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CASE CONSULTATION

Scott Ames: A Man Giving Up on Himself

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EDITOR'S NOTE

The tragic story of Scott Ames raises a fundamental question concerning involuntary commitment of patients when suicide seems likely. What right has a physician ever to interfere when a patient proposes to take his own life? Under ordinary circumstances one argues that because of depression, or some other mental illness, the patient's judgment is impaired, so that intervention to prevent suicide is reasonable and ethical, given the high probability that once the illness is treated, the patient will no longer want to kill himself, and will be glad he was prevented from it. Over some years of clinical experience I have observed that there is a greater reluctance among clinicians to stop a suicide attempt when the patient is already dying, and when the death the patient faces promises to be a harrowing one. There is a tendency in these circumstances not to interfere, for a variety of reasons, some reasonable and some not.

Dr. Battin's interesting discussion suggests that there are circumstances in which deciding not to intervene to prevent suicide, and conveying this decision to the patient, opens the way to therapeutic intervention that may, in the long run, forestall suicide. At issue is the matter of leaving a patient's autonomy and control unchallenged. In view of the fact that some patients cherish control over living and dying more highly than life itself, avoiding a power struggle can be life saving. It has been argued by some psychotherapists that leaving the choice about living and dying strictly up to the patient is the correct stance, even when imminent death from physical illness is not anticipated (Birtchnell, 1983).

Of course, offering to assist such a patient as Scott Ames in completing his own suicide is very much another matter. Dr. Battin suggests that such a course is sometimes reasonable, but she knows hers is a minority view. The other point of view, that good palliative care is preferable to assisted suicide, is not addressed here, but readers will find it well argued in a recent volume edited by Foley and Hendin (2002).

CASE REPORT: SCOTT AMES

Scott Ames was at the peak of his career when the sky fell on him. At 38 he was a highly successful television executive in New York. His wife, Elaine, was a glamorous and intense mutual fund manager. Together, they were a much-admired couple. Their friends were shocked and horrified when Scott was urgently admitted to a psychiatric unit on the West Coast after he tried to asphyxiate himself with a poisonous gas.

Scott and Elaine had lived together for 4 years before they married in a fashionable church ceremony followed by an elegant and large reception. But a short time after the wedding Elaine fell ill; in the course of her medical work-up it was found that she was

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infected with HIV. Scott was promptly examined and to his horror discovered he was not only HIV positive, but that he had early symptoms of AIDS.

These calamities threw their lives into turmoil. Elaine blamed Scott for infecting her, but he maintained that he had been faithful to her throughout the time they were together, and that he had had a negative HIV test some time before the marriage. Scott in turn blamed Elaine for their infection. They kept their tragedy a secret for fear it would compromise their careers. Scott's health deteriorated, however, and 3 months before he tried to kill himself he became so sick he could not continue his work. In shame and desperation his family and a few close friends were told the truth about his health.

At first he accepted treatment for AIDS, but after a month, unable to tolerate the nausea, diarrhea, fever, and headache, he stopped the treatment though Elaine begged him not to.

He began to plan his own "euthanasia" from the time he received the AIDS diagnosis, and, keeping no more secrets, talked openly about his plans to die. He studied the web page of The Hemlock Society on the Internet, and visited other sites of a similar nature. He decided to use a plastic bag and toxic gas. On the morning of his attempt, he checked into a hotel without telling anyone, and tried to asphyxiate himself.

His suicide attempt failed. He lay in a coma in a hotel room for several hours before regaining consciousness. Disappointed to have survived, he telephoned his friend Roger, who immediately came to help. Roger contacted Scott's parents on the West Coast. Flight arrangements were made, and Roger drove Scott to the airport and helped him fly off. Scott's parents met the airplane and drove him to the emergency room of a large general hospital where he was promptly admitted to the psychiatric unit.

During the admission physical examination, a brain mass was discovered. A biopsy confirmed he had a tumor, and a diagnosis of lymphoma was made. A few days later he was further torn emotionally—in the psychiatric unit he learned Elaine, who had remained back home, was filing for divorce.

Scott cooperated in his medical work up, but he refused all treatment for AIDS and for the lymphoma. He believed that his prognosis was poor, and that he had only a few months to live. This was a fairly realistic estimate, if he refused treatment. His doctors urged him to accept treatment, which they believed could extend his life, but he rejected their advice and said he would be better off dead.

The nurses in the psychiatric unit found him difficult. Aloof, sullen, and irritable, he avoided conversation with everybody, except for a motherly older nurse who worked on the weekends. She felt she knew him better than the staff members and the other patients; only to her could he disclose his anguish and despair.

He was evasive when asked what he planned respecting suicide. He said he just wanted to live out his days with his parents and to die in peace, sooner rather than later. He accepted his doctor's prescription of antidepressant medication, but insisted that he wanted to leave the hospital.

The inpatient psychiatric team grew discouraged. They felt drained by Scott's hostility and his rejection of treatment, and feared he would kill himself if discharged. Some believed it might not be such a bad outcome, given his circumstances. In addition, the staff was under pressure to keep hospital stays brief, and they feared Scott might require an inpatient stay that could go on for months.

Scott wanted to be discharged to his parents' home, which was not far from the hospital. His father had retired at the close of a distinguished civil service career, and his mother, an outstanding teacher, had given up her work at the same time. They were politically conservative people, active in their church and in local politics. Their social life was focused in their country club.

Scott was raised in privileged circumstances and attended private schools, and graduated from a prominent university before

moving to New York. He had good relationships with his three siblings, a sister and two brothers, who lived not far away from the parents. Though he described his parents as "good natured, hard working, educated, and loving," they impressed the ward staff as emotionally cold and angry about what had happened to their son.

Scott denied any previous psychiatric history, but he was evasive about previous drug and alcohol abuse. He had never before attempted suicide.

A suicide risk consultation was arranged. The psychiatrist described Scott as a slim, fit, attractive man who was uncomfortable and tense through the interview. He answered questions reluctantly and sparingly, plainly feeling that they were intrusive, though he denied it. There was no evidence of delusions, hallucinations, or thought disorder. He acknowledged feeling depressed, and his affect was constricted. He was in some postbiopsy discomfort, and seemed unenergetic, slowed down, and moved about little.

The psychiatrist asked him about suicide. Scott replied that he only wanted "a place to rest," but was otherwise evasive. He said he just wanted to go home with his family.

The psychiatrist noticed that Scott had moved from horror and shame at the time of the original diagnosis to a depressed hopelessness. His privacy had been exploded, his wife was sick, she had rejected him, and he had a brain tumor. Plainly he was a ruined and dying man. The consultant thought that there was a considerable risk the patient would take his life if he were discharged, but his parents appeared loving and supportive (even if horrified). Scott was willing to see a psychiatrist on an outpatient basis, and accepted antidepressant prescriptions.

Though questions about his competency were raised, the prospect of a forced prolonged hospitalization seemed more likely to worsen the situation than to make it better. The patient and his parents would be certain to resist. Any course other than discharge seemed not only unwise but also meddlesome.

CASE DISCUSSION

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To begin, suppose all the facts asserted or implied in this case are true: Scott Ames does have AIDS, he does have a brain tumor, he did infect his new bride with the HIV virus, he is angry, hostile to treatment, and isolated, and he is highly likely to kill himself if he is released from the hospital. Here's the dilemma: Discharge him—to his death—or keep him hospitalized indefinitely against his will, in order to prevent the suicide. What to do?

This case comes from a major teaching hospital, where the patient was given a very extensive workup and the diagnoses were not in doubt. If there were space here to present all these details, we would have full access to the entire range of professional opinions concerning Scott's diagnosis and the prognosis for his HIV infection, his response to treatment, his lymphoma, and his depression, details it is important to know but which cannot be presented in a necessarily brief sketch of the case like that presented here. To fully understand Scott's case, we'd also want the opportunity to examine him in person, in part to see what he understands of what he has been told. We'd want to ask him questions: Why did he have an HIV test prior to his marriage? What risk behaviors, if any, occurred between the time of his test and the marriage, and is he willing to talk about them? Why exactly does he experience the diagnosis of AIDS with such shame? Why has he refused to continue treatment for his AIDS—is it really a matter of the side effects? And we'd want to ask his treating physicians questions as well: Given that Scott has blamed his wife for the HIV infection they share, has any attempt been made to confirm with laboratory

*Dr. Battin wishes to acknowledge a helpful discussion of this case by Brooke Hopkins, and a medical review from Dr. Jay Jacobson, M.D.

studies who infected whom, or whether each of the new spouses had been infected independently? What were his early symptoms of AIDS, and what about the complaints associated with his treatment? After all, the complaints sound more like symptoms of HIV infection than adverse reactions to the drugs used to treat it. We'd also want to know what type of lymphoma Scott has; most lymphomas are treatable and many are curable, though his may be different. In what ways can his type of tumor be expected to impair his emotional experience and cognitive functioning? Could it be a physiological cause of his depression? And, finally, we'd want to know whether or not the antidepressant Scott was taking was an appropriate choice, since it's not clear that sufficient time had elapsed to evaluate its effectiveness.

These are the medical questions. There may be institutional issues as well, about funding, bed space, and the like. And we'd want more information about social issues: What about the siblings with whom he spent a happy childhood; how do they understand their brother's "giving up on himself," and what help can they offer now? Does the motherly older nurse have any special insight to offer into Scott's refusal of treatment?

Yet even if we had full access to all the information gained in Scott's very thorough workup and psychosocial investigation, it seems, nothing really changes the picture: He still has AIDS (now quite far advanced); he still has the brain tumor (a bad one, progressing rapidly), and he still clearly intends to commit suicide if he can escape to his parents' house. Scott's case poses what seems to be a compelling ethical dilemma: Honor his wishes and thus consign him to suicide, or keep him in the hospital and violate his moral, if not legal, rights to liberty?

To discharge him, or to keep him hospitalized? This is no easy choice. But part of what makes it difficult is the very way it is framed, as a choice between two stark alternatives. Indeed, clinical choices in suicide-risk situations often look like this: discharge to death, or continue incarceration (as Scott might put it) against the patient's will and not clearly in the patient's interests. Yet I think there is a third alternative: Take Scott's interest in suicide as perhaps reasonable, certainly as an understandable choice for someone in his predicament, and work *with* him, not against him, in planning for it.

This may seem to be heresy, but in this case it seems far preferable to the other two alternatives. How to do it? Let someone volunteer (we hope it will be the sympathetic, motherly nurse) to work with Scott, help him explore his options, help him see his choices not from the panicked position he feels himself to be in, but as objectively as possible. For example, explore with him whether he really does have in mind to kill himself at his (loving, supportive) parents' house—is that what he wants for them? Where might he want to go instead? Would he plan to let his parents know in advance? What about his (ex) wife—would he like a farewell visit with her, perhaps facilitated by a neutral but understanding party? After all, she too has HIV. What about Roger, the friend who came to his rescue after his previous suicide attempt? How about other old friends—would he like help in contacting them and some idea of how to say a meaningful goodbye that does not blame them for his misfortunes or implicate them in his suicide? Does he need prescription drugs for his suicide, or more information from the Hemlock Society, or what? What about funeral arrangements, his will, the obituary for the newspaper? And would he like to have someone nearby, if not in the same room, when he finally ends his life, someone to accompany him the last few steps?

There is no way to predict the outcome of a strategy like this. My guess is that if Scott were really offered help in thinking through his plans for suicide in a straightforward, non-disapproving, non-duplicitous way, he would be much less likely to kill himself, at least not right away. With time, it might be possible, in working with him to explore his options, to put him in touch with that underground network of people with AIDS (including many physicians) who provide help to each other in dying. Should he happen to live in Oregon, he could even seek *legal* phy-

sician-assisted suicide, complete with counseling and medical support. If it is true that his life is ending—if it is true that he has reached the end stages of AIDS, and that the brain tumor, though palliable, is ultimately untreatable, lethal, and sure to disrupt his cognitive functioning—then in such grim circumstances the most loyal, respectful way to treat this person, this suffering human being, is to support him in a choice that may be truly his own about how his life shall end. Perhaps his choice will shift away from suicide if he finds that he really is offered genuine understanding and loyal support; perhaps it will not, but we will have helped him in his misery rather than thwarted him in what he now sees as the only solution to his desperate situation. We can realistically hope to make him less desperate, even if we cannot presume to change his mind.

With this answer, we can see what made the original dilemma so hard—to discharge him to his parents' house and let him kill himself, or to keep him hospitalized indefinitely against his will to prevent the suicide. *Both* these options are bad choices, and though I realize that it is heresy in circles dedicated to traditional ways of thinking about suicide prevention, both of them are I believe far less realistic and humane than the one I am suggesting here: To offer this patient support and help with the solution he sees. Of course, I wouldn't recommend this for just any suicidal person, but assuming that Scott really is facing death from AIDS compounded by a brain tumor that will destroy his capacity for cognitive function, it is appropriate to support what in these circumstances may be a reasonable choice and that is a choice of his own.

Of course, paradoxically, this support may be just what enables Scott to live a little longer, and certainly a little better, despite the conditions that afflict him.

CASE DISCUSSION

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This uncomfortable case increases our awareness of the murky areas in the study of suicidal patients, and makes us think about the rights of individuals. It raises questions about patient competency to make treatment decisions, and the right to die. It highlights treatment difficulties. What is considered amenable to medical and psychological intervention at this specific clinical juncture, according to proven scientific data? What is beyond the realistic reach of clinical treatments? And, what is subjectively distorted by depression or shame?

Scott Ames was shocked and humiliated when AIDS was diagnosed. He tried conventional AIDS therapies for just one month, but then abandoned the treatment, and any hope for recovery. When his AIDS became apparent, 10 months later, he gave up all hope, and acted on what he called his "euthanasia plan." Suicidality developed in reaction to this development in his life, a complex synthesis of his personality style, as he tried to cope with the trauma of an AIDS diagnosis, viewed through the lens of depression.

His personality style was one that may produce success in the business world, but makes accepting illness and weakness difficult. He was self-reliant and private, to the point of isolation and suspiciousness. Narcissism propelled him into the upper ranks of his industry at a very young age. Unfortunately, these traits can also make illness unbearable. AIDS cannot be treated by sheer willpower alone. One must rely on the clinical competence of a treatment team, and on the compassion and support of friends and family. Scott was unable to do this. Feelings of shame or anger kept him isolated and withdrawn.

Most likely, Scott also suffered under the burden of a major depression. He was started on antidepressant medication for the first time during his hospitalization, but by the time discharge was planned, appeared to have experienced little or no benefit. It is highly likely that he had been depressed for at least the past year, since his infection with HIV became apparent. Unfortunately, Scott was not able to obtain psychological or phar-

macological therapy for this depression, and his suicidal pressure has escalated.

By the time Scott presented himself for hospitalization, the illnesses of AIDS and lymphoma had progressed so that treatment would not likely promise an acceptable period of comfortable living that would be acceptable to many reasonable people. Similarly, the episode of depression had worsened to the point of hopelessness.

The trauma of the HIV diagnosis eroded Scott's ability to face his life. This diagnosis is often accompanied by humiliation when a heretofore secret homosexual life is exposed to the world. A sense of life's betrayal and rage drive much needed supporters away.

Although Scott denied any apparent suicidal plans during his hospitalization, he was not convincing. Two further important stressors, the divorce and the lymphoma, worsened the situation. The treatment team was faced with the decision of how to help a hostile, rejecting patient. The modern day inpatient unit has limited resources. The psychiatric staff had to struggle with the question of how they might safely discharge Scott to outpatient care, and not be considered callous or liable, should he kill himself.

To have legally forced Scott to remain an inpatient against his will, and to submit to involuntary treatment for lymphoma or AIDS, would probably have been counterproductive. Such maneuvers would undermine any efforts of a therapist to help him. Psychotherapy could help Scott, in his remaining time, to come to terms with his feelings of guilt and shame associated with AIDS, to say farewell to his wife, and to accept some comfort from his family and friends. The counter argument is that Scott is ambivalent and therefore needs the institution to resolve his feelings toward his care. But this does not carry as much weight, given the deterioration of his condition, and development of brain lymphoma.

Was Scott in fact competent to make treatment decisions? It is possible that his cognitive function was impaired by his physical illnesses or by his depression. However, his judgment at this point was consistent with the one that he articulated prior to the lymphoma diagnosis, when he discontinued treatment for AIDS, and sent himself down a deadly path. It could be argued that he was never really competent to make his own treatment decisions, because he was impaired by his mental illness. It is quite possible that Scott became so depressed at the initial time of AIDS diagnosis, that it clouded his ability to make competent treatment decisions. But that is a *fait accompli*.

The ward staff were asking for consultation around how to proceed therapeutically; that is, could they reasonably discharge Scott to outpatient care? At this point Scott remained a serious risk for suicide, and he was evasive about his safety. As his illness had deteriorated to such an extent, it seemed best to avoid a power struggle with him over competency issues, and forced medication. Wisely the treatment team concentrated instead, on assembling an appropriate outpatient treatment team, one that should include a psychotherapist, psychopharmacologist, AIDS specialists, and hospice workers.

To discharge Scott at this time would involve risk, but this risk is limited by several factors. His family was now involved in his treatment, and might be expected to be extremely vigilant about his safety. He was physically reliant on them, and not in a position to easily do himself harm.

The goal of outpatient treatment would be to help Scott and his family understand and cope with these overwhelming illnesses. Hope needed to be held out that he could expect psychological relief in time, and that he could die with some dignity and without undue suffering, for himself, or for those who loved him.

Scott had been compliant with antidepressant medication, and he had also demonstrated that with the right approach he could engage in therapeutic work (he seems to have made an alliance with at least one clinician).

Patients like Scott, suffering with severe illnesses, can still benefit greatly from aggressive psychopharmacological treatment for depression. Psychotherapy too can be extremely helpful. At the very least it would

help Scott deal with his losses, and come to terms with his imminent death. Were Scott able to form an alliance with an outpatient therapist, he might find a way to confront his own feelings of rage and shame about the developments in is life. Possibly, he might agree to allow his wife to attend some meetings where they could come to terms with each other and to face their illnesses and his impending death without rancor and needless pain.

Even though Scott's family appears private and reluctant to expose their feelings, they all might benefit from the opportunity to express themselves in family sessions, possibly for the last time. Termination work allows the possibility for all parties to say good-bye, free of shame and resentment.

REFERENCES

BIRTCHNELL, J. (1983). Psychotherapeutic considerations in the management of the suicidal patient. *American Journal of Psychotherapy, 37,* 24–36.

FOLEY, K., & HENDIN, H. (Eds.). (2002). *The case against assisted suicide: For the right to end-of-life care*. Baltimore: Johns Hopkins University Press.