

This is a resident case log of a patient encounter in which an “Aware Medicine topic” was central.

Mental Illness and the Right to Die

While on an inpatient medicine rotation I admitted an elderly woman in her 80s with pneumonia. I had never met her before, but according to her records she had a long history of intractable depression, anxiety and borderline personality disorder. As she began to recover in the hospital, she became more alert, and both the physicians and staff caring for her were struck by how profoundly miserable she was. She had battled chronic mental illness (unsuccessfully) throughout her life. She had no friends or family, and she continued to live alone long after she was able to take care of herself. She was competent, but refused help of any kind. The Emergency Medical Service record from her transport to the hospital reported that her apartment was covered in garbage, and that she had been covered in layers of dried feces and urine.

After her pneumonia resolved, she continued to refuse admission to a nursing home. After a long period of negotiation, she agreed to go to an assisted living apartment with home nursing help. She refused to cooperate with a psychiatric evaluation. On the day she was to be discharged she became unresponsive, pale, incontinent of urine, and hypotensive. She regained consciousness without intervention, but she was in severe distress. She was crying out for help and repeatedly asked us to help her die. She would not answer any questions –she just kept repeating that she wanted us to let her die. She had already expressed her wishes to be Do Not Resuscitate/Do Not Intubate. I was with an experienced faculty member in the room and we decided to start her on a comfort care pathway and sedate her with morphine. After she was sedated she died within the next few hours.

In some ways it was a challenge to accept her decision to end her life. We could not be sure without further testing what was actually wrong with her. Although she was alert and spoke logically, she also had a history of severe depression, psychosis and paranoia. Her depression and anxiety had destroyed her life and she had never been able to manage her mental illness.

I was comfortable with the decision to sedate her without further testing or treatment partially because I believe that patients have the right to end their life if they choose. In some ways it was easier to watch her make that decision than to force her to continue living a life that she could no longer tolerate. This was the first time that I had ever been involved in a transition to comfort care that was so fast and patient-driven. I was grateful that there was a faculty member there to share this decision. I continue to find dealing with issues of patient autonomy in the mentally ill patient very challenging.