

Treating the Patient, Not the Disease

*As told by
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I was not on service at the time that one of my AIDS patients came into the hospital. I had known him for a number of years and seen him through a number of crises. He ended up seeing one of the Infectious Disease Consultants (IDC). Later that day I got a phone call from the IDC fellow who said my patient was very depressed, wanted to stop dialysis, and go home and die. The IDC asked me to come see the patient.

So I went and asked my patient what was going on. He had just had a dialysis access put in his arm in addition to the implanted I.V. catheter port in his chest. He also had a line in another vessel for dialysis. Unfortunately, septic emboli were coming off one of those lines into his lungs, and the other doctors were telling him that the port had to come out of his chest.

Having this port was incredibly important for him, and he didn't want to lose it. It had seen him through an episode of lymphoma and all his draws for blood tests so he didn't have to be stuck in a vein every time. To make matters worse, he had had his gallbladder out recently and just before that his kidneys failed. Needless to say, he was very discouraged. With all of these things going wrong, losing that port was like the last straw.

After listening to him, I said, “Well, what if we tried treating you for a time with antibiotics and if that works, fine. If it doesn’t work, then we have to take the port out.” He was willing to try that.

I then made a phone call to my colleague who was the infectious disease attending physician. He is probably the smartest in the division, and I asked him what he would think about doing this. Emphatically, he said, “Absolutely not, absolutely not. That is not the gold standard and there is nothing in the literature that would support that!” After ranting and raving for a while, he calmed down and said, “But I won’t fight you if you want to do that. It is very clear this patient likes you. The first time I walked in the room, he mentioned five times that you were his doctor. So if you decide to do that, I’ll support you.”

I was taken aback by his response, and felt a little stupid. But I wasn’t surprised, because it isn’t the standard treatment. What hit me as I was finishing the phone call, and before I went into the patient’s room, was that my colleague was treating the disease, not the person. What I felt was critical at that point was to treat the person, because this person was ready to stop dialysis, go home and die, rather than have this line taken out.

So I went into the patient’s room and explained to him again what I thought we could do, but I also explained the downsides. “This is not without risk, and there is no way we can predict what will happen. What would you like to do?” He opted to try it.

The big lesson for me was learning the difference between treating the disease and treating the human being. It’s not always the same thing. There are times you can kill the person—in a sense, killing their spirit—by insisting that something be done a certain way. Patients still have to make their own decisions even if it is not what we think is best medically.

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