Duty and Denial: On Falling and Rising after a Tokyo Dinner

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Words that are spoken to us become words we speak to ourselves.

Many today will recall the moment January 8, 1992, when President George H. W. Bush was attending a state dinner in Tokyo, seated next to the Japanese Prime Minister with scores of official attendees, and international press cameras rolling. Very abruptly during the dinner, the President became acutely ill and vomited—prodigiously—and collapsed. It's all a matter of public record, enshrined in emetic perpetuity.

I was, at the time, a 38-year-old physician in the United States Navy, assigned to the White House Medical Unit; I was on the medical support team for the President's Pacific Rim trip, which was winding up that week in Tokyo. And I was on duty that night for the president of the United States, or "Timberwolf," as the Secret Service had dubbed him.

We knew that the President was not feeling well earlier in the day, suffering from the same unequivocally gastrointestinal symptoms that sidelined several dozen staffers during the trip. Certain of the diagnosis, and of how it could potentially play out, I had respectfully advised the President twice before the dinner to consider sitting this one out—wouldn't be prudent.

But, President Bush felt he had to be at the dinner. It was his duty to go, and it would be an insult to the Japanese if he didn't. This was, of course, signature George Bush Sr., the ultimate Naval officer, world leader, and gentleman. He remains in my mind, and as *The Washington Post* would report years later, a "great and noble man."

I, too, was ill—quite seriously, as it turned out.

A dream job

I was living the dream, in the unique and unexpected assignment to the White House. As the Pacific Rim trip began in Sydney, I decided to train for a marathon. Second leg of the trip was Singapore and we arrived late at night at the Shangri La Hotel. Rising early, I sprinted up the first flight of stairs to a morning meeting—but stopped dead in my tracks—stunned by the de-novo onset of 10-out-of-10 retrosternal pressure/pain—a deep visceral burn. Minutes later, it was gone. Second flight (I walked this time), it was back. These symptoms, also, were unequivocal, and my diagnosis, certain. I knew immediately, without any question, precisely what I had.

Except—I couldn't have this diagnosis.

Solution—mind games. Take control. Don't exert for the remainder of the trip. And, since this can't be what I knew it was, it must be something else. Take antacids and inhalers.

My angina persisted several days later, when we arrived in Tokyo, our last stop. By then I was coming to terms with my diagnosis and had formed an action plan—I'd find my way to the U.S. Naval Hospital at Yokosuka, where I knew the doctors.

The morning of January 8, I disclosed my plan to the lead physician, who scowled, "Hell, Al, you're thirty-eight—you're not sick!"

Words internalized; denial affirmed and propagated.

And then, the Secret Service, also aware of Bush's symptoms, wanted reassurance that I would be present to be part of the team covering the state dinner. Duty was calling. In the cognitive thickets of denial, "duty" becomes morphine.

I never went to get checked out at Yokosuka. I joined the medical team at the dinner.

Self-diagnosis confirmed

The events of the evening are history. Bush vomited, collapsed, passed out cold. To the TV-watching world, he looked dead. But the medical team, cognizant of his earlier gastrointestinal symptoms, were confident of his recovery. He woke up, and, borne up by strong agents, arose, made his apologies, and left the dinner. His physical recovery was uneventful.

Fast forward thirty-six hours, to Bethesda Naval Hospital, where I failed a treadmill test. One hundred percent occluded RCA on cardiac catheterization, and I underwent an angioplasty which, given the time elapsed, was extraordinarily painful but successful.

There followed acute liver injury secondary to lovastatin, the earliest of its class, and a bleeding complication of the heparin infusion, which required additional painful procedures.

As I languished, I recalled with private and deep chagrin the abnormal cholesterol tests going back a dozen years—all of which I had ignored, because everyone in my family lived into their 90s. And, the dawning realization of the sheer enormity of my denial, the specter of what might have been. This could have gone very badly, not only for me, but literally for everyone involved. Unnecessarily, and unwisely, I had placed not only my life, but also the mission, at risk. Bad decision. It wasn't prudent.

Thus burdened, and with no apparent remedy for the cholesterol, I became convinced that I would surely die a premature death.

This was a defining time of deep waters; a time of passing through torrents and cords, through the valley of the shadow—words spoken by the Psalmist, to whom I was to turn not a few times in the months and years ahead. Out of the depths, words spoken to me, and for me.

From my hospital bed I jettisoned plans for my fellowship in Critical Care Medicine at George Washington University Hospital, scheduled to start in July.

The patience of being a patient

Through all this, I was finding out what a patient's life was all about. No patient portals, then, no advocates and no navigators. Lab and stress-thallium results by callback from the doctor. Time sitting by the phone, waiting for return calls with test results.

I began to acquire a few, admittedly imperfect, insights on what patients go through emotionally and physically during, and after, an illness. I knew about these things before, but now I experienced and understood them. I had known before, but learned afresh, the

pure gold of the physician's or nurse's presence, and of the sitting—not standing—of the physician on rounds. I was reminded of the need for visitors, and of the need for rest without visitors.

By being a patient, I was unknowingly studying to be a better physician. I learned to tell patients that they could expect certain things, like the deep flat fatigue after hospitalization, like the depression and its fruit of inertia. I learned to look for this depression in my patients and in colleagues who have suffered illness. I advised them to seek the help that I never sought.

And, I learned to recognize in patients and colleagues the subtle signs of their own denial of symptom and illness, which is its own virus, most assuredly transmissible to kith and kin and medical team alike. Denial, when we see it, requires acute intervention and compassionate frankness.

It took a full year, and a series of favorable test results, for me to realize that I might actually survive, for lamentation to turn to thanksgiving, and mourning to dancing.

Three things

Early in the healing journey, there were three brief conversations, three things spoken, none of which registered at the time, but in which were the seeds of healing. The interventionist sitting with me late into the evening after the procedure saying, "You're going to be OK," a barely audible, still, small voice through the fog of sedation. Second was the program director at George Washington University Hospital saying, "Yes we want you, coronary disease and all." And finally, the gently piercing blue "Timberwolf" eyes, "Al, I know this is a rough patch for you—but you have a great career ahead."

Priceless words, "You're going to be OK." I'm in a line of work where I can't say those words terribly often, so I do say them whenever I can, when I know them to be true.

Curlin and Tollefsen have recently written thoughtfully on the philosophy of medicine, wherein they advocate a virtue-ethic model for the profession, termed "The Way of Medicine."[1] Within their construct, the physician, in every clinical encounter, bears moral agency and duty. These authors have built on the foundations laid by the late Edmund Pellegrino, who contended that even the very ethical principles of medicine are inefficacious if not shepherded by a virtuous physician.[2]

The intervention of the spoken word in the clinical—and even the casual—encounter, is at the heart of the right and good healing act, which, Pellegrino contended, was the *telos* of medicine.[3] Words spoken to us become words we quietly speak to ourselves, and internalize, for better or worse, for illness or recovery. Words we speak to our patients, and colleagues, and friends, and strangers are themselves cardio-interventional by their very nature—words of mentorship that carry executive authority in the hearts of their hearers.

More hope is to be found in these than in test results. Healing and restoration, finally, are as much a ministry of word as of elixir, and of being borne up by strong and faithful colleagues and friends.

I did the fellowship at George Washington University Hospital where I learned critical care from the best of mentors. And there I met my wife, Afsoon, who is the love and treasure of my heart. After 30 years in critical care practice, I am thankful for the seeds that were planted at a time of sorrow, but which bore a joyful harvest. It was good for me that I was afflicted, that I might better know the things that make for the way of medicine, and of life.

References

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