toms of depression to their physicians in the first place.

Incursions on the doctor–patient relationship could be justified if they produced sufficient benefits to patients or to society at large. In theory, wellness programs use financial penalties not to punish unhealthy employees but to encourage them to adopt behaviors that will improve their health — behaviors many employees may want to adopt but lack the motivation to maintain. If these programs worked as intended, the health of individual employees would improve and employers' insurance costs would fall, making health insurance more affordable for everyone.

But the evidence regarding whether wellness incentives actually help achieve these goals is mixed at best. An expansive literature review in 2013 found that financial incentives had statistically significant effects on smoking, exercise, and weight loss — on the order of 0.03 pounds of weight lost for every $10 in incentives — and no effect on cholesterol levels.[5] The same report also noted the potential for such programs to have harmful consequences, particularly for vulnerable employees. Notably, wellness programs can save money for employers even if employee health does not improve, simply by shifting more health care costs to less healthy employees. Since low-income employees are more likely to have the conditions that wellness programs target, these programs may increase insurance costs for the people who can least afford them.

Punitive wellness programs can leave doctors in a position that is all too familiar to them: saddled with conflicting duties and largely powerless to influence the systemic forces that give rise to the tension. Physicians may resist being conscripted into helping employers save money at the expense of their patients. Yet doctors do not control which insurance plans are available to patients or whether their patients consent to the terms of those plans. Patients enrolled in wellness programs need their doctors to cooperate with these terms in order to qualify for lower-cost plans. Individually, physicians may have little choice but to accede to wellness-program requirements. But as a group, doctors can advocate for policies that protect patients, the medical profession, and the relationship between the two. In the absence of compelling evidence that incentive-based wellness programs improve employee health, I would urge physicians to oppose arrangements in which the penalty for poor health is reduced access to health care.

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

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The Name of the Dog

Taimur Safder, M.D., M.P.H.

It was July 1, my first day of residency, and a queasy feeling lodged in my stomach as I donned my new white coat. It was different from the previous ones I'd worn — not just longer, but heavier. I was carrying in my pockets everything I thought I needed as a freshly minted doctor: my three favorite pens, a glossy Littmann Cardiology III stethoscope, copies of studies related to my patient with cirrhosis, and of course my trusty purple Sabatine's *Pocket Medicine*.

Before the day was over, my bodily-fluid–covered white coat would have made a fitting prop for a *CSI* episode, my attending physician wasn't nearly as impressed as I'd hoped with the studies I waved in front of her, and worst of all, I had lost all three of my pens. But with the aid of my pockets, I'd gotten through. I'd played my part reasonably well most of the day, but the moment

when my attending had brought me up short with a question kept replaying in my mind. During morning rounds, I had presented a patient who was admitted for chest pain after walking his dog. My attending had asked, "What was the name of his dog?"

I was stumped. Worse, I didn't know why we needed to know. Nowhere in the books or the studies I'd read had a dog's name contributed to the differential. But the attending took us back to the patient's bedside and asked. "Rocky," the patient said. And there followed a brief conversation that was more colorful than any other I'd had with a patient that day. It led to a transformation I did not fully appreciate at the time: there was an actual person behind that hospital-issued gown.

Four years later, I'm not sure anything I've carried from residency has been more useful than that question.

It's because of that question that I found myself discussing the plot of a Spanish soap opera with another patient, a show I found him watching every morning. We even had company sometimes, when the translator would join us and explain the murder of the stepson by his twin brother or some other complicated event. Later, the patient and I would have difficult discussions about his immigration status and what it meant for his treatment plan. But I like to think that because he and I were fellow witnesses to an evil twin's murder, he had faith in me when I asked him to trust our medical team as we did our best to get him the care he needed.

The question was my guidepost when I saw a "difficult" patient who nearly left against medical advice while being admitted by the night team. She was 62, with new-onset heart failure. She was refusing medications, since she trusted the herbal supplement in her purse and not the "toxic chemicals" we doled out. Every day she would hand me a new article on a miraculous plant found on the Ivory Coast or a mineral from Chilean mines that promised her a cure. I couldn't offer the same, but I would return at the end of the day and discuss the article with her. When she was discharged, she asked me to be her primary care doctor. Soon we signed a treaty under which I would read the "studies" she brought in about black cherry and milk thistle and she would start taking one new medication every 2 months. We started with an ACE inhibitor.

Sometimes, the lessons of the question helped when little else could. Ms. W. was 78 years old, although she looked no older than 68 when I admitted her. She had white and gray hair with some curls; she also had heart disease. She had been admitted for influenza, but most mornings we would discuss stuffing or pie recipes. Thanksgiving was only a few days away, her grandchildren were coming, and she was the brains behind the family feast operation. She insisted on going home to help her daughters.

Diagnosed with atrial fibrillation while in the hospital, she stayed an extra night because her heart rate dipped to the 30s. Maybe this year, I suggested, she should take it easy and let her daughters do more of the work. We stopped some of her medications that could be affecting her heart rate and, with the agreement of both the patient and her cardiologist, started blood thinners. But there were risks: I drew a diagram of the heart on a whiteboard in her room to show where a blood clot could form and discussed the risk of bleeding. She noted that she was glad I had gone to medical school and not art school.

She made it home before Thanksgiving after all. But on Thanksgiving Day, she was back

in the emergency department because her family found her to be drowsy. A CT scan of her brain showed a severe bleed. She spent a few days in the ICU and then was moved to hospice.

Before Ms. W. died, I went to visit her. As a trainee, I had viewed hospice as medicine's kryptonite: our powers were no good there. I stood outside her room having a staring contest with the closed wooden door, unable to command my hand to grasp the doorknob. What would her family think of the decisions we'd made? What did I think of them myself, given how things had worked out? Once I opened the door, though, I found Ms. W.'s family entirely supportive and understanding of the care we'd provided. They asked about my training and my plans and we talked about their kids, while my patient, their mom, rested under a pink-and-white checkered blanket in the bed beside us.

It led to a transformation I did not fully appreciate at the time: there was an actual person behind that hospital-issued gown.

I stepped out of that room and took a breath — something I realized I hadn't done since I first scrolled through Ms. W.'s CT images. Hospice provided some comfort to her family that I had not thought possible, and they provided me a comfort I could not find in the evidence-based medicine we practiced. I found that the question that I'd been carrying around since my first day of residency could work another type of transformation: it helped my patients see the person behind the white coat.

It is easy to lose sight of yourself during residency, as you endure the countless hours spent in windowless rooms entering data in electronic medical records or completing administrative tasks or juggling a dozen other competing priorities. But if I may offer one piece of advice to my new colleagues who don a long white coat for the first time each July: Make sure to get the name of the dog.

Names and identifying characteristics have been changed to protect the privacy of patients and dogs.

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