
LEGISTROTHANATRY: A NEW SPECIALTY FOR ASSISTING IN DEATH

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The debate on physician-assisted suicide and voluntary euthanasia is still active and unresolved. Clear resolution in the near future seems unlikely, because moral visions of the acceptable and unacceptable are diverse, and arguments on practical grounds are supported by little data. Suicide itself is viewed by some as morally unacceptable, but most of that opinion is religiously based. Because we are a secular, pluralistic society, suicide should be viewed, if not as morally acceptable, at least as lying within an individual’s moral purview and not subject to legal prohibition.

If suicide should not be subject to legal prohibition on moral grounds, then it seems difficult on moral grounds to justify, *prima facie*, prohibiting assisted suicide, or its close cousin, voluntary euthanasia.

There is a fundamental difference, however, between suicide and assisted suicide: the former is ultimately chosen and executed by one person with a single set of values; the latter draws in a second person with a second set of values. While the second person may be concerned only with the interests of the suicide subject, there is potential that he may act in his own interest, based on his own values, in encouraging and assisting suicide. Thus, there is an important empirical question that looms larger under conditions of assisting suicide than suicide: to what extent and with what frequency is the act of suicide motivated by the best interests of the subject? Self-serving motivation by the assister may be an attendant risk of a permissive social attitude toward assisted suicide; debate on the subject has provided no clear answers because few unequivocal data are available. Objective evidence that the interests of second or third parties will frequently motivate encouragement of suicide by assisters would argue strongly for legal prohibition of assisted suicide, whereas evidence that this will seldom occur would weigh toward a more permissive attitude that promises substantial benefits to some patients who have unrelievable suffering.

Public support and opposition to assisted suicide have been roughly evenly divided: referendums in Washington and California have rejected and Oregon has passed, all by narrow margins, laws permitting assisted suicide. The concern that motivates much of the support of such initiatives is the desire to retain control of one’s own destiny at the end of life, a desire that some feel may be frustrated by sophisticated life-sustaining technologies. We will assume, for the purpose of this discussion, that the benefits to suffering patients outweigh the risks that suicide may be encouraged or provoked by a misguided or unscrupulous assister. If this assumption were correct, then perhaps assisting suicide should be permitted by law.

If it should be legal, we may ask the question, Should physicians be the assisters? Some say they should, because physicians have access and expertise in the use of appropriate lethal drugs, and, more importantly, they have a responsibility to minister to all a patient’s needs, including relief of untreatable suffering at the end of life. Others argue they should not, because killing by physicians is contrary to their healing role and would undermine the trust that grounds the healing relationship between physicians and patients. Moreover, they argue, there may be a steep slippery slope leading to involuntary euthanasia of incompetent persons when physicians are permitted to assist in or cause death.

We cannot resolve this ethical and legal debate here, because there are deeply held views on both sides of the issue, and there are insufficient empirical data to clarify pertinent issues, like the extent to which trust of physicians may actually be undermined. We would, however, like to propose an answer to the following perplexing question: If assisted suicide and voluntary euthanasia should be legal, and if physicians should not help patients to die, who should? Although curing pneumonia and restoring
coronary blood flow may require the knowledge and skills of a physician, causing death requires no such expertise, so could be carried out effectively by lay persons.

A comment recently made by Shana Alexander suggests a possible solution. In discussing the rise of life-sustaining technology, and end of life decision-making, she said, "... Physicians, I am frightened of you. I no longer trust you. Today I trust my lawyer more than I trust my doctor. Why? Very simple. Because after the lawyer and I discuss my problem, and I listen to his professional advice, and I think it over, and then tell him the way I have decided I want to handle it--at that point, I have a reasonable expectation that he will do it my way. I no longer feel that way about my doctor." Such fears about trusting doctors, at least in end-of-life decisions, may not be groundless. There is evidence that, in this country, physicians usually do not know what their patients’ values actually are; consequently, end of life decisions, like discontinuation of life support and denial of cardiopulmonary resuscitation in the event of arrest, are more likely to be made on the basis of the physician’s values than the patient’s.

We name the following proposition the Alexander Hypothesis: lawyers can be trusted more than doctors to act on the basis of patients’ values rather than their own. If true, this hypothesis suggests an answer to the puzzle of who, if not physicians, should assist in the death of patients who desire it: lawyers. Attorneys who wish to provide this service would require only a small amount of additional training. The knowledge of pharmacology required would be limited to effective doses of lethal drugs, because drug efficacy, side effects, pharmacokinetics, and safety would all be irrelevant. A new legal specialty, legistrothanatry, would comprise lawyers certified in the effective use of lethal drugs and devices. The aim of legistroth-anatrist would be to help people in pain who choose to die comfortably.

Many thorny legal, social, and ethical issues must be addressed before this notion could be implemented: For example, exactly which skills should be required and who should certify practitioners? For which conditions should assistance be indicated (e.g., severe pain, unresponsive to medication, in a non-depressed, terminally ill client) or contraindicated (e.g., otherwise healthy, but suicidally depressed, untreated client)? How could persons with diminished capacities be protected? Would billable hours provide suitable compensation for practitioners? What should be the limits of professional liability of the legistrothanatrist in the (rare) case of negligence leading to wrongful life?

It seems likely that these and many other related problems could be worked out. If so, it may be that Ms. Alexander has hit upon a suitable profession in which to locate the role in question.

REFERENCES


