Learning from Amy

A remarkable patient provokes anguished debate about rationality, autonomy and the right to die

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Experience

Expérience

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Good physicians learn from their patients. The patient I will call Amy was an extraordinary teacher. The impression she left remains vivid even though our encounter was brief. I met her when a colleague asked me to admit a new patient of his to hospital. He explained that she had a number of enlarged lymph nodes and needed a CT-guided needle biopsy; he felt the need to warn me that she was somewhat "eccentric."

The person I encountered was a petite, bright and charming woman who came across as younger than her 77 years. She exuded a vivacity, a determination to make the most of every moment, but hinted that she was aware of the bad news the biopsy might bring. During her history and physical she regaled me with a long, rambling monologue. Her garrulousness didn't strike me as at all unusual. Many people deal with anxiety by talking, and Amy was evidently concerned about the biopsy. She asked about my wife and children. The encounter seemed quaint and understandable, given the circumstances.

The biopsy went uneventfully, and after examining her the next day I discharged Amy back to the care of her family physician. Later that week a plastic shopping bag appeared on my desk. In it were three inexpensive ceramic cups containing chocolate eggs, along with a handwritten note from Amy. She thanked me for my care and informed me that the gifts were for my children. This unexpected gesture gave me a moment's pause. I concluded it was genuine courtesy; chances were I'd never see Amy again.

That autumn, a boater spotted Amy "swimming" in the harbour. Suspicious of her intentions, he pulled her out of the water and called the police, who took her to hospital.

It was there that the extent of Amy's determination to die became evident. She reported that she had swallowed large quantities of water, believing that this would ensure her submersion. She had given away all of her money and possessions over the previous 9 months. She had paid her rent and utilities, given up her apartment and made funeral arrangements. She had even completed a final income tax return. The staff in the emergency department felt she had to be admitted, if only because she had no place to go and no clothes other than what she was wearing.

More of Amy's story was pieced together by the family medicine resident who admitted her. When the biopsy in the spring had shown a lymphoma, Amy was unwilling to accept treatment. After some coaxing, she had seen a hematologist, who found her to be "an alert and intelligent lady" and told her that the disease could be arrested and that the therapy would likely have few side effects. Nevertheless, Amy remained unwilling to accept intervention.

She returned the next month, as the hematologist had suggested, to discuss the situation in more detail. His follow-up letter noted, "She has an excellent understanding of this disease and has decided not to have any treatment." In late summer, when she began to experience anorexia, bloating and dysphagia, Amy saw the hematologist once more. She discussed possible terminal events with him, including gastrointestinal hemorrhage and renal failure. The hematologist offered symptom relief and palliative care, which she declined.

Amy had decided to end her life on her own terms. She began to clip newspaper articles about serious illness, physician-assisted suicide and the Sue Rodriguez case. She methodically and secretly emptied her apartment. She wrote farewell letters to the newspaper, the police, her lawyer and her physician. This planning extended even to the last physician who would attend to her: Amy called upon the coroner to tell him that she intended to take her life and wanted to give consent for an autopsy! This caused the medical examiner considerable concern. He called a psychiatrist friend and Amy's family physician. There was some disagreement: the coroner concluded that nothing *could* be done, the family physician that nothing *should* be done.

Her decision to die was, to me, not the defeated wish of a depressed person, but an affirmative act.

When she had cleared her apartment Amy checked into a hotel, where she set about writing the notes she planned to carry when she died. She put on two bathing suits, carefully placing the letters between them. Then she donned a raincoat, put on her remaining pair of shoes and set off to the waterfront.

Amy told the resident that she was not happy that her endeavour to take her life was termed a "suicide attempt." This term, she felt, should be reserved for the mentally ill. Her own situation was different, she claimed: she was rational and had made a conscious, well-informed decision.

The resident got an impression of a lonely and intensely private woman. She mentioned that her neighbours talked about her and called her "the Queen" in a derogatory fashion. She was divorced and had no idea of her ex-husband's whereabouts. She refused to divulge the names or addresses of any relatives; she had written to them but did not want any further involvement. The resident requested a psychiatric consultation on her behalf.

The psychiatrist who saw Amy that afternoon was a highly respected member of staff. He found her orientated but was concerned with her mental state. For him, her habit of speaking tangentially was evidence of mental illness. He recorded inconsistencies in her behaviour, such as reporting "intense pain" while refusing to take analgesics. During the interview Amy became unhappy with the psychiatrist. She shouted and banged her fist on the table and refused to discuss her suicide plans further. However, she did show the psychiatrist her clippings and suicide notes. She had written:

I have endured the unendurable since early spring and was told by a doctor . . . "I'm so sorry" — Well many months later, of unbelievable torture, mind over matter, time to off set, no human help in a hospital, but to keep you in torture — medical ethics.

In his report the psychiatrist raised the issue of paranoid ideation and said that psychosis could not be ruled out. He said he needed to do a full assessment and suggested that Amy be certified and transferred to the psychiatry department. Amy made it clear that she would resist any such move and threatened to take her life if she were placed on that ward. Undaunted, the psychiatrist and his resident filled out certification papers.

After reviewing the resident's admission data and talking with Amy, the attending physician was convinced that Amy was competent. He was an experienced and well-regarded staff member, known for a healthy scepticism and for his advocacy of the rights of psychiatric patients. He conferred with Amy's family physician; both agreed that, as difficult as the situation was, Amy had the right to take her own life.

Amy's mood fluctuated when she was in hospital. At times she seemed cheerful and content and it appeared to several people that she was proud of her decision to end her life. At other times she made angry outbursts. Nursing staff recorded her as being markedly suspicious of others. Another psychiatrist was called in to mediate the intercollegial disagreement. After a second psychiatric assessment and further consultation with the two family physicians it was agreed that Amy was not a candidate for psychiatric intervention. A social worker was called in to assist with arrangements for discharge accommodation.

The social worker also expressed concern that Amy appeared mentally ill. She felt that she was "unstable, paranoid and grandiose . . . not rational." Realizing that Amy was isolated from her family and community, she recommended that Amy stay on in the family medicine unit for further assessment.

There were numerous meetings of staff in various combinations. Everyone wondered what could be done when well-intentioned professionals disagreed.

On her fourth day in hospital Amy was discussed at clinical rounds, attended by members of the team and some of the unit's medical staff. Amy was not my patient now, but I found myself deeply affected by the deliberations. Initially they centred on the rationality of her decision to die. Her attending physician felt that her actions were rational: she had a value system and had made a decision consistent with her beliefs. He also noted wryly

that the current test of rationality was often concurrence with the opinions of one's physician.

I recalled how suicide was regarded as honourable in other cultures and societies, such as ancient Rome. But Amy wasn't an ancient Roman. She was a patient under our care. How could we resolve the conflict between patient autonomy and the duty of beneficience?

The discussion of rationality gave way to a consideration of whether Amy was mentally ill. The attending physician insisted that, although she was eccentric and had paranoid traits, Amy had no identifiable psychiatric illness. Not everyone agreed. Some believed that Amy might be suffering from a treatable mental illness and should be referred for psychiatric help. I found this argument seductive. "Why not just send her off and see what happens?" I thought. Yet, my respect for Amy's autonomy made this option seem misguided.

The social worker still felt that Amy was mentally ill, but reluctantly concluded that discharge was the best option. She noted that the patient had refused all offers of assistance and would respond poorly to psychiatric intervention. Given the advanced state of her lymphoma now, Amy might even succumb to the cancer before psychiatric treatment could help.

Curiously, there was little consideration of the legal implications. No one suggested that a lawyer's opinion be sought. I sensed a reluctance to let Amy out of our hands only to deliver her to the legal system. Any concerns we might have had about legal liability were pushed aside by the debate about the patient's interests. Finally, despite differences in opinion and considerable angst, the group reached the consensus that Amy's interests would be best served by her discharge from hospital.

Amy left that day. With a smile, she told the attending physician she would not do anything to harm herself. He knew she was as determined as ever. "The patient did not receive any special benefit from her hospital stay" he wrote in the discharge summary. "The institution may have benefited, since she raised a number of very important issues that were discussed in the department of family medicine, in psychiatry, and with the ethics committee."

A few days later, the coroner informed Amy's family physician that Amy's body had been taken from the harbour. He recalled their meeting: "She even brought me some chocolates. That was a first for me."

I was saddened by this woman's death in a way that was unique. The decision to let Amy leave hospital was not a black-and-white issue. Like many people on our team, I felt very uncomfortable allowing her to commit suicide. Amy didn't have to die; her death lacked the inevitability that accompanies terminal illness. I didn't feel that she was mentally ill in the clinical sense. Her decision to die was, to me, not the defeated wish of a depressed person, but an affirmative act to conclude her life on her own terms. But what if we had gotten past her social isolation? What if she had been befriended? Would an understanding that she was appreciated and respected have changed her outlook?

As I grappled with this ambivalence, I kept returning to one theme, one certainty. I was confident that we had respected Amy's rights. She died the way she wanted to, with her dignity intact. At least this I was reconciled to, and from it I took a measure of peace. I think Amy taught me that it is imperative to respect the autonomy of the people we care for even if we disagree with their reasoning. Maybe that is why her death affected me less like the loss of a patient and more like that of a respected teacher. Pretty impressive teaching, Amy.

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