NO. 51PA08 TENTH DISTRICT

****

SUPREME COURT OF NORTH CAROLINA

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NORTH CAROLINA DEPARTMENT OF CORRECTION, THEODIS BECK, Secretary of the North Carolina Department of Correction, in his official capacity, and GERALD BRANKER, Warden of Central Prison, in his official capacity,	)	From Wake County 07 CVS 3574
Plaintiffs-Appellees,	)	
v.	)	
NORTH CAROLINA MEDICAL BOARD,	)	
Defendant-Appellant.	)	

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AMICUS CURIAE BRIEF OF AMERICAN MEDICAL ASSOCIATION

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AMICUS CURIAE BRIEF OF AMERICAN MEDICAL ASSOCIATION

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STATEMENT OF THE FACTS

The American Medical Association (the "AMA") adopts the Statement of Facts of the North Carolina Medical Board.

ARGUMENT

The North Carolina Medical Board (the "Medical Board") is empowered to discipline physicians for various forms of misconduct and character deficiencies, some of which involve the clinical aspects of medical practice and some of which do not. N.C. Gen. Stat. § 90-14(a)(6) authorizes physician discipline for:

> *Unprofessional conduct, including, but not limited to, departure from*, or the failure to conform to, the standards of acceptable and prevailing medical practice, or *the ethics of the medical profession*, irrespective of whether or not a patient is injured thereby, or the committing of any act contrary to honesty, justice, or good morals, whether the same is committed in the course of the physician's practice or otherwise, and whether committed within or without North Carolina.

(emphasis added).

In recognition of AMA Code of Medical Ethics Opinion E-2.06 (App. pp. 1-2), which prohibits physician participation in executions, the Medical Board adopted a "Position Statement" opposing such participation, except to the extent specifically required under the North Carolina Capital Punishment Statute. See N.C. Gen. Stat. §§ 15-190, 15-192. Notwithstanding the deference ordinarily given an administrative agency to make reasonable interpretations of its enabling

statute, the lower court found this Position Statement to be untenable and enjoined its enforcement. Among other things, it found that "[a] judicial execution is not a medical event or medical procedure" and "a judicial execution is outside the scope of Chapter 90 [the Medical Practice Act]." (R pp. 210-211)

Ethical Opinion E-2.06 is not some arbitrary restriction, merely reflecting the personal and transient whims of a fraction (or even all) of the medical profession. Rather, it is part and parcel of the professional standards that are crucial to patient care. The importance of professionalism in medicine has been recognized since the time of Hippocrates. It is universally recognized today, and the Medical Practice Act itself upholds the importance of that professionalism. Moreover, after researching the issue, the AMA has been unable to find even a single suggestion in the medical literature that physician participation in capital punishment is not a medical event or medical procedure.

This appeal ultimately involves a conflict between policies promulgated by two administrative agencies. Neither policy conflicts overtly with a statute; yet these two policies cannot be reconciled. One mandates physician participation in judicial executions, while the other prohibits such participation by physicians. Thus, this appeal presents a policy question, not a legal question. This policy question is not properly resolvable by the courts. Instead, it should be resolved by the branch of State government that delegated the authority to these two

administrative agencies to make such policy decisions in the first place – the General Assembly.

I. THE PROHIBITION ON PHYSICIAN ASSISTANCE IN CAPITAL PUNISHMENT FOSTERS THE PHYSICIAN-PATIENT RELATIONSHIP AND THUS FACILITATES THE GENERAL PROVISION OF MEDICAL CARE.

A. The Physician-Patient Relationship is Built on Trust Between Physicians and Their Patients.

Ethical Opinion E-10.01, entitled "Fundamental Elements of the Patient-Physician Relationship," makes the following basic observation:

> From ancient times, physicians have recognized that the health and well-being of patients depends upon a collaborative effort between physician and patient. Patients share with physicians the responsibility for their own health care. The patient-physician relationship is of greatest benefit to patients when they bring medical problems to the attention of their physicians in a timely fashion, provide information about their medical condition to the best of their ability, and work with their physicians in a mutually respectful alliance.

(App. p. 3)

Likewise, the Medical Board's Position Statement on the Physician-Patient Relationship makes the following observation:

> The Board believes the interests and health of the people of North Carolina are best served when the physician-patient relationship, founded on patient trust, is considered sacred, and when the elements crucial to that relationship and to that trust . . . are foremost in the hearts, minds, and actions of the physicians licensed by the Board.

(App. p. 5) Similarly, E-10.015 states: "The relationship between patient and physician is based on trust . . .." (App. p. 7)

N.C. Gen. Stat. § 90-14 fosters the trust underlying the physician-patient relationship by requiring that physicians exemplify upstanding moral character as well as technical ability. Physician morality and ethics are a necessary component of the effective practice of medicine, in North Carolina and throughout the country.

B. Physician Participation in Capital Punishment Undermines the Trust Between Physician and Patient.

"Trust" is not some mechanical response to a closely defined set of circumstances; rather, it is a partly emotional, partly logical reaction to a larger person-to-person interaction. Physicians foster patient trust through their "hearts, minds, and actions."

Physicians are fundamentally healers, not instruments of death. See AMA Code of Medical Ethics Opinion E-2.211 (App. p. 9). When they mix those roles, the perception of the profession changes and patient trust erodes. And when that trust erodes, the physicians' ability to care for the patient is diminished. Physician participation in executions, even if legally sanctioned, interferes with the ability to care for patients in wholly different settings.

The lethal injection process in particular employs some of the same devices and skills that physicians use to save lives. Physician participation in a process with medical overtones that has as its objective causing involuntary death distorts

the role of medicine and its professionals. "Medicine is at heart a profession of care, compassion, and healing. Physician-assisted capital punishment does not encompass these virtues." R.D. Truog and T.A. Brennan, *Participation of Physicians in Capital Punishment,* 329 N. Engl. J. of Med. 1346, 1348 (1993) (App. p. 13).

Thus, "[t]he image of physician as executioner under circumstances mimicking medical care risks the trust of the public." CEJA, *Physician Participation in Capital Punishment*, 270 JAMA 365, 366 (1993) (App. p. 17). As described by one physician:

> The public has granted us extraordinary and exclusive dispensation to administer drugs to people, even to the point of unconsciousness, to put needles and tubes into their bodies, to do what would otherwise be considered assault, because we do so on their behalf – to save their lives and provide them comfort. To have the state take control of these skills for its purposes against a human being – for punishment – seems a dangerous perversion. Society has trusted us with powerful abilities, and the more willing we are to use these abilities against individual people, the more we risk that trust. The public may like executions, but no one likes executioners.

Atul Gawande, M.D., M.P.H., *When Law and Ethics Collide – Why Physicians Participate in Executions*, 354 N. Engl. J. of Med. 1221, 1227-28 (2006) (App. pp. 26-27).

It may well be illogical for patients to reduce their trust in their personal physician on account of other physicians' participation in legally authorized executions. That, however, is a not unexpected reaction.

Of the twelve members of the Medical Board, eight are licensed physicians, one is a licensed physician assistant or nurse practitioner, and three are public members. See N.C. Gen. Stat. § 90-2(a). They are better situated than are the members of the legal profession to gauge patient reactions to physician behavior. The Position Statement on Capital Punishment is a reasonable step by the Medical Board to preserve the health of North Carolinians, regardless of one's personal feelings toward capital punishment. Such preservation lies at the heart of the Medical Practice Act.

II. AT THE TIME OF HIPPOCRATES AND AT THE PRESENT, THE MEDICAL PROFESSION HAS CONSIDERED PHYSICIAN PARTICIPATION IN CAPITAL PUNISHMENT TO BE UNETHICAL.

There can be no real dispute that the medical profession disavows physician participation in executions. Under the oldest known version of the Hippocratic Oath medical practitioners were required to swear: "I will not give a lethal drug to anyone if I am asked, nor will I advise such a plan."[1]

[1] See http://www.nlm.nih.gov/hmd/greek/greek_oath.html.

The AMA, the largest medical society in the United States, unequivocally deems physician participation in capital punishment to be unethical, but at the same time it makes no attempt to dictate the morality of capital punishment generally. Ethical Opinion E-2.06 states, in part, as follows:

> 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.

(App. p. 1) The opinion goes on to define the parameters of this ethical prohibition in detail, with particular reference to the lethal injection process. The opinion prohibits physicians from, among other activities, monitoring vital signs and pronouncing the death of the inmate – both of which are specifically required by the Execution Protocol at issue in this case. (R p. 43)

Numerous other professional medical organizations have also considered the issue of whether physicians can ethically participate in capital punishment. The consistent conclusion of virtually all these groups has been that such participation by physicians is ethically prohibited.

On the state level, this is the unequivocal position taken by both the North Carolina Medical Board and the North Carolina Medical Society. "The North Carolina Medical Board takes the position that physician participation in capital punishment is a departure from the ethics of the medical profession . . .." (App.

pp. 29) Likewise, the North Carolina Medical Society has adopted the position of the AMA that "[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 state execution." (App. p. 31) The North Carolina Medical Society first articulated its position on this issue in 1983. Id.

In addition, many national medical specialty societies have addressed this issue. For example, the Society of Correctional Physicians, which represents physicians who provide health care services to incarcerated patients, states in its Code of Ethics that "[t]he correctional health professional shall . . . not be involved in any aspect of execution of the death penalty." (App. p. 32) Likewise, the American College of Physicians states in its Ethics Manual that "[p]articipation by physicians in the execution of prisoners except to certify death is unethical." (App. p. 34) Similarly, the American Public Health Association has formally announced its policy position that "health professional participation in executions or pre-execution procedures is a serious violation of ethical codes." (App. pp. 35-36) The American Society of Anesthesiologists has likewise taken the position that "[i]t is a fundamental and unwavering principle that anesthesiologists, consistent with their ethical mandates, cannot use their art and skill to participate in an execution." (App. pp. 37) The American Psychiatric Association has also stated

in its Principles of Medical Ethics that "[a] psychiatrist should not be a participant in a legally authorized execution." (App. p. 39)

At the international level, this is also the position of the World Medical Association ("WMA"), an international organization whose members include approximately 80 national medical associations. (App. pp. 40-42) The WMA's policy, which was first adopted in 1981, provides that "it is unethical for physicians to participate in capital punishment, in any way, or during any step of the execution process." Id.

Without question, the ethical prohibition on physician participation in capital punishment is a well-established principle of medical ethics. As described by one commentator:

> In its formally defined standards, medicine has drawn up a uniform and invariant standard against direct participation of physicians in execution that is neither unclear nor ambiguous. It does not appear that any professional medical group that has considered the matter has ever come to a different conclusion.

Timothy F. Murphy, *Physicians, Medical Ethics, and Capital Punishment*, Journal of Clinical Ethics, Summer 2005, at 160, 161 (App. p. 44).

This ethical prohibition on physician participation in capital punishment was also recently recognized by the United States Supreme Court. In Baze v. Rees, 128 S. Ct. 1520 (2008), the Court considered whether Kentucky's lethal injection procedure constituted cruel and unusual punishment under the Eighth Amendment

to the United States Constitution. In Justice Alito's concurring opinion, he recognized that "the ethics rules of medical professionals . . . prohibit their participation in executions." Id. at 1539. In support of this, Justice Alito cited to, and quoted extensively from, the AMA's Ethical Opinion E-2.06. Id.

The medical authorities that recognize the ethical prohibition on physician participation in capital punishment cut across time, space, and all components of the political spectrum. Their common goal is patient care, and their common experience is rooted in the physician/patient relationship. That goal and that experience has led to the same conclusion: physician participation in capital punishment should be considered unethical because it undermines patient trust and thus the medical care that physicians can provide for their patients.

III. THE LOWER COURT FINDING THAT PHYSICIAN PARTICIPATION IN CAPITAL PUNISHMENT IS OUTSIDE THE PRACTICE OF MEDICINE IS WITHOUT SUPPORT IN THE MEDICAL LITERATURE.

While the overwhelming weight of medical practitioners and of commentators is that physician participation in capital punishment is unethical, there have been dissenters. The AMA has searched the medical literature to ascertain whether these dissenters have seized on the rationale of the lower court: "judicial execution is not a medical event or medical procedure." (R p. 210) While it is impossible to prove this negative proposition conclusively, the AMA has been unable to find medical authority for the court's assertion.

For example, a recent article by Dr. David Waisel argued for physician participation in capital punishment. He discussed the role of physicians and their ability and skills in alleviating pain, particularly in the lethal injection context. D. Waisel, *Physician Participation in Capital Punishment*, 82 Mayo Clinic Proceedings 1073 (2007) (App. pp. 53-60). However, the procedures that go into execution by lethal injection were not discussed as anything other than medical.

Similarly, the 31 January 2008 issue of the New England Journal of Medicine recounted a discussion among physicians and a law professor who had published extensively on the subject of lethal injection. A. Gawande, D.W. Denno, R.D. Truog, and D. Waisel, *Physicians and Executions—Highlights from a Discussion of Lethal Injection*, 358 N. Engl. J. of Med. 448 (2008) (App. pp. 61-64). Although the majority felt that physicians should be permitted to participate under the current lethal injection protocols, none of the participants even hinted that participation should be permitted because it would not constitute the practice of medicine. Indeed, much of the discussion as to the need for physician involvement related to those technical aspects of lethal injection which might be facilitated by physician expertise (gained, of course, from training and experience in medical practice).

In another article examining physician participation in execution, the physicians interviewed discussed varying attitudes toward such participation.

Some of them suggested that it would be appropriate to participate in order to provide competent services. One physician had actually participated but had limited his participation to the determination of death—and was uneasy even with that limited action. Another physician had participated because he believed it was his duty to assist inmates in their dying moments. Each of these physicians saw that their expertise in medicine could be used in some way. None of the physicians interviewed stated or even alluded that participation would not be the practice of medicine. Atul Gawande, M.D., M.P.H., *When Law and Ethics Collide – Why Physicians Participate in Executions*, 354 N. Engl. J. of Med. 1221 (2006) (App. pp. 20-28).

It is self-evident that physician participation in lethal injections would involve medical skills and, perhaps, the alleviation of anxiety or physical pain. These are attributes of medical practice. While it is true that the object of such participation is to extinguish life, rather than to preserve it, N.C. Gen. Stat. § 90-14 makes it clear that it is within the discretion of the Medical Board to determine whether the application of medical skills in this manner is consistent with "the ethics of the medical profession." The findings of the trial court are, at least as far as the AMA can discern, medically unprecedented.

IV. BECAUSE THE NORTH CAROLINA MEDICAL BOARD'S POSITION STATEMENT IS CONSISTENT WITH STATUTORY LAW, THIS CASE PRESENTS A POLICY DISPUTE THAT

SHOULD ONLY BE RESOLVED BY THE GENERAL ASSEMBLY, NOT THE COURTS.

This case presents a situation in which two administrative agencies – the North Carolina Medical Board and the Department of Corrections ("DOC") – have each acted within the scope of the authority delegated to them by the General Assembly. Unfortunately, the policies promulgated by these agencies are in conflict.

Pursuant to N.C. Gen. Stat. § 15-188, the DOC has promulgated an Execution Protocol that requires the participation of physicians in the lethal injection process. (R pp. 41-43) The Medical Board, on the other hand, has promulgated a Position Statement that deems physician participation in capital punishment a violation of medical ethics. (R pp. 38-39) This is consistent with the Medical Board's power to discipline any North Carolina licensed physician based on "unprofessional conduct" which includes a "departure from . . . the ethics of the medical profession." N.C. Gen. Stat. § 90-14(a)(6); see also N.C. Gen. Stat. § 90-5.1 ("The Board shall . . . [i]ssue interpretations of this Article.").

Neither of these agencies' policy positions is directly contrary to any statutory or constitutional authority. As a result, this case presents a policy question, as opposed to a legal question. Questions of policy, such as this one, are for resolution by the General Assembly, not the courts. This Court should reverse

the trial court's Order enjoining the Medical Board from enforcing its Position Statement.

A. The North Carolina Medical Board's Position Statement is Consistent with All Statutes.

Chapter 15, Article 19 of the North Carolina General Statutes (the "Capital Punishment Statute") imposes only two requirements on physicians. First, "the surgeon or physician of the penitentiary" is required to be "present" at the execution. N.C. Gen. Stat. § 15-190. Second, "the surgeon or physician of the penitentiary," together with the warden, "shall certify the fact of the execution of the condemned person . . . to the clerk of superior court in which such sentence was pronounced." N.C. Gen. Stat. § 15-192.

Importantly, the Medical Board's Position Statement is expressly written in conformity with both of these statutory requirements. The Position Statement provides that "the Board will not discipline licensees for merely being 'present' during an execution in conformity with N.C. Gen. Stat. § 15-90." (R p. 38) The Position Statement further specifies that "certifying death" does not constitute physician participation in execution, provided that the inmate has been declared dead by another person. Id.

B. The Superior Court Erroneously Concluded that the Capital Punishment Statute Requires Physician Participation in Executions.

From the simple statutory requirements that a physician be "present" at executions and "certify the fact of the execution," the Superior Court made the erroneous leap to the conclusion that "the legislature clearly intended that a physician attend and provide professional medical assessment, assistance and oversight in every judicial execution . . . ." (R p. 210) This unsupported conclusion regarding the "intent" of the General Assembly runs contrary to the plain language of the statute as well as the legislative history.

1. The Plain Language of the Capital Punishment Statute Only Requires a Physician to be "Present."

The Capital Punishment Statute requires numerous individuals to be "present" at an execution and indicates no greater role for the physician than any other witness. Specifically, the statute provides:

> *Some guard or guards* or other reliable person or persons to be named and designated by the warden from time to time *shall cause the person*, convict or felon against whom the death sentence has been so pronounced *to be executed* as provided by this Article and all amendments thereto. . . . At such execution there shall be *present* the warden or deputy warden or some person designated by the warden in the warden's place, and the surgeon or physician of the penitentiary. Four respectable citizens, two members of the victim's family, the counsel and any relatives of such person, convict or felon and a minister or member of the clergy or religious leader of the person's choosing may be *present* if they so desire.

N.C. Gen. Stat. § 15-190 (emphasis added).

The plain language of this statute specifies who shall "cause the person . . . to be executed" – some guard or guards or other reliable persons to be named by the warden. The statute further provides who shall be "present" at such execution – the warden, a physician, four citizens, two members of the victim's family, counsel and relatives of the inmate, and a religious leader of the inmate's choosing. The statute provides in no uncertain terms that these are the individuals to be "present" and specifies no further role for any of them. To be sure, this statute

cannot reasonably be read to mandate the participation of all of these individuals in the execution process based on the mere requirement for them to be "present." Certainly the citizens and family members would not participate in the execution, and the services of the inmate's legal and religious counselors would have been provided prior to, not during, the execution. This statute cannot reasonably be read to select only the physician from among this list of those required to be "present" and assign him or her an active role in assisting with the execution.

"In the construction of any statute . . . words must be given their common and ordinary meaning, nothing else appearing." Appeal of Clayton-Marcus Co., Inc., 286 N.C. 215, 219, 210 S.E.2d 199, 202-203 (1974). "Dictionaries may be used to determine the plain meaning of language." Sawyers v. Farm Bureau Insurance of N.C., Inc., 170 N.C. App. 17, 21, 612 S.E.2d 184, 188 (2005). To be "present" means "being at hand or in attendance." The American Heritage Dictionary 1432 (3d ed. 1992). "Presence" is not synonymous with "participation."

The Capital Punishment Statute further shows why a physician is required to be present at executions. The statute requires that, following the execution, the warden and physician shall file a certificate with the clerk of court to certify the fact that the execution occurred. The statute provides:

> The warden, together with the surgeon or physician of the penitentiary, *shall certify the fact of the execution* of

> the condemned person, convict or felon to the clerk of the superior court in which such sentence was pronounced, and the clerk shall file such certificate with the papers of the case and enter the same upon the records thereof.

N.C. Gen. Stat. § 15-192 (emphasis added).

The warden and physician are treated identically in both statutes. First, the warden and physician are both required to be "present" at the execution. N.C. Gen. Stat. § 15-190. Then, the warden and physician are both required to "certify the fact of the execution" to the clerk of court. N.C. Gen. Stat. § 15-192. The most obvious reason why both the warden and physician are required to be present is so that they can later make the certification required by the statute.

"Where the language of a statute is clear and unambiguous, there is no room for judicial construction and the courts must give [the statute] its plain and definite meaning, and are without power to interpolate, or superimpose, provisions and limitations not contained therein." Union Carbide Corp. v. Offerman, 351 N.C. 310, 314, 526 S.E.2d 167, 170 (2000) (quoting State v. Camp, 286 N.C. 148, 152, 209 S.E.2d 754, 756 (1974)). The Superior Court erred by going well beyond the plain meaning of the Capital Punishment Statute and reading into this statute requirements for physician participation that simply are not there.

2. Legislative History Shows that the General Assembly Did Not Intend to Require Participation by Physicians in Executions.

As recognized by the Superior Court, the language in the Capital Punishment Statute dates back to 1909, when North Carolina was using the electric chair for judicial executions. (R p. 207) This language remained in the statute through the conversion to the gas chamber and, most recently, to lethal injection.

The Medical Board adopted its Position Statement on 18 January 2007. (R pp. 30, 72) The DOC promulgated its Execution Protocol on 6 February 2007. (R pp. 30, 73) As a result of the conflict between these two agency policies, proposed legislation was introduced in the General Assembly in both the House and the Senate that would have resolved this conflict in favor of the DOC's Execution Protocol. However, the General Assembly declined to move forward with either of these bills.

Senate Bill 114 was filed on 8 February 2007, and House Bill 442 was filed on 1 March 2007. Both bills contained identical language that:

> Any assistance rendered with an execution . . . by any licensed health care professional, including . . . physicians . . . shall not be cause for any disciplinary . . . measures by any board . . . including . . . the North Carolina Medical Board . . .

(App. pp. 65-66) Both bills were referred to committee where they remained through the end of the legislative session. Id.

If it was indeed the intent of the General Assembly that the Capital Punishment Statute mandates, or even permits, physician participation in capital

punishment, it had two bills which it could have used to make its intent clear. These bills were under consideration at the very time when the Medical Board had formally announced its Position Statement on this issue. Yet, the General Assembly declined to move forward with either bill, rejecting these legislative attempts to override the Medical Board's Position Statement. This shows that, contrary to the conclusion of the Superior Court, it was *not* the intent of the General Assembly to require physician participation in executions.

During the same legislative session, the General Assembly passed revisions to the Medical Practice Act. Among these revisions, the General Assembly added a new section to the Act that sets forth the "powers and duties" of the Medical Board. N.C. Gen. Stat. § 90-5.1. This new section mandates that "[t]he Board shall . . . [i]ssue interpretations of this Article." This is exactly what the Medical Board has done with its Position Statement.

Accordingly, the legislative history shows not only a rejection of efforts to override the Position Statement, but also support for the Medical Board's authority to issue such interpretations.

C. <u>This Policy Dispute Between Two Administrative Agencies Should be Resolved by the General Assembly and Not the Courts.</u>

Because the Position Statement does not conflict with any statutory authority, this case represents a policy dispute between two administrative agencies regarding whether or not physicians should participate in capital punishment. It is

not the role of the courts to establish this type of policy. City of Raleigh v. Hatcher, 220 N.C. 613, 18 S.E.2d 207, 211 (1942) ("Courts do not say what law ought to be, but only declare what it is."). Instead, that is the role of the General Assembly. "Only the General Assembly . . . can establish the public policy of this State . . . ." D & W, Inc. v. City of Charlotte, 268 N.C. 577, 591, 151 S.E.2d 241, 250-51 (1966). See also Spicer v. Spicer, 168 N.C. App. 283, 290, 607 S.E.2d 678, 684 (2005) ("[T]his situation presents competing policy considerations. A decision regarding how to balance these interests . . . falls uniquely within the purview of the General Assembly.") Indeed, this separation of powers is mandated by the North Carolina Constitution. See N.C. Const. Art. I, § 6 and Art. II, § 1.

It is the General Assembly's role to decide whether it wants to maintain the current method of capital punishment with the current Execution Protocol in light of the conflict with long-standing, well-established principles of medical ethics. The General Assembly could resolve this policy question in a number of ways. It could override the Position Statement, as was proposed in House Bill 442 (App. p. 66) and Senate Bill 114 (App. p. 65). The General Assembly could also choose to require a different method of execution that does not call for medical skills or devices.

Alternatively, it could mandate that any execution protocol conform to the ethical prohibition against physician participation in judicial executions. For

example, when the Kentucky legislature was confronted with this issue, it amended its lethal injection statute to explicitly provide that "[n]o physician shall be involved in the conduct of an execution except to certify cause of death provided that the condemned is declared dead by another person." Ky. Rev. Stat. § 431.220(3) (App. p. 67). Just recently, the United States Supreme Court reviewed Kentucky's lethal injection procedures and decided that they do not violate the Eighth Amendment's ban on cruel and unusual punishment. See Baze v. Rees, 128 S. Ct. 1520 (2008). This Supreme Court decision shows quite clearly that it is possible to design an execution protocol that complies with constitutional requirements, while also honoring the well-established principle of medical ethics that prohibits physician participation in capital punishment.

CONCLUSION

Because the Medical Board's Position Statement was promulgated pursuant to a proper delegation of power by the General Assembly, and because the Position Statement does not conflict with any statutory or constitutional authority (indeed, it explicitly conforms to the requirements of the Capital Punishment Statute), there is no basis on which to determine that the Medical Board acted in a manner contrary to the law. Rather, this case simply presents conflicting policies of two administrative agencies. The proper branch of government to resolve this policy dispute is the branch that delegated these powers to these agencies to begin with –

the legislative branch. It is not the role of the courts to resolve these policy questions. This Court should reverse the Order of the Superior Court.

Respectfully submitted this 2nd day of June, 2008.

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CERTIFICATE OF SERVICE

This is to certify that the undersigned has served a copy of the foregoing ***Amicus Curiae*** **Brief of American Medical Association** on counsel of record for all parties by mailing a true copy thereof, via U.S. Mail, first class postage prepaid, addressed as follows:

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