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Perspective

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# Heart and Sole — Of Metatarsals, Meaning, and Medicine

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One Sunday a few months ago, I was walking in Central Park and my ankle rolled out of my shoe. I slammed my foot down to regain my balance and felt a shooting pain. A minute later, my father called, as he does every Sunday. He's a physician-scientist, and we typically talk about what we're working on, but I couldn't concentrate. When I described my pain, he said, "You probably broke your fifth metatarsal."

He was right. "Jones fracture," the ED attending called out as he walked by. "Can I ask you a few questions?" I began — but he was gone. Everyone around me had been assigned an algorithm, and I had apparently come to the end of mine. So after asking to be wheeled to the physician's station to photograph my x-rays, to the vending machine for a snack, and several times to speak to an orthopedist, I'd been parked in a waiting area where I could no longer make eye contact with anyone. A physician assistant eventually came and said, "Boot and crutches and ortho follow-up." He put the boot on me, assembling the many straps, provided crutches (first too small, then too big), and handed me discharge instructions showing exercises that all seemed to require putting weight on the foot I'd just been told not to put weight on.

The following week, an orthopedist adds me to her busy schedule. She explains why she recommends conservative management and tells me to follow up with her PA in 6 weeks, when they'll check to make sure I'm not worse.

"But how will I know if I'm not getting better?" I ask.

She says I'll have good days and bad days, and she tells the resident that I'm already bending the rules by being in a boot rather than a cast.

"Can I swim?" I ask, explaining that my mental health depends on exercise.

"No," she says. "You have a notoriously poor-healing fracture."

And then they're gone.

I know I've been similarly dismissive when patients don't seem to understand the importance of "the rules." As an on-call cardiology trainee, I received the first page for all potential ST-segment elevation myocardial infarctions. Given a mandate to get patients to the cath laboratory within 90 minutes, I had little patience for

any requests that could cause delay.

"I need to call my attorney," a business traveler said as I wheeled him to the cath laboratory.

"I can't read this form until my husband brings me my glasses," said a woman as I shoved a consent form in her face.

A laserlike focus on speed may seem justified under such high-stakes circumstances. But as we strive to adhere to evidence-based protocols, we sometimes fail to see where such rules don't or shouldn't apply.

A colleague tells me about a relative, dying of widely metastatic cancer, admitted to a hospitalist service. The patient elects to be discharged home with hospice, but after 3 days during which arrangements are made, a new hospitalist takes over and tells the patient he can't go. "Your potassium is too low," he explains. "I can't let you leave the hospital."

Another patient admitted with heart block needs a pacemaker. The overnight physician goes through the admission checklist, but when he tries to address code status, the family notes the patient's high anxiety level and asks that the discussion be deferred. The physician insists that such documentation is required before the procedure — so offending the family that they request transfer elsewhere. "*Can you please get off your script,*" *they are pleading,* "*and just care for the patient?*"

When you're visibly injured, you discover that the world outside medicine is full of unscripted caring. Everywhere I go, people run to help me. An elderly man notices me searching for an elevator in the subway station and carries my scooter up two flights of stairs; he returns it to me at the top, and I watch as he limps away. A neighbor I've never spoken to leaves me a pillow to make the scooter seat more comfortable. A man I used to see at the gym runs after me to say he has a better scooter to give me. Though I can't adequately express my gratitude, I sense that that's not what they're seeking. They are clearly happy for the mere opportunity to help. Many of us become doctors precisely for such opportunities. So why has it become so hard to translate this impulse into truly caring for patients?

In my own quest for understanding and reassurance, I read obsessively about the Jones fracture. The name comes from Sir Robert Jones, sometimes considered the father of modern orthopedics, who first described the injury in 1902.[1] Perhaps fortuitously for the other five patients in his case series, the first was Jones himself, who thought he'd ruptured a tendon while dancing, until an x-ray revealed a fracture three quarters of an inch from the metatarsal base. Of the other patients, one was a businessman who had been running for the train and who, despite the injury, for "some days" continued transacting his business. Another was a powerful-looking man who'd been walking up an inclined plank when it yielded inward, who also kept working despite the pain. Though Jones's report has little pragmatic value, I return to it repeatedly, sensing that for him, the process of understanding was intimately bound to the act of caring.

Indeed, Jones was uniquely attuned to the psychic toll of injury and believed that engagement in meaningful work was part of the cure. Witnessing the alienation of many injured World War I veterans, for example, he observed that even after a soldier's injured limbs had been repaired, "his spirit was often broken."[2] Overcoming political resistance, Jones pioneered the "curative workshop,"[3] intended to quickly return the injured to meaningful work. I suspect that to recognize the curative nature of work for others, Jones must have found essential meaning in his own work — to the benefit of his own psyche and those of his patients.

As the weeks pass and my days lose their shape, I become disconnected from my own work. When my dad asks me, one Sunday, what I'm writing, I confess I'm watching music videos from Lady Gaga's new movie, "A Star is Born." When he asks what's captivated me, I wonder whether the theme that resonates most is equally relevant to medicine: that art cannot be automated. Lady Gaga's character, Ally, is a struggling singer–songwriter who's "discovered" by a rock star. At first, Ally is without pretense; raw and real, her music is beautiful. When her talent becomes widely known, however, she succumbs to the forces of the music industry. With her hair dyed and her routine rehearsed, accompanied by dancers she doesn't want, she is a stunning success by industry standards. But stripped of her creative control, the music becomes mechanical. Similarly, as the fruits of medical discovery have been systematized to provide the best treatments to as many people as possible, we have achieved success. Yet as creating has given way to clicking, the work seems to have lost its beauty. If caring is our art, it's not surprising that it would crumble under the weight of standardization.

When the same bone breaks in my right foot, I know immediately. The lateral aspect of that foot had been causing discomfort for months, but in trying to work around the left foot, I ignored the right one, putting all my weight on it until suddenly I couldn't. But there are unexpected perks to having both feet broken at the same time. Beyond the relative ease of balancing in two boots rather than one and the thrill of abandoning the scooter, being confronted with the inadequacy of one's workarounds forces a change in course. Something similar may be true of medicine.

Facing growing unease among both doctors and patients, medicine teeters atop an edifice of workarounds. We insert the words "patient-centered" in front of all we do, pursue "personalized medicine," grade physicians on their patient-experience scores, and hire scribes so that, for 2 minutes, we may actually look at our patients. Meanwhile, physicians are told to somehow both tend to their own wellness and complete additional tasks for more patients in less time. What was once a profession as life-giving to physicians as it was to patients has become, for many, a job. For physicians like Jones, the act of discovery was intimately tied to the treatment of disease; today, these pursuits are largely separated — for those who have opportunities for discovery at all. Although for many physicians, patient relationships are all that's left to create, the time for forging these connections is too often consumed by box-checking.

*An audio interview with Drs. Rosenbaum and Drazen is available at NEJM.org*

When my dad calls the Sunday after the Pittsburgh synagogue shooting, we talk about how we grieve the familiar. I had sent him a tribute to Jerry Rabinowitz, a family medicine physician and one of the 11 people killed.[4] In the tribute, Ben Schmitt tells a story about his father, one of Rabinowitz's patients, developing a gastrointestinal illness while on business in India. The elder Schmitt called Rabinowitz, who promptly called him back — and then called again every day until Schmitt returned home. My dad says, "He was the kind of doctor we all want to be."

Evidently, Rabinowitz, who lacked traditional heirs, had stood every week during the Jewish prayer of mourning, in honor of deceased community members who had no living relatives to stand for them. At Rabinowitz's funeral, 300 people stood in his honor. I hope that the medical community will rediscover how to stand for all that he stood for, too. I don't know how Rabinowitz found the space to care meaningfully, but somehow he shut out the noise — until he couldn't. Rabinowitz had been in another room when he heard the gunshots — safely out of the line of fire. But he rose and continued to live as he would soon die: running to help those in need.

Disclosure forms provided by the author are available at NEJM.org.

1. Jones R. I. Fracture of the base of the fifth metatarsal bone by indirect violence. Ann Surg 1902;35:697-700.2.
2. Jones R. Notes on military orthopedics: published for the British Red Cross Society. London: Cassell and Co., 1918.
3. Jones R. Military orthopedic surgery: its scope and aims. Boston Med Surg J 1918; 179:416-21.
4. Schmitt B. Remembering Jerry Rabinowitz: 'Kind, gentle' doctor among the victims in Pittsburgh synagogue shooting. Trib Live. October 28, 2018 (https://triblive.com/local/allegheny/14222874-74/jerry-rabinowitz-kind-gentle-doctor-among-the-victims-in-pittsburgh-synagogue-mass).

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# A Step toward Protecting Payments for Primary Care

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Even as the U.S. health care system increasingly adopts alternative payment models such as accountable care organizations, the traditional fee-for-service system continues to be the most commonly used method of physician payment. Moreover, although alternative payment models often involve budgets that require organizations to accept risk for spending, fee for service is still the principal payment method under these models and is used to track spending against the budgets. Thus, challenges posed by fee-for-service payment will not be solved simply by more rapid adoption of new payment models.

A major criticism of the fee-for-service system is that it penalizes primary care physicians and others who principally provide evaluation and management