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"Please Don't Keep Me"

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"I love you, love you, love you," my Grandma Lolo said on the voice mail she left me the evening before she attempted suicide.

The next morning, on a blue-sky Sunday in May 2018, I received a call from an unknown number. "Your grandmother was found down," said a woman who introduced herself as an emergency department physician assistant. As the only physician in my family, I raced for the next flight to Cleveland.

"Why didn't I die?" were the first words my grandma uttered when she was extubated.

"Say that again?" I asked, nearly choking. Until that moment, I had no idea my 87-year-old grandma had been found lying unconscious on the floor, tramadol and Tylenol strewn across her floral comforter. Only then did I realize the significance of her voice mail: she had called to say goodbye.

I spent the next week at the hospital, painfully aware that my grandma was trapped between the medical team's goal to keep her "safe" and alive and her ambition (and readiness) to die. On top of that struggle, the shame that the medical team implied my grandma — and our family — should feel about her suicide attempt cast a shadow over her care and continues to be a source of pain for me.

In the years leading up to my grandma's overdose, her quality of life had swiftly declined. She had brittle osteoporosis that had resulted in multiple fractures. She was always in pain. She weighed 80-something pounds. Though she'd been living independently, albeit with extensive help from my mother and home health aides, by the time she attempted suicide, she could no longer prepare food, shower, use the toilet, or stand on her own. She was completely dependent.

Still, Lolo's mind was sharp. She loved Barack Obama and Rachel Maddow. She would often call me to recommend movies, like a PBS documentary on Jewish composers. "Don't shit on your ancestors," she said. She slayed the *New York Times* crossword. A former top sales associate at Saks Fifth Avenue, she still loved designer clothes and took pride in looking put-together. This regard for self-image and her undiminished cognitive capacity made her physical losses feel that much worse. Her body was a tangle of kudzu vines slowly suffocating a tree.

"When I was young, I could always work on things being better," she told me. "I always had hope. But recently, I knew it was only going to get worse." I knew she was right.

Moving to a nursing home was inevitable, and any place she could afford on Social Security would be far from upscale. Lolo had never been a warm or gentle mother — she could be cruel and vain, with a tendency toward histrionic provocations — so living with her children now was not an option. Yet she'd always found joy in being active: traveling, drinking martinis, selling high fashion, playing bridge. Now, she was stuck in limbo: too well to die, yet too ill to live the way she wanted to, the way that gave her meaning.

In the years since her suicide attempt, this heartbreaking liminal space has become her reality. Though she receives excellent care in her nursing home, her life has shrunk to the size of her room. She cannot do any of the activities that bring her joy. Sometimes paranoia or delirium sets in, and she calls me, convinced that someone has stolen her Keds or her wallet. Most recently, she thought she was trapped in someone else's home. "There are no doors here," she said frantically. Her vibrancy has diminished. Watching her decline in this way, with no choice or control over the trajectory, has been its own kind of suffering.

At the hospital, the medical team spoke to us as if every syllable about suicide was shameful. They avoided the word at all costs, referring to the event only obliquely: "we all know why we're

here" or "the thing that happened." No one named or validated my grandma's suffering.

Everyone asked, "Are you still feeling suicidal?"

No one (but me) asked, "What in your life is worth living for?"

Only in retrospect do I see that her doctors probably dreaded her answer. In medicine, we're so often afraid to ask about problems when we know they have no tangible solution. We have a low tolerance for sitting with sadness. We find it hard to believe that our presence is enough.

"Don't you see she's suffering?" I wanted to scream. The hospital halls were cold and nameless. I felt abandoned, alone, and disappointed. Hospitals were familiar ground for me, and I spoke the medical team's language. And yet my grandma had become a diagnosis that no one discussed, beyond making plans for psychiatry and nutrition consultations.

The hospital psychiatrist wanted to start an antidepressant. "I'm not depressed," my grandma kept saying. Her distress over her physical losses and quality of life may have caused depression, but depression had not caused her distress. I knew giving her mirtazapine would not make her magically feel better. I didn't fault the psychiatrist for wanting to try it, yet the lack of honest conversation about what brought my grandma to this point and how she felt about her death created a chasm between us and the doctors. This avoidance was a painful erasure of my grandma's reality and my family's experience.

Until that week, I had not known how high the incidence of suicide was among older Americans. Adults 65 years or older make up 12% of the U.S. population but account for 18% of suicide deaths.[1] Men 85 years or older have the highest suicide rate of any group.[2] Yet the medical team treated my grandma as if her action was groundless and exceedingly rare.

Despite my own sadness, I knew Lolo had her reasons. She felt she'd lived a full life and had been accepting of death for a while now. I was willing to sit with this reality. But the team implied that if she only took this medication or "tried harder," things would get better. Though I know interventions are critical when suicidality is fueled by depression or other crises, that was not the case for my grandma. I know that many older adults can adapt to alterations in functionality and independence, given the right, individualized attention to social engagement or therapy. But Lolo knew herself well, and her disposition and values seemed to preclude that outcome. Yet even if there was no "cure" for her team to offer, I felt they fundamentally missed the opportunity to offer their presence and compassion for her suffering.

Looking back, I've speculated about what they were experiencing. Medicine is founded on the premise that lives should be saved. The fear of death permeates our profession and our culture, and doctors are principally called on to offer treatments. When there's nothing tangible that we can do to "fix" things, we can feel like failures. Physicians are also expected to be objective, yet I wondered about the personal opinions of those on her medical team. Did they fear that showing sympathy regarding a suicide attempt would imply that they condoned it?

Perhaps I was expecting too much, but I needed from her doctors what I imagine they would have wanted for their own families: I wanted them to tell my grandma that they knew her pain and losses were real and to name her suffering. Instead, they celebrated when she gained a pound, even as it made her more hopeless. They never acknowledged her reality, and they gave no sign of recognizing that my family was grieving alongside her.

One night, I stayed late at the hospital to watch a movie with Lolo. Something had been weighing on me for days. I took a deep breath and said, "I'm sorry you didn't die, Grandma. This is incredibly hard to say, but I say this out of love because I know it's what you wanted."

"Please, don't keep me," she said simply, with a timbre I will never forget.

"I love you, Lolo, so I would never keep you," I replied. I reached out for her hand; it was so thin I could see each extensor tendon. Dark bruises lined her arms.

"I know you do, sweetheart," she said, "and I love you too, so, so, so much." I sat with my feet propped on her bed, holding her hand in mine, wishing there was more I could do.

Disclosure forms provided by the author are available at NEJM.org.

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