Men's Health

THE DOCTORS OF MERCY

Physician-assisted suicide: Should the men who save our lives be able to end them too?

By Bob Drury, Photographs by Marc Asnin

Editor's Note: This article is part of a 3-part series on doctors. Also check out "The Doctors of War," about what doctors and medics go through to save lives on the battlefields of Iraq, and "The Doctors of Chaos,"about the medical personnel who save lives in Darfur.

The patient meets me in his front yard. It is the noon hour, "my best hour," he says, when he has the most strength to converse. He is not as frail looking as I had anticipated.

He wears a denim shirt, khakis, and white tennis shoes, with a blue kerchief tied around his neck. Above his gray goatee, below his rheumy green eyes, his cheeks are drawn and sallow -- from jaundice, he would explain later. His full head of meringue hair, parted on the side, has been spared the ravages of the chemotherapy treatments for the cancer that has spread from his colon to his liver, and is now attacking his vertebrae.

In obvious pain, he walks me into his house on a leafy cul-de-sac tucked away in Oregon's Willamette Valley. It is late June, thick stands of coniferous trees are in full splendor, and the air is sweet with the aroma of ripening pinot gris grapes from the vineyards interlacing the valley from the coast to the Cascades.

We stroll through the foyer and into a dining room, the walls adorned with oil paintings he created in his spare time during a career as a scientist, medical-school professor, and biotechnology researcher at a university in nearby Portland. He introduces me to his wife, who is a pediatrician, and explains that she is the reason for his requested anonymity. He's already been harassed by protesters, he says. "I'll be gone by the time your article comes out, and I would not want to burden my wife with more of that by having my name publicized in a national magazine after I'm dead."

Then The Patient, who despite his illness looks at least a decade younger than his 79 years, begins to explain how he came to the decision to take advantage of the Oregon statute -- the only one of its kind in the United States -- that sanctions physician-assisted suicide. "Up until a few weeks ago, my wife and I were able to walk the dog every morning, perhaps a mile each day," he says. "No longer."

As his liver was overwhelmed by the cancer -- "biological dissolution," he calls it -- his ankles swelled

to the point at which even walking to his front door caused excruciating pain. He had discontinued his chemotherapy treatments 6 weeks before, when analysis showed no headway, yet his daily bouts of nausea continued to increase in number and intensity. His immune system crumbling from the chemo -- - therapy, he contracted shingles. He was so uncomfortable that he asked his wife if it was time "to start the process." She instead prescribed the antiviral drug Valtrex, which provided some relief, and the decision was postponed.

"I wouldn't be here talking to you right now if my wife wasn't a doctor," he says.

After meeting all the rigorous medical qualifications of Oregon's Death with Dignity Act, he discussed his decision to take his own life with his five children and numerous close friends. Although he sensed that two of his daughters were not pleased, neither they nor anyone else tried to dissuade him. "Lapsing into a coma, dying peacefully, that would be one thing. But you cannot control that," he says. "I imagined lying in a hospital bed with a morphine drip, still receiving the chemo, my central nervous system destroyed."

His wife says, "'Control' is the big word for my husband; control over his own destiny."

He says, "Just lying there. Without the joy of memories. The memory of being alive. The memory of loving, and being loved. Insensate . . . " His voice trails off, and his wife gently places her hand over his.

"I see this as a clinical process," he goes on. "It's the teacher in me. Birth, adolescence, maturity, old age, death. Death is the end of growth. I feel it is my right to decide."

I glance over The Patient's shoulder and down a hallway beyond the kitchen. I wonder in which of the bedrooms he will methodically break apart 100 capsules of secobarbital, stir the powder into a bowl of applesauce, shake his physician's hand, kiss his wife goodbye, and kill himself.

No More Pain

In the spring of 2005, around the time of the Terri Schiavo political controversy, I wrote about my mother's death for the first time. Though her body was ravaged, her will remained iron, and she had been adamant about dying at home. So, against the advice of her doctor, my father and I bundled her into a blanket, and I carried her out to the family car. She was light, as if her bones were hollow. I doubt much more than 100 pounds. She was 59 years old.

Two decades earlier, my mother had been diagnosed with breast cancer. She'd undergone a radical mastectomy and hysterectomy, which she was not supposed to survive. But she went into remission,

kicked the Carltons, and watched her four children grow into adulthood. She said she was lucky. My younger sisters, my younger brother, me, we were luckier.

In 1988 the cancer came back. This time it metastasized to her lungs. Death sentence. She underwent months of chemotherapy with grace and dignity. She occasionally smoked again -- "What the hell," she said. She was weak and dizzy and nauseated. But she never showed the pain.

Toward the end, I began to commute each day to my parents' town in northern New Jersey. My boss at the time pretended to be a tough guy, but in fact had an enormous heart, and he gave me work I could do by phone. My father still went to work on his one leg, but he was in pretty bad shape -- he died a year later from a diabetes-fueled heart attack. My sisters and brother did not deserve a deathwatch. I was the oldest. It's what oldest sons do.

The day after we took my mother home from the hospital, she fell. I heard the thump and ran upstairs. She was on the bathroom floor. Too proud to ask for help to pee. Her forehead was gashed, badly. She was unconscious, her head lolling in a pool of blood.

My father met me at the hospital. When they allowed us in to see my mother, it was too much for my sisters. Her arms and legs were no thicker than kindling, her rice-paper skin bruised purple and yellow from the fall. A blood-caked bandage covered her head. She tried to talk, but it came out as a rasp. An oxygen tube fed into her nose. A morphine drip snaked into her right arm.

My mother lived that way for 3 days, straddling consciousness. On the fourth day, my father asked me, my sisters, my brother, and my grandmother to leave the hospital room so he could be alone with my mom. After a time, he asked me to come back in. "Your mother and I have talked," he said. His face was contorted, anguished. "She doesn't want to be in any more pain, and I don't want her in any more pain." I was holding my mother's hand. "You tell the doctor. No more pain. Do you understand what we are saying?"

I nodded and looked at my mother. Her eyelids fluttered. She croaked out the word "dignity" and squeezed my hand. I don't remember why or how, but I knew about morphine drips. What they could do. I also recalled a snatch of Latin from my Catholic prep-school days. Petrarch wrote, "A good death does honor to a whole life." Back in the hallway, I took the doctor aside. I understood why my father couldn't do this. "My mom is in a lot of pain," I said. "You have to increase the morphine drip."

Our eyes met. He said nothing but knew what I was asking. "It's what she wants," I said. "No pain." I gripped his shoulder, squeezed, to bring the point home. He nodded. He increased the drip.

My mother died the next morning. In the hospital. It was the last place she wanted to die.

When I tell this story to Timothy Quill, M.D., the lead plaintiff in the court challenge to overturn the New York State law prohibiting physician-assisted suicide -- one that ultimately failed -- he is not the least bit surprised. "Doctors are involved in these kinds of cases all the time," he says.

"Outside of Oregon," he goes on, "what the current regulations kind of force you to do -- as you describe with your mom -- is to keep it ambiguous. Wink wink, nudge nudge. To me, that's incredibly dangerous. Let's get it out in the open. Let's allow the patient to decide, clearly, with no ambiguities. Let's do this with the proper safeguards and oversight. Unfortunately, as of this moment, in the United States only the State of Oregon is allowing this to occur."

Dr. Quill is a professor of medicine, psychiatry, and medical humanities at the University of Rochester, in New York, where he directs the Center for Palliative Care and Clinical Ethics. He is also a practicing palliative-care physician who, in 1991, published in the *New England Journal of Medicine* the story of one of his patients, an adult he called Diane. Diane had requested assistance in killing herself after a long, debilitating battle with leukemia. After ensuring over a period of months that Diane's illness was terminal, that she was of sound mind and not despondent, Dr. Quill complied with her appeal for a prescription for barbiturates.

He wrote at the time, "I made sure that she knew how to use the barbiturates for sleep, and also that she knew the amount needed to commit suicide."

Dr. Quill says today that his objective in documenting Diane's case was to make people think more deeply about the issue. "It's an intense experience for any doctor. But there are a lot of things doctors do that are intense," he says. "We take people who are dying off ventilators. We help people stop other treatments when we know they are going to die.

"This is part of what it means to be a doctor," he continues. "If you're going to take care of really sick people, you need to take care of them all the way through to death."

Go on to the next page to read more about legal assisted-suicide in Oregon...

License to Kill?

It's not easy to kill yourself in Oregon. Certainly not as easy as the law's opponents suggest. First, the patient must be a "mentally capable" adult with a terminal illness that will lead to death within 6 months, as diagnosed by an attending physician. The patient must make two verbal requests, separated by at least 15 days, for a prescription for lethal medication. The patient must also provide a written request for the lethal medication, signed in the presence of two witnesses. It is the prescribing physician's duty to inform the patient of feasible alternatives to assisted suicide, including hospice care and pain-control therapy. Finally, if either the attending physician or a (required) consulting

physician believes the patient's judgment is impaired by a mental disorder, the patient must submit to a psychological evaluation.

"They are not just handing these drugs out," says Dr. Quill, who adds that the Oregon Death with Dignity Act -- voted into law in 1994, reaffirmed by a 1997 statewide referendum after a series of lower-court battles, and upheld by the United States Supreme Court last January -- lays out the most humane physician-assisted suicide process in the world. "Still, it's been a hard road just to get this one law passed in this one state."

Part of the reason: the emotional and psychological toll physician-assisted suicide takes on the doctors who prescribe and perform it. The sudden shift from "healer" to "executioner," according to the New York State Task Force on Life and the Law, which investigated the Quill lawsuit, "violates [medicine's] fundamental values.

"Even in the absence of widespread abuse," the report continues, "some argue that allowing physicians to act as 'beneficent executioners' would undermine patients' trust, and change the way both the public and physicians view medicine." This is one of the reasons the American Medical Association considers physician-assisted suicide "fundamentally inconsistent with the physician's professional role" and strongly opposes its legalization.

Moreover, there's the personal anguish. In 2000, an anonymous study of 35 Oregon physicians whose patients requested lethal medication produced mix responses. One acceded to his first patient's appeal, but then wondered if he had the necessary emotional peace to continue to participate. Another admitted that after having helped a terminal patient kill himself, "I find I can't turn off my feelings at work as easily . . . because it does go against what I wanted to do as a physician." And a third confessed, "It was an excruciating thing to do; it made me rethink life's priorities."

"Physician-assisted suicide reinterprets the phrase 'freedom of choice' to mean 'license to kill,' " says Charles Bentz, M.D., FACP, president of the Physicians for Compassionate Care Educational Foundation, a Portland-based group opposed to the Death with Dignity Act. "What this law has done is take suicide and say it's no longer suicide, it's strictly a medical procedure. Unlike any other aspect of treatment, there is no peer review, there is no transparency, there is no recourse for abused patients. Ethically, it offends me."

Dr. Bentz, an internist and associate professor of medicine at the Oregon Health and Science University, argues that the Oregon statute is intentionally causing harm. "Once our profession loses its first precept, the admonition to do no harm, society has lost something."

These opinions, of course, must be pitted against the wink wink, nudge nudge medical contortions that proponents such as Dr. Quill say are common throughout the other 49 states. Such, he adds,

could have been the case with Diane 15 years ago. "At the time, I got the bright idea of writing about it partly because I thought people needed to talk more openly about it," Dr. Quill says, "and partly because the only real alternative out there at the time was Jack Kevorkian."

Death With Dignity

At the mention of Kevorkian's name, Eli Stutsman leans forward with a look of scorn. We're sitting in a crowded Portland restaurant, where we've come to talk. "That man," he says, just short of a sputter, "enjoyed the atmosphere he created around his own antics. He got a lot of attention, and consequently he is in prison."

Tall, fit, with a distinguished carriage, 49-year-old Stutsman is a Portland attorney, a self-professed "political junkie," and the primary author of *Oregon's Death with Dignity Act*. He also contributed a chapter to Dr. Quill's book *Physician-Assisted Dying: The Case for Palliative Care and Patient Choice*. Two days earlier, I had visited Stutsman in his downtown Portland office with a simple question: "Why Oregon?" He handed me that chapter, advised me to read it, and set our subsequent dinner date.

In a nutshell, the chapter reveals that of the many states -- Maine, Washington, California, Arizona, Hawaii, Michigan, Vermont -- that either have pending or have over the past 15 years introduced Death with Dignity statutes through public initiatives, popular referenda, or state legislative proposals, only Oregon's proponents framed the issue beyond a grassroots level with a professional, political organization. This has come to be known as the "Oregon-style campaign."

Now our conversation has come around to Kevorkian, Michigan's "Dr. Death," who is scorned within the medical community for his dearth of knowledge of pathology, lack of medical-assessment capabilities, and deficient palliative-care credentials. "That's how opponents of physician-assisted suicide frame the issue: a descent into Kevorkianism," Stutsman says. "We see it time and again, and it is not a valid argument about what is happening in Oregon now, but about what might happen in the future. And it is supremely disingenuous.

"The law we have now is the codification of a secret and covert practice. We helped write a law that created a standard of care to do it well. Our goal was to take it out of the secret confines and expose it to the public, create charting, have annual reports to our state health division, and make sure everyone understands that it is safe -- and rare.

"If our primary opponents were intellectually honest," Stutsman continues, "they would admit that their opposition was faith based and would make a faith-based argument. But that doesn't resonate with voters."

Indeed, the feared wave of "suicide tourists" has not materialized. Nor has the law escalated to

include the "mercy killing" of the mentally challenged, babies born with hideous birth defects, or unwilling paraplegics and quadriplegics.

According to Stutsman, it never will. "We expressly prohibit euthanasia, lethal injection, mercy killing. We do not want anybody making decisions for another. We do not want anybody administering lethal drugs to another. We make sure the patient is always in control. We are not going to allow 17-year-olds to do this. We are not going to allow the mentally incompetent to do this. We are not going to allow those not terminally ill, the chronically ill, to do this. We are not going to allow the depressed to do this."

Given his background, Stutsman seems an odd, if not ironic, figure -- head for the physician-assisted-suicide movement. An Oregon native, he was raised in a strict Mennonite household, attended church three times a week growing up, and minored in religious studies in college. "I am a Christian," he tells me with not a little vehemence. "At one time, I considered the seminary as opposed to law school. I had then, and I still have today, a sensitivity for the faith-based opposition to the Death with Dignity law."

The Roman Catholic Church -- and not any organized medical association -- has for years provided the primary financial support to opponents of physician-assisted suicide. So after my meeting with Stutsman, I contact a parish priest I know and respect. Because he is not authorized to speak for his church regarding such volatile matters, I agree to withhold his name.

I ask him one question: What honor to God is it to soldier on through life debilitated, wracked with pain, and awaiting an end that's destined to arrive soon?

My priest friend ponders this for a moment. We kick phrases from the Bible back and forth, some seemingly pro, some seemingly con. Finally he says, "All I can tell you is that deep in my heart, I know suicide is wrong. It is a sin, no matter the circumstances. It is what the church teaches, and it is what I sincerely believe."

I can't argue with this. Nor can I agree.

Go on to the next page to find out who supports assisted-suicide, and how many doctors would be willing to perform the task...

Prescription for Death

Are you a religious man?" I ask Peter Rasmussen, M.D. The soft-spoken, 60-year-old oncologist strokes his chin in a manner that solidifies my first impression that he has stepped out of a Norman Rockwell painting. Dr. Rasmussen has been the prescribing doctor in "more than several" physician-assisted suicides -- he declines to give me the exact number -- and his avuncular demeanor

persuades me that should I ever need to go out that way, this is the doctor I want by my side.

"Tell me why I should answer that," he says, shifting in his chair in his office in Oregon's Salem Hospital. I explain that thoughtful people -- the internist Dr. Bentz, my friend the priest -- do exist who honestly believe that any form of suicide is morally wrong.

Another chin stroke, then, "Let me just say that I think religion is an important issue. And for many patients who are interested in death with dignity, religious issues are definitely on their minds. I've seen such a tremendous variety in the patients I have been with when they've died. Roman Catholics. Buddhists. Christian Scientists. Baptists. But they had all dealt with their religious issues and concerns in a way that was satisfying to them.

"I always ask about spiritual concerns," he continues. "I raise the question to trigger their thinking, and also to let them know that these are legitimate concerns to think about and to talk about. I always recommend that they consult with a spiritual advisor. I'm not sure that a physician could fill that role. At least I have trouble filling that role."

It is Dr. Rasmussen who introduced me to The Patient and prescribed his secobarbital. Both Dr. Rasmussen and The Patient agreed to speak with me, he said, in the hope of contradicting the assertion that the Death with Dignity Act had turned Oregon into a "kill-crazy" state. "I assume you already have the numbers," he says now.

I do. Between 1998 and 2005, the latest years for which statistics are available, 246 Oregon residents committed suicide legally. Their median age was 69, they were about equally split between men and women, and most suffered from terminal chronic lower-respiratory illnesses, cancer, or Lou Gehrig's disease.

In addition, as Peggy Jo Sandeen, director of the Death with Dignity National Center, pointed out when I visited her in the center's suite of downtown Portland offices, the majority of those taking advantage of the law tend to be white, well educated, and wealthier than the average Oregon resident. But it is something else Sandeen said that stuck in my mind as I spoke with Dr. Rasmussen. Specifically, regarding the great leaps that modern medical technology has made in keeping people alive beyond a "reasonable" point.

Physician-assisted suicide "is a reasonable health-policy response to the state of medicine today," Sandeen had told me. "We have medicine that can keep the physical body alive while throwing away the quality of life. The dying process has changed tremendously with technology." In fact, of the 2 million deaths a year that happen on a doctor's watch, 85 percent to 90 percent occur only after a decision to end life support, Dr. Steven Miles, an expert at the University of Minnesota on the care of dying patients, told the *New York Times* in July.

To this, Dr. Rasmussen answers, "Some patients are very thoughtful and are not swept up by the medical juggernaut. They have the ability to say, 'I'll take A and B, but I don't want C' and communicate that to their physicians. And so they remain in control of their life and their death. Those are often the people most interested in this law."

Dr. Rasmussen has been helping terminally ill patients end their lives since the Oregon law went into effect in 1997. When the first ballot measure was introduced in 1994, he says, the Oregon Medical Ethics Committee held public forums throughout the state to debate the issue. "It was only after I went to several of these public meetings that I realized I was in favor of the law, and I would be willing to work with patients," he says. Since then he has had 169 serious inquiries. "Most, of course, did not go through all the requirements."

How many have? I ask. "Maybe one in 10." (Not all of these patients, of course, went on to commit suicide. In fact, only about half of patients who receive lethal medication end their lives intentionally. The others die naturally.)

Dr. Rasmussen's practice is a partnership with several fellow oncologists, none of whom has ever assisted in a patient suicide. When that option is requested, the patient is referred to Dr. Rasmussen. Dr. Bentz told me that when the Oregon Death with Dignity law was enacted, although a majority of the state's voters obviously approved of it, his organization was deluged with calls from "regular folks" who wanted to know if their personal physician would be enabling suicide. "The implication was clear," said Dr. Bentz. "Philosophically they might have agreed with it -- this is America, a free country, after all -- but they didn't want their doctors doing it." (Physicians have the choice to remain anonymous, and most do.)

This reminds me of a statistic from Dr. Quill: Sixty percent of doctors across America support assisted suicide, but only half of those say they would perform the task themselves. I ask Dr. Rasmussen if he has ever reached a point at which, despite viewing the practice as morally justified, the strain has become just too much.

"The first, and the second, and the third patients were very emotionally stressful," he says. "But I've been through the process with several people now, and in that sense it is easier. I don't want to suggest it's too easy. It certainly isn't that. But in the first few cases, I had trouble sleeping. Just the gravity of the event was stressful to me.

"I've had a couple of occasions since then when I've felt overwhelmed by the number of people who were in the queue for assisted suicide," he says. "Just the house calls themselves are extremely time consuming. But I've never reached the point at which I thought about not doing it."

Before visiting Dr. Rasmussen, I had contacted Kenneth Stevens, M.D., a retired and much respected Portland radiation oncologist who had written an article earlier this year for the journal *Law & Medicine* that severely criticized Oregon's Death with Dignity law. The gist of Dr. Stevens's argument was that the practice was too emotionally and psychologically traumatizing for physicians assisting in legal suicides, and, more important, the act itself breaks a solemn trust between doctors and patients.

From Sydney, Australia -- where Dr. Stevens, 66, and his wife are currently serving as medical advisors to Mormon missionaries in Australia and Papua New Guinea -- he relates a personal story to drive the point home. In 1979, his first wife, then 36, the mother of his six preteen and teenage children, was diagnosed with advancing malignant lymphoma. Over the next 3 years, despite chemotherapy and radiation treatments, the disease spread from her lymph nodes to her brain, spinal cord, and bones. "It was obvious that there was no further treatment that would halt the cancer's progression."

In May 1982, at the end of a doctor visit, his wife's physician said to her, "Well, I could write you a prescription for an extra-large amount of pain medication." Dr. Stevens and his wife both interpreted this as a less-than-subtle hint toward suicide.

"She and I were devastated," Dr. Stevens tells me. "We had felt much discouragement during the prior 3 years, but not the deep despair that we felt at the time when her trusted physician suggested that suicide should be considered. His message to her was 'Your life is no longer of value. You are better off dead.' "

Six days later, Dr. Stevens's wife passed naturally. "I have felt that this is one of the examples of how physician-assisted suicide destroys trust between patient and physician," he concludes. I tell this story to Dr. Rasmussen.

"I hear that argument a lot, and it doesn't resonate with me," he says. "I know nothing about Dr. Stevens's situation, but I can tell you that there is very commonly a misunderstanding about what physicians in Oregon are offering at the end of life. It, frankly, only comes up if the patient brings it up. A thorough conversation follows, and in-depth discussion of pros and cons, what can happen, and what adverse events can occur. And everybody's comfortable with that.

"If a person is really close to death, and they're in so much pain, and you can't seem to get them really comfortable, it's fairly standard practice to give them a bigger dose of narcotic. I think a lot of patients and family members confuse that. They may be offering more morphine, whereas some people say, 'Aha, he's talking about suicide.' "

All the more reason, Dr. Rasmussen argues, to codify the system legally and avoid "so much circuitous conversation." He adds that he has been present for the final moments of every suicide he

has prescribed, "and I've just been struck by the variety of individual motivations and personalities."

Which is why I am floored when I hear Dr. Rasmussen's answer to my question about whether he would personally opt for physician-assisted suicide: "Probably not." He quickly adds, "It's not because I have reservations about it. It's just that life is very precious. Even life of low quality is still life."

His one caveat, he says, would be if he were financially, emotionally, or physically dragging his loved ones "down with me." But even were he to be in terrible pain, he says, "I know that you can almost always control pain.

"My support for the law is not so much that people shouldn't suffer," he goes on. "It's that people ought to make their own decisions. People should be in charge of their own deaths, just like they should be in charge of their own lives."

This is precisely the point The Patient was making.

Go on to the next page to witness physician-assisted suicide as it happens...

Killing Me Softly

You know, we had a hard time filling the prescription," The Patient says during my visit. "Some pharmacists have moral arguments, but some also don't want to be picketed or protested or, Lord forbid, prosecuted, should the Death with Dignity law ever be overturned in the future."

His wife says, "I had to go all the way up to Portland for the pills. Only one pharmacy, privately owned, would give them to us. I'd prefer you didn't mention the name."

On the table before us, pushed aside for the uneaten soup and sandwiches The Patient's wife had served, are several books, including *Einstein's Dreams*, by MIT professor Alan Lightman, and Sam Harris's *The End of Faith*, a treatise on mankind's willingness to suspend reason in favor of religious beliefs. This sparks a thought and a question. "And your faith?" I ask The Patient.

He replies with a story. "One of my daughters teaches fifth grade at a Roman Catholic elementary school. Not long after I made the decision, she brought a package with her when she visited." His wife rises from the table, leaves the room, and returns with a pile of homemade get-well cards created with construction paper and crayons.

"Look here," The Patient says. He points to several of the inscriptions. "God Loves You," reads one. Another child has written, "Don't worry, you'll go to Heaven."

In a whimsical voice, he says, "Don't worry, I'll still go to heaven?" He smiles. "I hope so . . . though I tend to doubt the existence. Well, let's just leave it at that. I hope so." He smiles again.

We speak for a while about other states where Death with Dignity movements are afoot. California's senate defeated such a proposal in July, though experts predict it will resurface in 2008 as a statewide referendum. The Patient says his money would be on Washington State -- "if I were a betting man, that is" -- becoming the first to follow Oregon's lead; a replica of Oregon's bill is awaiting debate in that state's senate.

I can sense that his strength is flagging -- I've overstayed by 30 minutes my 1-hour time limit -- and as I rise to leave, The Patient grabs my hand. "It's not as if I want to die," he says. "Who would? But I am dying. Soon. And I insist on doing this my way."

Then he tells me to drive slowly, casually, back to my Portland hotel. He insists I pause to enjoy the sights, sounds, and smells of his lovely Willamette Valley. "Please, please," he says, "do take the time to enjoy the moment."

I think of our goodbye again when, a little more than a week later, The Patient's wife telephones to tell me he is dead. "We were sitting around the living room, and he turned to me and said, 'This is the night. I'm ready,' " she says. "I tried to jolly him out of it, but he wore such a serious look that I knew. He made the decision while he could still think straight.

"Dr. Rasmussen wasn't here," she continues. "We didn't call him -- it felt too much like, well, like making an appointment. But one of our good friends, a retired surgeon who lives across the street, came over to be with us."

In the living room, The Patient started to pull the capsules apart and mix them into the applesauce. "But there were so many of them that we had to help," his wife tells me. "It took longer than I'd thought. Finally, the applesauce was so thick, we had to add juice to it. He ate it all, and he smiled again. As we walked him into the bedroom, my husband said, 'I'm being led to my bed by the two best physicians in the world.' And he smiled, lay down, and went to sleep.

"It all went smoothly, perfectly as planned," she goes on. "His death was good, as he wanted, but that doesn't take anything away from the loss. The loss will always be with me."

I offer my condolences, and we speak a bit more. After we hang up, I think once again of my mother. A good death does honor to a whole life, indeed.

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