greater schedule flexibility, a personal coach, and online peer-support groups, eliminating the need for in-person assessments. Online programs result in weight loss similar to that seen in the standard DPP.[5] Web-based platforms have been used successfully in contingency management for both chronic disease and substance abuse. In these programs, biochemical markers such as carbon monoxide and blood glucose or vital signs such as blood pressure can be assessed by means of virtual observation of patients using monitoring equipment in their homes. Such platforms facilitate important innovations in supporting management of a growing range of diseases and care for hard-to-reach populations.

For health care's transformation from a volume- to a value-based framework to be successful, we think that putting coverage of preventive services and treatments on more even footing will deliver great value. Historically, preventive services have been adopted only if they have been proven to save money, whereas treatments have been evaluated on the basis of their benefits and risks, without consideration of costs. The slow movement toward coverage and implementation of behavioral interventions may accelerate substantially as population-based financing becomes the norm. Payment reform has the potential to bring about a paradigm shift whereby all services are evaluated using the same standard: Do they improve health at a reasonable price? Such a shift could increase insurers' willingness to cover high-value preventive services and providers' interest in designing ways to facilitate the uptake and deployment of those services on a broader scale — enabling us to achieve better health at lower cost.

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From the Center for Health Incentives and Behavioral Economics, and the Department of Medical Ethics and Health Policy, Perelman School of Medicine, University of Pennsylvania, Philadelphia.

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Moving On

Abigail Zuger, M.D.

Everyone in my examining room is aging on schedule, patients and doctor alike. It's quite a change from the scene a few decades ago, when all of us were young and the patients were dying, one HIV-fueled departure after another, each one surrounded by a little medical care to soothe the worst of it.

Now I'm the one contemplating a permanent departure. My health is fine, but my stamina is pretty much gone. Our health care system is not kind to the chronically ill and marginally insured, and it is not particularly kind to their doctors, either. Our patients are condemned to an unending swim against a hostile tide. Doctors can head for shore.

Taped to my wall is a list of cutting-edge HIV drug combinations: their perplexing brand names refuse to adhere to my feeble old neurons. I clearly remember the drugs we no longer use but cannot retain the ones we do. The day I pasted up that list, I knew my time was nigh. Surely my patients deserve a cheerful young M.D., version 2.0.0, to bear them upstream for their final miles with energy and brio, unencumbered by sentiment, cynicism, or useless memories.

The stroke of the axe between patient and doctor is not a unique separation, no more inevitable than graduation, no more final than divorce. But divorce at least brings relief to two warring parties, and graduation celebrates the arrival of the new as much as the departure of the old. When a doctor says "enough," that's it. There will be no family reunions or tentative rapprochements between me and my patients, no alumni weekends. No matter how tight we are now, should we meet

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again we will be polite former acquaintances.

I will lose dozens of very old friends, and quantities of power and influence. No more license to ask rude personal questions, to issue edicts and stride away. No more urging poisons on those who would rather avoid them ("Oh, just try it for a week") or withholding poisons from those who crave more ("No more Percocet for you!").

And what will my patients lose? Theoretically, not too much. All our guidelines and algorithms, herding us to march in lockstep, are intended to guarantee just that. When one soldier in the line crumples, another steps right in and the professional formation moves on. The quality metrics of my patients' health care should only improve when I go, assuming the new soldier thinks a little more highly of some of those guidelines than I do.

And the memories of my patients' decades of life with a dire disease will become theirs alone. Their old paper medical records are off in storage now, and their digital charts are full of inane computer-speak, cut and pasted into gibberish. Here's one mandate that's not part of any guideline: understand the patient's past before the two of you waltz off into the future. But now the past is accessible only with a call to a warehouse and a long wait. Though many patients, given the time and encouragement, will eagerly talk about their long journey from sick to well, a 20-minute appointment slot allows for neither.

One Friday morning, my 10:40 is a tall, handsome, overweight guy who just turned 40. We first met in 1995, but I haven't seen him for almost 2 years: he changed jobs, endured a long hiatus without insurance and, I assume, curled back into himself like a frightened animal, waiting for the apocalypse. I remember that he spent his early 20s in exactly such a state. He was quite thin back then and always dressed entirely in white ("My shroud," he would say) in expectation of the inevitable.

Whatever will happen to her, my big worry and secret pride, my last great resurrection? What will happen to every last one of them? Someday soon I will lose the right to know.

The inevitable never came for this one; we finally found a set of HIV drugs his nervous stomach could tolerate, and his labs recovered. He himself never did recover, although he married, bought a house, got a series of good jobs. Now he smiles at me ("How gray he's gotten," I think) and shrugs. "I keep wondering," he says. "Is this all there is?" Depression leaks from his pores. He is as post-traumatic as any wounded warrior, as stressed, as disordered. Will his new doctor dismiss him as just one more entitled GenX-er? Could he even muster the stamina to describe the years he spent enshrouded?

My 11:20 doesn't show up — or, rather, he doesn't show up until a little before noon, when there is a small kerfuffle at the front desk, the slam of a hand on a counter, a whirl out the door. He was told he can't be seen during lunch, and he is angry, even angrier than usual. This patient also survived a perilous postadolescent brush with illness, and many slammed hands on many counters are one result. He has told me at length how much he hates it all: the pills, the appointments, the blood tests, even little old me. And yet he never skips a dose or a vaccination or a visit; his discipline is extraordinary, his rage terrifying. He is my own personal tiger, and I am not entirely unhappy to hand him over to a new keeper. How will he fare?

My 1 p.m. is also missing in action, but then I hear her opening lines, and she rushes into the room: "Sweetheart! The traffic!" She is always late, always in a hurry, apologetic and worried about my commitments to other patients.

"My love! I know you're busy. I'll be quick. I just need my prescription, and I won't keep you. Oh, look at you! Look at you! Love, love, love the shoes!"

We are of an age, she and I. Even so, the moment she shows up, I am transported back in time: I am a terrified young doctor again, all alone in unmapped medical terrain, charged with healing a skeleton.

My patient's hair is moth-eaten cotton batting, her frame all bone, the skin on her face has darkened and mottled, her eyelashes are long behind bottle-thick lenses. A historical relic, she belongs in an AIDS museum, not my exam room.

She has never, ever taken her HIV meds. I have scoured her old

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charts and emerged without answers. She doesn't appear to be selling the pills. She dabbles in heroin, cocaine, and methadone but otherwise lives an ordinary middle-class life. Over the years, other doctors issued all the usual ultimatums. She shrugged them off, and survived, even thrived. Her blood tests screamed disaster, her health remained fine. Now she's impervious to all reprimand and warning. Can anyone blame her for concluding that she's immortal?

But the virus is clearly catching up with her, sapping her energy and appetite. She still talks a good game, but she looks like a walking corpse.

She is the toughest nut I've ever tried to crack, and instead — predictably enough, I suppose — she has cracked me. I cannot stand to see her die, not on my watch, not in this century, and so I have struck a very dubious bargain with her. Call me Dr. Faustus. If she takes her meds, I told her a few months ago, I will stop tapering the gigantic daily doses of Percocet another provider gave her, and leave her on a small amount. Percocet is the only prescription drug she really respects.

My project is working beautifully. She still looks like hell, but she has gained 10 pounds, her blood tests have turned around dramatically, and her increased vigor is apparent.

Whatever will happen to her, my big worry and secret pride, my last great resurrection? What will happen to every last one of them? Someday soon I will lose the right to know.

When I close the door to my airless little clinic room for the last time, I will be closing hundreds of charts in the middle and walking away before the stories end. In all of medicine, is there anything more difficult to do than that?

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From the Mount Sinai Health System, New York.

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