The End In Two Acts

Both men were dying. One took advantage of Oregon's Death With Dignity Act. The other, unfortunately, lives in California.

By Lauren Kessler


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Fourteen months ago, Tom McDonald heard the news no one wants to hear. At 76, he was an active retiree who lived in a comfortable ranch house overlooking Lake Oroville, north of Sacramento, a good-looking man with a luxuriant head of silver hair and an outdoorsman's ruddy, fleshy face. He and his second wife, Dolores, traveled the West Coast in their 28-foot RV, took weekend jaunts to Tahoe, lounged with friends and family on their "party barge." Tom went trout fishing. He invented gadgets.

Three years before, he had felt a pinhead-sized bump behind his right knee. The dermatologist thought it was probably nothing to worry about but did a biopsy to make sure. When the results came back positive for melanoma, Tom took it calmly. He had had a cancerous growth removed from his lip years before. They'll just take this one off, he thought, and I'll be done with it.

The doctors thought they got it all. But a later CAT scan showed that the melanoma had penetrated deep into the tissue. On Jan. 5, 2006, in his doctor's office in Roseville, Tom and Dolores heard the results: The cancer had spread to his shoulder, into his lungs and was threatening to move to a lymph node beneath his jaw. Chemotherapy doesn't work well in these cases, the doctor explained, and radiation isn't much better. Tom had, the doctor figured, a year to live.

It took Tom only a few days to think through his situation. A 30-year career as an electronics technician, much of it in the aerospace industry, had taught him to look at problems dispassionately, find the elegant solution—simple, workable, quickly implemented—and then go to it. His terminal disease was the problem. His solution was simple: When the time came, he told his wife, daughter and son, when he felt he could no longer tolerate whatever the end-stage illness was doing to him, he would take matters into his own hands.

IN THE U.S., citizens have many rights, but they do not, strictly speaking, have the right to control their own deaths. Although attempting to take one's life isn't considered a felony, aiding and abetting the act is. If Tom McDonald wanted, or needed, medical help to end his life, he couldn't legally get it in California, where it's a crime to help terminally ill patients hasten their deaths. Now California—for the fifth time in 15 years—is considering legislation that would decriminalize such assistance. A bill similar to one defeated by a single vote in the state's Senate Judiciary Committee last summer was just introduced, with proponents hoping to take advantage of what they see as a more favorable atmosphere in the Legislature following the November
2006 election. (A Field Poll of registered voters last year showed that 69% believed incurably ill patients should have the right to ask for and get life-ending medication.) Should the bill become law, California will be the second state—its neighbor, Oregon, is the first and only—to legalize aid in dying. The California bill, modeled after the Oregon law, would allow a doctor to prescribe lethal drugs to a terminally ill patient.

When the state Senate Judiciary Committee held its hearings last June, Tom McDonald was there. He was then six months into what he had been told would be the last year of his life.

"My doctor told me I'd know when I'm near the end because I'll be coughing up blood," he testified. He was sitting motionless, a little slumped, at the witness table. "I'm not too thrilled with the prospect of ending my life drowning in my own blood." His voice cracked. Someone brought him a glass of water, and he composed himself. He didn't want to expose his family to the "horrors" of his dying, he continued. He didn't want to lose his dignity. In the absence of a humane and legal way to end his life, in the absence of help from a compassionate doctor, Tom said he didn't want to end his life violently, as some in his situation choose to do. He had expressed a different opinion in a letter he had written earlier to California Assemblywoman Patty Berg, the bill's cosponsor. In the letter, he said he planned to end his life with "a 9mm injection to my head."

During the months between Tom McDonald's first and second surgeries, David Bradley was diagnosed as terminally ill. He had esophageal cancer—like melanoma, tough to beat. He had noticed months before that he was having trouble swallowing, but Midwestern-born David was not one to run to a doctor. He was 79 years old, and had become, in his later years, part desert rat, part cowboy.

He lived alone in the high desert of southwest New Mexico. He stopped every morning for coffee at a cowboy diner, rode his horse, walked his dog, painted, socialized, took photographs. He worked out at a gym several times a week. He was a free spirit, a nature-lover, a man who carried an eagle feather talisman, a man who had married and parted company with four wives.

He learned during the winter of 2005 that he had six months to live. For him, as for Tom McDonald, the reaction was swift and decisive. "I'm just going to take care of this myself," he told his family. They knew what he meant.

But David had something that Tom did not. David had family in Oregon. If he moved there to stay with one of his daughters, he would have—if he cared to exercise it—a choice about how and when he died. He could, unlike Californian Tom McDonald, legally and with medical consultation and support, end his own life.

For more than nine years it has been possible in Oregon for a competent, communicative person with a documented prognosis of six months or less to live to obtain a prescription from a doctor for a lethal dose of barbiturates. The person must be capable of taking the medication him or herself. There are no injections. There is no Dr. Kevorkian standing bedside.

Although Oregon's Death With Dignity Act is simple and straightforward, the public battle to keep it in place has been anything but. Oregonians passed the law in 1994 only to have it immediately challenged by the National Right to Life Committee, the powerful antiabortion lobbying group. A U.S. district judge ruled in favor of Right to Life, and an injunction against the Oregon law kept it in limbo until the ruling was overturned on appeal in October 1997. Right to Life then sought a review by the U.S. Supreme Court, meanwhile lobbying the Oregon Legislature to call for an election to repeal the act. When the high court refused to hear the case,
and when Oregonians overwhelmingly re-endorsed the legislation at the polls in 1997, it looked as if the battle was over.

It wasn't.

Four years later, then-U.S. Atty. Gen. John Ashcroft, followed by his successor, Alberto Gonzales, challenged the legislation. It took two U.S. District Court cases, two appeals to the 9th Circuit and, finally and decisively, a Supreme Court ruling in January 2006 to uphold Oregon's Death With Dignity Act.

During all that, the act was quietly working. According to the most recently available figures compiled by the Oregon Department of Human Services, 246 people took lethal medications between 1998 and the end of 2005. Information about who they were, what diseases they had and why they chose the option they did has been dutifully compiled in annual reports. The picture that emerges is nothing like the picture feared by those who have argued, in California and elsewhere, against such a law. Those against the Oregon law feared that aid in dying would be used disproportionately by the poor, the uninsured, the uneducated or those living with lifetime disabilities. Those who couldn't afford decent end-of-life care might choose death to remove the financial burden on loved ones. Those with lifelong disabilities might conclude that their lives were not valued if society provided for a quick exit. Some argued that the state might be tempted to provide less medical assistance for the poor and disabled because the option of death was easier and cheaper.

So far, none of that has happened in Oregon.

All of the people who used the act in 2005 had private or public healthcare coverage, and almost all were enrolled in hospice programs when they died—and thus already receiving compassionate end-of-life care. College-educated Oregonians were almost eight times more likely to use the act than those without a high school diploma. And, contrary to fears, those with lifetime disabilities have not used the act. Oregonians who hastened their own deaths were most likely to be in the end stages of cancer, AIDS or ALS.

As for the broader concern that the option of physician-assisted death would make citizens, politicians and the medical community callous to end-of-life care, the opposite has happened in Oregon. The state is a national pioneer in such care, according to national data compiled at Dartmouth and studies conducted by the Oregon Health Sciences University Center for Ethics in Health Care. That, say many in the healthcare community, is a direct result of the extensive public discussion that has surrounded Oregon's death with dignity legislation, as well as the existence of the act itself, which has challenged stalwart opponents to enhance end-of-life care.

Sitting in room 4203 in the California state Capitol last summer, Tom McDonald didn't know much about the Oregon law. What he knew, as he testified before the committee, was that he was dying. He was dying, and he didn't want to die in pain. More than 40 years ago, his mother had died in pain.

She was at home, in bed, with end-stage cancer. These were the days before hospice care, before sophisticated pain management. A shelf in the kitchen refrigerator was stacked with little bottles of liquid morphine. Maybe the pain was too great, or the dosage too small, or the twice-a-day injections his older brother administered too infrequent, because what Tom remembered when he came by the house every afternoon was his mother, in agony, waiting for the next shot.
Tom was not afraid of the fact of death. He was afraid of the act of dying.

A few days before Tom McDonald testified, Dr. Nick Gideonse sat before the Senate committee. An Oregon physician, Gideonse had talked with dozens of patients about Oregon's law. He had written eight prescriptions for life-ending drugs under the law, and had been at the bedside of six people who took drugs to hasten their deaths. He knew that terminally ill patients often feared pain, along with loss of independence and loss of control. He had learned that, for many people, simply knowing that they could take control was relief enough. In 2005, for example, doctors wrote 64 lethal-dose prescriptions, but only 32 of those people used the medication to end their lives.

Gideonse, a lanky, energetic man with wiry salt-and-pepper hair captured in a low ponytail, had gone to Harvard and Case Western Reserve. He'd been an EMT in Boston, a country doctor in rural Oregon and was now a family physician and part-time medical director at a clinic in Portland that served the poor. Intense and driven, he also is tender-hearted and soft-spoken, one of those physicians who understand the medicinal qualities of eye contact.

He was in Sacramento to explain to the committee how a Hippocratic oath-swearing physician could be actively involved in helping people die. He had not been an immediate fan of the law. His patients had converted him. He told the committee: "The notions that physicians know best and that the patient cannot be trusted with the ability to make good decisions about their care, even the care at the end of their life, is an outdated ethical precept."

David Bradley had first met Gideonse in the Veterans Administration hospital in Portland. David had moved there from New Mexico after calling his daughter Allison to tell her about his six-months-to-live prognosis, saying that he would "take care of it himself."

Even over the phone she heard fear and uncertainty in his voice. She hung up and immediately called Compassion & Choices of Oregon, the organization that, since 1997, has been providing support and information to Oregonians considering using the aid-in-dying law. She talked with George Eighmey, an attorney and former state representative who is the nonprofit group's executive director, and felt, despite her anguish over her father's illness, a sense of comfort, even hope. Allison reported the conversation to her father, and he decided he would go to Oregon to stay with her and her family, and begin to plan a peaceful death.

Comfortably installed in a spare upstairs bedroom in Allison's home, David spent his first six weeks in Portland quietly. He read, phoned friends, enjoyed his grandchildren, thought about his life. Then, one day, he was rushed to the VA hospital. The cancer, blocking his throat, had made swallowing increasingly difficult. He was coughing all the time. Now he had pneumonia. Soon he would be too sick or too weak to self-administer the lethal drugs. He needed to formally make a request under the Oregon law to get the process going. Gideonse was called in to see if David "qualified," meaning that he was not desperate or depressed, not mentally unstable, but rather fully competent to make this decision. They talked for a long time.

"I want to wrap things up," David told the doctor. I want to "finish the story." He said: "I am hoping you will help me die."

Gideonse wanted to know what David was afraid of. David did not have to die in pain, but it was not pain he feared. It was that his quality of life was untenable. Just five months before, David had been riding his
horse every day. Now he was virtually bedridden, taking nourishment through a tube in his stomach. Gideonse understood. You could palliate pain, but you could not palliate loss of independence.

When David was released from the hospital the next day, Gideonse visited him at Allison's home, the first of four house calls he was to make during the next two weeks. They talked it all through. David understood what medication he would take, how he would take it and what exactly would happen. All the necessary paperwork was filed. In a week, David would get his prescription for liquid Nembutal.

It was December 2006, and Californian Tom McDonald figured he had a month left to live. But with the clock ticking, he still had no plans in place to control his own death. From his home overlooking Lake Oroville, Tom was now in e-mail correspondence with a counselor at the national Compassion & Choices organization (www.compassionandchoices.org), a nurse named Helen Beum who worked out of the organization's northwest Portland headquarters. She was one of five counselors who fielded questions from people all over the country. The office got more than 250 calls a month and actively worked with about 200 clients at a time, helping people such as Tom, terminally ill people without the legal choice that Oregonians have, figure out how to hasten their own deaths.

Tom had decided against the "9mm injection." It would be too traumatic for his family. He wanted to do what Oregonians could do—take a lethal dose of barbiturates. Helen knew this would not be easy, but it was possible. At Compassion & Choices, they called it the "wink-wink approach."

It worked like this: While counseling patients about their options, she would offer information about which drug would be most suitable and how to phrase the request to a physician for a prescription. A sympathetic doctor might write such a prescription. But prescriptions for such drugs could be written for only a one-month supply, not enough to reliably cause death. That meant Tom would have to stockpile the pills, ask for another one-month prescription, stockpile those pills and then ask for a third prescription. Advance planning was essential. A two-month minimum was necessary. Tom McDonald, with what he thought was a month left, hadn't begun the process.

Downstairs, eight people sat in a circle on the floor, including David's three daughters and his sister. In the
middle of the circle were objects Allison had gathered that were important to David: the eagle feather, the Leatherman tool he always carried with him, a battered stuffed animal he had when he was a child. Each person picked up an object and told a story about it. Then they went around the circle again, this time each person holding David's eagle feather and saying whatever they wanted to say. David had wanted someone to recite the strong, unsentimental poem John Wayne had said at Howard Hawks' funeral, "Do not stand at my grave and weep," and so someone did.

Upstairs, David yawned. The Nembutal was beginning to take effect. David motioned Gideonse closer. He had one more thing to say.

"You know," David said quietly, "I've done a lot of things right."

David smiled and closed his eyes and fell asleep. Within a few minutes, he was unconscious. Within 10 minutes he stopped breathing. Gideonse felt for his pulse and found none, listened for his heartbeat and heard none.

Downstairs, Allison felt a change in the air pressure in the room, as if someone had opened a window.

It was January 2007, a year and a half after David Bradley's death, a year after Tom McDonald's diagnosis. Tom's Compassion & Choices counselor, Helen, had been e-mailing him, concerned that he was not taking the steps that would allow him to control his own death. Tom hadn't followed up.

Partly that was because, to his great surprise, he was not yet experiencing the significant pain he associated with the end game. If he wasn't in agony, then maybe everything was OK. If he wasn't in agony, then perhaps he wasn't really dying. When the time comes, he said to himself, I'll do something.

He didn't want to think about it. No one but Helen, in occasional e-mails, was asking him to think about it. She had told him about difficulties in finding a sympathetic physician, about the time it took to stockpile drugs. Now it was up to him. Compassion & Choices didn't give referrals to physicians in other states. There was no master list of doctors who might agree to write prescriptions. Tom thought his primary-care doctor would know just why he was asking for the drug, and he was pretty sure she wouldn't write the prescription. He had no idea who else to ask.

In California, doctors cannot openly discuss such end-of-life issues with their patients. Tom had never had what Gideonse called "The Conversation," the frank talk with a knowledgeable, sympathetic physician who knew him well, the talk about death, how it would occur and how it might be hastened. Tom had testified in favor of California's aid-in-dying legislation, but now, when it counted, he had very little aid for himself.

Maybe Tom McDonald will find a doctor to write a prescription, and maybe he will live long enough to stockpile the pills. And maybe, when the time comes, he will be physically able to take them. Or, if California's fifth attempt at passing aid-in-dying legislation is successful, Tom McDonald can relax into his final days and still get the kind of death he wants, the kind David Bradley had: peaceful and painless and in his own bed, at home.

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To see Tom McDonald's testimony before the state Senate Judiciary Committee, go to www.latimes.com/endoflife