Richard Selzer, who is a professor of medicine at Yale University, is part of a distinguished tradition of physicians who have mastered the literary expression of their professional experience. This piece was first published in the New York Times Magazine in September 1991.

Almost two years ago, I received a phone call from a poet I knew slightly. Would I, he wondered, be willing to intervene on behalf of a friend of his who was dying of AIDS?

"Intervene?"

"His suffering is worthy of Job. He wants to commit suicide while he still has the strength to do it."

"Do you know what you're asking?"

"I know, I know."

"No," I told him. "I'm trained to preserve life, not end it. It's not in me to do a thing like that."

"Are you saying that a doctor should prolong a misfortune as long as possible?"

"There is society," I replied. "There is the law. I'm not a barbarian."

"You are precisely that," he said. "A barbarian."

His accusation reminded me of an incident in the life of Ambroise Paré, the father of surgery, who in the 16th century accompanied the armies of France on their campaigns. Once, on entering a newly captured city, Paré looked for a barn in which to keep his horse while he treated the wounded. Inside he found four dead soldiers and three more still alive, their faces contorted with pain, their clothes still smoldering where the gunpowder had burned them.

As Paré gazed at the wounded with pity, an old soldier came up and asked whether there was any way to cure them. Paré shook his head, whereupon the old soldier went
up to the men and, Paré recounted in his memoirs, cut their throats "gently, efficiently and without ill will." Horrified at what he thought a great cruelty, Paré cried out to the executioner that he was a villain.

"No," said the man. "I pray to God that if ever I come to be in that condition, someone will do the same for me." Was this an act of villainy, or mercy?

The question still resists answering. Last year, a Michigan court heard the case of a doctor who supplied a woman with his "suicide machine"—a simple apparatus that allows a patient to self-administer a lethal dose of drugs intravenously. Since then, it seems that each day brings reports of deaths assisted by doctors. A best-selling book, "Final Exit," written by the director of the Hemlock Society, now instructs us in painless ways to commit suicide should the dreadful occasion arise. Even the most ideologically opposed must now hear the outcry of a populace for whom the dignity and mercy of a quick pharmacological death may be preferable to a protracted, messy and painful end.

"But why are you calling me?" I asked my friend.

"I’ve read your books. It occurred to me that you might just be the right one."

I let the poet know that I had retired from medicine five years before, that I was no longer a doctor.

"Once a doctor, always a doctor," he replied.

What I did not tell him was that each year I have continued to renew the license that allows me to prescribe narcotics. You never know. . . . Some day I might have need of them to relieve pain or to kill myself easily should the occasion arise. If for myself, then why not for another?

"I’ll think about it," I said. He gave me the address and phone number.

"I implore you," said the poet.

The conversation shifted to the abominable gymnastics of writing, a little gossip. We hung up.

Don’t, I told myself.

Diary, Jan. 14, 1990

My friend's friend lives with a companion on the seventh floor of an apartment building about a 10-minute walk from my house. The doorman on duty is a former patient of mine. He greets me warmly; lifts his shirt to show me his gallbladder incision, how well it has healed.

"You can hardly see it," he says. That is the sort of thing that happens when I leave my study and re-enter the world. The doorman buzzes me in.

At precisely 4 P.M., as arranged, I knock on the apartment door. It is opened by L., a handsome, perhaps too handsome, man in his late 30’s. We recognize each other’s presence on the Yale campus. He is an ordained minister. He tells me that he has made use of my writings in his sermons. In the living room, R. is sitting on an invalid’s cushion on the sofa. A short, delicate man, also in his 30’s, R. is a doctor specializing in public health—women’s problems, birth control, family planning, AIDS. He is surprisingly unwasted, although pale as a blank sheet of paper. He gives me a brilliant smile around even white teeth. The eyes do not participate in the smile. L. and R. have been lovers for six years.

R.’s hair is close-cropped, black; there is a neat lawn of beard. He makes a gesture as if to stand, but I stop him. His handshake is warm and dry and strong. There is a plate of chocolate chip cookies on a table. L. pours tea. L.’s speech is clipped, slightly mannered. R. has a Hispanic accent; he is Colombian.

For a few minutes we step warily around the reason I have come. Then, all at once, we are engaged. I ask R. about his symptoms. He tells me of his profound fatigue, the depression, the intractable diarrhea, his ulcerated hemorrhoids. He has Kaposi’s sarcoma. Only yesterday a new lesion appeared in the left naso-orbital region, the area between the nose and eye. He points to it. Through his hair I see another large black tumor. His mouth is dry, encrusted from the dehydration that comes with chronic
diarrhea. Now and then he clutches his abdomen, grimaces. There is the odor of stool.

"I want to die," he announces calmly.

"Is it so bad?"

"Yes, it is."

"But how can I be sure? On Tuesday, you want to die; by Thursday, perhaps you will have changed your mind."

He nods to L., who helps him to stand. The three of us go into their bedroom, where R., lying on his side, offers his lesions as evidence. I see that his anus is a great circular ulceration, raw and oozing blood. His buttocks are smeared with pus and liquid stool. With tenderness, L. bathes and dresses him in a fresh diaper. Even though I have been summoned here, I feel very much the intruder upon their privacy. And I am convinced.

We return to the living room. L. and R. sit side by side on the sofa, holding hands. A lethal dose of barbiturates is being mailed by a doctor friend in Colombia. R. wants to be certain that it will not fail, that someone will be on hand to administer a final, fatal dose should he turn out to be physically too weak to take the required number of pills. He also wants L. to be with him, holding him. He asks that L. not cry. He couldn’t bear that, he says. L. says that of course he will cry, that he must be allowed to. L. is afraid, too, that it might not work, that he will be discovered as an accomplice.

"I am the sole beneficiary of the will," he explains. L. does not want to be alone when the time comes. He has never seen anyone die before. (A minister? Has he never attended a deathbed?) "It has just worked out that way," he says, as though reading my mind. Still, I am shocked at such a state of virginity.

We have a discussion. It is about death as best friend, not enemy. How sensible were the pagans, for whom death was a return to the spirit world that resides in nature. One member of the tribe vanishes forever, but the tribe itself lives on. It is a far cry from the Christian concept of death and resurrection.

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R. passes a hand across his eyes as if to brush away a veil. His vision is failing; soon he will be blind. He coughs, shifts on the pillow, swallows a pain pill. He tells me that he has taken all of the various experimental medicines without relief of the diarrhea. His entire day is spent medicating himself and dealing with the incontinence. Despite chemotherapy, the tumors are growing rapidly. His palate is covered with them. He opens his mouth for me to see. Above all, he wants to retain his dignity, to keep control of his life, which he equates with choosing the time and method of suicide. Soon he will be unable to do it.

"But death," I say, "It’s so final."

"I want it," he says again, on his face a look of longing. He wants me to promise that I will obtain the additional narcotics that would insure death, if needed. I offer only to return in a few days to talk. R. urges me to think of myself as an instrument that he himself will use for his rescue. An instrument? But I am a man.

The tone turns conspiratorial. Our voices drop. We admonish each other to be secretive, tell no one. There are those who would leap to punish. I suggest that R. arrange for a codicil to his will requesting that there be no autopsy.

Jan. 16

Four in the afternoon. R. answers the door. He has lost ground. His eyes are sunken, his gait tottering. He is in great pain, which he makes no effort to conceal. As arranged, he is alone. L. is to return in an hour. The barbiturates have arrived from Colombia. He shows me the bottles of tablets in the bottom drawer of the dresser. A quick calculation tells me that he has well over the lethal dose. The diarrhea has been unrelenting. The Kaposi’s sarcoma is fulminating, with new lesions every day.

"I have always counted so much on my looks," he says shyly and without the least immodesty. "And now I have become something that no one would want to touch." Without a pause, he asks, "What if I vomit the pills?" I tell him
to take them at a regular pace, each with only a sip of water so as not to fill up too quickly. If necessary, would I inject more medication? "I have good veins," he says, and rolls up a sleeve, I see that he does. There are several needle puncture marks at the antecubital fossa—the front of the elbow—where blood has been drawn. One more would not be noticed.

"When?" I ask him. No later than one month from today. Do I want to choose a date? R. rises with difficulty, gets a calendar from the kitchen. We bend over it.

"Are you free on Feb. 10?" he asks. "It's a Saturday."

"I'm free."

Feb. 10! There is a date!

I ask R. about his life. He was born and raised in Medellin, one of four sisters and three brothers. His mother had no formal education, but she is "very wise." It is clear that he loves her. No, she knows nothing; neither that he is gay nor that he is ill. He has written a letter to be sent after his death, telling her that he loves her, thanking her for all that she has done. In the family, only an older brother knows that he is gay, and to him it is a disgrace. He has forbidden R. to tell the others. His sisters live near his mother in Medellin. There are 12 grandchildren. She will not be alone.

(He smiles at this.)

Had he always known he was gay? He discovered his attraction to men at age 8, but of course it was impossible to express it. Colombia is intolerant of homosexuality. At 17, he went to Bogotá to study medicine. For six years he lived in an apartment with four other students. There was close camaraderie but no sexual expression. It was a "quiet" student's life. After one year of internship in a hospital, he decided against clinical medicine.

It was while working toward a degree in public health at Yale that he met L. The year was 1983. After completing his studies, he was separated from L. for two years, working in another city, although he returned to visit L. frequently. There followed a three-year period when they lived together in New Haven. Shortly after they met, R. began to feel ill, thought he had an infection. He suspected it was AIDS. He told L. at once and they agreed to discontinue sex. Aside from mutual caressing, there has been no sexual contact between them since.

"It was not sex that brought us together," he says. "It was love." I lower my gaze, I who have always hesitated before expressing love.

L. returns. It is the first day of the semester at Yale. A day of meeting with students, advising, counseling. He is impeccably dressed. He is accompanied by a woman, someone I know slightly. He notices my surprise.

"This is M.," he announces. "She's all right." He places his arm around her waist, explaining that they have been close friends and confidantes for many years. "She is the sister I have always wanted." L. bends to kiss R. on the cheek.

"Chiquito! You are wearing your new shirt," says L. I am alarmed by the presence of M. It is clear that she knows everything. We sit around the table drinking tea.

"Tell me about death," said L.

"What do you mean?"

"The details. You're a doctor, you should know. What about the death rattle?"

"It has been called that." I explain about not being able to clear secretions from the lungs.

"What sort of equipment will we need?"

"Nothing. You already have the diapers."

"R. has to die in diapers?" I explain about the relaxation of the bowel and urinary sphincters, that it would be best.

"I shouldn't have asked." L. seems increasingly nervous. "I'm terrified of the police," he says. "I always have been. Should I see a lawyer? What if I'm caught and put in prison?" He begins to weep openly. "And I'm losing R. That is a fact, and there is not a thing I can do about it!"

When he continues to cry without covering his face, R. reaches out a hand to console him.

"Look," I say. "You're not ready for this and, to tell the truth, I'm not sure I am either."
"Oh please!" R.'s voice is a high-pitched whine of distress. "It is only a matter of a few minutes of misery. I would be dying anyway after that."

L. pulls himself together, nods to show that he understands. I begin to feel that my presence is putting pressure on him; it makes R.'s death real, imminent, I tell him that I am ready to withdraw. How easy that would be. A way out.

"You are the answer to R.'s prayers," he says. "To him you are an angel." But to L. I am the angel of death. "Of course, I agree to whatever R. wants to do," he says. It is R. who turns practical.

"If it is too hard for you, L., I won't mind if you are not here with me." And to me: "L., simply cannot lie. If questioned by the police, he would have to tell the truth." I see that the lying will be up to me. All the while, M. has remained silent.

We go through the "script"—L.'s word. In the bedroom, R. will begin taking pills. I will help him. L. and M. will wait in the living room.

L.: "Will we be in the apartment all the time until he dies?"

M. (speaking for the first time): "Not necessary. We can go out somewhere and return to find him dead."

L.: "Where would we go?"

M.: "Anywhere. For a walk; to the movies."

L.: "How long will it take?"

Me: "Perhaps all day."

L.: "What if the doctors notify the police? R. has made no secret of his intention at the clinic. They have even withheld pain medication because he is 'high risk.'"

Me (to R.): "Next time you go the clinic, ask for a prescription for 50 Levo-Dromoran tablets. It's a narcotic. Maybe they'll give you that many. Maybe not."

L.: "I simply can't believe they would turn us in, but there's no way to be sure, is there?"

More and more we are like criminals, or a cell of revolutionaries. L.'s fear and guilt are infectious. But then there is R. I stand up to leave, assuring them that I will come again on Sunday at 4 in the afternoon. M. says that she will be there, too. L. hopes he has not shaken my resolve. He apologizes for his weakness.

"We'll talk further," I say. R. takes my hand. "You have become my friend. In such a short time. One of the best friends of my life."

Jan. 17

In the mail there is a note from L. in his small, neat handwriting. He thanks me. Enclosed is a copy of a lecture he had given in 1984 in which he cited an incident from one of my books, about a doctor who, entreated by a suffering patient who wants to die, stays his hand out of mercy. It is strangely prophetic and appropriate to the circumstances.

My nights are ridden with visions: I am in the bedroom with R. We are sitting side by side on the bed. He is wearing only a large blue disposable diaper. The bottles of pills are on the nightstand along with a pitcher of water and a glass. R. pours a handful of the tiny tablets into his palm, then with a shy smile begins to swallow them one at a time. Because of the dryness of his mouth and the fungal infection of his throat, it is painful. And slow.
"You’re drinking too much water," I say. "You’ll fill up too quickly."

"I will try," he says. What seems like hours go by. From the living room comes the sound of Mozart’s Clarinet Quintet. R. labors on, panting, coughing. When he has finished one bottle, I open another. His head and arms begin to wobble. I help him to lie down.

"Quickly," I tell him. "We don’t have much time left." I hold the glass for him, guide it to his lips. He coughs, spits out the pills.

"Hold me," he says. I bend above him, cradle his head in my arm.

"Let yourself go," I say. He does, and minutes later he is asleep. I free myself and count the pills that are left, calculate the milligrams. Not enough. It is too far below the lethal dose. I take a vial of morphine and a syringe from a pocket, a rubber tourniquet. I draw up 10 cc. of the fluid and inject it into a vein in R.’s arm. The respirations slow down at once. I palpate his pulse. It wavers, falters, stops. There is a long last sigh from the pillow.

All at once, a key turns in the door to the hallway. The door is flung open. Two men in fedoras and raincoats enter the bedroom. They are followed by the doorman whose gallbladder I had removed.

"You are under arrest," one of them announces.

"What is the charge?" I ask, clinging to a pretense of innocence. "For the murder of R.C." I am startled by the mention of his last name. Had I known it? I am led away.

Jan. 21

M., L., R. and I: R.’s smile of welcome plays havoc with my heart. It is easy to see why L. fell in love with him. I offer an alternative: R. could simply stop eating and drinking. It would not take too many days. Neither L. nor R. can accept this. L. cannot watch R. die of thirst. There is a new black tumor on R.’s upper lip. He has visited the clinic and ob-
tained 30 Levo-Dromoran tablets. Suddenly, I feel I must test him again.

Me: "I don’t think you’re ready. Feb. 10 is too soon."

R. (covering his face with his hands, moaning):

"Why do you say that?"

Me: "Because you haven’t done it already. Because you’ve chosen a method that is not certain. Because you’re worrying about L."

L.: "I feel that I’m an obstruction."

Me: "No, but you’re unreliable. You cannot tell the lies that may be necessary."

L.: "I’m sorry, I’m sorry."

Me: "Don’t apologize for virtue. It doesn’t make sense."

R.: "There is one thing. I prefer to do it at night, after dark. It would be easier for me."

That, if nothing else, is comprehensible. Youth bids farewell to the moon more readily than to the sun.

We rehearse the revised plan. L., M. and R. will dine together, "love each other," say goodbye. L. and M. will take the train to New York for the night. At 6 p.m. R. will begin to take the pills. At 8:30 I will let myself into the apartment. The doorman may or may not question me, but I will have a key. I will stay only long enough to be sure that R. is dead. If he is not, I will use the morphine; if he is, I will not notify anyone. At noon the next day, L. and M. will return to discover the body and call the clinic. It is most likely that a doctor will come to pronounce death. Of
course, he will ask questions, perhaps notice something, demand an autopsy. In that case, L. will show him the codicil to the will. M. asks whether the codicil is binding. At the end of the session we are all visibly exhausted.

Feb. 3

Our final visit. R. is worried that because of the diarrhea he will not absorb the barbiturate. He has seen undigested potassium tablets in his stool. I tell him not to worry; I will make sure. His gratitude is infinitely touching, infinitely sad. We count the pills. There are 110 of them, totaling 11 grams. The lethal dose is 4.5. He also had the remaining Levo-Dromoran tablets. I have already obtained the vial of morphine and the syringe. R. is bent, tormented, but smiles when I hug him goodbye.

"I’ll see you on Saturday," I tell him.

"But I won’t see you," he replies with a shy smile. On the elevator, I utter aloud a prayer that I will not have to use the morphine.

Feb. 7

Lunch at a restaurant with L. and M.

"It’s no good," M. says to me, "You’re going to get caught."

"What makes you think so?"

"Why would a doctor with a practice of one patient be present at his death, especially when the patient is known to be thinking about suicide?" She has contacted the Hemlock Society and talked with a sympathetic lawyer. She was told that there is no way to prevent an autopsy. By Connecticut law, the newly dead must be held for 48 hours before cremation, R.’s preference. The coroner will see the body. Because of R.’s youth and the suspicion of suicide, the coroner will order an autopsy. Any injected substance would be discovered. The time of death can be estimated with some accuracy. I would have been seen entering the building around that time. The police would ask questions. Interviewed separately, L., M. and I would give conflicting answers. I would be named. There would be the publicity, the press. It would be vicious. "No, you’re fired, and that’s that." I long to give in to the wave of relief that seeps over me. But there is R.

"What about R. and my promise?"

"We just won’t tell him that you’re not coming."

"The coward’s way," I say.

"That’s what we are, aren’t we?"

Feb. 11

A phone call from L.: R. is "very much alive." He is at the hospital, in the intensive-care unit. They have put him on a respirator, washed out his stomach. He is being fed intravenously.

"I had to call the ambulance, didn’t I?" he asks. "What else could I do? He was alive."

Feb. 15

The intensive-care unit is like a concrete blockhouse. The sound of 20 respirators, each inhaling and exhaling at its own pace, makes a steady wet noise like the cascade from a fountain. But within minutes of one’s arrival, it becomes interwoven with the larger fabric of sound—the clatter and thump, the quick footfalls, the calling out, the moaning. Absolute silence would be louder.

From the doorway I observe the poverty of R.’s body, the way he shivers like a wet dog. The draining away of his flesh and blood is palpable. The skin of his hands is as chaste and dry, as beautiful as old paper. I picture him as a small bird perched on an arrow that has been shot and is flying somewhere.

"R.I. I call out. He opens his eyes and looks up, on his face a look that I can only interpret as reproach or disap-
pointment. He knows that I was not there. L. the Honest has told him.

"Do you want to be treated for the pneumonia?" I ask. He cannot speak for the tube in his trachea, but he nods.

"Do you want to live?" R. nods again. "Do you still want to die?" R. shakes his head no.

Twelve days later, R. died in the hospital. Three days after that, I met L. on the street. We were shy, embarrassed, like two people who share a shameful secret.

"We must get together soon," said L.

"By all means. We should talk." We never did.