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In 1991, in the tiny town of New Berlin, in upstate New York, a young physician named Bill Thomas performed an experiment. He didn't really know what he was doing. He was thirty-one years old, less than two years out of family medicine residency, and he had just taken a new job as medical director of Chase Memorial Nursing Home, a facility with eighty severely disabled elderly residents. About half of them were physically disabled; four out of five had Alzheimer's disease or other forms of cognitive disability.

Up until then Thomas had worked as an emergency physician at a nearby hospital, the near opposite of a nursing home. People arrived in the emergency room with discrete, repairable problems—a broken leg, say, or a cranberry up the nose. If a patient had larger, underlying issues—if, for instance, the broken leg had been caused by dementia—his job was to ignore the issues or send the person somewhere else to deal with them, such as a nursing home. He took this new medical director job as a chance to do something different.

The staff at Chase saw nothing especially problematic about

the place, but Thomas with his newcomer's eyes saw despair in every room. The nursing home depressed him. He wanted to fix it. At first, he tried to fix it the way that, as a doctor, he knew best. Seeing the residents so devoid of spirit and energy, he suspected that some unrecognized condition or improper combination of medicines might be afflicting them. So he set about doing physical examinations of the residents and ordering scans and tests and changing their medications. But, after several weeks of investigations and alterations, he'd accomplished little except driving the medical bills up and making the nursing staff crazy. The nursing director talked to him and told him to back off.

"I was confusing care with treatment," he told me.

He didn't give up, though. He came to think the missing ingredient in this nursing home was life itself, and he decided to try an experiment to inject some. The idea he came up with was as mad and naive as it was brilliant. That he got the residents and nursing home staff to go along with it was a minor miracle.

But to understand the idea—including how it came about and how he got it off the ground—you have to understand a few things about Bill Thomas. The first thing is that, as a child, Thomas won every sales contest his school had. They'd send the kids off to sell candles or magazines or chocolates door-to-door for the Boy Scouts or a sports team, and he'd invariably come home with the prize for most sales. He also won election as student body president in high school. He was chosen captain of the track team. When he wanted to, he could sell people on almost anything, including himself.

At the same time, he was a terrible student. He had miserable grades and repeated run-ins with his teachers over his failure to do the work they assigned. It wasn't that he couldn't do the work. He was a voracious reader and autodidact, the kind of a boy who would teach himself trigonometry so he could build

a boat (which he did). He just didn't care about doing the work his teachers asked for, and he didn't hesitate to tell them so. Today, we'd diagnose him as having Oppositional Defiant Disorder. In the 1970s, they just thought he was trouble.

The two personas—the salesman and the defiant pain in the neck—seemed to come from the same place. I asked Thomas what his special technique for sales was as a kid. He said he didn't have any. It was simply that "I was willing to be rejected. That's what allows you to be a good salesperson. You have to be willing to be rejected." It was a trait that let him persist until he got what he wanted and avoid whatever he didn't want.

For a long time, though, he didn't know what he wanted. He had grown up in the next county over from New Berlin, in a valley outside the town of Nichols. His father had been a factory worker, his mother a telephone operator. Neither had gone to college, and no one expected Bill Thomas to go either. As he came to the end of high school, he was on track to join a union training program. But a chance conversation with a friend's older brother who was visiting home from college and told him about the beer, the girls, and the good times made him rethink.

He enrolled in a nearby state college, SUNY Cortland. There, something ignited him. Perhaps it was the high school teacher who predicted as he left that he'd be back in town pumping gas before Christmas. Whatever it was, he succeeded far beyond anyone's expectation, chewing through the curriculum, holding on to a 4.0 grade point average, and becoming student body president again. He had gone in thinking he might become a gym teacher, but in biology class he began thinking that maybe medicine was for him. He ended up becoming Cortland's first student to get into Harvard Medical School.

He loved Harvard. He could have gone there with a chip on his shoulder—the working-class kid out to prove he was nothing

like those snobs, with their Ivy League educations and trust fund accounts. But he didn't. He found the place to be a revelation. He loved being with people who were so driven and passionate about science, medicine, everything.

"One of my favorite parts of medical school was that a group of us had dinner at the Beth Israel Hospital cafeteria every night," he told me. "And it would be two and a half hours of arguing cases—intense and really great."

He also loved being in a place where people believed he was capable of momentous things. Nobel Prize winners came to teach classes, even on Saturday mornings, because they expected him and the others to aspire to greatness.

He never felt the need to win anyone's approval, however. Faculty tried to recruit him to their specialized training programs at big-name hospitals or to their research laboratories. Instead, he chose family medicine residency in Rochester, New York. It wasn't exactly Harvard's idea of aspiring to greatness.

Returning home to upstate New York had been his goal all along. "I'm a local guy," he told me. In fact, his four years at Harvard were the only time he ever lived outside upstate New York. During vacations, he used to bicycle from Boston to Nichols and back—a 330-mile ride in each direction. He liked the self-sufficiency—pitching his tent in random orchards and fields along the road and finding food wherever he could. Family medicine was attractive in the same way. He could be independent, go it alone.

Partway through residency, when he'd saved up some money, he bought some farmland near New Berlin that he'd often passed on his bike rides and imagined owning some day. By the time he finished his training, working the land had become his real love. He entered local practice but soon focused on emergency medicine because it offered predictable hours, on a shift, letting him

devote the rest of his time to his farm. He was committed to the idea of homesteading—being totally self-reliant. He built his home by hand with friends. He grew most of his own food. He used wind and solar power to generate electricity. He was completely off the grid. He lived by the weather and the seasons. Eventually, he and Jude, a nurse who became his wife, expanded the farm to more than four hundred acres. They had cattle, draft horses, chickens, a root cellar, a sawmill, and a sugarhouse, not to mention five children.

"I really felt that the life I was living was the most authentically true life I could live," Thomas explained.

He was at that point more farmer than doctor. He had a Paul Bunyan beard and was more apt to wear overalls beneath his white coat than a tie. But the emergency room hours were draining. "Basically, I got sick of working all those nights," he said. So he took the job in the nursing home. It was a day job. The hours were predictable. How hard could it be?

FROM THE FIRST day on the job, he felt the stark contrast between the giddy, thriving abundance of life that he experienced on his farm and the confined, institutionalized absence of life that he encountered every time he went to work. What he saw gnawed at him. The nurses said he would get used to it, but he couldn't, and he didn't want to go along with what he saw. Some years would pass before he could fully articulate why, but in his bones he recognized that the conditions at Chase Memorial Nursing Home fundamentally contradicted his ideal of self-sufficiency.

Thomas believed that a good life was one of maximum independence. But that was precisely what the people in the home were denied. He got to know the nursing home residents. They had been teachers, shopkeepers, housewives, and factory workers,

just like people he'd known growing up. He was sure something better must be possible for them. So, acting on little more than instinct, he decided to try to put some life into the nursing home the way that he had done in his own home—by literally putting life into it. If he could introduce plants, animals, and children into the lives of the residents—fill the nursing home with them—what would happen?

He went to Chase's management. He proposed that they could fund his idea by applying for a small New York State grant that was available for innovations. Roger Halbert, the administrator who'd hired Thomas, liked the idea in principle. He was happy to try something new. During twenty years at Chase, he had ensured that the facility had an excellent reputation, and it had steadily expanded the range of activities available to the residents. Thomas's new idea seemed in line with past improvements. So the leadership team sat down together to write the application for the innovation funding. Thomas, however, seemed to have something in mind that was more extensive than Halbert had quite fathomed.

Thomas laid out the thinking behind his proposal. The aim, he said, was to attack what he termed the Three Plagues of nursing home existence: boredom, loneliness, and helplessness. To attack the Three Plagues they needed to bring in some life. They'd put green plants in every room. They'd tear up the lawn and create a vegetable and flower garden. And they'd bring in animals.

So far this sounded okay. An animal could sometimes be tricky because of health and safety issues. But nursing home regulations in New York permitted one dog or one cat. Halbert told Thomas that they'd tried a dog two or three times in the past without success. The animals had the wrong personality, and there were difficulties arranging for proper care. But he was willing to try again.

So Thomas said, "Let's try two dogs."

Halbert said, "The code doesn't allow that."

Thomas said, "Let's just put it down on paper."

There was silence for a moment. Even this small step pushed up against the values at the heart not just of nursing home regulations but also of what nursing homes believed they principally exist for—the health and safety of elders. Halbert had a hard time wrapping his mind around the idea. When I spoke to him not long ago, he still recalled the scene vividly.

The director of nursing, Lois Greising, was sitting in the room, the activities leader, and the social worker. . . . And I can see the three of them sitting there, looking at each other, rolling their eyes, saying, "This is going to be interesting."

I said, "All right, I'll put it down." I was beginning to think, "I'm not really into this as much as you are, but I'll put two dogs down."

He said, "Now, what about cats?"

I said, "What about cats?" I said, "We've got two dogs down on the paper."

He said, "Some people aren't dog lovers. They like cats."

I said, "You want dogs AND cats?"

He said, "Let's put it down for discussion purposes."

I said, "Okay. I'll put a cat down."

"No, no, no. We're two floors. How about two cats on both floors?"

I said, "We want to propose to the health department two dogs and four cats?"

He said, "Yes, just put it down."

I said, "All right, I'll put it down. I think we're getting off base here. This is not going to fly with them."

He said, "One more thing. What about birds?"

I said that the code says clearly, "No birds allowed in nursing homes."

He said, "But what about birds?"

I said, "What about birds?"

He said, "Just picture—look out your window right here. Picture that we're in January or February. We have three feet of snow outside. What sounds do you hear in the nursing home?"

I said, "Well, you hear some residents moaning. You possibly hear some laughter. You hear televisions on in different areas, maybe a little more than we'd like them to be." I said, "You'll hear an announcement over the PA system."

"What other sounds are you hearing?"

I said, "Well, you're hearing staff interacting with each other and with residents."

He said, "Yeah, but what are those sounds that are sounds of life—of positive life?"

"You're talking birdsong."

"Yes!"

I said, "How many birds are you talking to create this birdsong?"

He said, "Let's put one hundred."

"ONE HUNDRED BIRDS? IN THIS PLACE?" I said, "You've got to be out of your mind! Have you ever lived in a house that has two dogs and four cats and one hundred birds?"

And he said, "No, but wouldn't it be worth trying?"

Now that's the crux of the difference between Dr. Thomas and me.

The other three that were sitting in the room, their

eyes were bugging out of their heads now, and they were saying, "Oh my God. Do we want to do this?"

I said, "Dr. Thomas, I'm into this. I want to think outside the box. But I don't know that I want to look like a zoo, or smell like a zoo." I said, "I can't picture doing this."

He said, "Would you just hang with me?"

I said, "You've got to prove to me that this is something that has merit."

That was just the opening Thomas needed. Halbert hadn't said no. Over a few subsequent meetings, Thomas wore him and the rest of the team down. He reminded them of the Three Plagues, of the fact that people in nursing homes are dying of boredom, loneliness, and helplessness and that they wanted to find the cure for these afflictions. Wasn't anything worth trying for that?

They put the application in. It wouldn't stand a chance, Halbert figured. But Thomas took a team up to the state capital to lobby the officials in person. And they won the grant and all the regulatory waivers needed to follow through on it.

"When we got the word," Halbert recalled, "I said 'Oh my God. We're going to have to do this.'"

The job of making it work fell to Lois Greising, the director of nursing. She was in her sixties and had been working in nursing homes for years. The chance to try a new way of improving the lives of the elderly was deeply appealing to her. She told me that it felt like "this great experiment," and she decided that her task was to navigate between Thomas's sometimes oblivious optimism and the fears and inertia of the staff members.

This task was not small. Every place has a deep-seated culture as to how things are done. "Culture is the sum total of shared habits and expectations," Thomas told me. As he saw it,

habits and expectations had made institutional routines and safety greater priorities than living a good life and had prevented the nursing home from successfully bringing in even one dog to live with the residents. He wanted to bring in enough animals, plants, and children to make them a regular part of every nursing home resident's life. Inevitably the settled routines of the staff would be disrupted, but then wasn't that part of the aim?

"Culture has tremendous inertia," he said. "That's why it's culture. It works because it lasts. Culture strangles innovation in the crib."

To combat the inertia, he decided they should go up against the resistance directly—"hit it hard," Thomas said. He called it the Big Bang. They wouldn't bring a dog or a cat or a bird and wait to see how everyone responded. They'd bring all the animals in more or less at once.

That fall, they moved in a greyhound named Target, a lap-dog named Ginger, the four cats, and the birds. They threw out all their artificial plants and put live plants in every room. Staff members brought their kids to hang out after school; friends and family put in a garden at the back of the home and a playground for the kids. It was shock therapy.

An example of the scale: they ordered the hundred parakeets for delivery all on the same day. Had they figured out how to bring a hundred parakeets into a nursing home? No, they had not. When the delivery truck arrived, the birdcages hadn't. The driver therefore released them into the beauty salon on the ground floor, shut the door, and left. The cages arrived later that day, but in flat boxes, unassembled.

It was "total pandemonium," Thomas said. The memory of it still puts a grin on his face. He's that sort of person.

He, his wife, Jude, the nursing director, Greising, and a handful of others spent hours assembling the cages, chasing the

parakeets through a cloud of feathers around the salon and delivering birds to every resident's room. The elders gathered outside the salon windows to watch.

"They laughed their butts off," Thomas said.

He marvels now at the team's incompetence. "We didn't know what the heck we were doing. *Did, Not, Know* what we were doing." Which was the beauty of it. They were so patently incompetent that most everyone dropped their guard and simply pitched in—the residents included. Whoever could do it helped line the cages with newspaper, got the dogs and the cats settled, got the kids to help out. It was a kind of glorious chaos—or, in the diplomatic words of Greising, "a heightened environment."

They had to solve numerous problems on the fly—how to feed the animals, for instance. They decided to establish daily "feeding rounds." Jude obtained an old medication cart from a decommissioned psychiatric hospital and turned it into what they called the bird-mobile. The bird-mobile was loaded up with birdseed, dog treats, and cat food, and a staff member would push it around to each room to change the newspaper liners and feed the animals. There was something beautifully subversive, Thomas said, about using a medication cart that had once dispensed metric tons of Thorazine to hand out Milk-Bones.

All sorts of crises occurred, any one of which could have ended the experiment. One night at 3:00 a.m., Thomas got a phone call from a nurse. This was not unusual. He was the medical director. But the nurse didn't want to talk to him. She wanted to talk to Jude. He put her on.

"The dog pooped on the floor," the nurse said to Jude. "Are you coming to clean it up?" As far as the nurse was concerned, this task was far below her station. She didn't go to nursing school to clean up dog crap.

Jude refused. "Complications ensued," Thomas said. The next morning, when he arrived, he found that the nurse had placed a chair over the poop, so no one would step in it, and left.

Some of the staff felt that professional animal wranglers should be hired; managing the animals wasn't a job for nursing staff and no one was paying them extra for it. In fact, they'd hardly had a raise in two or three years because of state budget cuts in nursing home reimbursements. Yet the same state government spent money on a bunch of plants and animals? Others believed that, just as in anyone's home, the animals were a responsibility that everyone should share. When you have animals, things happen, and whoever is there takes care of what needs to be done, whether it's the nursing home director or a nurse's aide. It was a battle over fundamentally different worldviews: Were they running an institution or providing a home?

Greising worked to encourage the latter view. She helped the staff balance responsibilities. Gradually people started to accept that filling Chase with life was everyone's task. And they did so not because of any rational set of arguments or compromises but because the effect on residents soon became impossible to ignore: the residents began to wake up and come to life.

"People who we had believed weren't able to speak started speaking," Thomas said. "People who had been completely withdrawn and nonambulatory started coming to the nurses' station and saying, 'I'll take the dog for a walk.'" All the parakeets were adopted and named by the residents. The lights turned back on in people's eyes. In a book he wrote about the experience, Thomas quoted from journals that the staff kept, and they described how irreplaceable the animals had become in the daily lives of residents, even ones with advanced dementia:

Gus really enjoys his birds. He listens to their singing and asks if they can have some of his coffee.

The residents are really making my job easier; many of them give me a daily report on their birds (e.g., "sings all day," "doesn't eat," "seems perkier").

M.C. went on bird rounds with me today. Usually she sits by the storage room door, watching me come and go, so this morning I asked her if she wanted to go with me. She very enthusiastically agreed, so away we went. As I was feeding and watering, M.C. held the food container for me. I explained each step to her, and when I misted the birds she laughed and laughed.

The inhabitants of Chase Memorial Nursing Home now included one hundred parakeets, four dogs, two cats, plus a colony of rabbits and a flock of laying hens. There were also hundreds of indoor plants and a thriving vegetable and flower garden. The home had on-site child care for the staff and a new after-school program.

Researchers studied the effects of this program over two years, comparing a variety of measures for Chase's residents with those of residents at another nursing home nearby. Their study found that the number of prescriptions required per resident fell to half that of the control nursing home. Psychotropic drugs for agitation, like Haldol, decreased in particular. The total drug costs fell to just 38 percent of the comparison facility. Deaths fell 15 percent.

The study couldn't say why. But Thomas thought he could. "I believe that the difference in death rates can be traced to the fundamental human need for a reason to live." And other research

was consistent with this conclusion. In the early 1970s, the psychologists Judith Rodin and Ellen Langer performed an experiment in which they got a Connecticut nursing home to give each of its residents a plant. Half of them were assigned the job of watering their plant and attended a lecture on the benefits of taking on responsibilities in their lives. The other half had their plant watered for them and attended a lecture on how the staff was responsible for their well-being. After a year and a half, the group encouraged to take more responsibility—even for such a small thing as a plant—proved more active and alert and appeared to live longer.

In his book, Thomas recounted the story of a man he called Mr. L. Three months before he was admitted to the nursing home, his wife of more than sixty years died. He lost interest in eating, and his children had to help him with his daily needs more and more. Then he crashed his car into a ditch, and the police raised the possibility of its having been a suicide attempt. After Mr. L.'s discharge from the hospital, the family placed him at Chase.

Thomas recalled meeting him. "I wondered how this man had survived at all. Events of the past three months had shattered his world. He had lost his wife, his home, his freedom, and perhaps worst of all, his sense that his continued existence meant something. The joy of life was gone for him."

At the nursing home, despite antidepressant medications and efforts to encourage him, he spiraled downward. He gave up walking. He confined himself to bed. He refused to eat. Around this time, however, the new program started, and he was offered a pair of parakeets.

"He agreed, with the indifference of a person who knows he will soon be gone," Thomas said. But he began to change. "The changes were subtle at first. Mr. L. would position himself in bed

so that he could watch the activities of his new charges." He began to advise the staff who came to care for his birds about what they liked and how they were doing. The birds were drawing him out. For Thomas, it was the perfect demonstration of his theory about what living things provide. In place of boredom, they offer spontaneity. In place of loneliness, they offer companionship. In place of helplessness, they offer a chance to take care of another being.

"[Mr. L.] began eating again, dressing himself, and getting out of his room," Thomas reported. "The dogs needed a walk every afternoon, and he let us know he was the man for the job." Three months later, he moved out and back into his home. Thomas is convinced the program saved his life.

Whether it did or didn't may be beside the point. The most important finding of Thomas's experiment wasn't that having a reason to live could reduce death rates for the disabled elderly. The most important finding was that it is possible to provide them with reasons to live, period. Even residents with dementia so severe that they had lost the ability to grasp much of what was going on could experience a life with greater meaning and pleasure and satisfaction. It is much harder to measure how much more worth people find in being alive than how many fewer drugs they depend on or how much longer they can live. But could anything matter more?

IN 1908, a Harvard philosopher named Josiah Royce wrote a book with the title *The Philosophy of Loyalty*. Royce was not concerned with the trials of aging. But he was concerned with a puzzle that is fundamental to anyone contemplating his or her mortality. Royce wanted to understand why simply existing—why being merely housed and fed and safe and alive—seems

empty and meaningless to us. What more is it that we need in order to feel that life is worthwhile?

The answer, he believed, is that we all seek a cause beyond ourselves. This was, to him, an intrinsic human need. The cause could be large (family, country, principle) or small (a building project, the care of a pet). The important thing was that, in ascribing value to the cause and seeing it as worth making sacrifices for, we give our lives meaning.

Royce called this dedication to a cause beyond oneself loyalty. He regarded it as the opposite of individualism. The individualist puts self-interest first, seeing his own pain, pleasure, and existence as his greatest concern. For an individualist, loyalty to causes that have nothing to do with self-interest is strange. When such loyalty encourages self-sacrifice, it can even be alarming—a mistaken and irrational tendency that leaves people open to the exploitation of tyrants. Nothing could matter more than self-interest, and because when you die you are gone, self-sacrifice makes no sense.

Royce had no sympathy for the individualist view. "The selfish we had always with us," he wrote. "But the divine right to be selfish was never more ingeniously defended." In fact, he argued, human beings *need* loyalty. It does not necessarily produce happiness, and can even be painful, but we all require devotion to something more than ourselves for our lives to be enduring. Without it, we have only our desires to guide us, and they are fleeting, capricious, and insatiable. They provide, ultimately, only torment. "By nature, I am a sort of meeting place of countless streams of ancestral tendency. From moment to moment . . . I am a collection of impulses," Royce observed. "We cannot see the inner light. Let us try the outer one."

And we do. Consider the fact that we care deeply about what happens to the world after we die. If self-interest were the

primary source of meaning in life, then it wouldn't matter to people if an hour after their death everyone they know were to be wiped from the face of the earth. Yet it matters greatly to most people. We feel that such an occurrence would make our lives meaningless.

The only way death is not meaningless is to see yourself as part of something greater: a family, a community, a society. If you don't, mortality is only a horror. But if you do, it is not. Loyalty, said Royce, "solves the paradox of our ordinary existence by showing us outside of ourselves the cause which is to be served, and inside of ourselves the will which delights to do this service, and which is not thwarted but enriched and expressed in such service." In more recent times, psychologists have used the term "transcendence" for a version of this idea. Above the level of self-actualization in Maslow's hierarchy of needs, they suggest the existence in people of a transcendent desire to see and help other beings achieve their potential.

As our time winds down, we all seek comfort in simple pleasures—companionship, everyday routines, the taste of good food, the warmth of sunlight on our faces. We become less interested in the rewards of achieving and accumulating, and more interested in the rewards of simply being. Yet while we may feel less ambitious, we also become concerned for our legacy. And we have a deep need to identify purposes outside ourselves that make living feel meaningful and worthwhile.

With the animals and children and plants Bill Thomas helped usher into Chase Memorial Nursing Home, a program he called the Eden Alternative, he provided a small opening for residents to express loyalty—a limited but real opportunity for them to grab on to something beyond mere existence. And they took it hungrily.

"If you're a young doc, and you bring all these animals and

children and plants into a sterile institutional nursing home circa 1992, you basically see magic happen in front of your eyes,” Thomas told me. “You see people come alive. You see them begin to interact with the world, you see them begin to love and to care and to laugh. It blows your mind.”

The problem with medicine and the institutions it has spawned for the care of the sick and the old is not that they have had an incorrect view of what makes life significant. The problem is that they have had almost no view at all. Medicine’s focus is narrow. Medical professionals concentrate on repair of health, not sustenance of the soul. Yet—and this is the painful paradox—we have decided that they should be the ones who largely define how we live in our waning days. For more than half a century now, we have treated the trials of sickness, aging, and mortality as medical concerns. It’s been an experiment in social engineering, putting our fates in the hands of people valued more for their technical prowess than for their understanding of human needs.

That experiment has failed. If safety and protection were all we sought in life, perhaps we could conclude differently. But because we seek a life of worth and purpose, and yet are routinely denied the conditions that might make it possible, there is no other way to see what modern society has done.

BILL THOMAS WANTED to remake the nursing home. Keren Wilson wanted to do away with it entirely and provide assisted living facilities instead. But they were both pursuing the same idea: to help people in a state of dependence sustain the value of existence. Thomas’s first step was to give people a living being to care for; Wilson’s was to give them a door they could lock and a kitchen of their own. The projects complemented each other and

transformed the thinking of people involved in elder care. The question was no longer whether a better life was possible for people made dependent by physical deterioration: it was clear that it was. The question now was what the essential ingredients were. Professionals in institutions all over the world began trying to find answers. By 2010, when Lou Sanders’s daughter, Shelley, went out searching for a nursing home for her father, she had no inkling of this ferment. The vast majority of places that existed for someone like him remained depressingly penitentiary. And yet new places and programs attempting to remake dependent living had begun springing up across the country and the city.

In the Boston suburbs, just twenty minutes’ drive from my home, there was a new retirement community called NewBridge on the Charles. It was built on the standard continuum-of-care framework—there’s independent living, assisted living, and a nursing home wing. But the nursing home that I saw on a visit not long ago looked nothing like the ones I was familiar with. Instead of housing sixty people to a floor in shared rooms along endless hospital corridors, NewBridge was divided into smaller pods housing no more than sixteen people. Each pod was called a “household” and was meant to function like one. The rooms were all private, and they were built around a common living area with a dining room, kitchen, and activity room—like a home.

The households were human size, which was a key intention. Research has found that in units with fewer than twenty people there tends to be less anxiety and depression, more socializing and friendship, an increased sense of safety, and more interaction with staff—even in cases when residents have developed dementia. But there was more to the design than just size. The households were built specifically to avoid the feel of a clinical setting. The open design let residents see what others were up to, encouraging them to join in. The presence of a central

kitchen meant that, if a person felt like having a snack, he or she could go have a snack. Just standing and watching people, I could see the action spill over boundaries the way it does in real homes. Two men were playing cards in the dining room. A nurse filled out her paperwork in the kitchen instead of retreating behind a nurses' station.

There was more to the design than just architecture. The staff I met seemed to have a set of beliefs and expectations about their job that was different from what I'd encountered in other nursing homes. Walking, for instance, wasn't treated as a pathological behavior, as became instantly apparent when I met a ninety-nine-year-old great-grandmother named Rhoda Makover. Like Lou Sanders, she'd developed blood pressure problems, as well as sciatica, that resulted in frequent falls. Worse, she'd also become nearly blind from age-related retinal degeneration.

"If I see you again, I wouldn't recognize you. You're gray," Makover told me. "But you're smiling. I can see that."

Her mind remained quick and sharp. But blindness and a tendency to fall make a bad combination. It became impossible for her to live without twenty-four-hour-a-day help. In a normal nursing home, she would have been confined to a wheelchair for her safety. Here, however, she walked. Clearly there were risks. Nonetheless, the staff there understood how important mobility was—not merely for her health (in a wheelchair, her physical strength would have rapidly deteriorated) but even more for her well-being.

"Oh thank God I can go myself to the bathroom," Makover told me. "You would think it's nothing. You're young. You'll understand when you're older, but the best thing in your life is when you can go yourself to the bathroom."

She told me that in February she would turn one hundred.

"That's amazing," I said.

"That's old," she replied.

I told her my grandfather lived to almost one hundred and ten.

"God forbid," she said.

Just a few years earlier she'd had her own apartment. "I was so happy there. I was living. I was living the way people should live: I had friends, I played games. One of them would take the car, and we'd go. I was *living*." Then came the sciatica, the falls, and the loss of her vision. She was moved into a nursing home, a different one, and the experience was terrible. She lost almost everything that was her own—her furniture, her keepsakes—and found herself in a shared room, with a regimented schedule and a crucifix over her bed, "which, being Jewish, I didn't appreciate."

She was there for a year before moving to New Bridge, and it was, she said, "No comparison. No comparison." This was the opposite of Goffman's asylum. Human beings, the pioneers were learning, have a need for both privacy and community, for flexible daily rhythms and patterns, and for the possibility of forming caring relationships with those around them. "Here it's like living in my own home," Makover said.

Around the corner, I met Anne Braveman, seventy-nine, and Rita Kahn, eighty-six, who told me they had gone to the movies the week before. It wasn't some official, prearranged group outing. It was just two friends who decided they wanted to go see *The King's Speech* on a Thursday night. Braveman put on a nice turquoise necklace, and Kahn put on some blush, blue eye shadow, and a new outfit. A nursing assistant had to agree to join them. Braveman was paralyzed from the waist down due to multiple sclerosis and got around by motorized wheelchair; Kahn was prone to falls and needed a walker. They had to pay the \$15 fare for a wheelchair-accessible vehicle to take them. But it

was possible for them to go. They were looking forward to watching *Sex and the City* on DVD next.

"Have you read *Fifty Shades of Grey* yet?" Kahn asked me, impishly.

I allowed, modestly, that I had not.

"I had never heard of chains and that stuff," she said, marveling. Had I? she wanted to know.

I really didn't want to answer that.

NewBridge allowed its residents to have pets but didn't actively bring them in, the way Bill Thomas's Eden Alternative had, and so animals hadn't become a significant part of life there. But children had. NewBridge shared its grounds with a private school for students in kindergarten through eighth grade, and the two places had become deeply intertwined. Residents who didn't need significant assistance worked as tutors and school librarians. When classes studied World War II, they met with veterans who gave firsthand accounts of what they were studying in their texts. Students came in and out of NewBridge daily, as well. The younger students held monthly events with the residents—art shows, holiday celebrations, or musical performances. Fifth and sixth graders had their fitness classes together with the residents. Middle schoolers were taught how to work with those who have dementia and took part in a buddy program with the nursing home residents. It was not unusual for children and residents to develop close individual relationships. One boy who befriended a resident with advanced Alzheimer's was even asked to speak at the man's funeral.

"Those little kids are charmers," said Rita Kahn. Her relationship with the children was one of the two most gratifying parts of her days, she told me. The other was the classes she was able to take.

"The classes! The classes! I love the classes!" She took a

current events class taught by one of the residents in independent living. When she learned that President Obama had not yet visited Israel as president, she fired off an e-mail to him.

"I really felt I had to tell this man to get off his bun and go to Israel stat."

It seemed like this kind of place might be unaffordable. But these weren't wealthy people. Rita Kahn had been a medical records administrator and her husband a high school guidance counselor. Anne Braveman had been a Massachusetts General Hospital nurse, and her husband was in the office supply business. Rhoda Makover used to be a bookkeeper and her husband a dry goods salesman. Financially, these people were no different from Lou Sanders. Indeed, 70 percent of NewBridge's nursing home residents had depleted their savings and gone onto government assistance in order to pay for their stay.

NewBridge had been able to cultivate substantial philanthropic support through its close ties to the Jewish community, and that had been vital to its staying afloat. But less than an hour's drive away, close to where Shelley and her husband lived, I visited a project that had nothing like NewBridge's resources and nonetheless found ways to be just as transformative. Peter Sanborn Place was built in 1983 as a subsidized apartment building with seventy-three units for independent, low-income elderly people from the local community. Jacquie Carson, its director since 1996, hadn't intended to create nursing-home-level care there. But, as her tenants aged, she felt that she had to find a way to accommodate them permanently if they wanted it—and want it they did.

At first, they just needed help around their homes. Carson arranged for aides from a local agency to help with laundry, shopping, cleaning, and the like. Then some residents became weak, and she brought in physical therapists who gave them

canes and walkers and taught them strengthening exercises. Some tenants required catheters, care for skin wounds, and other medical treatment. So she organized visiting nurses. When the home care agencies started telling her that she needed to move her residents into nursing homes, she remained defiant. She launched her own agency and hired people to do the job the way it should be done, giving people help with everything from meals to medical appointments.

Then one resident was diagnosed with Alzheimer's disease. "I took care of him for a couple years," Carson said, "but as he progressed, we weren't ready for that." He needed around-the-clock checks and assistance with toileting. She began to think she'd reached the limits of what she could provide and would have to put him in a nursing home. But his sons were involved with a charity, the Cure Alzheimer's Fund, which raised the money to hire Sanborn Place's first overnight staff member.

A decade or so later, just thirteen of her seventy-some residents were still independent. Twenty-five required assistance with meals, shopping, and so on. Thirty-five more required help with personal care, sometimes twenty-four hours a day. But Sanborn Place avoided becoming a certified nursing home or even an assisted living facility. Officially, it's still just a low-income apartment complex—though one with a manager who is determined to enable people to live in their own homes, in their own way, right to the end, no matter what happens.

I met a resident, Ruth Barrett, who gave me a sense of just how disabled a person could be while managing to still live in her own place. She was eighty-five and had been there eleven years, Carson said. She required oxygen, because of congestive heart failure and chronic lung disease, and she hadn't walked in four years, because of complications from arthritis and her brittle diabetes.

"I walk," Barrett objected from her motorized wheelchair. Carson chuckled. "You don't walk, Ruthie."

"I don't walk *a lot*," Barrett replied.

Some people shrink to twigs as they age. Others become trunks. Barrett was a trunk. Carson explained that she needed twenty-four-hour assistance available and a hydraulic lift to safely move her from her wheelchair to the bed or toilet. Her memory had also faded.

"My memory is *very good*," Barrett insisted, leaning into me. Unfairly, I asked her how old she was. "Fifty-five," she said, which was off by only three decades. She remembered the past (at least the distant past) reasonably well, though. She never finished high school. She married, had a child, and divorced. She waitressed at a local diner for years to make ends meet. She eventually had three husbands in all. She mentioned one of them, and I asked her to tell me about him.

"He never killed himself working," she said.

Her desires were modest. She found comfort in her routine—a leisurely breakfast, music on the radio, a chat with friends in the lobby or her daughter on the phone, an afternoon snooze. Three or four nights a week, people gathered to watch movies on DVD in the library, and she almost always joined in. She loved going on the Friday lunch outings, even if the staff had to put her in a triple layer of Depends and clean her up when she returned. She always ordered a margarita—rocks, no salt—despite its being technically forbidden for a diabetic.

"They live like they would live in their neighborhood," Carson said of her tenants. "They still get to make poor choices for themselves if they choose."

Achieving this required more toughness than I'd realized. Carson often found herself battling the medical system. A single emergency room visit could unravel all the work she and her

team had done. It was bad enough that, in the hospital, her tenants could be subject to basic medication errors, left lying on gurneys for hours (which caused their skin to break down and form open bedsores from the pressure of the thin mattresses), and assigned doctors who never called Sanborn Place for information or planning. The residents were often also shipped off to rehabilitation centers where they and their families would be told that they could never go back to apartment living again. Carson gradually worked out relationships with individual ambulance services and hospitals, which understood that Sanborn Place expected to be consulted about care for its residents and could always take them back home safely.

Even the primary care doctors the residents saw needed education. Carson recounted a conversation she'd had that day with the physician of a ninety-three-year-old woman with Alzheimer's disease.

"She's not safe," the doctor told her. "She needs to be in a nursing home."

"Why?" Carson replied. "We have bed pads. We have alarms. We have GPS tracking." The woman was well cared for. She had friends and familiar surroundings. Carson wanted him just to order some physical therapy.

"She doesn't need that. She's not going to remember how to do that," he said.

"Yes she is!" she insisted.

"She needs to be in the nursing home."

"You need to retire," I wanted to tell him," Carson recounted. Instead, she said to the patient, "Let's just change your doctor, because he's too old to learn." She told the woman's family, "If I'm going to waste my energy, it's not going to be on him."

I asked Carson to explain her philosophy for enabling her

residents to continue to live their own lives, whatever their condition. She said her philosophy was, "We'll figure this out."

"We will maneuver around all the obstacles there are to be maneuvered around." She spoke like a general plotting a siege. "I push probably every envelope and beyond."

The obstacles are large and small, and she was still sorting out how best to negotiate many of them. She hadn't anticipated, for example, that residents themselves might object to her efforts to help other residents stay in their homes, but some do. She said they would tell her, "So-and-so doesn't belong here anymore. She could play bingo last year. Now she doesn't even know where she is going."

Arguing with them didn't work. So Carson was now trying a new tack. "I say, 'Okay. Let's go find a place for her to live. But you're going with me, because you could be this way next year.'" So far, that has seemed enough to settle the matter.

Another example: A lot of the residents had pets, and despite the increasing difficulties they had with managing them, they wanted to keep them. So she organized her staff to empty cats' litter boxes. But the staff balked at dogs, as they required more attention than cats. Recently, though, Carson had worked out ways that her team could help with little dogs, and they'd begun allowing residents to keep them. Big dogs were still an unsolved problem. "You have to be able to take care of your dog," she said. "If your dog is running the roost, it may not be such a good idea."

Making lives meaningful in old age is new. It therefore requires more imagination and invention than making them merely safe does. The routine solutions haven't yet become well defined. So Carson and others like her are figuring them out, one person at a time. Outside the first-floor library, Ruth Beckett

was chatting with a group of friends. She was a tiny ninety-year-old woman—more twig than trunk—who had been widowed years ago. She had stayed on in her house alone until a bad fall put her into a hospital and then a nursing home.

“My problem is I’m tippy,” she said, “and there’s no such thing as a tippy doctor.”

I asked her how she’d ended up in Sanborn Place. That was when she told me about her son Wayne. Wayne was a twin born without enough oxygen. He developed cerebral palsy—he had trouble with spasticity when he walked—and was mentally delayed, as well. In adulthood, he could handle basic aspects of his life, but he needed some degree of structure and supervision. When he was in his thirties, Sanborn Place opened as a place offering just that and he was its first resident. Over the three decades since, she visited him almost every day for most of the day. But when her fall put her in a nursing home, she was no longer permitted to visit him, and he wasn’t cognitively developed enough to seek to visit her. They were all but completely separated. There seemed no way around the situation. Despairing, she thought their time together was over. Carson, however, had a flash of brilliance and worked out how to take them both in. They now had apartments almost next to each other.

Just a few yards away from where I was talking with Ruth, Wayne sat in a wing chair sipping a soda and watching people come and go, his walker set to his side. They were together, as a family, again—because someone had finally understood that little mattered more to Ruth than that, not even her life.

It didn’t surprise me to learn that Peter Sanborn Place had two hundred applicants on its wait list. Jacques Carson hoped to build more capacity to accommodate them. She was, once again, trying to maneuver around all the obstacles—the lack of funding, the government bureaucracies. It will take a while, she told

me. So in the meantime she’s created mobile teams that can go out to help people where they live. She still wants to make it possible for everyone to live out their days wherever they can call home.

THERE ARE PEOPLE in the world who change imaginations. You can find them in the most unexpected places. And right now, in the seemingly sleepy and mundane precincts of housing for the elderly, they are cropping up all over. In eastern Massachusetts alone, I came across almost more than I could visit. I spent a couple mornings with the founders and members of Beacon Hill Villages, a kind of community cooperative in several neighborhoods of Boston dedicated to organizing affordable services—everything from plumbing repair to laundry—in order to help the elderly stay in their homes. I talked to people running assisted living homes who, against every obstacle, had struck with the fundamental ideas Keren Wilson had planted. I’ve never encountered people more determined, more imaginative, and more inspiring. It depresses me to imagine how differently Alice Hobson’s last years would have been if she’d been able to meet one of them—if she’d had a NewBridge, an Eden Alternative, a Peter Sanborn Place, or somewhere like them to turn to. With any of them, Alice would have had the chance to continue to be who she was despite her creeping infirmities—“to really live,” as she would have put it.

The places I saw looked as different from one another as creatures in a zoo. They shared no particular shape or body parts. But the people who led them were all committed to a singular aim. They all believed that you didn’t need to sacrifice your autonomy just because you needed help in your life. And I realized, in meeting these people, that they shared a very particular

philosophical idea of what kind of autonomy mattered most in life.

There are different concepts of autonomy. One is autonomy as free action—living completely independently, free of coercion and limitation. This kind of freedom is a common battle cry. But it is, as Bill Thomas came to realize on his homestead in upstate New York, a fantasy—he and his wife, Jude, had two children born with severe disabilities requiring lifelong care, and someday, illness, old age, or some other mishap will leave him in need of assistance, too. Our lives are inherently dependent on others and subject to forces and circumstances well beyond our control. Having more freedom seems better than having less. But to what end? The amount of freedom you have in your life is not the measure of the worth of your life. Just as safety is an empty and even self-defeating goal to live for, so ultimately is autonomy.

The late, great philosopher Ronald Dworkin recognized that there is a second, more compelling sense of autonomy. Whatever the limits and travails we face, we want to retain the autonomy—the freedom—to be the authors of our lives. This is the very marrow of being human. As Dworkin wrote in his remarkable 1986 essay on the subject, “The value of autonomy . . . lies in the scheme of responsibility it creates: autonomy makes each of us responsible for shaping his own life according to some coherent and distinctive sense of character, conviction, and interest. It allows us to lead our own lives rather than be led along them, so that each of us can be, to the extent such a scheme of rights can make this possible, what he has made himself.”

All we ask is to be allowed to remain the writers of our own story. That story is ever changing. Over the course of our lives, we may encounter unimaginable difficulties. Our concerns and desires may shift. But whatever happens, we want to retain the

freedom to shape our lives in ways consistent with our character and loyalties.

This is why the betrayals of body and mind that threaten to erase our character and memory remain among our most awful tortures. The battle of being mortal is the battle to maintain the integrity of one's life—to avoid becoming so diminished or dispirited or subjugated that who you are becomes disconnected from who you were or who you want to be. Sickness and old age make the struggle hard enough. The professionals and institutions we turn to should not make it worse. But we have at last entered an era in which an increasing number of them believe their job is not to confine people's choices, in the name of safety, but to expand them, in the name of living a worthwhile life.

LOU SANDERS WAS on his way to joining the infantized and caratonic denizens belted into the wheelchairs of a North Andover nursing home when a cousin told Shelley about a new place that had opened in the town of Chelsea, the Leonard Florence Center for Living. She should check it out, he said. It was just a short drive away. Shelley arranged for her and Lou to visit.

Lou was impressed from the first moments of the tour, when the guide mentioned something Shelley barely noted. All the rooms were single. Every nursing home Lou had ever seen had shared rooms. Losing his privacy had been among the things that scared him most. Solitude was fundamental to him. He thought he'd go crazy without it.

“My wife used to say I was a loner, but I'm not. I just like my time alone,” he told me. So when the tour guide said that the Florence Center had single rooms, “I said, ‘You must be kidding!’” The tour had only begun and already he was sold.

Then the guide took them through it. They called the place a

Green House. He didn't know what that meant. All he knew was, "It didn't look like a nursing home to me."

"What did it look like?" I asked.

"A home," he said.

That was the doing of Bill Thomas. After launching the Eden Alternative, he had grown restless. He was by temperament a serial entrepreneur, though without the money. He and his wife, Jude, set up a not-for-profit organization that has since taught the Eden principles to people from hundreds of nursing homes. They then became cofounders of the Pioneer Network, a kind of club for the growing number of people committed to the reinvention of elder care. It does not endorse any particular model. It simply advocates for changes that can transform our medically dominated culture of care for the elderly.

Around 2000, Thomas got a new itch. He wanted to build a home for the elderly from the ground up instead of, as he'd done in New Berlin, from the inside out. He called what he wanted to build a Green House. The plan was for it to be, as he put it, "a sheep in wolf's clothing." It needed to look to the government like a nursing home, in order to qualify for public nursing home payments, and also to cost no more than other nursing homes. It needed to have the technologies and capabilities to help people regardless of how severely disabled or impaired they might become. Yet it needed to feel to families, residents, and the people who worked there like a home, not an institution. With funding from the not-for-profit Robert Wood Johnson Foundation, he built the first Green House in Tupelo, Mississippi, in partnership with an Eden Alternative nursing home that had decided to build new units. Not long afterward, the foundation launched the National Green House Replication Initiative, which supported the construction of more than 150

Green Houses in twenty-five states—among them the Leonard Florence Center for Living that Lou had toured.

Whether it was that first home for a dozen people in a Tupelo neighborhood or the ten homes that were built in the Florence Center's six-story building, the principles have remained unchanged and echo those of other pioneers. All Green Houses are small and communal. None has more than twelve residents. At the Florence Center, the floors have two wings, each called a Green House, where about ten people live together. The residences are designed to be warm and homey—with ordinary furniture, a living room with a hearth, family-style meals around one big table, a front door with a doorbell. And they are designed to pursue the idea that a life worth living can be created, in this case, by focusing on food, homemaking, and befriending others.

It was the look of the place that attracted Lou—there was nothing dispiritingly institutional about it. But when Lou moved in, the way of life became what he valued most. He could go to bed when he wanted and wake when he wanted. Just that was a revelation to him. There was no parade of staff marching down the halls at 7:00 a.m., rustling everyone through showers and getting them dressed and wheeled into place for the pill line and group mealtime. In most nursing homes (including Chase Memorial, where Thomas had gotten his start), it had been thought that there was no other way. Efficiency demanded that the nursing aide staff have the residents ready for the cook staff, who had to have the residents ready for the activity coordinator staff, who kept them out of the rooms for the cleaning staff, et cetera. So that was the way the managers designed the schedules and responsibilities. Thomas flipped the model. He took the control away from the managers and gave it to the frontline caregivers. They were each encouraged to focus on just a few

residents and to become more like generalists. They did the cooking, the cleaning, and the helping with whatever need arose, whenever it arose (except for medical tasks, like giving medication, which required grabbing a nurse). As a result, they had more time and contact with each resident—time to talk, eat, play cards, whatever. Each caregiver became for people like Lou what Getasim was for Ivan Ilyich—someone closer to a companion than a clinician.

It didn't take much to be a companion for Lou. One staff member gave him a big hug every time she saw him, and he confided to Shelley how much he loved the human contact. He had got so little of it, otherwise. On Tuesday and Thursday afternoons, he'd go down to the coffee shop and play cribbage with his friend Dave, who still visited him. Plus he'd taught the game to a man paralyzed by a stroke who lived in a home on another floor and sometimes came by Lou's place to play. An aide would hold his cards or, if necessary, Lou would, taking care not to peek. Other afternoons Shelley would come by. She'd bring the dogs, which he loved.

He was also happy, though, to spend most of the day on his own. After breakfast, he'd retreat to his room to watch television—"see about the mess," as he put it.

"I like keeping up on what's going on in politics. It's like a soap opera. Every day another chapter."

I asked him what channel he watched. Fox?

"No, MSNBC."

"MSNBC? Are you a liberal?" I said.

He grinned. "Yeah, I'm a liberal. I would vote for Dracula if he said he was a Democrat."

A while later he took some exercise, walking with his aide around the floor, or outside when the weather was good. This was a big deal to him. In his last months in assisted living, the

staff had consigned him to a wheelchair, arguing it wasn't safe for him to walk, given his fainting spells. "I hated that chair," he said. The people at the Florence Center let him get rid of it and take his chances with a walker. "I'm kind of proud that I pushed the matter," he said.

He'd eat lunch at noon around the big dining table with the rest of the house. In the afternoon, if he didn't have a card game or some other plan, he'd usually read. He had subscriptions to *National Geographic* and *Newsweek*. And he still had his books. He'd finished a Robert Ludlum thriller recently. He was starting in on a book about the defeat of the Spanish Armada.

Sometimes, he pulled up to his Dell computer and surfed YouTube videos. I asked him which ones he liked to watch. He gave me an example.

"I hadn't been to China in many years"—not since the war—"so I said, let me go back to the city of Chengdu, which happens to be one of the oldest cities in the world, going back thousands of years. I was stationed near there. So I got onto the computer, and I punched in 'Chengdu.' Pretty soon I was tripping all over the city. Did you know they have synagogues there! I said 'Wow!' They tell you there's one over here, there's one over there. I was bouncing all over the place," he said. "The day goes by so fast. It goes by incredibly fast."

In the evening, after dinner, he liked to lie down on his bed, put on his headphones, and listen to music from his computer. "I like that quiet time at night. You'd be surprised. Everything is quiet. I put the easy listening on." He'd pull up Pandora and listen to smooth jazz or Benny Goodman or Spanish music—whatever he felt like. "Then I lie back and think," he said.

One time, visiting Lou, I asked him, "What makes life worth living to you?"

He paused before answering.

"I have moments when I would say I think it's time, maybe one of the days when I was at a low point," he said. "Enough is enough, you know? I would badger my Shelley. I would say, you know in Africa, when you got old and you couldn't produce anymore, they used to take you out in the jungle and leave you to be eaten by wild animals. She thought I was nuts. 'No,' I said. 'I'm not producing anything anymore. I'm costing the government money.'"

"I go through that every once in a while. Then I say, 'Hey, it is what it is. Go with the flow. If they want you around, so what?'"

We had been talking in a sitting room off the kitchen with ceiling-high windows on two sides. The summer was turning to fall. The light was white and warm. We could see the town of Chelsea below us, Boston Harbor's Broad Sound in the distance, the ocean-blue sky all around. We'd been talking about the story of his life for almost two hours when it struck me that, for the first time I can remember, I did not fear reaching his phase of life. Lou was ninety-four years old and there was certainly nothing glamorous about it. His teeth were like toppled stones. He had aches in every joint. He'd lost a son and a wife, and he could no longer get around without a walker that had a yellow tennis ball jammed onto each of its front feet. He sometimes got confused and lost the thread of our conversation. But it was also apparent that he was able to live in a way that made him feel that he still had a place in this world. They still wanted him around. And that raised the possibility that the same could be the case for any of us.

The terror of sickness and old age is not merely the terror of the losses one is forced to endure but also the terror of the isolation. As people become aware of the finitude of their life, they do not ask for much. They do not seek more riches. They do not

seek more power. They ask only to be permitted, insofar as possible, to keep shaping the story of their life in the world—to make choices and sustain connections to others according to their own priorities. In modern society, we have come to assume that debility and dependence rule out such autonomy. What I learned from Lou—and from Ruth Barrett, Anne Braveman, Rita Kahn, and lots of others—was that it is very much possible.

"I don't worry about the future," Lou said. "The Japanese have the word 'karma.' It means—if it's going to happen, there's nothing I can do to stop it. I know my time is limited. And so what? I've had a good shot at it."