

How Brittany Maynard renewed debate on ethics of right to die movement

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(The Christian Science Monitor) The decision by Brittany Maynard—a 29-year-old who had received a terminal brain cancer diagnosis—to end her life on Sunday has sparked a heated national discussion about when such a move should be legally available in the U.S.

The California newlywed had argued online and in numerous media appearances on behalf of right-to-die advocates that individuals need the right to choose the manner and timing of their death.

Religious, medical, and social ethicists on the other hand, have spoken out about the social policy's potentially unintended consequences, noting most Americans are deeply ambivalent about right-to-die laws.

Maynard was a very publicly sympathetic figure on behalf of the right-to-die advocates, said Charles Camosy, an associate professor of theology at Fordham University in New York. Her high-profile choice “does give new life to the pro-assisted-suicide movements.”

But, he added, a high percentage of people who support physician-assisted dying do so only in the rare cases where pain medication cannot stop overwhelming suffering. These people are therefore skeptical in cases where suffering is not yet involved, he said.

“Even the very liberal state of Massachusetts rejected assisted suicide in 2012 after those against the law were able to make their case, so it is fair to say that our country is divided,” Camosy said.

Maynard had moved to Oregon, one of five states where some form of access to assisted suicide is legal, during the final months of her life.

She had embraced the death with dignity cause, lobbying for state lawmakers to pass legislation on the issue.

In an October 22 post, she noted, "I want to thank you all, for resonating powerfully with my story. Because of the incredible reaction, something monumental has started to happen. Last week alone, lawmakers in Connecticut and New Jersey came forward in support of DWD bills, and promised to put them back in the spotlight."

"She is a unique case and a very narrow lens on this issue," said Tia Powell, director of the Montefiore Einstein Center for Bioethics.

"Before we start recommending policies on this subject, we should take a broader look at the populations likely to be affected by policies one way or another," Powell said.

She noted that Maynard clearly had access to quality health-care and was not driven by financial concerns. This is far from typical for most Americans, she added.

Powell pointed out that other nations with some form of aid-in-dying policies have done a better job of providing health care to their entire populations first. She noted that while we have technological innovation in medicine, we lag far behind other countries in making it widely available and affordable.

"Before we have a decent safety net in our health care, it's premature to put resources into aid in dying," she said.

Powell worries that without better access to both palliative and curative care, the most vulnerable populations, such as minorities and lower-income families, may find themselves resorting to assisted death "simply as a way to avoid bankruptcy by unaffordable health care or lack altogether."

However, others suggest such concerns are overblown in the face of the tiny numbers of those who actually utilize the aid-in-dying laws.

"Despite the high-profile nature of this and other cases of assisted suicide, it remains extremely rare," said James Hoefler, a political scientist at Dickinson College whose research focuses on end-of-life care and assisted dying. "There has been no evidence of a slippery slope—the concern that this law will lead the most vulnerable (minorities, less educated, and those without insurance) to take their own lives prematurely."

While many have expressed concern that “the law will just be a way of dealing with inconvenient people, ” this has not been Oregon's experience, said Lehigh University biomedical ethics expert Dena Davis.

“Maynard is a great showcase for that: she is not being forced to do this by lack of resources, she is making a choice,” Davis wrote in an e-mail.

But this focus on individual rights “hollows out” our national discussion precisely at the moment when a more subtle and robust conversation about end-of-life issues is urgently needed, said Brett Wilmot, associate director of the Ethics Program at Villanova University in Philadelphia.

“Is there any concern that the increasing availability of aid with dying may begin to tilt toward a duty to die, especially when one fears becoming a burden (emotional, economic, or otherwise) to one’s caregivers?” he wrote in an e-mail.

The debate could shift from a right to assisted suicide in cases of terminal illness to a more general right to die based on quality-of-life grounds, such as for those diagnosed with various chronic diseases or disabilities or those who have suffered serious injuries that result in significant loss of physical function, he said.

“All of us should desire a world with less suffering, but we must also be on guard against letting that noble purpose too easily justify means that we might well want to resist, if doing so seems necessary for preserving other important values alongside that of our respect for patient autonomy,” he said.