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DEPARTMENTS AND COLUMNS: THE CASE I CAN'T FORGET

Sam's Story: Reflections on Suicide and the Doctor/Patient Relationship

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The phone rang as I sat down to dinner with our guests. It was Sam.

"Bill, I am calling to say goodbye."

"Where are you going Sam?"

"To heaven, I hope, but probably not."

"What do you mean?"

"I am going to die. I just shot myself up with a whole bottle of insulin."

"Sam, that's not a good idea."

"Maybe not, but it's the only choice I have. My life is over. I just called my three other friends and told them. They wished me well and said they understood. You are the last person on my list, and I don't want you to feel bad when they find my body in the morning."

"Sam, we should call an ambulance."

"That wouldn't do any good. You don't know where I live and, besides, I moved the refrigerator up against the door to make sure nobody can get in. I also called you on your home phone, not through the answering service, so there will be no record of this call."

"But Sam…".

"Bill, you've been a great doctor to me for the past four years and I appreciate everything you have done for me. Because of you, I have been able to stay in my hotel, and out of a nursing home, but I can see the writing on the wall, I can't stand the thought of going to a place like that."

"Sam, I appreciate the call, and understand how you feel, but I wish you had sent me a letter."

"Goodbye Bill, and thanks again for everything you have done. You will be a fine doctor."

And then he hung up.

I walked back into the dining room, poured myself a glass of wine, and proceeded to tell our dinner guests about Sam, without including any information that would identify him.

Sam was nearly eighty. He had lived a hard life. He killed a man in Cleveland with a crowbar when he was in his twenties and spent his thirties in the penitentiary. When he got out, he moved to San Francisco to start over. That explains his reluctance to be incarcerated again in a nursing home. He struggled with alcoholism and had been an insulin-dependent diabetic for over fifteen years. He came to see me every month, regaling me with stories of his life in the Tenderloin, the price of street drugs, the pimps, and the con men. Sometimes I wasn't sure if the visits were for him, or for me.

But his diabetes was getting the best of him. One of his sources of extra income was playing poker with the ladies in his single room hotel building on the day the Social Security checks arrived. He had always been a bit of a card shark and I often accused him of dealing from the bottom of the deck. He denied nothing, but admitted that his worsening neuropathy was making it difficult to deal the cards.

Even worse, his peripheral vascular disease resulted in festering, nonhealing ulcers on his legs. He lost his right leg three months earlier, and it was clear that his left one would have to go soon. We both realized that he could no longer live independently when that happened.

To complicate matters further, I had filled out some disability forms for him a few days earlier, and I remembered his address, on Eddy Street.

Our guests were shocked and horrified. "Clearly, this is a call for help" they exclaimed. "You must do something."

But I was not convinced. I knew Sam was serious and determined in his actions. He was not looking for a way out. He just wanted to say goodbye. His friends accepted this, why couldn't I?

And then I thought back to Doctor Ed Pellegrino. He was my Chancellor at the University of Tennessee Medical School a few years earlier. I first met him at orientation my freshman year. Somehow my interest in philosophy came up and it led to an invitation to visit him in his office a few weeks later. That is when I told him that I had one question for him. "How do my responsibilities to others change when I become a doctor?" That question cemented our friendship until the day he died.

We talked about role responsibility and supererogatory behavior. He compared it to a lifeguard on the beach when someone is struggling in the surf. The beachgoers had limited responsibility to risk their lives to save someone they didn't know. Maybe the strong swimmers might feel obliged to help, but that would be above and beyond their responsibilities as a citizen, supererogatory. Certainly, the nonswimmers should feel no obligation beyond calling the lifeguard. But the lifeguard, based on their role, must act. I was the lifeguard, or in this case the doctor. My responsibility was clear. I called an ambulance and gave them Sam's address. They broke down the door with an ax, moved the refrigerator, and brought him to the hospital.

I finished my wine and, much to the relief of my guests, walked up the hill to see my patient.

As soon as I walked into the emergency department, I could hear him bellowing from a room down the hall.

"I screwed up! I always screw up! I used NPH (long-acting insulin) instead of Regular!"

He spent several days in the ICU with blood sugars ranging from forty to four hundred. But he survived. Unfortunately, we had to remove his left leg. Afterward, he was sent to a nursing home.

I went to visit him about a month after he was discharged. A few weeks before he died it turned out. He was glad to see me. We talked about the old times, the good and the bad. His other friends had stopped by as well, to say goodbye again.

As I got up to leave, he turned to me with a smile.

"Bill, I understand what you did, and why you did it. You were being a good doctor. I don't blame you for that."

And then he winked, and said, "But I wish I would have sent you a letter."

Epilogue:

Sam died over 40 years ago, and his memory continues to haunt me. I have presented his case to students, interns, medical residents, ethicists, and practicing physicians dozens of times since then. I focused on the physician's unique responsibility based on the medical ethic espoused by Dr Pellegrino. This fireman/lifeguard/hero model is clear for doctors to understand and leaves less room for ambiguity. In general, the outcomes are pretty good. Despite the lessons imparted in my lectures, however, Sam's case has stayed with me over the years due to the realization that I may have made the wrong decision. At the time, I felt that injecting an interpersonal element into the doctor/patient relationship would hinder the objectivity necessary to be a good physician.

As a young physician, I was dedicated to the concept of objectivity. Science dictated all. Pneumonia needed antibiotics, appendicitis needed surgery, regardless of the poor soul suffering the ailment. The roles and responsibilities of the physician were clear. Some years later, I was asked by Dr. Pellegrino's long-standing colleague, David Thomasma, to contribute a chapter to a book he was editing entitled: The Health Care Professional as Friend and Healer. I found the title odd and wrote a chapter about the effect of commercialism on clinical medicine.[1] But the idea of a physician as the patient's friend stuck with me.

Sam's life was over, and we both knew it. His only future was to return to incarceration in a nursing home until his body died along with his spirit. Now, 40 years later, we could have considered physician aid-in-dying, but at the time his actions were considered suicide—morally unacceptable and illegal. Despite the social circumstances, I now realize the appropriate course of action would have been to forgo the heroics and, like his other three friends, said goodbye, hung up the phone, and returned to dinner to engage in pleasant conversation.

As I approach the conclusion of a long career in clinical medicine, I realize that I never discussed Sam's case with retired physicians. Perhaps they might have seen things as I do now. David Thomasma taught me that healing requires more than technical skill and knowledge. It requires trust. Real trust requires you to know someone at a deeper level, to know their values and character. It requires a personal connection. This connection leads to my sense of fulfillment as a physician.

Many of my patients have been with me for over 20 years. We have been through the highs and lows of their lives and come to wherever we are now as a team. This type of doctor/patient relationship rarely develops in an urgent care center visit, or even an outpatient clinic with short, focused appointments and providers who change from visit to visit, relying on the electronic record for continuity. The idea seems to be to shift the focus of trust from the individual provider to the institutional brand.

The Pellegrino model of the physician as virtuous savior/lifeguard can still hold in brief encounters and remains an aspirational standard for those entering the profession. With time and familiarity, the relationship becomes deeper however. It saddens me that many of the young, idealistic physicians entering the profession now may never have a chance to get to know their patients as I have. The constraints of modern medical practice may confine them to being always the lifeguard, and never the friend.

Competing interest. I have no financial conflict of interest.

Note

1. Andereck WS. Money, medicine, and morals. In: Thomasma D, Kissell JL, eds. *The Health Care Professional as Friend and Healer*. Washington, DC: Georgetown University Press; 2000:233–43.

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