Executions and Torture: The Consequences of Overriding Professional Ethics

Michael K. Gottlieb
NOTE

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INTRODUCTION

Physicians often face conflicts between their professional duty of loyalty to patients and their concomitant responsibilities to third parties. These latter responsibilities may be to family members or to other parties interested in a patient’s welfare. Or they may take an economic form, as is increasingly reflected by the influence of health plans and other third-party payers in clinical decision-making.¹ A physician may have a responsibility to perform a court’s

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¹ See Marc Rodwin, Conflicts in Managed Care, 332 New Eng. J. Med. 640 (1995); see also Marsha R. Gold et al., A National Survey of the Arrangements Managed-Care Plans Make with Physicians, 333 New Eng. J. Med. 1678 (1995) (describing physicians’ financial and other incentives to withhold services from patients). Conflicts between professional duty and financial incentives are not new to the medical profession. They existed well before managed care was introduced in the United States. Indeed the ancient symbol of the physician and healing, the Staff of Asclepius (a simple rod adorned by a single serpent), has long been confused with and mistakenly replaced by the Caduceus of Mercury (Hermes), a winged staff wrapped in a pair of snakes. Hermes was also identified as “the patron god of thieves, merchants, and travelers . . . the god of games, luck, and commerce . . . [and] an ingenious deceiver.” See Robert A. Wilcox & Emma M. Whitham, The Symbol of Modern Medicine: Why One Snake Is More Than Two, 138 Annals Intern. Med. 673, 676 (2003).
request for a forensic evaluation or to perform actions on behalf of state institutions like prisons, which require specific duties of physicians that conflict with their traditional commitments. Or the responsibility may be to the military, whose ultimate goal is to protect the security of a population. In each case, a physician’s additional or peripheral responsibilities may divide her initial duty to patient care.

Military duties are often particularly difficult to reconcile with other personal, professional, or even legal duties. The history of judicial deference to the military in this country, embedded in the Constitution and known as the separate community doctrine, reflects our willingness to cabin military duties as both separate from other duties and, for the most part, unconditional. Perhaps it should not be surprising that when a service member believes a given order to be in conflict with his or her own moral value or ethical code, an available justification for otherwise unethical behavior is employed: The imposed military duty constitutes a separate responsibility, apart from those normally attaching to an individual in his or her “personal” life. If duties can be thus


4. See Rostker v. Goldberg, 453 U.S. 57, 64-65 (1981) (“[I]n no other area has the Court accorded Congress greater deference.”); see also Wallace v. Chappell, 661 F.2d 729, 732 (9th Cir. 1981) (“[T]he Supreme Court has voiced a general objection to judges ‘running the army’ . . . .” (quoting Orloff v. Willoughby, 345 U.S. 83, 93-94 (1953))), rev’d on other grounds, 462 U.S. 296 (1983); Joseph E. Broadus, Don’t Ask, Don’t Tell, Yes: Don’t Second-Guess the Military, 79 A.B.A. J. 54 (Oct. 1993) (noting that military policy has always been upheld in the courts because the special needs of the military require that the courts defer to expert military opinion).

5. This justification reflects what Gerald Postema refers to as a “schizophrenic” view of role morality, by which one “simply dissociates the private personality from the . . . professional
EXECUTIONS AND TORTURE

compartmentalized, one may consider himself free from personal responsibility for actions performed while operating in a specific and sanctioned role such as soldier, attorney, or physician. One may only be held professionally responsible and thus judged on the basis of shared professional ethical guidelines. It remains an open question how individuals ought to honor their personal values when professional duties require conflicting action, and much of the literature on role morality has focused on this question. The implications that follow from sacrificing one’s personal moral values for professional obligations can be disturbing, even if they are ultimately justifiable from a utilitarian perspective.

More disturbing, however, should be the apparent ease with which robust professional norms and duties in one profession can be suppressed in favor of those in another. Such has been the case with the medical profession and the military. The strong evidence that doctors ignored, justified, or even helped in the humiliation, degradation, and physical abuse of Iraqi detainees at Abu Ghraib has shocked many in both the medical and non-medical communities. Mounting evidence suggests that physicians falsified and delayed death certificates, shared detainees’ medical information with military interrogators, ignored abuse, and covered up homicides—all activities in contravention of international law and medical ethics. This Note argues that, while these activities were arguably


7. See M. Gregg Bloche & Jonathan Marks, When Doctors Go to War, 352 NEW ENG. J. MED. 3 (2005).

8. Id. (reporting that U.S. medical personnel: (1) failed to report evidence of detainee abuse and murder in Iraq and Afghanistan; (2) shared health information, including patient records, with army units that planned interrogation; (3) participated in interrogation that was tantamount to torture; and (4) medics and “others” neglected the clinical needs of some detainees. The Pentagon responded to the accusations of the International Committee of the Red Cross by denying allegations that detainee medical files were used to harm detainees.); see also, Robert Jay Lifton, Doctors and Torture, 351 NEW ENG. J. MED. 415 (2004); Benjamin Meier, International Criminal Prosecution of Physicians: A Critique of Professors Annas and Grodin’s Proposed International Medical Tribunal, 30 AM. J. L. & MED. 419 (2004).

9. “Doctors shall not countenance, condone, or participate in torture or other forms of degrading procedures . . . in all situations, including armed conflict and civil strife.” World Medical Association Declaration of Tokyo (1975), reprinted in THE BREAKING OF BODIES AND MINDS: TORTURE, PSYCHIATRIC ABUSE, AND THE HEALTH PROFESSIONS, at 272-73 (Eric Stover & Elena O. Nightingale eds., 1985). Though some of the activity also violated military laws, much of it did not.
outside the realm of military duties, they would not have been committed had medical professional norms been obeyed.

The abuse by non-medical reservists has attracted substantial Congressional and media attention\(^\text{10}\) centering on personal culpability and the individual transgressions of a few of those involved. The discussion of abuse by physicians and nurses, however, has been far less widespread. Additionally, the focus of discussion about caregiver abuse is often shifted to institutional problems stemming from the influential power of the military and its virtual non-reviewability.\(^\text{11}\) After all, if the Supreme Court of the United States defers to the judgment of the armed forces, why shouldn't a uniformed physician do the same?

The query itself reveals the answer in its implied understanding of the physician and her role. The physician in question is a professional who has been enlisted, recruited, hired or seconded like any other professional, to advance the goals of the military. She would seem not to have any discrete medical obligations that might challenge, much less override, those attached to her military duties. Her professional ethics are no more robust, supported, or recognized by the military or government than her personal ethics. Given the current status of medical professional norms and responsibilities in the military, which make them virtually indistinguishable from personal norms and responsibilities, a physician's complicity and involvement in "legal" but medically unethical activity in Iraq and Afghanistan should be no more surprising than the participation of non-medical military personnel who follow orders that later come under judicial review.\(^\text{12}\)

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\(^\text{10}\) See, e.g., Associated Press, Soldier Gets Closer to Abuse Retrial, N.Y. TIMES, May 25, 2005, at A8 (discussing the most recent covered event at the time of this writing, regarding the last of several trials to prosecute army reservists involved in the abuse of Iraqi detainees at Abu Ghraib).

\(^\text{11}\) Meier, supra note 8.

\(^\text{12}\) Whether the actions of those reservists prosecuted in connection with abuses at Abu Ghraib were the result of explicit or implied orders from military leadership apparently remains an open question. However, reservists involved in misconduct that were formally charged include, but are not limited to, the following: Spc. Charles Graner (sentenced to ten years and demoted to private), Sgt. Javal Davis (sentenced to six months, reduced to private and dishonorably discharged), Spc. Roman Krol (sentenced to ten months and bad conduct discharge), Staff Sgt. Ivan L. "Chip" Frederick, II (sentenced to eight and a half years, reduced to private and dishonorably discharged),
This view of the physician and her professional role as deferential to military norms, be they legal or not, is neither new nor unique. On the contrary, the disempowerment of medicine's professional role is a result of gradual degradation by courts and by physicians themselves over the past thirty years. It is perhaps surprising that certain institutionalized physician behavior has only recently caused widespread concern. The physician involvement at Abu Ghraib typifies a broader situation in which American physicians increasingly allow other duties or perceived duties to trump their ethical obligations to patients and to the profession. This Note focuses on one recent example of the degradation of a physician's core responsibilities—the forced medication of death row inmates for the purpose of executing them—as an example of factors leading up to the professional transgressions committed by physicians and nurses who otherwise represent the best of the medical profession through their service and sacrifice.

Underlying this analysis are two basic claims. First, the state has an interest in preserving, or at least not threatening, public trust in certain professions that benefit society. And second, medical professionals should be given greater


13. When physicians engage in behavior that is inconsistent with their professional code, they reify the misguided conception of their role. Physicians who give expert testimony to frivolous tort allegations fuel a dangerous growth in malpractice claims. See, e.g., Kathy George, Doctor Wants Fellow Doctor Suspended over Malpractice Testimony, SEATTLE POST-INTELLIGENCER, June 7, 2004, at B1. Similarly, those who engage in unethical behavior—even when it is legal—contribute to the degradation of important professional values.

14. In fact, abuse and misconduct by physicians should be of no less concern than transgressions in other professions. The past seventy-five years have borne witness to numerous atrocities in U.S. clinical and research medicine. A series of American medical abuses followed the Nazi experiments on prisoners during the Third Reich (1933-1945). See Belinda Seto, History of Medical Ethics and Perspectives on Disparities in Minority Recruitment and Involvement in Health Research, 322 AM. J. MED. SCI. 246 (2001).

15. The trust of military soldiers in physicians is also important. The role of the soldier requires that soldiers put their lives and safety at risk in all sorts of especially demanding ways. To be potentially subjected to harm by their own physicians may frustrate a soldier’s willingness to be potentially subjected to harm in warfare. If physicians are known to cause harm to enemies for the sake of national security, they may be perceived or known to cause harm to their countrymen when called on by the interests of national security.

16. Though not an obvious claim, this Note takes for granted the proposition that public trust in
deference in pursuit of their ethical obligations than other professionals by virtue of the nature of their work and its effects. The work of the physician involves particular vulnerabilities on the part of patients and carries the potential to elicit powerful and conflicting psychological and emotional impulses on the parts of both physicians and patients. Although it would be foolish to suggest that medical professional mores should always override competing values, the integrity of the medical professional role is of greater importance than is immediately apparent. Stronger support of medicine’s autonomy is called for, as well as a more formal structure of accountability for those who would violate the profession’s core values. A history of medical involvement in immoral activity, state-sanctioned or otherwise, demonstrates that abuse flourishes when physicians become morally detached from the interests of their patients. At the very least, judges and policy makers ought to attend more carefully to this phenomenon in their evaluations of medical ethical norms.

Recent medical jurisprudence has either ignored or denied a connection between patient-centered professional morality and responsible care giving.

the medical profession is worth preserving. Indeed, in some cases, government regulation takes general and specific notice of the importance of the doctor-patient relationship and its impermeability. The Medicare anti-kickback statute (42 U.S.C. § 1320a-7b(b) (2005)) and related regulations, for example, were enacted (and are currently enforced) to preserve the traditional role of the physician “to provide treatments . . . in the best interest of the patient.” Office of Inspector General, 59 Fed. Reg. 65,372, 65,376 (Dec. 19, 1994). They may serve the additional function of curtailing inappropriate or over-utilization, but that is a secondary purpose. See, e.g., Thomas N. Bulleit, Jr. & Joan H. Krause, Kickbacks, Courtesies or Cost-Effectiveness?: Application of the Medicare Antikickback Law to the Marketing and Promotional Practices of Drug and Medical Device Manufacturers, 54 FOOD & DRUG L.J. 279 (1999). As one commentator notes, “It must . . . be shown that the particular relationship and the particular kind and degree of [public] trust it promotes or engenders is, from the standpoint of morality, worth preserving.” Wasserstrom, supra note 6, at 35. Two questions arise out of Wasserstrom’s analysis. First, should a certain role exist? And second, if a certain role exists, should the occupant of that role do what the role, so constituted, requires? This Note focuses more on the second question than the first, which has been argued convincingly in the affirmative. See generally Ralph Cranshaw et al., Patient-Physician Covenant, 273 JAMA 1553 (1995); Ezekial J. Emanuel & Nancy N. Dubler, Preserving the Physician-Patient Relationship in the Era of Managed Care, 273 JAMA 323 (1995).

EXECUTIONS AND TORTURE

Courts' and legislators' inattention in this area degrades the integrity of a physician's professional role and its subsequent responsibilities. Physicians' obligations to non-therapeutic ends ought to be reconsidered in light of increasing role conflict faced by physicians and decreasing support from courts and legislators. Policies protecting physician autonomy in the ethical pursuit of the medical profession should be supported. And the primary duties of physicians employed by the state, whether in prisons, courts, or the military, should be clarified and protected by law.

Reasoning from a specific case to general policy, this Note discusses the involvement of physicians in the forced medication of a death row inmate against the backdrop of the abuse at Abu Ghraib, as well as the psychological dynamics of medical care, which have been all but disregarded in the discussion of physician responsibility to the aims of criminal justice and the military. This Note begins its analysis by reviewing Singleton v. Norris, a case that highlights the extreme conflicts of duty that physicians must face when their first-order duty to patient health is challenged and divided. It then reviews further court precedents on the issues raised by Singleton and critique the paradoxical concept of "medical best interest" that courts have imposed upon physicians. Next, it considers the conflict between the demands of common morality and professional ethics. Finally, this Note evaluates these competing claims from a consequentialist perspective and concludes by advocating for judicial recognition of the primacy of physicians' professional duties over competing claims.

I. SINGLETON V. NORRIS: PHYSICIAN-ASSISTED EXECUTION

On a warm summer night in Arkansas in 1979, a young man named Charles Singleton walked into York's Grocery Store in the small town of Hamburg and asked for a pack of cigarettes. When Mary Lou York turned around to hand over the cigarettes, Singleton showed his gun and demanded all the money in the register. Singleton fired the gun and missed, then stabbed Mary Lou York in the neck with a knife. Charles

18. The Oklahoma House of Representatives is, at the time of this writing, debating a bill that would prevent medical licensing boards from retaliating against state doctors and nurses who participate in executions in Oklahoma. See H.B. 2660, 50th Leg., 1st Sess. (Okla. 2006). The bill was requested by the State Department of Corrections following the refusal of two anesthetists in California to comply with a federal court order to anesthetize a death row inmate before lethal doses of medicine were administered. See infra note 60.

20. Id.
21. Id.
22. Id.
Singleton was prosecuted for robbery and felony murder. Evidence of his guilt was overwhelming and included blood on his clothes, as well as eye and ear witness accounts of the crime. Singleton was convicted and sentenced to death by electrocution in 1979 by the Circuit Court of Ashley County, Arkansas, for capital murder. He then remained on death row for longer than any other prisoner in the state’s history. He appealed through both the state and federal systems on procedural grounds, claiming ineffective assistance of counsel and invalid aggravating factors until 1998, after twenty years of appeals, when a new issue arose at the intersection of medical ethics, health policy, and law.

During Charles Singleton’s lengthy incarceration, he became psychotic and was diagnosed as likely schizophrenic. In 1997, the State medicated him involuntarily because he was found to be a danger to himself and others. He was subsequently granted a stay of execution by Arkansas’s Supreme Court. Assuming, arguendo that the medication was in Singleton’s medical best interest—as well the state’s best interest—at the time it was ordered, that rationale expired when Singleton’s stay of execution was dissolved. The Constitution requires that prisoners be mentally competent to be executed. No state may execute mentally retarded individuals or individuals who are insane.

27. Singleton v. Norris, 319 F.3d at 1021.
28. Id. at 1031.
29. Id. at 1021. Singleton had been intermittently medicated, sometimes voluntarily, during much of his stay in prison prior to 1997. Psychotropic medication was initially prescribed to alleviate anxiety and depression. Singleton did not present with psychotic symptoms until 1987. Id. at 1030.
32. Atkins v. Virginia, 536 U.S. 304 (2002). The governing standard for determining whether a prisoner is competent to be executed is that the Eighth Amendment forbids the execution only of those who are unaware of the punishment they are about to suffer and why they are to suffer it. Ford, 477 U.S. at 422 (Powell, J., concurring). The prohibition against executing inmates who are mentally retarded, therefore, rests on the presumption that mentally retarded individuals are incompetent to be executed because they are unaware of the punishment and its justification.
33. Singleton v. Norris, 319 F.3d at 1023. The Eighth Amendment precludes psychotic inmates from being executed only if they are unaware of the punishment and its justification. See supra note
The general legal standard is that the individual being executed understand the crime committed and the punishment prescribed. Thus, Singleton’s physicians were faced with a troubling dilemma. Charles Singleton would remain floridly psychotic if left unmedicated, suffering from hallucinations, delusions, and self-mutilation. But he would also remain alive. If he were medicated, he would be killed. The question before the Eighth Circuit Court of Appeals in Singleton v. Norris was whether a psychotic prisoner could be medicated without consent, even if his psychosis were the only factor keeping him from being executed by the state. The court ruled that a state does not violate the Eighth Amendment when it executes a prisoner who became incompetent during a long stay on death row, but who subsequently regained competency through forced treatment.

II. EXECUTION OF INCOMPETENT INDIVIDUALS: “A MISERABLE SPECTACLE”

The notion that it is inappropriate to execute incompetent individuals dates back to late fifteenth-century common law. Sir Edward Coke argued, for example, that “because execution was intended to be an ‘example’ to the living, the execution of ‘a mad man’ was such a ‘miserable spectacle . . . of extreme inhumanity and cruelty’ that it ‘can be no example to others.’” The Supreme Court recently made the following observation in Ford v. Wainwright:

[T]oday, no less than before, we may seriously question the retributive value of executing a person who has no comprehension of why he has been singled out and stripped of his fundamental right to life. . . . Similarly, the natural abhorrence civilized societies feel at killing one who has no capacity to come to grips with his own conscience or deity is still vivid today. And the intuition that such an execution simply offends humanity is evidently shared across this Nation.

The Court noted the prohibition against killing the insane does not merely “protect the condemned from fear and pain without comfort of understanding” but also “protect[s] the dignity of society itself from the barbarity of exacting mindless vengeance.”

32. Singleton, 319 F.3d at 1023.
34. Id. at 1027.
35. Id. at 1027.
36. State v. Perry, 610 So. 2d 746, 749 (La. 1992) (quoting 3 E. COKE, INSTITUTE 6 (1794)).
38. Id. at 410; see also Paul J. Larkin, Note, The Eighth Amendment and the Execution of the Presently Incompetent, 32 STAN. L. REV. 765, 777 n.58 (1980) (suggesting no societal retributive interest in executing persons who have no comprehension of why they have been singled out and stripped of their rights to life).
The Ford Court, therefore, deferred to an historical and "natural abhorrence" to such "barbarity," and found that the state interest for retribution did not overcome the rights of the condemned nor the dignity of society. According to the Court, the punishment becomes "mindless" when the person does not know the reason for which the punishment is being meted out. Additionally, the Supreme Court has required competency so that convicted individuals would have the opportunity to appeal. The procedural safeguards anticipated cannot be actively pursued if the individual is not competent. Some believe that competency is required for individuals to make peace with their God before death, or at least to come to terms with their death. Lastly, others have argued that it is inhumane to kill someone with severe disturbances of the cognitive capacities of consciousness, comprehension, or reasoning, regardless of whether these capacities rise to the level sufficient to participate in their own defense or to seek reconciliation in religion.

Clearly, this case presents a number of issues concerning the death penalty. The important question, however, for understanding physician behavior is what are, or what should be, doctors' duties to their patients, and in what manner the law should respect such duties. This Note aims to address the issues raised by Singleton's claim and to specifically discuss the ethical duty of a physician employed and instructed by the government to render care so as to effectively


40. This falls out of the Court's longstanding pronouncement that "[t]he fundamental requisite of due process of law is the opportunity to be heard." Grannis v. Ordean, 234 U.S. 385, 394 (1914).


42. Most state death penalty statutes currently allow or even require physician participation in executions. See Kenneth Baum, "'To Comfort Always': Physician Participation in Executions, 5 N.Y.U. J. LEGIS. & PUB. POL'Y 47, 73 n.81 (2001).
EXECUTIONS AND TORTURE

prepare his patient for execution. It will not address the ethics of execution as a criminal penalty in the United States, nor will it address the so-called Lackey claim made on behalf of individuals like Singleton who have been on death row for an extended period of time. It will, however, include a brief legal history of the issue with the intention of uncovering and introducing some of the professional ethical conflicts for physicians that contribute to the dilemma presented by the Singleton case.

III. LEGAL HISTORY: THE "MEDICALLY APPROPRIATE" REQUIREMENT

The Eighth Amendment bars executions of mentally-ill prisoners. And although the Supreme Court has decided several cases in which a criminal defendant or a convicted criminal may be medicated against his or her will, it denied certiorari on the Singleton case.

The Court has noted that a prisoner has a "significant liberty interest" in avoiding the unwanted administration of an antipsychotic drug. But there are cases in which the Supreme Court has allowed the state to forcibly medicate an inmate or criminal defendant without consent. In Washington v. Harper, the Court held that if an inmate is a threat to himself or others while incarcerated and if medication is also in his "medical interest," then the state may forcibly medicate without consent. The Court has also noted that a state may be justified

43. Singleton's defense did not include a priori Constitutional objections to the death penalty. Singleton v. Norris, 319 F.3d 1018 (8th Cir. 2003).
44. Claims that the Eighth Amendment would be violated by the execution of an inmate after many years on death row are called Lackey claims, following Lackey v. Texas, 514 U.S. 1045 (1995) (mem.) (Stevens, J., respecting the denial of certiorari). Such claims, while not yet ruled on by the Supreme Court, have gained support in international law and in dissents from the Court's denial of certiorari by Justice Stevens and Justice Breyer. See Jeremy Root, Cruel and Unusual Punishment: A Reconsideration of the Lackey Claim, 27 N.Y.U. REV. L. & SOC. CHANGE 281 (2001-2002); see also Soering v. United Kingdom, 161 Eur. Ct. H.R. (ser. A) at 44-45 (1989) (holding that extradition of a German national to Virginia in a capital case would violate the prohibition against "inhumane or degrading treatment or punishment" under the European Convention because of the likely length and extreme nature of confinement while on death row); Richard B. Lillich, Harmonizing Human Rights Law Nationally and Internationally: The Death Row Phenomenon as a Case Study, 40 ST. LOUIS U. L.J. 699 (1996) (examining the "death row phenomenon" as an example of the growing internationalization of human rights law, i.e., national courts looking to international norms, and international and regional bodies taking national court decisions into account).
48. Id. at 227.
in forcibly medicating an insane criminal defendant if it can establish that "it [cannot] obtain an adjudication of [a defendant's] guilt or innocence by using less intrusive means." 49

Non-dangerous criminal defendants may also be forcibly medicated if doing so will render them competent to stand trial and if doing so is "sufficiently important to overcome the individual's protected interest in refusing it." 50 In Sell v. United States, the Court found that the government had not shown a need for treatment without consent and reversed the Eighth Circuit's judgment on this issue. 51

The Eighth Circuit is the only federal court that has addressed the issue of whether the state can medicate an inmate for the primary purpose of carrying out his sentence once he has been found guilty. 52 In a sharply divided six-to-five decision, the Eighth Circuit held in Singleton that the Eighth Amendment, forbidding "cruel and unusual punishments," is not violated by forcibly medicating an insane condemned person so that he becomes sufficiently sane to execute. 53 The court held that the state could force a mentally ill criminal defendant to take antipsychotic medication in order to render him sufficiently competent to be executed. To reach this decision, it applied the same test that it used in Sell, which went uncontested by the Supreme Court on appeal: The state must: "(1) present an essential state interest that outweighs the individual's interest in remaining free from medication, (2) prove that there is no less intrusive way of fulfilling its essential interest, and (3) prove by clear and convincing evidence that the medication is medically appropriate." 54

A bare majority of the Eighth Circuit found that the government has a compelling interest in carrying out a lawfully imposed criminal sentence. It ruled that the state's interest in carrying out Singleton's sentence outweighed Singleton's interest in remaining free from medication. Even Singleton preferred to be medicated rather than unmedicated, so long as he was not going to be executed as a result. The court also found that no less-intrusive method existed

51. Id.
52. In Perry v. Louisiana, 498 U.S. 38 (1990) (per curiam), the Supreme Court was presented with the issue of whether the state, in its efforts to cure death row inmates, could force antipsychotic medication on them, but the Court remanded the case to Louisiana and has not resolved the question.
53. Singleton v. Norris, 319 F.3d 1018, 1027 (2003) ("A State does not violate the Eighth Amendment . . . when it executes a prisoner who became incompetent during his long stay on death row but who subsequently regained competency through appropriate medical care.").
54. Id. at 1024 (referencing United States v. Sell, 282 F.3d 560, 567 (8th Cir. 2002)) (internal quotations omitted).
EXECUTIONS AND TORTURE

by which the state could attain its end. Finally, the court found Singleton’s medication was medically appropriate and there was no need to factor the issue of execution into the consideration of Singleton’s medical interest. Because it was in Singleton’s short-term interest to be medicated, it satisfied the third prong of the Eighth Circuit’s *Sell* test.

Several problems have been noted in the Eighth Circuit’s ruling. Most troubling to physicians, however, is the problem noted in *State v. Perry*: “[F]orcing a prisoner to take antipsychotic drugs to facilitate his execution does not constitute medical treatment but is antithetical to the basic principles of the healing arts.” The physician who prescribes the drugs arguably violates medical ethical tenets of beneficence and non-maleficence.

The predominant legal question in Singleton’s case was whether the forced administration of antipsychotic drugs to render Singleton competent to be executed unconstitutionally deprived him of his “liberty” to reject medical treatment. But an equally important question, one more reflective of the medical-legal norms surrounding recent scandals in Iraq, Afghanistan, and Guantanamo Bay, is whether the same forced care deprives the medical profession of a right to set appropriate standards for ethical practice. And if not,


56. 610 So. 2d 746, 751 (La. 1992).

57. Four central principles (autonomy, beneficence, non-maleficence, and justice) have dominated the public health literature, though the two highlighted (beneficence and non-maleficence) in this discussion have a more robust historical footing in medical ethics. See TOM L. BEAUCHAMP & JAMES F. CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* (4th ed. 1994). Moreover, under these circumstances, the physician is re-cast in the role of punisher. The prisoner does not consent to the administration of the drugs, and if the primary reason for their administration is to carry out the condemned prisoner’s sentence (rather than, for example, the prisoner’s own medical benefit or the safety of fellow prisoners and prison staff), then the administration of the drug arguably becomes part of the sentence. It is no doubt a harm (at the very least a dignitary harm) to the patient. And if it is both a harm and part of the prisoner’s sentence, it constitutes punishment—punishment to which no court lawfully sentenced the prisoner.

58. U.S. CONST. amend. V. (stating that the government may not “deprive[]” any person of “liberty . . . without due process of law”).

59. One report indicates that, of the thirty-six states with death penalty statutes, at least twenty-one require a physician to “pronounce” or “determine” death. AM. COLL. OF PHYSICIANS ET AL., *BREACH OF TRUST: PHYSICIAN PARTICIPATION IN EXECUTIONS IN THE UNITED STATES* 49-72 (1994).
why not? When, if ever, should the law defer to a profession’s ethical standards and requirements? In other words, Singleton may not have had a compelling legal or ethical right to avoid execution, but his physician had not only a right, but an obligation to refuse to treat Singleton given the fatal consequences of that treatment and the potential consequences for the profession. One wonders how the Singleton case might have been argued or decided if it had remained before the court during or after the reports of physician involvement at Abu Ghraib had surfaced.

IV. PRECEDENT: THE OFFENSE PRINCIPLE

With more than twenty years of history and appeals, Singleton’s case is far more complicated than described thus far. But the central issue of when the state may and should forcibly medicate a person has been difficult for the courts to adjudicate. There is, however, some guiding case law. Several similar issues have come before the courts. In Washington v. Harper, which involved the forced medication of a prisoner in a correctional facility, the Supreme Court recognized that an individual has a “significant” constitutionally protected “liberty interest” in “avoiding the unwanted administration of antipsychotic drugs.” However, the Court, apparently guided by principles of harm and

available at http://www.hrw.org/reports/1994/usdp/breach_of_trust.pdf. In twenty-eight states, statutes or regulations require that a physician “shall” or “must” be present at the execution (an additional four states say a physician “may” be present and an additional three states say a physician “shall” or “must” be invited). Id. The researchers also found that some state laws, while vague on participation, are often interpreted so that a physician is directly involved in the execution. Id.

60. The physicians treating Singleton probably have an exercisable right not to treat him against his wishes, just as physicians are generally protected from professional activity that violates personal, moral, or religious values. See infra note 85 (discussing conscience clauses). In February 2006, for instance, two anesthesiologists refused to assist in a California execution after their presence was required by a district court judge. Louis Sahagun & Tim Reiterman, Execution of Killer-Rapist Is Delayed, L.A. TIMES, Feb. 21, 2006, at B1. This Note argues that, instead, physicians should have an obligation not to forcibly treat patients under these circumstances that, while not absolute, ought to be afforded greater deference by law and policy. It may be further argued that state medical licensing boards and societies should enforce the prohibition against which Singleton’s physicians transgressed by rescinding medical licenses from physicians who violate their professional ethics. At least one state legislature (Oklahoma) has anticipated this move by proposing legislation that would protect physicians from the disciplinary actions of licensing boards when physicians participate in executions. See H.B. 2660, 50th Leg., 1st Sess. (Okla. 2006).

61. As previously noted, Singleton did not present physicians’ professional obligations as a defense on his behalf.

paternity, concluded that the state law authorizing involuntary treatment amounted to a constitutionally permissible “accommodation between an inmate’s liberty interest in avoiding the forced administration of antipsychotic drugs and the state’s interests in providing appropriate medical treatment to reduce the danger that an inmate suffering from a serious mental disorder represents to himself or others.”

Singleton’s case differed from Harper’s in that the state’s interest extended beyond protecting Singleton and others from harm since it included a justice interest in carrying out a sentence for punishment. One might easily anticipate an argument on behalf of the state based on the Offense Principle claiming that an offense is committed against Singleton’s victims and their fellow citizens when Singleton escapes his sentence. An argument of this type can be found in another case—Riggins v. Nevada.

In Riggins, a case involving a defendant unfit to stand trial without treatment by antipsychotic medication, the Court decided that an individual has a constitutionally protected liberty “interest in avoiding involuntary administration of antipsychotic drugs” which only an essential or overriding state interest might overcome. The Court suggested that forced medication in order to render a defendant competent to stand trial for murder was constitutionally permissible. Citing Harper, the Court noted that the state “would have satisfied due process if the prosecution demonstrated ... that treatment with antipsychotic medication was medically appropriate and, considering less intrusive alternatives, essential for the sake of Riggins’s own safety or the safety of others.” The Court further noted that the state “might have been able to justify medically appropriate, involuntary treatment with the drug by establishing that it could not obtain an adjudication of Riggins’s guilt or innocence” of the murder charge “by using less intrusive means.” The question in Singleton’s case, then, may have been whether the execution of an individual is as “essential” or “overriding” a state interest as the adjudication of that individual’s guilt or innocence.

The Supreme Court’s rulings thus far point toward a constitutional permission granted to the government to involuntarily administer antipsychotic drugs to a mentally ill person if and only if, among other things, the treatment is

63. Id. at 236.
64. Riggins v. Nevada, 504 U.S. 127, 135 (1992) (stating that due process would have been satisfied in connection with administration of antipsychotic drugs to defendant during trial if state court had found that treatment was medically appropriate and essential for the sake of the safety of others).
65. Id. at 134-35.
66. Id. at 135.
67. Id.
medically appropriate, which the Court defines as "in the patient’s medical interest." 68

V. PRIMARY ETHICAL CHALLENGES

How can any treatment be considered in a patient’s best medical interest when the consequence of that treatment will be certain death for that patient? And what is meant by “the patient’s medical interest”? Should one view the determination of that interest as guided only by the narrow medical evaluation of health before and after treatment? Clearly, the concerns of most physicians will be that while the patient may benefit from treatment in the short term, the secondary result will be death, which is decidedly not in the patient’s best medical interest. Physicians are trained to view patients in light of their full medical history and underlying diagnoses as well as the current environment and situation in which they are evaluated. Physicians must include in their evaluations of treatments all likely effects—intended and incidental, immediate and eventual. 69 The Eighth Circuit disregarded this requirement by dividing Singleton’s medical interests into short- and long-term, and then by considering only the former.

As the four dissenting circuit judges indicated, the majority’s opinion,

leaves those doctors who are treating psychotic, condemned prisoners in an untenable position: treating the prisoner may provide short-term relief but ultimately result in his execution, whereas leaving him untreated will condemn him to a world such as Singleton’s, filled with disturbing delusions and hallucinations . . . [This] ethical dilemma . . . is not simply a policy matter; courts have long recognized the integrity of the medical profession as an appropriate consideration in its decision-making process. 70

Both the American Medical Association and the American Psychiatric Association have stated that participation in execution by physicians is unethical. 71 Most professional medical organizations share a broad view of what

68. Id.
70. Singleton v. Norris, 319 F.3d 832, 1037 (8th Cir. 2003).
71. “An individual’s opinion on capital punishment is the personal moral decision of the individual. A physician, as a member of a profession dedicated to preserving life when there is hope of doing so, should not be a participant in a legally authorized execution.” A physician may make a determination or certification of death as currently provided by law in any situation. AM. MED. ASS’N, CODE OF ETHICS: ANNOTATED CURRENT OPINIONS § 2.06 (1992) (adopted 1980); AM. PSYCHIATRIC ASS’N, ETHICAL CODE PmbI. § 1.4 (1992). In 1981, the World Medical Association
is meant by "participation." Generally, it is agreed that no physician should pursue a course of treatment that will result in or lead to a patient's death, be that treatment the proximal, secondary, or remote cause.

There may be exceptions to these guidelines, but when they exist they should be asserted explicitly. It is boldly disingenuous to claim that one's involvement in a patient's care ceases the moment a physician's labor is


72. The AMA's Council on Ethical and Judicial Affairs has defined physician participation in executions to include three categories of actions: (1) actions that "directly cause the death of the condemned," such as administering the lethal injection itself; (2) actions that "assist, supervise, or contribute to the ability of another individual to directly cause the death of the condemned," such as prescribing the necessary drugs; and (3) actions that "could automatically cause an execution to be carried out on a condemned prisoner," including determinations of death during an execution. Council on Ethical and Judicial Affairs, Council Report: Physician Participation in Capital Punishment, 270 JAMA 365 (1993).

73. One may further question what is meant by "treatment," and, specifically, what constitutes a doctor-patient relationship. What are the duties of a physician to an individual he sees for a forensic evaluation? It would be odd to presume that in the context of forensic evaluation confidentiality would be protected, but informed consent might still be required. In Singleton's case, there was no doubt among the parties that a doctor-patient relationship existed, though the law avoids defining the specific ways in which the scope of a physician's duty is narrowed in the prison setting. For a discussion of the history of physician participation in executions, see Baum, supra note 42.

74. The courts have employed a "double effect" argument by focusing on whether treating physicians ever intended to medicate Singleton for the purpose of executing him. In one of the district court's denials of a petition for habeas corpus, the court reasoned that no evidence could be found "that the actions and decisions of the medical personnel involved [in forcibly medicating Singleton] were in any degree motivated by the desire, purpose or intent to make Mr. Singleton competent so that he could be executed." Singleton, 319 F.3d at 1022 (quoting the district court, then reversed by the Eighth Circuit, which granted a stay of execution). This reasoning is as specious as the kind employed as a defense by physicians involved in torture. A physician called upon to evaluate a military prisoner for the purpose of interrogation can easily claim that his intent was unrelated to the interrogation or torture. Similarly, treating prisoners who have been tortured, without reporting the suspected abuse, may be justified because such a responsibility would fall outside the direct scope of the physician's duties as proposed. These claims must fail if physicians are to be held accountable to any reasonable professional ethical standard.
complete. Other values such as national security or public health and safety may override the physician’s duty to care for the patient, but in Singleton’s case the legal fiction employed was that physicians were caring only for the patient’s immediate medical condition and that their treatment was unrelated to its deferred consequences.

Such a fiction, while implausible, is not unprecedented. Singleton’s involuntary medication was legal under Washington v. Harper during a stay of execution, but became unethical once an execution date was set because treatment was no longer in the patient’s best medical interest. This was a novel issue for the courts, as the consequences of treating Singleton with antipsychotic medication affected his medical interests in a way that it did not affect Harper’s or Riggins’s. While serving a long prison sentence or standing trial may not have been in Harper’s or Riggins’s best medical interest, neither necessarily constituted a specific and certain medical harm. These claims failed in Singleton’s defense because they were made on behalf of the inmate-defendant and not the physicians. Limited to a balancing test between the justice of carrying out a lawful sentence and the liberty of an individual not to be forcibly medicated, Singleton’s argument ended up begging the question of why he

75. One common approach to the conflict presented by physician participation in executions has been the enactment of state legislation explicitly declaring that such participation does not constitute the practice of medicine. See FLA. STAT. ANN. ch. 922.105(6) (Harrison 2000) (“[F]or purposes of this section, prescription, preparation, compounding, dispensing, and administration of a lethal injection does not constitute the practice of medicine, nursing, or pharmacy.”); IDAHO CODE § 19-2716 (Michie 2004) (“[A]ny infliction of the punishment of death by administration of the required lethal substance or substances in the manner required by this section shall not be construed to be the practice of medicine . . . .”); 725 ILL. COMP. STAT. ANN. 5/119-5(g) (West 2002) (“Notwithstanding any other provision of law, assistance, participation in, or the performance of ancillary or other functions pursuant to this Section, including but not limited to the administration of the lethal substance or substances required by this Section, shall not be construed to constitute the practice of medicine.”); N.J. STAT. ANN. § 2C:49-3(a) (West 2005) (“Any imposition of the punishment of death by administration of the required lethal substances in the manner required by section 2 of this act shall not be construed to be the practice of medicine . . . .”); OR. REV. STAT. § 137.473(2) (2003) (“The person who administers the lethal injection under subsection (1) of this section shall not thereby be considered to be engaged in the practice of medicine.”); S.D. CODIFIED LAWS § 23A-27A-32 (Michie 1998) (“Any infliction of the punishment of death by administration of the required lethal substance or substances in the manner required by this section may not be construed to be the practice of medicine . . . .”); WYO. STAT. ANN. § 7-13-904(a) (Michie 2001) (“Administration of the injection does not constitute the practice of medicine.”). Additional measures have recently been taken by at least some legislators, who have introduced legislation that would protect physicians who participate in executions from disciplinary action by state medical licensing boards. See, e.g., H.B. 2660, 50th Leg., 1st Sess. (Okla. 2006).

EXECUTIONS AND TORTURE

should not be treated. It asserted that he should not be treated because doing so would lead to his execution. And it claimed that he should not be executed because execution was only possible after treatment. It is doubtful that the Supreme Court in its discussion of “best medical interests” intended that criminals should be protected by the state from the very actions that the state imposes upon those individuals. Of course execution is not in the patient’s medical best interest, but in this case the state does not have that kind of medical interest in mind.

Because Singleton was tried for his crimes, convicted, and sentenced, to claim a right not to be forcibly medicated because it would result in the very punishment to which he had been legally and ethically sentenced seems illogical, unreasonable, and unethical. If one accepts, arguendo, the justice of the legal proceedings and their ultimate sentence, one is compelled to evaluate Singleton’s desire not to be treated on the same core grounds as anyone else’s desire not to be treated. One ought not be swayed by the result of the decision to forcibly treat only because one believes that result to be unfortunate. Unfortunate though it may be, it has been accepted as just. In other words, Singleton’s autonomy claim against forcible medical treatment is weak because it is predicated on a desire to avoid consequences that he has no right to avoid.

Therefore, the realm of potential ethical challenges posed by the first question, regarding the threat to Singleton’s liberty by forced medication, seems rather limited. In a sense, the competent Singleton has made himself inaccessible and has left in his place an insufficient proxy, the psychotic Singleton. It may be unreasonable to suggest, therefore, that Singleton is being unfairly harmed by medication that will restore his sanity. In this view, it is Singleton who sacrifices his own autonomy and liberty interests when he sacrifices sanity for psychosis. Of course psychosis is not voluntarily acquired, but the decision to remain psychotic is voluntary when it is made by a patient with full, if temporary, competence.

More compelling and appropriate to the balancing of competing social values were the interests of the physician and the medical profession. The second legal question, then, was whether the forced care of Singleton deprived the treating physician or physicians of a right to practice medicine within their profession’s ethical framework and guidelines. It is this question that would have been more productive from the perspective of all stakeholders, except the prosecution.

Implicit in this legal question are two ethical questions: Should physicians ever treat a patient when such treatment is not only without the patient’s consent but also not in the patient’s best medical interest? And do the state’s justice interests ultimately trump those of the physicians?
The question Singleton's case presents for physicians may be seen as a conflict between a common morality and a professional ethic. Viewed in that light, the moral dilemma resembles that of Tarasoff v. Regents of University of California. In that case, the California Supreme Court held that in certain limited circumstances, when a physician determines or should have determined that her patient presents a serious danger of violence to another, she incurs a duty to use "reasonable care to protect the intended victim." If she fails to use such care she may be liable for tort damages.

The common morality goal in Tarasoff of protecting potential victims from harm was judged by a majority of the presiding court to outweigh the reasonable and valuable professional ethic of confidentiality and undivided commitment to the patient. Should we be guided, then, by the majority in Tarasoff when they concluded that the "protective privilege ends where the public peril begins?" Should Singleton's right to liberty end only where public peril begins? More importantly, should the descriptive ethics of a professional code be honored only until such time as it creates or assists some kind of public threat, ranging anywhere from menace to peril?

Even the ethical guidelines of psychiatry, a profession historically supportive

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77. Bassanio's bootless plea to Portia in the trial scene. WILLIAM SHAKESPEARE, MERCHANT OF VENICE act 4, sc. 1.
79. Id. at 340. The facts of Tarasoff were as follows: Poddar, a University of California graduate student, told his therapist that he intended to kill Tatiana Tarasoff, a young woman whom he had previously dated. The therapist consulted with his supervisor and then contacted the campus police who questioned Poddar and released him once he promised to stay away from Ms. Tarasoff. Two months later, Poddar went to Ms. Tarasoff's home and killed her. Subsequently, her parents filed suit on a variety of tort theories, including the failure of Poddar's therapists to warn Ms. Tarasoff's parents that Poddar was a "grave danger" to their daughter. Id. at 339-41.
80. See id. at 342. In its second decision in the case, the California Supreme Court found that a "duty to protect," rather than a "duty to warn," exists:

when a therapist determines, or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger. The discharge of this duty may require the therapist to take one or more of various steps, depending upon the nature of the case. Thus it may call for him to warn the intended victim or others likely to apprise the victim of the danger, to notify the police, or to take whatever other steps are reasonably necessary under the circumstances.

Id. at 340.
81. Tarasoff, 551 P.2d at 347.
of strong professional autonomy, ultimately yield to a common morality represented by law. The Ethical Guidelines for the Practice of Forensic Psychiatry of the American Academy of Psychiatry and Law (AAPL), for instance, clearly state that “substituted consent” may be obtained “in accordance with the laws of the jurisdiction,”\(^8\) suggesting that the profession’s ethical guidelines readily yield to the law of the land, whatever it may be. According to AAPL, it would seem that if the courts decide that forcible medication of a psychotic person is legal, then the physician is ethically free and perhaps obligated to act in accordance with that decision, regardless of whether it is in the medical interest of that patient. This represents the unjustified resignation of professional morality to legislative fiat without any regard or concern for potential harm. In fact, by excusing actions when they are sanctioned by law, the AAPL has willingly aligned itself with any practice a legislature may approve. The potential for unwitting collusion is great. The obvious point is that “[t]he law is not the repository of our moral standards and values, even when the law is directly concerned with moral problems. . . . From the fact that something is legally acceptable, it does not follow that it is morally acceptable.”\(^8\)

Physicians have historically taken their moral guidance from the maxim *primum non nocere*, meaning “Above all, do no harm.” As W. D. Ross suggests, a prima facie obligation must be fulfilled unless it conflicts on a particular occasion with an equal or stronger obligation.\(^8\) The physician has no obligation to punish. His obligation is to provide care. It should be his first, if not only, obligation.\(^8\) When a physician enters a treatment relationship with a patient, his

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83. *Id.*


85. Of course physicians are also citizens whose professional obligation is one of many. A physician may feel compelled by certain moral and religious obligations, in which case she may be able to legally avail herself of conscience clause protection. See Church Amendment, 42 U.S.C. § 300a-7 (West 2002); IND. CODE § 16-34-1-4 (Michie 2002); KY. REV. STAT. ANN. §311.800 (Lexis 2001); VA. Code Ann. § 18.2-75 (Lexis 2002). See also J. Andrew West, Defining the Limits of Conscientious Objection in Health Care, NEWSL. ON PHIL. & L. (Am. Phil. Ass’n, Newark, De.), Fall 2005, at 25. But in balancing her obligations to patient and her conflicting moral and religious obligations, a physician ought to be required to refer patients in need to other physicians. While a physician may feel precluded from rendering certain types of care, and may even feel compelled to counsel a patient against what she believes to be immoral actions, she ought to assist her patient in finding appropriate care, so long as it is within the boundaries of standard practice among her colleagues. A physician who objects to abortion on moral or religious grounds ought nonetheless to assist her patient in finding a capable physician elsewhere. To do otherwise would be to take advantage of a patient’s dependency. Some physicians may feel compelled by other duties to
role is clear. He must treat the patient. Any obligation the physician may have to contribute to a wider social justice does not, a priori, outweigh the obligation to provide care to the patient. If such a competing value were accepted, such as a duty to create greater societal justice, it might be considered unethical for physicians to treat and care for murderers, rapists, and enemies of the state.

Some suggest, however, that the physician can step in and out of her role without difficulty. This position is extremely problematic. Physicians may refuse to enter a doctor-patient relationship, and such is the case of physicians who take advantage of conscience clauses, which excuse them from the legal
counsel patients against what they believe to be immoral actions (e.g., abortion, risky sexual behavior, unnecessary or cosmetic medical procedures, refusing to donate blood, bone marrow, or organs to a family member in need), but their influence should extend no further than that counsel. The enormous influence physicians have over their patients by virtue of the entrenched and implicit norms of the doctor-patient relationship warrants caution. A physician's influence may be used appropriately in communicating medical advice—as that is the task for which the physician is trained and qualified, and (more importantly) for which the patient seeks a physician out. Offering moral guidance is a primary duty of a clergyperson, not a physician. Again, this is in part because of a clergyperson's experience and training in both ethical decision-making and counseling congregants on moral issues, but more importantly, the clergyperson's influence in that area (ethics, religion, and morality) is implicitly recognized when his or her counsel is sought by a congregant or parishioner.

86. The sufficient elements for a treatment relationship are unclear. Viewed in the context of professional responsibility, one may find a treatment relationship when a medical professional brings his or her medical skills and talents to bear. A physician is not compelled to do so—doctors are free to contract at will. Nor are they compelled to act, always, as physicians. A witness to a crime, for instance, who happens to be a physician, is under no obligation other than those that would attach to non-physicians. But if they bring medical skills, which they are licensed by the state to use, to a task, they should be responsible to at least the core values of the profession. Health organizations as well as professional medical organizations generally interpret treatment and physician responsibility for care broadly. In the case of domestic violence, for instance, the physician's duty is often read to include preserving health not just in the narrow context of the patient's clinical presentation, but in his or her activity beyond the observation room. See, e.g., Council on Ethical and Judicial Affairs, Physicians and Domestic Violence, Ethical Considerations, 267 JAMA 3190 (1992).

responsibility to treat under circumstances that violate their religious or moral beliefs. If, however, a physician does treat an individual with medical care, a doctor-patient relationship necessarily exists. If the rules and role definitions surrounding the doctor-patient relationship are meant to protect both individuals from potential consequences of the treatment relationship, then what other than treatment would be sufficient criterion for the relationship to exist?

VII. THE CONSEQUENTIALIST APPROACH

Consequences of forced medication include the preservation of effective justice. In the case of Singleton, a guilty man will be punished, his victims will be avenged, and the circle of justice will be complete. On the other hand, forced medication weakens the integrity of physicians’ autonomy and professional ethics. Doctors will participate in the execution of their patients against their patients’ wishes and without legal recognition of their professional values. Is this, then, truly the best utilitarian outcome?

The deterrent function of criminal justice relies on the perception that sentences are carried out. Perceived weaknesses in the system may weaken its effectiveness. The relevant adverse consequences of this particular action are, however, extremely limited. It is not the criminal justice system, en toto, that is being obstructed or impeded. Rather it is the prescribed justice in a particular case in which a certain punishment—the most severe the system allows—is undeliverable. Further, Charles Singleton never attempted to fully escape punishment. He was incarcerated without parole. He was suffering. While he

88. See supra note 85.

89. Physicians are often called upon by courts to treat individuals, in which case a doctor-patient relationship does exist and all values that normally attach to the relationship (e.g., confidentiality) should be respected. See, e.g., Pettus v. Cole, 57 Cal. Rptr. 2d 46 (Ct. App. 1996) (finding a physician’s duty of confidentiality to be inviolable beyond description of “functional limitations” in response to an employee’s request for disability leave).

90. The research context, as well as that of forensic evaluations, provides difficult and useful cases. In both, though a doctor-patient relationship is understood not to exist, it is helpful to consider which responsibilities remain (e.g., informed consent, do no harm), and which do not (e.g., confidentiality). The military context provides a third and more difficult example. In this case, as with many prompted by the military, extraordinary deference has historically been granted. Once an individual’s body is not her own (which must be the case either when an individual voluntarily joins the military or when she is drafted), individual autonomy has been so seriously compromised that patient autonomy can no longer be plausibly respected. Following the same reasoning, a physician’s autonomy may be no more robust than a patient’s, if they are both soldiers of the state. It may, then, only be professional autonomy, granted by states through the licensing of medical practice, that preserves important social and ethical obligations in the military context.

91. Singleton’s Eighth Circuit appeal was not a challenge to the validity of his conviction or
continued to live, he did so in a psychotic state. With regard to the potential weakening of deterrent values, the number of cases involving a death row inmate who is insane and has refused to be treated medically for his mental illness is likely to be insignificant. The integrity of the justice system was not, therefore, practically threatened in this case.

The ruling in *Singleton* more substantially affected the integrity of the medical code. First, Singleton’s treating physicians were instructed to act in a professional capacity that was not in their patient’s medical best interest. They arguably violated the most sacred provision of their professional code. More important, however, is the potential effect of this ruling on the medical community. A precedent was set establishing the state’s right to order a physician to treat a patient not only against the patient’s expressed wishes, but also against the physician’s best medical judgment, her professional code of ethics, and her prima facie responsibility to do no harm. The consequences of such a precedent are broad. They can be read into the debate over physician-assisted suicide,92 the duties of military physicians, forensic evaluation, and palliative care.

This narrow interpretation of a patient’s medical best interest favored by the Eighth Circuit renders the value of professional medical duties meaningless. If a physician’s duty extends no further than the immediate effect of treatment rendered, without regard to any consequences, then the physician “involvement” in interrogation and abuse at Abu Ghraib, Guantanamo, and in Afghanistan was not illegal. So long as a patient leaves a physician’s presence unharmed, it would seem that no misfortune that befalls him outside the doctor’s office should be of any concern to the physician. The argument is based on a “see no evil, hear no evil” logic of ethics. To restrict professional duties and obligations to the intent of the practitioner is to all but eliminate the concept of professional role morality. The effect of such a restriction can only be the reduction of professional responsibility to the scope of individual personal responsibility. Insofar as no individual ought to intentionally cause harm to another, the role morality of physicians ought to establish a higher standard of care, one which ought to be supported in law. Once physicians are permitted to deliver care that does not

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92. In its recent decision overruling Attorney General John Ashcroft’s challenge to Oregon’s Death With Dignity Act, the Supreme Court did not reach the issue of whether allowing physician participation in suicide would invite consequences to medical practice against the public interest. Gonzales v. Oregon, 126 S. Ct. 904 (2006). However, the American Medical Association (AMA) supported the Attorney General’s position with just such an argument. *Id.* at 932 (citing Attorney General). The AMA held a similar position in an earlier case. Indeed, in Washington v. Glucksberg, 521 U.S. 702, 731 (1997), the AMA determined that “[p]hysician-assisted suicide is fundamentally incompatible with the physician’s role as healer.”

374

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EXECUTIONS AND TORTURE

preserve life and health, by order of the state, by request from patients, or by their own will, the nature of the profession and of the work of a physician changes. Courts have often favored this line of reasoning, but only when it serves other public policies, like those disfavoring physician-assisted suicide\(^9\) or those aimed at pro-competition business models in health industries.\(^9\)

Even if the Singleton Court conceded that given these particular circumstances forced treatment is ethical, treatment still should not have been permitted. The moral acceptance of an act does not sufficiently justify the act.\(^9\)
Though justice may be best served by restoring Singleton to sanity—even if for the sole purpose of executing him—the decision so adversely affects the integrity of medical practice that the otherwise moral act should be avoided. Just as active euthanasia may be morally justified when patients experience extreme, uncontrollable, and unremitting pain, it may be ethically appropriate to nonetheless restrict physician-assisted suicide because of the difficulties involved in controlling abuses of the practice.

Of greater concern, however, will be the further complication of the already burdensome psychological task of the physician, addressed in Part IX, and the consequences of that complication. The strongest utilitarian argument against allowing physicians to ignore medical ethical norms is based on a psychological understanding of the inherent aggression in medical practice, which will be explored below. This Note argues that there exists a consequent need to rein in that aggression, which may be otherwise unleashed through practices like those that Singleton approved. By demanding, requesting, or even allowing physicians to participate in activity that is known to end a patient’s life, even if indirectly, courts and legislators are interfering with a delicate but important balance between harmful and helpful behavior that healers have maintained for many years.

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93. See, e.g., Vacco v. Quill, 521 U.S. 793 (1997); Cruzan v. Dir., Mo. Dep’t of Health, 497 U.S. 261, 278-80 (1990); Id. at 287-88 (O’Connor, J., concurring); George Annas, The Bell Tolls for a Constitutional Right to Physician-Assisted Suicide, 337 New Eng. J. Med. 1098 (1997). Palliative care, in these cases and their precedent, stands in for euthanasia, all seemingly in deference to the physician’s code. This is not so in Singleton’s case.

94. See, e.g., 42 U.S.C. § 1320a-7b(b) (1994) (prohibiting improper payments in connection with the delivery of items or services covered by a number of federal health care programs). Additionally, courts have often recognized legal duties outside of the doctor-patient relationship that attach by virtue of a particular relationship. See, e.g., Craig v. State, 155 A.2d 684 (Md. 1959) (parents to child); Territory v. Manton, 19 P. 387 (Mont. 1888) (husband to wife).

95. In other words, rule utilitarianism is to be favored in this case over act utilitarianism.
The prohibition against physicians’ participation in death has ancient roots. The Hippocratic Oath disavows this participation, which has been interpreted by many to be a prohibition against physician-assisted suicide, euthanasia, and involvement in executions. The National Catholic Bioethics Center has rewritten the passage as follows: “I will neither prescribe nor administer a lethal dose of medicine . . . nor counsel any such thing nor perform act or omission with direct intent deliberately to end a human life.” Though arguably valuable to contemporary medical ethics, this interpretation of the original prohibition is dubious. Ancient Greece practiced capital punishment. And although there is no record of whether physicians participated in executions, the rule does not seem to have been relevant to the prohibition against giving “deadly drugs.” Rather, it most likely addressed fears that physicians would collaborate with murder by poisoning. Appeals, therefore, to ancient values to support a contemporary prohibition against physician involvement in executions are ultimately unconvincing. Furthermore, the Supreme Court has clearly indicated that it shows little deference to the Hippocratic Oath in guiding its constitutional interpretation.

More convincing are appeals to another ancient value, one that has been historically misattributed, though not misinterpreted. The paramount principle in Western medical ethics is, and has been, “Do No Harm.” But where did this principle come from and what does it mean? The idea is often incorrectly attributed to the Hippocratic Oath, but neither the Oath nor any Greek medical treatise contains any such phrase. The closest idea appears in Epidemic I: “Practice two things in your dealings with disease: either help or do not harm the patient.” It is unclear how or when “First, do no harm” came to be attributed to...
EXECUTIONS AND TORTURE

Hippocratic medicine or how it became the paramount principle. Its history, however, reveals the medical norms our current jurisprudence threatens to degrade. Steven Miles traces the idea to 416 B.C.E., about the time the Hippocratic Oath was written, at which time Nicias, an Athenian general and politician, spoke against what he accurately judged would be a disastrous military expedition to Sicily. He called upon the chair of the Athenian Council to "be the physician of your misguided city... the virtue of men in office is briefly this, to do their country as much good as they can, or in any case no harm that they can avoid."\(^{104}\)

The analogy is striking. To compare a physician to a military leader illuminates the inherently aggressive nature of medical practice and the need to temper aggressive impulses with virtuous principles. It is remarkable to think that the most well known tenet of medical ethics originated from a restraint directed against explicitly hostile activity and not simply well intentioned risk as it has come to be used. As Steven Miles notes,

First do no harm... is of overrated utility.

All therapies entail risk. A physician could not perform any surgery or administer any drug (even one dose of penicillin that could cause a lethal allergic reaction) if he or she was obliged to avoid the chance of harm. The pursuit of therapy—any therapy—represents a decision that the probability and magnitude of benefits outweigh the chance and severity of harms. This clinical calculation accepts risks rather than avoiding them.\(^{105}\)

Yet it is worth recognizing the original meaning of the principle, especially when one frames the guidelines within a psychoanalysis of the practice of medicine.

IX. MANAGING CONFLICT AND AGGRESSION: A PSYCHODYNAMIC ACCOUNT

Why should a prohibition against aggression by a physician be so entrenched in the history of modern medicine? Regardless of its history, non-maleficence has persisted as a guiding principle of clinical medicine longer than any other\(^{106}\) and often undergirds denunciations of physician involvement in human rights

do no harm' (Hippocrates [1923a]). Jonsen notes that the Greek text does not contain the words "at least." Albert R. Jonsen, Do No Harm, 88 ANNALS INTERNAL MED. 827, 828 (1978).

103. BEAUCHAMP & CHILDRESS, supra note 57, at 144.


105. Id. at 144.

106. For an exhaustive account of the four principles (autonomy, beneficence, non-maleficence, and justice) approach to medical ethics, see RAANAN GILLON, PRINCIPLES OF HEALTH CARE ETHICS pt. 1 (1994).
abuses and capital punishment. But why should this one value be so important as to outweigh all others that may inform a physician’s decision-making? The answer reveals a potent conflict in the physician’s work that the courts have generally not understood or perhaps not valued.

This conflict is what Robert Burt calls the ubiquitous feature of medical practice: Helping patients frequently involves inflicting bodily harm, such as cutting them open, penetrating them with painful needles, catheters, or diagnostic scopes, or invading them with near-poisonous chemicals or radiation. To carry out these various iatrogenic invasions, physicians must overcome deep-seated inhibitions inculcated in everyone from early childhood. One of the implicit agenda items in initial medical training is to encourage and assist fledgling physicians to transcend their inhibitions (as in their dealings with cadavers, their so-called ‘first patients,’ in Gross Anatomy Laboratories). Many techniques are offered for this purpose, most notably, the fervent belief that patients are helped to restored health and prolonged life by all medical practice, no matter how horrific particular medical interventions might appear to patients or to physicians.

In almost every profession, there is a cardinal prohibition. While many professional transgressions may be tempting, and some more devastating than others, there is often one transgression that each profession tends to regard as most important. In most cases, the prohibition is against some transgression that, while devastating to the profession, is simultaneously seductive and not easily avoided by the professional. For the legal field, perhaps the prohibition against lying is paramount because of the ease and appeal to do so in an adversarial setting. While stealing a client’s assets may have equal or even worse practical consequences, the temptation to steal is no greater for a lawyer because of his role. It may, however, be of greater temptation for an accountant because of her role. For the clergy and for therapists, perhaps abuse of power in the relationship between clergyman and congregant or therapist and client is the ultimate transgression because of its adverse effects and also because of the strong pull toward such a transgression that must be consciously avoided. It is the nature of the role in these cases that provides the special opportunity for

108. See AM. MED. ASS’N, supra note 71.
111. See, e.g., CONFLICT OF INTEREST IN THE PROFESSIONS (Michael Davis & Andrew Stark eds., 2001).
EXECUTIONS AND TORTURE

particular maleficence. For physicians, there is a special opportunity for, and a strong—if largely unconscious—pull toward, aggression.\textsuperscript{112}

Much has been written about physicians and psychological conflict, particularly around feelings of aggression.\textsuperscript{113} Frederick Hafferty’s close observation of medical students and physicians is one of the most notable contributions to this discussion.\textsuperscript{114} In one series of interviews, Hafferty asked medical students near the conclusion of their first year laboratory experience whether they would donate their own bodies to medical schools for educational purposes. What is most interesting about the answers he recorded is the kind of language used by students: “One cannot help but be struck by the symbols of violence and destruction. Answers rarely contained such scientifically neutral terms as dissection, probe, and pick. In their place emerged more physical, graphic terms: slash, rip, pull apart, hack.”\textsuperscript{115}

This language of aggression was only present at the end of a lengthy interview and only when students were asked to put themselves in the place of the cadavers with which they had been working. Only then could these students acknowledge the inherently violent nature of medicine.\textsuperscript{116} The transgression of deep taboos about respect for bodily integrity has always accompanied the duty of the physician, and yet is rarely, if ever, discussed or acknowledged.\textsuperscript{117} In fact, from surgery to psychiatry, the practice of medicine is invasive, aggressive, and likely accounts for the often detached, or asocial, behavior that traditionally characterizes practitioners.\textsuperscript{118} Perhaps this is one explanation for some physicians’ tendency to depersonalize their encounters with patients. The stereotype of the arrogant surgeon, who has no interaction with his patient and views the body on the table not as a person but as an object, is likely rooted in this psychological conflict. And it is an implicit and historical recognition of this unconscious conflict that underlies the profession’s undeterred commitment to principles of beneficence and non-maleficence.

In 1964, Anna Freud addressed medical students at Western Reserve Medical School on the subject of what may dispose or predispose children to a later career in medicine. Drawing from her vast experience with children, she

\begin{footnotes}
\item[113] See \textit{id.}; see also BURT, supra note 109; JAY KATZ, THE SILENT WORLD OF DOCTOR AND PATIENT (Johns Hopkins University Press 2002).
\item[114] HAFFERTY, supra note 112.
\item[115] Id. at 123.
\item[116] BURT, supra note 109, at 92.
\item[117] HAFFERTY, supra note 112.
\item[118] Id.
\end{footnotes}
discussed the role of aggressive wishes and impulses in medical practice:

\[ T \]he child’s wish to help and to cure is . . . very close to the wish to hurt and to maim. The younger the child, the stronger his wish to hurt. The older and more socially adapted he becomes, the more this aggressive wish can be submerged under a strong urge to help.  

Some unconscious “work” is required for the physician to suppress the overwhelming feelings of guilt that would otherwise be associated with aggressive wishes sublimated through medical practice. In other words, for a surgeon to cut into the flesh of a fellow human being, he must depersonalize the object and rest assured that his actions are curative, and will not harm. A physician’s ability to do his work, therefore, is crucially based on the knowledge that that work, however antagonistic it may feel or appear, is for the patient’s benefit and health. To challenge that premise of medical professionalism is to introduce justification for harmful acts done by physicians consciously or unconsciously. More immediately, it is to threaten the public trust in medical practice.

X. THE SOCIAL PSYCHOLOGY PERSPECTIVE

For years, evidence from social psychology has demonstrated that minimal but incremental degradation of social and professional norms can lead to extreme and otherwise unexpected abuse. The famous experiments conducted by Stanley Milgram revealed the elements sufficient to turn “normal” people into executioners. In the early 1960s Milgram designed a series of experiments at Yale University to test subjects’ obedience to authority. Three of the most


121. Milgram, supra note 120, at 13. Subjects were instructed by a confederate—a “legitimate” authority figure—to give electric shocks to a “victim” whom they could not see. The confederate ordered the subject to give increasingly larger, potentially fatal, shocks to the “victim.” Though many of the subjects had reservations, they nevertheless followed orders and administered the shock. Id. at 42. The victim acted as though he had been shocked, sometimes crying out in pain and begging for the subject to stop, though in actuality, and unbeknownst to the subject, the victim had not been shocked. Id. at 22-23. Sixty-five percent of the “teachers” obeyed orders to punish the learner to the very end of the 450-volt scale. Id. at 35. The last two voltage levels were marked “XXX” and were administered after the “learner” had screamed out in protest, complained of a heart condition, and eventually gone silent. Id. at 28. In advance of the study, 39 psychiatrists were
important elements of these experiments were: (1) the minimal initial compromises made by subjects to their own sense of responsibility; (2) vague rules and boundaries; and (3) the re-labeling of roles. In the Milgram experiment, individuals were asked to minimally harm others who they were led to believe were fellow subjects, but were actually confederates in the experiment. Their instructions and obligations were vague and the person asked to administer lethal shocks was re-labeled as the helping “teacher.” Milgram’s experiment powerfully demonstrates the ease with which personal duties toward others can be abandoned in exchange for the identification with an “official” (especially institutional) aggressor.123

Phillip Zimbardo’s famous Stanford Prison Experiment further demonstrates the power of roles and individual transformation in obedience to prescribed role obligations.124 One guard wrote in his diary before the experiment, “[a]s I am a pacifist and nonaggressive individual, I cannot see a time when I might maltreat other living things.”125 By day five of the experiment, this same student wrote the following in his diary:

This new prisoner, 416, refuses to eat. That is a violation of Rule Two: “Prisoners must eat at mealtimes,” and we are not going to have any of that kind of shit . . . . Obviously we have a troublemaker on our hands.

asked how many subjects might administer all 450 volts. Id. at 27-30. The estimate was one in one thousand. Id. at 31. In the first experiment, none of the 40 subjects stopped before reaching 300 volts. Id. at 35. The studies were conducted at Yale University and in Branford and New Haven, Connecticut. They focused on the conflict between obedience to authority and personal conscience. Id. at 2-3. Milgram examined justifications for acts of genocide offered by those accused at the World War II, Nuremberg War Criminal trials. Id. at 1-2.

122. In the Milgram study, the rules of “the experiment” were clear, but not of the real subjects’ obligations to either the false experiment or the real study. See supra note 121.


124. Craig Haney & Philip Zimbardo, The Socialization into Criminality: On Becoming a Prisoner and a Guard, in LAW, JUSTICE, AND THE INDIVIDUAL IN SOCIETY: PSYCHOLOGICAL AND LEGAL ISSUES 198 (Tapp & Levine eds., 1977). In the summer of 1971, Philip Zimbardo of Stanford University led an incredible experiment using the psychology building on campus as a makeshift prison. He and two graduate assistants assembled a group of college-aged volunteers, sorted them for emotional stability, and randomly assigned them to positions of either guard or prisoner. Within a few days, those cast as guards assumed the roles of guards and the prisoners started to display the attributes of “first-timers” at real prisons. Within six days, the experiment had to be terminated because the situation became “too real” and too intense, with several prisoners having to be dismissed because of psychological trauma.

125. Id. at 207.
If that's the way he wants it, that's the way he gets it. We throw him into the Hole ordering him to hold greasy sausages in each hand. After an hour, he still refuses . . . I decide to force feed him, but he won't eat. I let the food slide down his face. I don't believe it is me doing it. I just hate him more for not eating.\(^\text{126}\)

Although the Stanford Prison Experiment is most often cited as an example of how role definitions can be used to incite individuals to perform harmful behavior they would otherwise eschew, it may serve as an example of the equally powerful potential of role definition to prevent harm. Whereas a pacifist cast into the role of a guard may be incited to do harm, a physician that self-identifies as such and honors his first-order medical duties may be protected from competing impulses or external incentives to do harm. Milgram's and Zimbardo's studies, despite ethical flaws that are striking in retrospect, helped explain the observation that good men do bad things and brought the interaction of situational variables into the foreground of criminal behavior. The studies also show how strong role identification can either support or counteract these situational factors.\(^\text{127}\)

XI. THIRD-PARTY INFLUENCES AND INFLUENCE ON THIRD PARTIES

While interested third parties may create a certain pressure that threatens medical professionals' loyal observance of medical ethics and values, these same third parties often rely on the medical profession's fidelity to its code of practice. Non-medical professionals expect and perhaps appreciate the staunch allegiance to medical codes and values traditional Western medicine demands. As Richard Wasserstrom observes,

The existence of a system of role-defined behavior can . . . create expectations relevant to the behavior of others not directly affected by the existence of the role. These other persons also will come to expect that the role-defined behavior will continue, and this may give them license to act on these

\(^{126}\) \textit{Id.} at 209.

\(^{127}\) One need only look to the psychological evaluations of the Nazis to remember the ease with which monstrous actions can be disassociated from personal morality, if protected by a defined role. \textit{See, e.g.,} \textit{The Nuremberg Interviews} (Leon Goldensohn & Robert Gellately eds., 2004); Hannah Arendt, \textit{Thinking and Moral Considerations: A Lecture}, 38 Soc. Res. 417 (1971) (describing, for example, the ease and disunity of personality with which Adolph Eichmann carried out his political and military obligations as he saw them). \textit{But see} Postema, \textit{supra} note 5 (discussing the Socratic observation of humanity's inherent need for unity of self and the consequent pain that comes from psychological disunity caused by moral conflict).
executions rather than from a more universal moral perspective.128

Wasserstrom’s analysis was directed at attorneys but is equally applicable to the recent events at Abu Ghraib, where it may be argued that physician involvement in detainee interrogation led to torture that might otherwise not have taken place. As Bloche and Marks note, interrogators knew that physicians were observing interrogation of detainees.129 Applying Wasserstrom’s intuition to this situation, one can easily imagine interrogators’ reliance on the medical role as a “check” on their behavior. Non-interference by physicians could easily be read as permission—not just by the individual physicians, but by the medical profession and its ethics.

XII. OBJECTIONS

The call for greater deference to the integrity of medical norms and guidelines is largely based on the physician’s right to honor her role obligation of non-maleficence. However, the physician’s prima facie obligation to “do no harm” may be interpreted as an instruction not to always avoid harming any patient, but to strive in one’s work to always balance harm against benefit. Clearly, the physician who breaks his patient’s ribs to administer CPR is weighing harm against benefit in a way that is unquestionably ethical and appropriate. As Jay Katz wrote in a discussion of the inadequacy of professional codes of medical ethics, many of the ethical dilemmas encountered by physicians have “been all too uncritically assumed [to] be resolved by fidelity to such undefined principles as primum non nocere . . . .”130 The objection, then, would be that the act of medicating Charles Singleton was not, in fact, in contradiction to the physician’s duty. It could be argued that the physician is not “doing harm” by treating the patient because the benefits to society of that action far outweigh the costs to the individual. One may further argue that by refusing to medicate Singleton, the physician has indeed “done harm” to Singleton’s victims, to society, and to the criminal justice system.

The problem with such an argument, however, is that while the idea of non-maleficence may include a balancing of harm and benefit to any one particular patient, it is quite a different matter to suggest that harms against that same patient should be weighed against benefits to someone or something other than that patient. In rare cases care may be ethically withheld from, or harm even inflicted on, a patient for the benefit of others. We may consider it ethical to sacrifice one for the good of the many, or we may have no choice but to do so—

128. Wasserstrom, supra note 6, at 32.
129. Bloche & Marks, supra note 7.
as in any number of classic ethical dilemmas in which an individual endangers the public health, harms another party, or makes use of scarce resources for which he cannot pay. But we should not allow physicians to make these decisions. Nor should we allow physicians to take part in care that is the result of others’ decision-making when that care violates the professional medical code.

Another objection is based on an argument for role differentiation, which asserts that some subjects of a physician’s clinical work like soldiers, prisoners, defendants in court proceedings, or detainees should not be considered patients. It may be argued, for instance, that in certain clinical contexts no doctor-patient relationship exists, even when a physician is providing care and treatment to an individual. If no such relationship exists, then the potential for harm to individuals is not the physician’s responsibility. This is a dangerous line of reasoning and brings to mind Edmund Burke’s well known caution that good people doing nothing is all that evil requires to succeed. Physicians who determined detainees’ “fitness” for torture under authoritarian regimes in the 1970s and 1980s maintained that their work served state campaigns against subversion and thus should not be judged by the ethics of patient-physician relations. The alternative view is that when a physician brings medical skills and training to a situation, he ought to be bound by medical ethics.

131. See, e.g., Eid v. Duke, 816 A.2d 844 (Md. 2003) (noting that generally, no doctor-patient relationship exists between an insured and a doctor who examines him for the insurance company or an employee and the doctor who examines him for the employer); Hoover v. Williamson, 203 A.2d 861 (Md. 1964) (same); New York Cent. R.R. Co. v. Wiler, 177 N.E. 205 (Ohio 1931) (same); see also Michael L. Perlin, Power Imbalances in Therapeutic and Forensic Relationships, 9 BEHAV. SCI. & L. 111, 115-21 (1991) (explaining why, in the context of forensic evaluations in which no doctor-patient relationship is believed to exist, the dual loyalties of forensic evaluators can lead them to misuse their power); Andrew Skolnick, Health Professionals Oppose Rules Mandating Participation in Executions, 269 JAMA 721, 722 (1993) (noting physicians’ arguments that no doctor-patient relationship exists between a condemned death row inmate and the physician who participates in the execution). But see, e.g., Betesh v. United States, 400 F.Supp. 238, 245 (D. D.C. 1974) (under Maryland common law, physicians who examine employees owe a “duty of good medical care with respect to all aspects of the examination, even if no doctor-patient relationship exists between them.”).

132. Various arguments along these lines have appeared in varying contexts, some notorious in the recent history of medicine. See, e.g., ROBERT PROCTOR, RACIAL HYGIENE (1988); see also CHRISTIAN PROSS & ALY GÖTZ, THE VALUE OF THE HUMAN BEING: MEDICINE IN GERMANY 1918-1945 (1991).

XIII. THE IMPORTANCE OF ROLE IN VARYING CONTEXTS

Few if any would argue with the view that physicians should not be involved in torture or human rights abuses and should be compelled to report such activities when they occur. But the idea that physicians should not use their skills and training to support legitimate social purposes such as public safety, justice, or the appropriate rationing of limited resources is not as compelling. The profession’s social responsibility has led many physicians to participate in a myriad of endeavors, some of which did not benefit their (non-)patients. Examples are physicians’ work in the military (where doctors treat wounded patient-soldiers for return to combat), in forensics (where doctors’ medical evaluations often lead to adverse consequences for their patient-evaluees), and in research (where doctors’ experimental “treatments” can have adverse consequences with little or no benefit to the individual patient-subject). In some cases, the competing values weighed by the physician are between the individual health and welfare of the patient and the relative health of the community. Vaccination, for instance, which may pose a minimal risk to the individual, is justified by the long-term collective benefit of high immunization rates preventing epidemics. But in other cases, a physician’s undivided commitment to patient well-being, either at the level of the individual or the population, is challenged by decidedly non-medically therapeutic duties, as in the Singleton case.

The problem exists not when an individual chooses one set of obligations over another, but when the individual ignores the sacrifice of one over the other. When personal or professional behavior potentially criticizable on moral grounds is blocked from such criticism by an appeal to the existence of the actor’s role which is claimed to make the moral difference, the integrity of other roles is not compromised, it is obliterated. And in eliminating the competing role(s), the actor eliminates those values that might otherwise be morally relevant, if not decisive, reasons for acting or not acting.

XIV. IMPLEMENTATION: “WHAT MEN DAILY DO”

Hard cases make bad law. And hard-line rules make bad ethics. It is

134. Jacobson v. Massachusetts, 197 U.S. 11 (1905) (upholding the constitutionality of a legislature choosing between medical arguments on behalf of individuals and medical arguments on behalf of the public population). See also Kathleen R. Stratton et al., Adverse Events Associated with Childhood Vaccines Other than Pertussis and Rubella: Summary of a Report from the Institute of Medicine, 271 JAMA 1602 (1994).

unfortunate that advocates for increased legal deference to physicians' professional responsibility and ethical norms often give short shrift to implementation concerns—specifically how, and how well, a policy protecting physicians' right to pursue life and health to the exclusion of other social values will be implemented. Given the unique nature of Singleton's case, presuming that a very small number of death row inmates are or will be psychotic and refuse treatment for their mental illness, one can imagine little difficulty in implementing a policy safeguarding physicians' duty to pursue health and life, even at the expense of other social or ethical values. However, other possible applications of such a bright line rule elevating physicians' responsibilities to do no harm and to pursue health above all other responsibilities are troubling. In the case of end-of-life care, for instance, a system of shared decision-making is preferable. If a competent patient wishes to refuse treatment, even if it will certainly hasten death, that wish should be honored. While such a policy may involve physicians in allowing patients to effectively commit suicide, it is informed by a greater concern about implementation. Ideally, one might encourage physicians to argue for life and pursue treatment even in the most dire of patients' circumstances. But a default rule that allows, or even requires, the substituted judgment of a physician for a patient poses intolerable risks, not only because of the insult to patient autonomy, but also because of the potential for abuse by physicians. Just as physicians may be drawn by unconscious aggressive impulses to hasten death, they may also overcompensate when guarding against these impulses by pursuing life when it should not be artificially maintained.

136. While it is estimated that approximately two-fifths of all males and two-thirds of all females in prison have pronounced psychiatric or behavioral problems, psychosis is rare in the prison population. See Rod Morgan, Imprisonment: Current Concerns and a Brief History Since 1945, in THE OXFORD HANDBOOK OF CRIMINOLOGY 1137, 1162 (Mike Maguire et al. eds., 2d ed. 1997). Over the past thirty years, the number of people with mental illness and other mental disabilities on death row has steadily increased. Nat'l Coal. to Abolish the Death Penalty, Fact Sheet: Mental Competency and the Death Penalty, http://www.ncadp.org/fact_sheet6.htm (last visited Mar. 22, 2006). Although precise statistics are not available, it is estimated that 5-10% of people on death row have a serious mental illness. ACLU, Mental Illness and the Death Penalty (Jan. 31, 2005), http://www.aclu.org/capital/mentalillness/10617pub20050131.html; see also Traolach Brugh et al., Psychosis in the Community and in Prisons: A Report from the British National Survey of Psychiatric Morbidity, 162 AM. J. PSYCHIATRY 776 (2005) (finding a weighted prevalence of probable functional psychosis of 4.5 per 1000 in the non-prison population and a weighted prevalence of 52 per 1000 in the British prison population).

137. The case of Dax Cowart, now famous in the bioethics literature, is an example of an unfortunate situation in which a patient's right to refuse life sustaining treatment ought to be protected (though not exclusively, and not without much conversation and counseling) even if treating physicians are required to forego their pursuit of health and life. See DAX'S CASE: ESSAYS IN MEDICAL ETHICS AND HUMAN MEANING (Lonnie D. Kliever ed., 1989).
The case of Donald Cowart is an illustrative counterpoint to the Singleton case. In the summer of 1973, Donald “Dax” Cowart was critically injured in an explosion in which his father lost his life. Cowart was left blind and with third-degree burns over more than sixty-five percent of his body. Despite his repeated protests, Cowart was forced to undergo excruciating medical treatments and surgeries for more than a year. He left treatment with severe disfigurement, the loss of his fingers, partial hearing loss, and blindness. He went on to marry and to become a successful attorney and remains steadfast in his position that treatment should have been stopped when he, a competent adult, ordered that he be allowed to leave the hospital and return home to die from his injuries. He was repeatedly declared to be competent by a psychiatrist during this period.138

In Cowart’s case, the value of patient autonomy may have ultimately outweighed a physician’s responsibility to avoid participation in patients’ death.139 This view is a concession to the theoretical goal that physicians never forego their pursuit of health and wellness, even in the face of patient protest. Again, the theoretical compromise is driven by practical concerns about institutional incapacity to care appropriately for patients forced to undergo treatment and the potential for abuse, especially when patients cannot be saved or cured. For most, Cowart presents a clear case in which the costs of requiring policy to defer to physicians’ credo outweigh the potential benefits. The costs include patients’ suffering and loss of liberty and physicians’ involvement in hastening certain death, while the potential benefits are possible recovery and restoration to health for the patient and protecting the integrity of the medical code. Singleton seems an equally clear case in which the known benefits of keeping physicians far from the possibility of doing harm outweigh the costs of postponing execution of a prisoner and maintaining a prisoner in a state of psychosis.

Between the Cowart and Singleton cases lies another set of cases for which implementation concerns are less clear: physician-assisted suicide. The cost of forcing those in pain and near the end of their lives to suffer needlessly or to commit suicide by other more desperate means must be weighed against the countervailing potential cost of physician abuse under a policy allowing physician participation in suicide. This conflict strikes at the center of an internal role conflict for physicians. Some who support physician-assisted suicide see the potential for a new ethic of caring, one encompassing assisted death as part of the professional role. But those well-meaning physicians who would euthanize their

138. Id.
139. This is indeed the predominant view in the medical ethics literature. But see ROBERT A. BURT, TAKING CARE OF STRANGERS: THE RULE OF LAW IN DOCTOR-PATIENT RELATIONS 1-21 (1979).
patients with compassion are also often stressed, fatigued, and bewildered by the new responsibility.\textsuperscript{140} In other words, the anxiety felt even by those who support physician-assisted suicide may reveal important dynamics of the physician-patient relationships that are protective of both individuals’ health and welfare and ought to be preserved.

Another implementation concern cuts the other way. An argument favoring individual moral reasoning when confronted with conflicting roles neglects the likelihood that external factors will almost always determine the outcome. Yeats writes about the dangers of making a thing “subject to reason.”\textsuperscript{141} Gerald Postema takes Yeats’s observation to be a condemnation of moral philosophers’ inclination to “play” with professional ethics without full knowledge of the concrete details.\textsuperscript{142} The physicians at Abu Ghraib were under attack daily by enemies with whom the detainees were formerly allied. Their safety was ensured by the same men and women who committed abuses and sought their aid. In these circumstances, the reasonable consideration of conflicting moral values is an unreasonable expectation. Two conclusions can follow: Either no role requirement will be observed in such situations or only the strongest will.

If courts and legislators fail to recognize—or worse, disregard—the importance of strong professional moral guidelines, the degradation of medical norms will continue even in the least stressful of environments and certainly in situations like those surrounding physicians at Abu Ghraib. Institutional endorsement and support for non-negotiable duties (such as “do no harm”) are required precisely for situations in which case-by-case evaluations are frustrated by situational bias.

CONCLUSION: THE PROTECTION OF ROLE

The problem of role conflict is a familiar one in moral theory. This Note does not attempt to resolve it. It is intended, however, to highlight the tensions inherent in the inevitable conflict among medicine’s various commitments. Clinical fidelity to the individual patient should be a standard of medical responsibility that is extremely difficult to violate. For some years, the public conception, self-conception, and morale of the medical profession have been

\textsuperscript{140} Roger S. Magnusson, “Underground Euthanasia” and the Harm Minimization Debate, 32 J.L. Med. & Ethics 486, 487 (2004). Magnusson’s observations about physicians’ reactions to assisted-suicide reveal the particular conflicts outlined above.

\textsuperscript{141} “Once one makes a thing subject to reason, as distinguished from impulse, one plays with it, even if it is a very serious thing. I am more ashamed because of things I have played with in life than of any other thing.” Postema, supra note 5, at 286.

\textsuperscript{142} Id.
declining.\textsuperscript{143} The productive transition from physician paternalism to patient autonomy has had the unfortunate consequence of dispiriting practitioners and rendering them less able to keep faith with patients.\textsuperscript{144} Whether this transition has prompted courts and policy makers to abandon their faith in physicians, or vice-versa, is unclear.

The current trend in medical legislation and jurisprudence is dangerous. It signals an environment in which doing harm is laudable and doing good amounts to "dangerous folly."\textsuperscript{145} Singleton v. Norris reflects the current disregard for physician's role integrity, and the abuses at Abu Ghraib reflect the serious consequences of further neglect. It remains, therefore, the responsibility of medical ethicists and professional organizations to convince and remind courts that there is more at stake in the protection of the physician's prescribed role than mere professional exclusion, political autonomy, or social equity. What is at stake is, quite literally, a matter of life and death.

\begin{itemize}
\item \textsuperscript{144} Bloche \textit{supra} note 87.
\item \textsuperscript{145} "I am in this earthly world; where to do harm / Is often laudable, to do good sometime / Accounted dangerous folly." \textsc{William Shakespeare}, \textit{Macbeth} act 2, sc. 2.
\end{itemize}