Forgotten Histories

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Disclosures: Brian C. Boulmay: None.

The content of this article has been reviewed by independent peer reviewers to ensure that it is balanced, objective, and free from commercial bias. No financial relationships relevant to the content of this article have been disclosed by the author or independent peer reviewers.

The first and most notable thing about my new consult was his age: a 47-year-old man, 30 years younger than most of the veterans in my patient panel. He had recently undergone a pneumonectomy for a large lung cancer that involved his hilar lymph nodes and he was sent to me to discuss chemotherapy options. It wasn't often that a patient I presumed to be otherwise healthy came to my clinic. As a slightly overwhelmed oncology fellow, efficiency was the highest priority and I had the plan formulated before seeing the patient. I certainly had my own agenda regarding treatment recommendations and anticipated a fairly straightforward patient encounter.

When he entered the exam room Nick looked robust and carried himself like a man still on active military service. At first glance, it seemed that having had surgery just 3 weeks before had not affected him. His younger, very nervous wife, Sarah, followed him into the room. I asked the patient how he was doing. "Pretty good," he replied. Despite the calm answer, his bearing did not completely mask his anxiety. He immediately followed up with, "So, am I going to live?" I put that question off for the moment and started from the beginning. What symptoms led to his diagnosis? "I had some wheezing for about a year." What else? "I was coughing up a bunch of blood for about 6 months." Anything else? "No, I felt fine . . . except for losing 30 pounds." *So what made you see a doctor?* "My old lady and my little

boy." I could not help thinking how the "old lady phenomenon" was most particular to the VA, but a reference to a young son was unexpected. Interested, our discussion moved to his military service. He joined the Army when he was 20, serving in leadership roles in Granada, Panama, and the first Gulf War; his wife characterized him as a "regular John Wayne." He retired from active duty when he was 39 to start a family; his only son was now 6 years old.

I asked Nick about his father's medical history, expecting the common things like heart disease or diabetes. Instead, I got a most unusual and remarkable story. When the patient was 7 years old he and his family were swimming in a small river near their house, something the family often did. Like most small rivers in Florida, whose shoreline trees become submerged in seasonal flooding, there were unseen tree limbs just below the surface on this particular spring day. While Nick and his brothers were swimming, their father's clothes became caught on a hidden branch and he was pulled underwater. Chaos ensued as three family members desperately tried to save him, to no avail. He had watched his father drown right in front of him, literally inches below the surface of the water and remarked that the sense of helplessness still haunted him. As a result, his primary concern now was ensuring his son, Caleb, would see him live. He needed to take command over his disease.

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Several weeks before we were scheduled to start adjuvant treatment, Nick developed pneumonia that worsened to the point of requiring mechanical ventilation. Sepsis ensued, resulting in hypotension, renal failure, and a brief course of dialysis. Despite the severity of his illness, he haltingly recovered over several weeks and later joked that “no one can kill a vet.” But after this setback, he was markedly changed for the worse. His weight was down to 160 pounds and the former strapping Army Sergeant was now a chronically ill-appearing old man. He was visibly short of breath; if his supplemental oxygen was removed, he struggled for air.

We visited with each other often in clinic over many months. Our conversations ranged over many topics but mostly dealt with anxieties stemming from his illness and the trauma of his childhood. Over time, his follow-up computed tomography scans suggested lymphangitic spread of cancer into his remaining lung. We decided not to pursue any further diagnostic testing because chemotherapy was definitely not an option. Even though I was frustrated by the inability to provide him meaningful medical care (what I thought at the time meant chemotherapy), he stressed that our simple talks gave him comfort. He stated that he felt better when he left the office, as if he was still doing “something” for his disease, as if he was in control.

Over several months, Nick became increasingly debilitated and bed bound. He required continuous high-flow-rate oxygen, without which he felt like he was drowning—a word of real significance for him. He sensed his death was approaching and remarked often on the tragedy of Caleb

watching him die as he had watched his own father’s death, albeit now in slow motion. His son clung to him all day, frequently missing school; they spent every waking hour together. At night, as Nick became more ill, he and Caleb shared the hospital bed that had been moved into the family living room.

When we said good-bye on what turned out to be our last clinic visit, Nick still had his strong handshake and stoic demeanor. “See you in a few weeks,” he said on the way out as he pulled his portable oxygen tank behind him. A month later, Sarah called to let me know that Nick had died peacefully in his sleep. My first thought and wish was that Caleb would eventually find some measure of peace his own father never really achieved. Caleb had known that time with his father was short, even though Nick never would state that fact outright to him. (“How can a 6-year-old fully realize the finality of death?” Nick asked me once.) Perhaps the months Caleb spent knowing that Nick was ill would allow him to come to terms with this profound loss as he grew to adulthood.

Knowledge of Nick’s family history would not have helped change my initial therapeutic plans, but as his disease worsened, his past experiences became increasingly relevant. In my brief career in medicine, I continue to relearn the lesson that knowing important aspects of a patient’s life plays a large role in their care. Indeed, part of care for the dying patient is helping provide psychological comfort. To do that well, I must continue to move beyond the diagnosis and listen to who the patient really is.