CAPITAL CASES

BY TY ALPER

Lethal Incompetence

Lethal Injection Litigation Is Exposing More Than Torturous Executions

It's not unusual for me to make mistakes. . . . I am dyslexic and that is the reason why there are inconsistencies in my testimony. I can make these mistakes, but it's not medically crucial in the type of work I do as a surgeon.

— Deposition Testimony of
Dr. Alan R. Doerhoff,
Doctor Responsible for Executions
in Missouri, June 5, 2006[1]

Six years ago, conservative columnist George Will declared himself appalled by the real probability that innocent people have been executed in this country. "Capital punishment, like the rest of the criminal justice system," he wrote, "is a government program, so skepticism is in order."[2]

Press coverage of the recent explosion of litigation around the country challenging lethal injection suggests that it may well generate a similar strain of skepticism among even death penalty proponents, particularly those who believe that lethal injection is a simple and humane method of execution, as it has been billed for so many years. Just as people are asking whether we have always executed the "right" person, there is now legitimate debate about whether our system is capable of getting it "right" when it comes to the actual practice of putting people to death. Is it possible for us to do so in a humane manner? Or has the lethal injection litigation once again revealed the fallibility of this all-too-human endeavor?

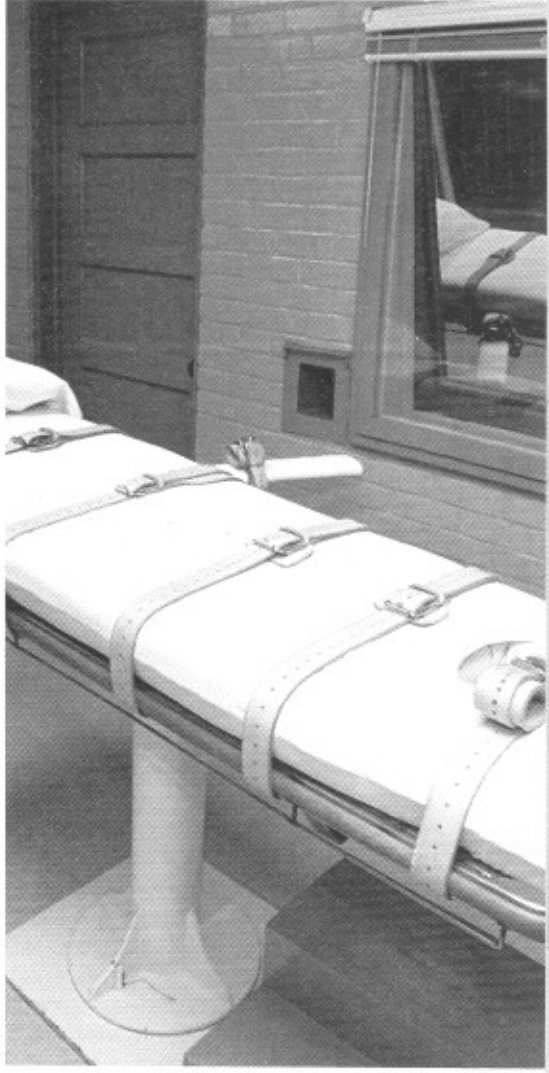
Background on Lethal Injection

Litigation challenging lethal injection has progressed in a number of states, and is likely to increase in the wake of the Supreme Court's decision in *Hill v. McDonough*,[3] which affirmed the right of death row inmates to challenge lethal injection as a civil matter pursuant to 42 U.S.C. § 1983. As a result, at this time next year, we are likely to know much more than we do now about lethal injection and how it is administered in death chambers across the United States. But what we know now is enough to conclude that it is very likely that, in numerous instances, men and women have been tortured as they were executed by this procedure.

All states that employ lethal injection do so by injecting inmates with a series of three powerful drugs. The first, sodium pentothal (or thiopental), is used to render the inmate unconscious. The second, pancuronium bromide (or similar drug), paralyzes the inmate. The third, potassium chloride, induces cardiac arrest. In short, the three-drug cocktail is intended to (1) put the inmate to sleep; (2) make him appear peaceful by eliminating his ability to move or cry out; and (3) stop his heart.

One problem with the sequence of drugs used in lethal injections is that there is absolutely no medical justification for the administration of the second drug, pancuronium bromide. This drug paralyzes the inmate, yet does not affect his consciousness or his ability to feel pain.[4] The induction of general anesthesia is a complex process and there are multiple opportunities for problems that would thwart the successful achievement of the appropriate level of anesthesia.[5] Obviously, the risk of error is greatly amplified if the anesthetic procedures are performed and monitored by unqualified staff in a prison setting as opposed to trained anesthesiologists in a hospital.

If it turns out that the inmate is not appropriately anesthetized by the first drug, the inmate may suffer excruciating suffocation caused by a paralyzing dose of pancuronium bromide *and* the heart attack induced by the potassium chloride, all without being able to say anything or even blink an eye to communicate awareness. This can occur if, for example, there has been an error in the mixing of the anesthetic or an unnoticed leak in the tubes that deliver the drug. In this scenario, although the inmate is in agonizing pain, the witnesses to his execution will see a "peaceful" death. Indeed, there appears to be no justification for the use of the second drug other than that it ensures, in most cases, that the execution will occur without causing undue distress to the witnesses.



Pancuronium bromide is, therefore, essentially used to maintain the illusion that lethal injection is a painless, humane, and simple procedure. In reality, its use masks the potentially horrifying effects of inadequately administered doses of the anesthetic and heart-stopping drugs. Consider, for example, a recent case from Salt Lake City. After being euthanized by lethal injection, a dog awoke as it was being put into the crematorium. When the animal shelter officials realized that

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the dog was not dead, they pulled it out of the oven and administered another injection to properly euthanize the animal.[6] Had the dog been given pancuronium bromide prior to the lethal injection, the shelter officials never would have known that the euthanasia had failed, and the dog would have been burned alive. It is for precisely this reason that as many as 30 states now outlaw the use of neuromuscular blocking agents such as pancuronium bromide when euthanizing animals.[7] Unfortunately, the strict laws and regulations governing the euthanasia of animals do not apply to the execution of human beings.

What *does* govern the use of lethal injection? Are lethal injections, in fact, being administered according to properly vetted protocols by trained medical professionals? If so, death penalty proponents can be comforted in the knowledge that as long as the rest of the legal process works, the execution itself will be a simple formality. But if not, there is reason to doubt whether lethal injection is even an improvement over the electric chair or the gas chamber. After all, there is a growing consensus, even among experts retained by various states,[8] that an un-anesthetized execution amounts to torture.[9]

What a difference a little due process makes. Until recently, courts have generally assumed that well-crafted protocols exist, and that these protocols have been diligently followed by the anonymous people asked to carry them out. Lethal injection claims have been viewed skeptically, as last-ditch efforts to stave off executions as opposed to serious challenges to a potentially torturous medical procedure that the prison has chosen to undertake.

Now that counsel for death row inmates are beginning to shed light on the process – through discovery, public records requests, and evidentiary hearings – it is no longer possible to maintain with a straight face the blithe assumption that lethal injection is being administered humanely. In hindsight, perhaps it should not have been surprising to discover that the fallibility that pervades the criminal justice system does not evaporate when the last appeal is exhausted and the warden gives the signal to begin the execution process.

"It is not Unusual for Me to Make Mistakes."

The case of Michael Anthony Taylor, a death row inmate in Missouri, is beginning to read like a legal thriller about which you might conclude, "There's no way this would happen in real life." After months of litigation, when Taylor was within hours of execution, his attorneys were finally allowed to depose the anonymous "Dr. John Doe #1," who, as it turns out, is responsible in almost every way for the procedures used in Missouri's executions.

Through the deposition of Dr. Doe[10] as well as discovery of documents and records related to the previous six Missouri executions, Taylor's lawyers learned that the state of Missouri has no written protocol for the administration of lethal injection. Dr. Doe, a surgeon with no formal training in anesthesiology, has sole discretion to determine how executions are carried out. He reports to no one.[11] Moreover, on his own and without telling anyone, Dr. Doe recently decided to start giving inmates *half* the amount of anesthetic previously given prior to the injection of the paralyzing agent. He did so apparently in response to a change in the drug's packaging that forced him to "improvise."[12]

It gets worse. Dr. Doe is dyslexic and admitted that "[i]t is not unusual for me to make mistakes," including the transposition of numbers. Although he is not an anesthesiologist, Dr. Doe claimed to be able to monitor the condemned inmate's level of consciousness simply by viewing his facial expression from another room, through a window obstructed by blinds.[13] Finally, Dr. Doe testified that the nurses who actually conducted the injections did so from within a darkened room, using a small flashlight to help them see what they were doing.[14]

Needless to say, these revelations did not reflect well on the state. An editorial in the *St. Louis Post-Disptach* opined, "You have to admire the dedication and persistence of a man who overcomes the learning disability of dyslexia and becomes a surgeon. However, you don't ask such a man to prepare the three-drug 'cocktail' used in executing condemned prisoners."[15] The federal district court judge presiding over the *Taylor* litigation agreed, and has halted all executions in Missouri until the state proposes a protocol that meets constitutional safeguards, including the participation of board-certified anesthesiologists.(So far, the state has been unable to find any willing participants, despite sending letters to 298 anesthesiologists in Missouri and Illinois, asking for assistance in executions and promising compensation.)[16]

After the judge's ruling in *Taylor*, the *St. Louis Post-Dispatch* revealed that "Dr. Doe" was a Missouri doctor named Alan R. Doerhoff. The doctor had been sued for malpractice more than 20 times and was publicly reprimanded by the State Board of Healing Arts for concealing the malpractice suits from a hospital where he was a treating physician.[17] The state was well aware of Dr. Doerhoff's reprimand and professional troubles; in fact, the office of the Missouri Attorney General both defended the *Taylor* litigation and signed off on the discipline of Dr. Doerhoff.[18] Yet the state fought to keep his identity a secret and said it would have no hesitation in allowing him to continue to carry out executions.[19]

Is the *Taylor* case an aberration? Hardly. In Alabama, prison officials scrambled at the last minute in an effort to figure out how to execute David Larry Nelson, whose veins were severely compromised by a lifetime of intravenous drug use. After initially refusing to tell Nelson how they were going to gain venous access in order to inject the lethal drugs, the prison administration came up with a procedure involving the "external carotid vein" in his neck as well as the "saphenous vein" in his arm.

As Nelson's lawyers pointed out, human beings do not have an external carotid vein – cows do – and the saphenous vein is located in the leg, not the arm.[20] State officials also proposed using a so-called "cut-down" procedure to locate a vein, which would involve making a series of sharp incisions though the skin and through several layers of connective tissue, fat, and muscle – all with only local anesthetic. Citing expert testimony that such a procedure was likely to be intolerably painful and dangerous, Nelson took his case to the Supreme Court. The Court, in a precursor to the *Hill* case, held that the lawsuit could proceed as a § 1983 action.[21]

The *Taylor* and *Nelson* cases are but two examples of incompetent administration of lethal injection in the absence of established protocols. There are likely more that we do not know about because lawyers have not yet gained access to crucial discovery in many states. It is worth noting that the same district court judge who halted all executions in Missouri after hearing from Dr. Doe had, just months earlier, on the basis of a much more limited hearing, concluded that there is no "significant risk that the means and method which the Missouri Department of Corrections uses will cause unnecessary pain and suffering."[22]

Tinkering With the Machinery of Death

Justice Harry Blackmun famously

declared in 1994 that, "[f]rom this day forward, I shall no longer tinker with the machinery of death."[23] Yet the states continue to literally tinker away, making cosmetic and inadequate changes to their lethal injection protocols, often only days or even hours before the executions are scheduled to take place.

The state of North Carolina, for example, recently executed Willie Brown Jr., after changing its lethal injection protocol at the last minute to include the use of a bispectral index (BIS) monitor, which the state claimed would ensure – without the presence of a physician – that the inmate was properly anesthetized. It is widely acknowledged in the field of anesthesiology, however, that the BIS monitor alone is insufficient to monitor anesthetic depth, as the manufacturer of the machine clearly states in its literature.[24] The medical director of the company that manufacturers the machines is so concerned that the BIS monitor is being contemplated for use in executions that he has refused to sell any more to states, and has said that the sale of one machine to North Carolina was a "regrettable" mistake.[25]

California, home to the nation's largest death row, has fared no better when it comes to developing a lethal injection protocol that ensures a "humane" execution. A federal district court judge recently rejected the state's protocol, which had been developed without the participation of any medical personnel. Prior to the scheduled execution of Michael Morales, the judge required that the state either procure the assistance of an anesthesiologist to verify the inmate's unconsciousness or change its method of execution to a lethal overdose of sodium pentothal, the first drug in the three-drug cocktail.[26]

The state initially found two anesthesiologists who were willing to participate, but these doctors backed out hours before the scheduled execution, apparently because they had not been told by state officials that they would be required to affirmatively intervene if the execution was not proceeding smoothly.[27] The next day, the state asked the judge for permission to execute Morales at 7:30 that evening by administering an overdose of sodium pentothal, an execution method that had never before been used in the United States. When the judge required that someone inject the overdose directly into Morales' veins, the state declined to go forward and the execution was postponed pending further hearings.

Conclusion

I will believe in the death penalty when you will prove to me the infallibility of human beings.

— Marquis de Lafayette

Ongoing lethal injection litigation has established, and brought to the public consciousness, two interrelated points: first, that it matters whether the people involved in lethal injections know what they are doing; and second, that, in fact, they often do not.

The unseemly scramble to execute Michael Morales in California – using a method of execution developed for the first time *on the day of the scheduled execution* – should give even death penalty proponents pause. So should the state of Missouri's reliance on an incompetent doctor to perform its executions. Just as there are some who are untroubled by the possibility that we have executed innocent people, there will always be some who are untroubled by the possibility that we are executing condemned inmates by torturing them to death. But many others should be, and will be, concerned that lethal injection is yet another aspect of this massive "government program" that is fraught with error.

Notes

1. *See Taylor* v. *Crawford et al.*, Case No. 05-4173-CV-S-FJG (W.D. Mo.) (Redacted testimony of Dr. John Doe #1), June 5, 2006, at 25, *available at* http://www.law.berkeley.edu/clinics/dpclinic/Lethal%20Injection%20Documents/Missouri/Taylor/June%202006%20Hearing/1983%20PR%20John%20Doe%20I%20Deposition%20Tr%20Redacted.pdf.

2. George Will, *A Must-Read Horror Book*, JEWISH WORLD REVIEW, April 6, 2006, available at http://www.jewishworldreview.com/cols/will040600.asp.

3. 126 S.Ct. 2096 (2006).

4. Pancuronium bromide is used during some surgeries to prevent the involuntary contraction of muscles.

5. Indeed, cases involving what is known as anesthetic (or intra-operative) awareness are well known. In such cases, patients wake up during surgery and suffer the excruciating pain of the surgery, sometimes without the ability to indicate their awareness. For a compelling and notorious account of a woman who endured the surgical removal of her eye while fully conscious (but paralyzed), see *Operation was Wake-Up Call*, CNN.COM (Oct. 25, 2005), available at http://www.cnn.com /2005/HEALTH/10/25/profile.anesthesia.advocate/index.html. The subject of the article, Carol Weihrer, has testified in several lethal

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6. Associated Press, *Dog Survives Lethal Injection, Is Nearly Burned Alive*, SALT LAKE TRIBUNE, July 22, 2006, available at http://www.sltrib.com/utah/ci_4082368.

7. Brief of *Amici Curiae* Drs. Kevin Concannon, Dennis Geiser, and Glenn Pettifer Supporting Petitioner at 15 n.3, *Hill v. McDonough*, 126 S.Ct. 2096 (2006) (citing statutes).

8. *See, e.g., Taylor* v. *Crawford et al.*, Case No. 05-4173-CV-S-FJG (W.D. Mo. June 26, 2006), at 6 ("There was no dispute that if an inmate is not sufficiently anesthetized when the potassium chloride is administered, it will cause excruciating pain as it is administered through the inmate's veins.").

9. Such torture violates the Eighth Amendment. *See Gregg v. Georgia*, 428 U.S. 153, 173 (1976) (prohibiting "[e]xecutions that involve the unnecessary and wanton infliction of pain").

10. *See Taylor* v. *Crawford et al.*, Case No. 05-4173-CV-S-FJG (W.D. Mo.) (Redacted testimony of Dr. John Doe #1), June 5, 2006, available at http:// www.law.berkeley.edu/clinics/dpclinic/Lethal%20Injection%20Documents/Missouri/Taylor/June%202006%20Hearing/1983%20PR%20John%20Doe%20I%20Deposition%20Tr%20Redacted.pdf.

11. *Id.* at 63-65.

12. *Id.* at 9-10.

13. *Id.* at 41-43.

14. *Id.* at 31.

15. Editorial, *Aggravating Circumstances*, ST. LOUIS POST-DISPATCH, June 29, 2006, at C8.

16. *Taylor* v. *Crawford et al.*, Case No. 05-4173-CV-S-FJG (W.D. Mo. July 25, 2006), at 1. The State got no response to the letters it sent out seeking assistance in executing Missouri inmates. See Exhibit B to State's Submission of Proposed Execution Protocol, *Taylor* v. *Crawford et al.*, Case No. 05-4173-CV-S-FJG (W.D. Mo. July 25, 2006) (affidavit of Terry Moore), available at http://www.law.berkeley.edu/clinics/dpclinic/Lethal%20Injection%20Documents/Missouri/Taylor/July%2014%20Filings/1983%20PR%20Doc%20No%20198%20Exh%20B%20Affidavit%20of%20Terry%20Moore%20c%20Sample%20Ltr.pdf. As of this writing, the case is pending on the state's appeal to the Eighth Circuit.

17. Jeremy Kohler, *Behind the Mask of the Missouri Execution Doctor*, ST. LOUIS POST-DISPATCH, July 30, 2006, at A1.

18. *Id.*

19. The Director of the Missouri Department of Corrections, Larry Crawford, testified at the evidentiary hearing in *Taylor* that he had confidence in Dr. Doerhoff's competence and training and that as far as he was concerned, the doctor would continue to participate in Missouri's executions. *See Taylor* v. *Crawford et al.*, Case No. 05-4173-CV-S-FJG (W.D. Mo. June 13, 2006) (testimony of Larry Crawford), at 388-99, available at http://www.law.berkeley.edu/clinics/dpclinic/Lethal%20Injection%20Documents/Missouri/Taylor/June%202006%20Hearing/TAYLOR3.TXT.

20. Brief of Petitioner at 9-10, *Nelson v. Campbell*, 541 U.S. 637 (2004).

21. *Nelson v. Campbell*, 541 U.S. 637 (2004).

22. *Taylor* v. *Crawford et al.*, Case No. 05-4173-CV-S-FJG (W.D. Mo. January 31, 2006), at 5.

23. *Callins v. Collins*, 510 U.S. 1141, 1145 (1994) (Blackmun, J., dissenting from denial of certiorari).

24. *Brown v. Beck*, 445 F.3d 752, 754-56 (4th Cir. 2006) (Michael, J., dissenting).

25. Adam Liptak, *State Proposes Using Device, Not Doctors, in Execution*, N.Y. TIMES, April 13, 2006.

26. *Morales v. Hickman et al.*, No. C-06-219 JF, (N.D. Cal. Feb. 14, 2006), at 14.

27. Stacy Finz, Bob Egelko, & Kevin Fagan, *Killer's Execution Rescheduled*, S.F. CHRON., Feb. 21, 2006, *at http://sfgate.com/cgi-bin/article.cgi?f=/c/a/2006/02/21/MNG14HC1HG16.DTL.*

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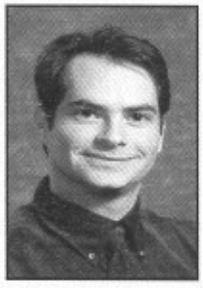

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