

60 REASONS TO SUPPORT NEW YORK'S MEDICAL AID IN DYING ACT

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Reason #18

So that no one's Thanksgiving dinner ends with a shotgun to the head in the barn out back because nothing else could provide relief.

Harry was a quirky, irascible guy in his early 60s with gray short-cropped, thinning hair that once had been blond. He wore steel-rimmed glasses usually in need of cleaning. Oddly he often arrived at appointments with bedroom slippers on. These would come in handy as his feet and ankles grew swollen.

He had smoked 2 packs of unfiltered cigarettes for 40 years. Now, due to chronic obstructive lung disease (COPD), any smoke irritated his inflamed airways and made him cough and gasp. The mere presence of tobacco smoke in a room now made him feel smothered and panicked.

As the months and years went by Harry's condition worsened, requiring more inhalers, steroids, water pills and round-the-clock oxygen. At first, he came to the office with a cane then a walker and finally a wheelchair. He was breathless and fatigued most of his daylight hours. His heart began to fail.

Shortly after Thanksgiving in the last year of Harry's life, my nursing colleagues brought me an obituary clipping from a local paper reporting his death. I called his home and spoke with his wife, Carol. She sobbed and had trouble telling me about Harry's death. As I came to understand the events of that Thanksgiving weekend, I shared her shock and sadness.

Carol explained that as the family gathered, Harry could barely talk. He had been restless and sleeping poorly. Harry told her he did not think he could eat the holiday meal — a full stomach caused more breathing distress. But on Thanksgiving, he made an effort and picked at some turkey and squash. He managed to eat some pumpkin pie with ice cream.

On the Saturday morning after the celebration ended and the children left, Carol awoke and Harry was not in the house. She called for him.

Receiving no answer she went to the barn and found that Harry had taken his life with one of his prized museum-quality Remington shotguns. Chaos ensued and the family was horrified, shattered, and numb. Harry's violent death marked this family indelibly.

This sobering experience caring for Harry taught me several important lessons.

First, There are finite, unforgiving limits to the power and magic of medical science. Second, wishful thinking creeps into clinical judgment in subtle ways. We know from medical research that the stronger the bond between caregiver and patient the less accurate the prognosis. Wishful thinking is a covert enabler of denial — here false hope erodes judgment. Caregivers need to be on guard against overly optimistic prognoses.

Third, for some patients, sudden, horrific, violent death is preferable to protracted suffering, humiliation and loss of autonomy. Could anyone have talked Harry down given his gasping, breathless days and nights? Was there an alternative to his violent end? I believe there should have been.

That brings me to my fourth lesson: there has to be a way to extend our medical care beyond curative medication, oxygen, and wheelchairs.

Harry should have had the option to end his life at the time and in the place he chose. If he had lived in a jurisdiction where medical aid in dying is now authorized, he would have had that option.

Imagine a scenario with Harry's family gathered at his bedside supporting and comforting him as he peacefully ended his life and the suffering he had endured. His end would have been dignified rather than horrific. Ultimately, this is what many people want in their final days.

As a physician who would have liked to give my patients the gift of peace at the end of their lives, my goal is to make the medical practice of aid in dying an open, accessible and legitimate option for terminally ill, mentally capable adults with less than six months to live.

We owe it to the sickest among us. We owe it to generations to come. We owe it to ourselves.

To join our mission, email Amanda Cavanaugh at acavanaugh@compassionandchoices.org.

