The Last choice
By Josh Sanburn
San Francisco

DANIEL SWANGARD NEVER THOUGHT HE WOULD LIVE A LONG LIFE. IT was a premonition he and his sister both had, like a cancer they silently carried with them. But neither talked about it until Swangard felt something hard and curious in his abdomen.

In March 2013, doctors discovered that Swangard, a 49-year-old anesthesiologist in Bolinas, Calif., had a mass in his liver the size of a grape-fruit. The initial diagnosis: hyperplasia, a benign tumor most often found in women. But Swangard thought differently. This is the beginning of the end, he told himself, his portent fulfilled.

When doctors went in to remove the growth, they discovered the real evil lurked in Swangard's pancreas, where a neuroendocrine tumor—the same kind that killed Steve Jobs—had developed into the size of a golf ball. They took out half of Swangard's pancreas, his spleen, part of his liver, and his gall bladder, leaving a 12-in. incision running from his sternum to below his belly button.

Today, Swangard's cancer is in remission, and when we met for lunch at a San Francisco taqueria over the summer, it was impossible to tell that he lives without a full set of vital organs. Toned, tan and maniacally com-mitted to his health—he ordered a single mushroom taco—Swangard looks like he's in the best shape of his life. But the disease that could have killed him has a coin flip's chance of returning. And if it does, he doesn't want to waste away like some of the terminally ill patients he's treated. He wants options. He wants a say in what could be the last decision he'll ever make. "I don't want to die in a hospital," Swangard says. "I've seen that happen. I don't want to be in a morphine fog. I want to be somewhere that's familiar to me and have the people around me that I love."

That choice may soon be possible. On Sept. 11, the California legislature passed a bill modeled after a law in Oregon that would allow physicians to prescribe life-ending medication for terminally ill patients. If Governor Jerry Brown signs the measure into law, California will become the fifth state to adopt a so-called right to die—and the first since the 2014 death of Brittany Maynard, the 29-year-old newly-wed who ended her own life after learning she had terminal brain cancer. If the Golden State's measure takes effect, it would also provide a jolt to the 23 other state legislatures that have proposed bills to legalize the practice since May-nard made use of Oregon's Death With Dignity law.

Maynard's wrenching story revived the debate over assisted suicide, giving the movement—which favors the more palatable terms death with dignity or end-of-life option—a champion who could command headlines and sympathy in equal measure. But in the tangled politics of the California legislature, where social issues can be decided by religion as much as party, that only counts for so much. In California, a critical reason the right-to-die bill passed Brown's desk was that doctors like Swangard advocated for it. Swangard sued the state earlier
this year to legalize the practice and is one of a growing number of physicians who publicly support letting terminally ill patients end their own lives.

In the spring, as negotiations over the bill intensified, the California Medical Association became the nation's first state-wide medical group to drop its opposition to aid in dying (its official stance is now "neutral"). The move, which several legislators described as essential to the law's passage, would have been considered anathema a generation ago. But no longer. While many medical groups oppose letting healers have any role in ending a life, plenty of doctors have come to feel otherwise. In a December 2014 Medscape poll of 21,000 doctors, 54% supported physician-assisted dying, up from 46% in 2010 and the first time a majority backed the practice.

Although nearly 70% of Americans favor legalizing aid in dying, efforts to do so often fail because of opposition from three groups: the Catholic Church, disability-rights organizations and doctors. If the shift in California is any indication, the nation may be headed for the biggest expansion of the right to die since it was first legalized almost two decades ago.

FOR CENTURIES, physicians tended to take a paternalistic approach to their patients. Doctor knows best, after all, and patients' wishes rarely factored into decisions about care. That began to change in the 1960s when doctors started telling patients the truth about serious diagnoses like cancer, the sort of gut-punch news that was once thought better to soften.

By the 1970s, physicians began practicing informed consent—letting patients know the risks of a procedure and obtaining their approval before going through with it. That helped lead to the wide-spread establishment of malpractice laws and the redefinition of care standards from what a reasonable doctor thinks should take place to what a reasonable patient should expect.

At the same time patients have become more empowered, medical breakthroughs have allowed us to live much longer with diseases that would've killed us years ago. "If you went back a generation, doctors did what they could, but their bag of tricks was small," says Arthur Caplan, the director of medical ethics at New York University. "Now it's possible to keep a dead body going on machines. You have more people who are older making it into the hospital where they use these technologies, and there are more older people who are surviving longer."

This has led to an explosion in end-of-life care. Hospice, which is designed to relieve pain and suffering for those with no chance of recovery, is now a $19 billion industry in the U.S. and projected to grow 7% annually. One and a half million Americans receive some sort of palliative care each year. But the caliber of that care varies widely, as does a patient's quality of life. For many, the prospect of choosing the terms of their death can be preferable to surrendering control to drugs and ventilators. "This is the endpoint in that evolution from doctor-centered to patient-centric care," Caplan says.

Since Hippocrates, doctors have taken their credo to be Do no harm. But what if a patient believes the treatment to keep them alive is more harmful than death? Being told she would likely die in a medically induced coma after losing her faculties is what prompted Maynard to
move to Portland, says her husband Dan Diaz. "That's the reason Brittany spoke out," he says. 
"It's ridiculous that somebody who's been told that they're going to die in six months has to drive 
600 miles north to die peacefully."

Her story resonated with the 40,000 members of the California Medical Association. Like 
many physicians, its doctors have wrestled with quietly giving a terminal patient extra painkillers 
that could ease their suffering—and potentially take their life. "There are many times when 
you're facing somebody with terminal illness when you have to say, 'If I give you this medicine, 
which will stop your pain, you may not wake up,'" says Dr. Theodore Mazer, a San Diego ear, 
nose and throat physician who is the speaker of the CMA's house of delegates.

The sense that patients have a right and doctors have a responsibility—to play a role in 
that decision prompted the CMA to abandon decades of institutional precedent. "Thirty years ago 
I would've said physicians never should've been involved in this," says Dr. Tanya Spirtos, a Red-
wood City, Calif., obstetrician and gynecologist on CMA's board of trustees. "But we couldn't 
just stand behind a blanket opposition statement we came up with in 1987."

CENTURIES OF MEDICAL ETHICS, however, can be difficult to discard in a generation. Many doctors are still strongly opposed to aiding dying, including the American Medical 
Association, the nation's largest physician group. Oncologists, who spend their lives fighting our 
most deadly diseases, tend to be particularly resistant to the practice.

"Having choice at the end of life is a very valid argument," says Dr. Daniel Mirda, an 
oncologist in Napa, Calif. "But we're never taught anywhere how to really kill someone. To 
administer some-thing is a really big step, and I think oncologists often feel that step is difficult 
to accept when so much of our effort is really protecting the patient from the consequences of 
their illness."

Prescribing a patient life-ending medication, Mirda says, is "like saying, 'I don't have a 
chance of helping you."

Some opponents say the conversation about end-of-life treatment in America shouldn't be 
about expanding a right to die but should focus instead on the quality of end-of-life care. Two-
thirds of hospice providers certified by Medicare were for-profit in 2013, the most recent year for 
which figures are available, which has led medical experts to question whether they're cutting 
costs at the expense of care. The palliative-care industry is four times bigger than it was in 2000, 
but oversight is lagging. More than half of the nation's facilities have been cited for medical and 
safety violations, while the average facility has not been fully inspected in over three years, 
according to an investigation by the Huffington Post.

"It's a little bit like approaching fire safety not by enforcing building codes and 
mandating safety education but by building diving boards to nowhere on the top floors;' says Dr. 
Ira Byock, a palliative-care doctor and one of the leading right-to-die opponents. "The public
knows that people are dying badly, but we're not having those conversations, and instead of fixing the problem, we're simply legalizing assisted suicide."

Other critics cite the potential for abuse. Marilyn Golden of the Disability Rights Education & Defense Fund says patients can be pressured to use the law by family members or choose to end their lives because it's less costly than continuing treatment. Data so far suggests coercion is limited, if it happens at all. In the four states that allow aid in dying, only a small percentage of terminally ill patients ever make use of the law. In Oregon, for example, 1,327 people have been prescribed life-ending medication since it was allowed in 1997, and 859 have actually died from taking it.

The largest obstacle to expanding the practice may be the oldest argument against it: that suicide devalues life. Only a handful of countries allow physician-assisted death, and an attempt to add Britain to the list failed in Parliament the same day California's measure passed. A few have legalized euthanasia, in which physicians actually kill patients through lethal injections. Some opponents warn that expanding aid in dying could lead to physician-prescribed treatments for nonterminal diseases like depression, a practice allowed in Belgium and the Netherlands.

"There are only a very few things from antiquity that have been honored well," Byock says. "One is that we don't let doctors kill patients. The proscription against doctors killing patients is one that we erode at our own peril."

THE QUESTION is likely to weigh heavily on Brown, a practicing Catholic who considered becoming a Jesuit priest before entering politics. The Democratic governor, who will have 12 days to decide once the bill hits his desk, criticized his party's strategy of using a special session to maneuver around socially conservative legislators, but he also spoke with Maynard days before she died. His faith may play a role, but so will politics. Brown is courting the Catholic Church's support for his efforts to reduce greenhouse-gas emissions. And while polling shows three-quarters of Californians support the right to die, public opinion may not sway a popular, term-limited governor.

"If California passes it, that'll be huge because that's a big state with major implications for the country," Caplan, the NYU bioethicist, says. "People can look at Oregon and say, 'Oh, that's a bunch of tree-hugging secularists somewhere out at the end of the country! You can't dismiss California that way!' Indeed, California has long been a policy bellwether for other states, and a right-to-die law could create momentum around the nation. A similar bill in Maine was defeated by a single vote earlier this year, and New Jersey is expected to revisit the issue in the fall.

It would be a welcome victory for Swangard. "Dying is something we all have to go through, some of us sooner than we'd like to,” he says. “I think dying is a really sacred thing that happens. It's a time that's really ripe with potential for it to be peaceful. The whole point is just to give people the choice.” Should his cancer come back with symptoms that make living unbearable and death imminent, he says he'd be glad to have the option, even if he doesn't end up taking it.