-pharmacist-participation-execution>; Am. Nurses Ass’n, Position Statement: Nurses’ Role in Capital Punishment at 1, 4-5 (1994) (“ANA Position Statement”), available at <http://www.nursingworld.org/MainMenuCategories/EthicsStandards/Ethics-Position-Statements/prtetcptl14447.pdf>; Am. Corr. Health Servs. Ass’n, Mission & Ethics Statement, Principles, <http://www.achsa.org/mission-ethics-statement/>; Nat’l Ass’n of Emergency Med. Technicians, Position Statement, EMT or Paramedic Participation in Capital Punishment (Jan. 26, 2010), available at <http://www.naemt.org/docs/default-source/Advocacy-Documents/1-26-10-EMT-or-Paramedic-Participation-in-Capital-Punishment.pdf>; Am. Public Health Ass’n, *Participation of Health Professionals in Capital Punishment*, *The Nation’s Health*, Sept. 1985, at 20; see also Am. Soc’y Anesthesiologists, *Statement on Physician Nonparticipation in Legally Authorized Executions* (approved Oct. 18, 2006; reaffirmed Oct. 19, 2011).

2. The medical profession's ethical opposition to physician participation in capital punishment is *not* grounded in opposition to the death penalty itself. As the AMA has put it: "Debate over capital punishment has occurred for centuries and remains a volatile social, political, and legal issue. An individual's opinion on capital punishment is the personal moral decision of the individual. However, as a member of a profession dedicated to preserving life when there is hope of doing so, a physician must not participate in a legally authorized execution." Rule 9.7.3, opening paragraph.⁶ "[V]iolations of professional integrity must be distinguished from matters of personal conscience, for which individual physicians might find certain actions personally morally objectionable." Sikora & Fleischman, *supra* p. 10, at 403.

It is thus not participation in the death penalty *per se* that the medical community condemns, but rather doing so *when acting as a physician*. Rule 9.7.3, opening paragraph. "As long as physicians use the knowledge and techniques attributed to medicine, they ought to be bound by the ethical standards of the profession." Sikora & Fleischman, *supra* p. 10, at 403.

⁶ See also Am. Bd. Anesthesiology, *Commentary: Anesthesiologists and Capital Punishment* (May 2014) ("ABA Commentary") ("The ABA has not taken this action because of any position regarding the appropriateness of the death penalty. Anesthesiologists, like all physicians and all citizens, have different personal opinions about capital punishment. Nonetheless, the ABA, like the AMA, believes strongly that physicians should not be involved in capital punishment."); ANA Position Statement, *supra* p. 13 n.5, at 5 (same, as to nurses).

3. Lethal injection “presents special problems for the medical profession.” CEJA Report, *supra* p. 10, at 365. “Death by lethal injection requires that mechanisms that are ordinarily used to preserve life in a medical setting be used to cause death and that a person with at least some medical knowledge perform the procedure.” *Id.* Lethal injection, therefore, is “a more obvious application of biomedical knowledge and skills than any other method of execution yet adopted by any other nation in modern history,” and so poses heightened ethical concerns. Curran, *supra* p. 11, at 228. Indeed, the use of drugs to bring about death is one of the oldest medical ethical issues known to man. An early version of the Hippocratic Oath dealt directly with the issue: “I will not give a lethal drug to anyone if I am asked, nor will I advise such a plan.” Nat’l Inst. Health, Hist. of Med. Div., Nat’l Libr. of Med., *Greek Med.*, https://www.nlm.nih.gov/hmd/greek/greek_oath.html.

Not surprisingly, then, the medical community promptly responded when states first proposed lethal injection as an execution method. In 1977, Oklahoma became the first state to adopt a lethal injection protocol for executions, and in 1982 Texas became the first state to use lethal injection to carry out an execution. *See Baze*, 553 U.S. at 42; P. Clark, *Physician Participation in Executions: Care Giver or Executioner?*, 34 J. L. Med. & Ethics 95, 96 (2006). In response, the World Medical Association addressed the propriety of physicians assisting in such executions, adopting a rule “that it is unethical for physicians to participate in capital punishment,” other than simply to certify death. *The Lisbon Assembly*, 28 World Med. J. 81, 84 (1982). The AMA’s Judicial Council issued a similar

recommendation. AMA Judicial Council Report, *supra* p. 9.

4. Consistent with the foregoing, medicine's leading professional associations have codified rules that prohibit physicians from participating in capital punishment. The most recent version of the AMA's rule was codified in 2016 as Code of Medical Ethics § 9.7.3, and is reproduced in relevant part above. *See* Rule 9.7.3, *supra* pp. 6–9.

In sum, the rule provides that “as a member of a profession dedicated to preserving life when there is hope of doing so, a physician must not participate in a legally authorized execution.” Rule 9.7.3, opening paragraph. The rule prohibits three broad categories of forbidden “participation”: Actions that “(a) Would directly cause the death of the condemned. (b) Would assist, supervise, or contribute to the ability of another individual to directly cause the death of the condemned. [or] (c) Could automatically cause an execution to be carried out on a condemned prisoner.” Rule 9.7.3(a)-(c). The rule then describes eleven specific acts that a physician cannot perform. Rule 9.7.3(d)-(n). Among those forbidden acts are “[p]rescribing or administering tranquilizers and other psychotropic agents and medications that are part of the execution procedure,” “[r]endering of technical advice regarding execution, . . .” and “[c]onsulting with or supervising lethal injection personnel.” Rule 9.7.3(f), (i), (n). The Rule delineates six acts that, though related to an execution, do not constitute forbidden participation, such as certifying (but not declaring) death, “[w]itnessing an execution in a totally nonprofessional capacity,” and “[r]elieving the acute suffering of a

condemned person while awaiting execution, including providing tranquilizers at the specific voluntary request of the condemned person[.]” Rule 9.7.3(o)-(t). Participation in the drafting or formulation of a lethal injection protocol is not on the list of acceptable acts.

5. Violating these ethical rules can have real consequences for medical professionals. Medical associations can withhold or revoke certification to physicians who improperly participate in an execution. For example, the American Board of Anesthesiology (ABA)—arguably one of the more important medical societies at issue here given that this case centers on the appropriate way to anesthetize the condemned prisoner—has determined that “ABA certificates may be revoked if the ABA determines that a diplomate participates in an execution by lethal injection,” with forbidden participation being “defined by the AMA’s policy.” ABA Commentary, *supra* p. 14 n.6. Loss of board certification can have adverse consequences for a physician’s career. “Certification is voluntary and not required by law, but in practice it is essential, because most hospitals and insurers require it and patients are increasingly encouraged to choose only specialists who are certified.” D. Grady, *Gynecology’s Gender Question*, N.Y. Times, Dec. 24, 2013, at D1; *see also* T. Brennan, et al., *The Role of Physician Specialty Board Certification Status in the Quality Movement*, 292 J. Am. Med. Ass’n 1038, 1042 (2004) (“certification and maintenance of certification are highly valued by the public” and “[m]ost [consumers] claimed they would change physicians if their current physician or specialist failed to maintain certification”).

Further, many states—including those that authorize the death penalty—have laws stating that violating a rule of medical ethics subjects a physician to discipline, up to and including revocation of the physician’s license to practice. *See, e.g.*, Ky. Rev. Stat. §§ 311.597(4), 311.595(9); Md. Code, Health Occ. § 14-404; Miss. Code § 73-25-29; N.H. Rev. Stat. § 329:17(VI)(d), (VII); N.H. Code Admin. R. Med. 501.02(h); Ohio Rev. Code. § 4731.22(B)(18); Tenn. Code § 63-6-214(a), (b)(1); Tenn. Comp. R. & Regs. 0880-02-.14(8); *cf.* Colo. Rev. Stat. § 12-36-117(1)(p); *but see* N. Sawicki, *Doctors, Discipline, and the Death Penalty: Professional Implications of Safe Harbor Policies*, 27 Yale L. & Pol’y Rev. 107, 125–30 (2008) (discussing “safe harbor” laws passed by some states that immunize doctors from ethical discipline for participating in an execution). Although eventually overturned by the Supreme Court of North Carolina, the North Carolina Medical Board invoked just such a rule to determine that participating in an execution would subject the physician to discipline. *See N.C. Dep’t Corr. v. N.C. Med. Bd.*, 675 S.E.2d 641, 645 (N.C. 2009). Other state medical boards could follow suit. Thus, although *amici* are aware of no such boards that have taken adverse action against a physicians’ license to practice medicine based on participation in an execution, *see Viewpoint*, *supra* p. 11, at 2376; T. Alper, *The Truth About Physician Participation in Lethal Injection Executions*, 88 N.C. L. Rev. 11, 29 (2009), such discipline is possible under many states’ laws.

II. Prohibited Participation Includes Suggesting An Alternative Lethal Injection Protocol, As The Court of Appeals Here Required.

1. The AMA ethical rules prohibit more than just taking part in the execution by, for example, setting the intravenous lines or monitoring the inmate's anesthetic depth during the execution. The ethical rules apply to assisting in the formulation of lethal injection protocols, too. Rule 9.7.3 explicitly prohibits a physician from taking any "action" that "[w]ould assist, supervise, or contribute to the ability of another individual to directly cause the death of the condemned," including "[r]endering . . . technical advice regarding execution" or "[c]onsulting with or supervising lethal injection personnel." Rule 9.7.3(b), (i), (n). As the AMA's head of ethics is reported to have opined, "[e]ven helping to design a more humane protocol would disregard the AMA code" because "[f]ormulating a way to kill somebody would violate the spirit of the policy." E. Marris, *Will Medics' Qualms Kill the Death Penalty?*, 441 *Nature* 8, 8 (2006) (quoting Priscilla Ray of the AMA). Thus, prohibited "[i]nvolvement in capital punishment includes the design of protocols and procedures to be used" in carrying out the execution. Sikora & Fleischman, *supra* p. 10, at 401. Indeed, in this case, the State's expert in anesthesiology and pharmacology testified that he has declined the request of certain states to make recommendations regarding the development of their lethal injection protocols on the ground that doing so would be unethical. Tab 42 at 33–35.

2. The district court's orders, affirmed by the Court of Appeals, directly implicate these ethical rules. The

district court ordered the parties to engage in a meet-and-confer process intended to result in “a modified protocol that reasonably addresses” petitioner’s health problems and to which both parties would stipulate. Tab 20 at 2. The parties ultimately reached an impasse and submitted their respective proposals to the district court for consideration. Tab 18; Tab 49. In its subsequent opinion, the district court made clear that the court expected petitioner to propose “specific, detailed, and concrete alternatives or modifications to the protocol” with “precise procedures, amounts, times, and frequencies of implementation.” Tab 3 at 11 (quoting Tab 16 at 3–4). And the Court of Appeals pointed to petitioner’s failure to meet that burden in rejecting his as-applied claim. Op. 82.

The ethical rules, however, constrained the evidence that petitioner could supply. Petitioner’s initial letter to the State made clear the quandary the district court’s order posed: “Counsel for Mr. Arthur are endeavoring to obtain further medical advice, *within the confines of ethical rules*, regarding timing and monitoring requirements” for the administration of midazolam. Tab 3 at 6 (quoting letter) (emphasis added). Petitioner’s attorneys then submitted a supplemental declaration from an expert physician, Dr. J. Russell Strader, Jr. See Supp. Decl. of J. Russell Strader, Jr., M.D., F.A.C.C. (Mar. 29, 2016), Tab 11. In that declaration, Dr. Strader made clear that ethical considerations sharply limited the advice he could provide in response to the Court’s order: “Under American Medical Association Opinion 2.06 [re-codified and amended as Rule 9.7.3], I am ethically prohibited from suggesting modifications to a lethal injection

protocol. Accordingly, I cannot opine regarding how the ADOC protocol should be modified.” Tab 11 ¶ 4.

The opinions Dr. Strader expressed were thus quite limited. Dr. Strader simply referred back to prior opinions he gave in this case about: (a) the general pharmacological effects of administering midazolam as the State’s protocol required (which would be “highly likely” to induce a painful heart attack), and (b) the fact that more gradual administration of midazolam could alleviate the inherent risks from a rapidly injected bolus dose of the drug, as required by the State’s present protocol. *Id.* ¶¶ 5–6. Dr. Strader also described the procedures used in a clinical setting to administer midazolam appropriately. *Id.* ¶¶ 7–9. Dr. Strader could not and did not suggest a detailed protocol for how to administer the drugs to account for Mr. Arthur’s unique medical conditions but also to bring about his death.

The ABA itself has recognized that no physician could ethically suggest the sort of detailed protocol the district court, affirmed by the Court of Appeals, required here. The State relied upon the expert testimony of Dr. Mark Dershwitz. *See, e.g.*, Tab 2 at 26–27. In this very case, Dr. Dershwitz sought out an ethical opinion from the ABA concerning the line between appropriate expert testimony and forbidden participation in an execution. Tab 17. In its response, the ABA stated “that providing expert testimony regarding the effects of specific pharmacologic agents . . . would be permissible in that you would not be making any recommendations as to the necessary pharmacologic agents needed to bring about death. In contrast, providing expert opinion on the relative effectiveness of different combinations of agents in bringing about death

would not be permissible in that providing such opinions constitutes a recommendation to the court or jury on a punitive matter.” *Id.* (emphasis in original). The ABA further emphasized its desire for “the public to clearly understand that board certified physicians specializing in anesthesiology are healers, not participants in executions.” *Id.* Consistent with that letter, Dr. Dershwitz refused to answer any questions regarding the relative effects of different drugs because doing so would violate ethical rules. Tab 42 at 7–8, 20, 31.

III. The Court of Appeals’ Decision Imposes A Nearly Impossible Burden On Prisoners And Raises Troubling Issues For The Medical Profession.

The Court of Appeals’ decision to affirm the district court essentially requires inmates to produce evidence that medical ethics rules forbid them from obtaining. The district court’s opinion itself makes clear the quandary it poses for inmates and for the experts who offer opinion testimony on their behalf. The district court noted Dr. Strader’s supplemental declaration, but disregarded it because it “failed to suggest how long to administer the prebolus protocol, how to determine when it has reached its intended effect, or even what would constitute the intended effect.” Tab 3 at 9 n.8. Of course, advice on such topics is precisely the “technical advice regarding execution” that Rule 9.7.3 forbade Dr. Strader to provide. Rule 9.7.3(i).

Amici take no position on the question whether, in the absence of expert testimony that Rule 9.7.3 forbids a physician from offering, a condemned prisoner in petitioner’s circumstances could ever meet the

Baze/Glossip standard to “identify an alternative [method of execution] that is ‘feasible, readily implemented, and in fact significantly reduce[s] a substantial risk of severe pain.’” *Glossip*, 135 S. Ct. at 2737 (quoting *Baze*, 553 U.S. at 52). But in resolving this case, this Court must be fully aware that condemned prisoners will not be able to offer the kind of expert testimony the district court effectively required Mr. Arthur to produce here. To the extent that the Court of Appeals interpreted *Baze/Glossip* to require that evidence, it held Mr. Arthur to an impossible standard.

The Court of Appeals’ decision creates a bias in favor of the state in method-of-execution litigation. *Baze* ruled that an inmate cannot establish a feasible alternative method of execution by pointing to procedures that would require medical professionals to violate ethical obligations, such as requiring an anesthesiologist to monitor the inmate’s anesthetic depth during the execution. *Baze*, 553 U.S. at 59-60. Such an argument, the Court held, is “nothing more than an argument against the entire procedure, given that” ethical rules “prohibit anesthesiologists from participating in capital punishment.” *Id.* *Baze* thus accepts the ethical rules as valid constraints on the evidence courts can consider in evaluating the available alternatives and prohibits inmates from tactically using those constraints to challenge their death sentences entirely through the guise of a method-of-execution claim.

It would be unfair to recognize the legitimacy of ethical constraints to block inmates’ method-of-execution claims but ignore those constraints when doing so favors the state. In particular, the state should not be allowed to defeat an inmate’s otherwise meritorious challenge

through the tactical ploy of inviting the district court to require the inmate to propose a step-by-step alternative procedure, which could only be done with the assistance of an expert medical professional. Rather, all that should be required is what petitioner here did: point to *available* evidence demonstrating that the state has potential alternatives that it could implement. Pet'r C.A. Reply Br. 24-25. Such an approach reasonably balances the burden this Court placed on inmates in *Baze* and *Glossip* with the practical reality that certain evidence is simply unavailable to inmates due to ethical rules governing medical professionals.

Finally, *amici* are concerned that the Court of Appeals' decision will have adverse consequences for members of the medical community. Most strikingly, approval of procedures like those employed by the district court and approved by the Court of Appeals in this case will place many physicians serving as experts in the difficult ethical quandary of either refusing to offer such opinions (thereby increasing the likelihood that an inmate will be executed under a protocol that is defective and that risks causing severe pain) or offering such opinions (and violating ethical rules and jeopardizing their licenses or board certifications). Further, similar orders in future cases may require physicians to engage in very difficult line-drawing to determine whether they can ethically provide an expert opinion regarding lethal injection or whether such an opinion crosses the line into prohibited "technical advice regarding execution." Rule 9.7.3(i). The possibility of such ethical conundrums could dissuade physicians from serving as experts in lethal injection cases in the first place, thus depriving the courts and litigants of appropriate expert testimony.

CONCLUSION

Amici respectfully submit that this Court should grant review to address an issue of exceptional importance to death penalty litigation nationwide: whether inmates are required to produce a detailed, alternative lethal injection protocol as a condition of meeting the alternative-method-of execution prong of the *Baze/Glossip* standard. The Court should determine that such evidence is not required. In resolving this question, the Court should also be mindful of the difficult ethical burden that orders like the one the district court issued here—with the blessing of the Court of Appeals—will place upon physicians called upon to provide expert testimony in lethal injection cases.

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