



Perspective

# The Art of Doing Nothing

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Article

Near the end of medical school, I injured my knee running a marathon. What began as classic “runner's knee” during training worsened when I ran the race anyway. A month later, I still couldn't run comfortably but assumed that with ibuprofen and round-the-clock icing, I'd be back to my old routine in no time.

Then one day, I felt an odd, round mass protruding from the most tender area. Was it a tear? An infection? A tumor? I tried to push it back in, but it wouldn't budge. The pain increased slightly. As any runner will tell you, you can live with the pain, but you can't live without running. The only logical solution seemed to be an MRI and a referral to an orthopedist. My time had come: I made an appointment with my primary care physician, Dr. B.

But Dr. B. eyed my lump and shook his head. “It's just a simple tendon cyst, a ganglion,” he told me. “You're still running, aren't you, Lisa?”

“No,” I lied. Sometimes I tested it for a few blocks — maybe if I warmed it up, everything would slide back into place.

“You don't need an MRI; you just need to rest,” he said.

“Rest?” I said.

“Ever heard of it?” he asked. “Why don't you try swimming?”

Telling a runner with an injured knee to swim is like telling an orthopedist with an injured hand to become a psychiatrist. He needed redirection. “I want to see an orthopedist.”

He glared.

The “what if” card seemed a cheap shot, but I saw no other option. “Feel this mass,” I pleaded. “What if I have cancer? Or lupus?”

“Lisa,” he scolded, “are you going to spend your professional life getting head CTs on every woman who comes into the hospital with a headache?” Dr. B. was prescient: for the next 3 years I would indeed order CT scans or MRIs on every aching head, belly, and toe that

made its way into our ER. But at that moment, the fact that I was demanding unnecessary care, care that could ultimately cause me more harm than good, simply did not occur to me.

“So that's it?” I accused. “You're just going to do nothing?”

My grandfather, who began medical school in 1925, avoided visiting doctors. But when he was 70, he got a cold that lingered. My grandmother dragged him to the doctor, but when they got home, my grandfather promptly threw the prescribed antibiotics in the trash. “Sometimes doctors give you medicine when they don't know what else to do,” he explained.

But eventually he became so hoarse he could not speak. After 6 months, three doctors, thousands of cough drops, and the verdict from his primary doctor that his illness was all “psychological,” he was diagnosed with laryngeal cancer. Having been a practicing rheumatologist for decades, he didn't find it easy to be a patient.

But when he returned to practice, he suddenly found being a doctor much harder. Modern medicine, he admitted, had saved his life. But in the process of achieving modern medicine's triumphs, something fundamental had been lost. When he entered medicine, it was a profession dedicated to aiding mankind; the doctor may have been an autocrat, but the patient was his master. That sentiment pervaded the therapeutic relationship. Now there were new masters: third-party payers, malpractice insurers, and hospital conglomerates. The fun of medical practice had disappeared.

So instead, he wrote a book, *A Taste of My Own Medicine*, published in 1988 and made into a movie, “The Doctor,” in 1991. On the lecture tour that followed, he asked his audiences, “Why, when we can do more for our patients than ever before, are patients increasingly unhappy with their care?” He would raise his hands. “I have many questions for you,” he would say, “But I can't pretend to have any of the answers.”

Fifteen years later, when I was accepted to medical school, my grandfather decided to seek answers. He began writing “our book” — a “then and now” dialogue meant to demonstrate that though the culture of medicine had changed, human nature in the face of illness had not.

He began sending me letters with stories gleaned from his 50 years of practice, to which I was supposed to respond. That my essential half was entirely missing did not once deter him. In fact, his obsession with “our book” only grew. By the time I was a resident he was plotting our reality TV series — “as advance press for the book” — and left messages with the producer of “The Doctor” to discuss his plan. The physicians in the family murmured that delusions were a part of his advancing Parkinson's disease. His medications were gently increased.

When I faced Dr. B. for round two, I informed him of the expert opinion of my distant cousin, an orthopedist, whom I had seen while visiting home. "He says I need an MRI," I told Dr. B. "I might have a torn meniscus or something."

"Why would you need an MRI, Lisa, when you've got your family?"

"I can barely stand," I protested.

"Sounds like you're in a lot of pain," Dr. B. empathized.

Three weeks later, I got an MRI. I then spent a week trying to get the results from Dr. B. but was told he was "out sick." Then, one day, he called.

"Good news," he announced. "You don't have a torn meniscus."

"That's great," I said.

"You do, however, have a muscle tear, a hematoma, a joint effusion, and lateral patellar bony edema consistent with either trauma or infection."

I had pushed my knee to the point where, on imaging, it looked like someone had repeatedly whacked me with a club. This was not good.

Dr. B. had already called an orthopedist, who had reviewed the images and wanted to see me immediately. "You have something called `lateral compression syndrome,'" Dr. B. told me.

"That sounds a lot like `compartment syndrome,' doesn't it?" I asked. We both knew that people with compartment syndrome could lose limbs.

"It does," said Dr. B. This was a turning point for me and Dr. B.; we had never agreed on anything before. He sounded scared.

"I suspect the orthopedist will recommend surgery," Dr. B. said, "though it doesn't sound like surgery works." With my internship fast approaching, surgery seemed the worst-case scenario. Sure, I wanted to run again, but more than anything, I wanted to be a doctor.

"But Dr. B.," I said, "don't you think I just need to rest?"

Of course, in the end it turned out that Dr. B. had been right all along; rest was all I ever needed. But alarmed by the results of a test he had not wanted but now could not ignore, Dr. B. hung up the phone. What could he possibly say?

My grandfather lived with Parkinson's disease for 20 years before it crippled him. By then he was in his 90s, living in assisted care where residents frequently fell ill: pneumonias, heart failure, delirium. And despite a profound motor impairment, my grandfather lived his life doing what he loved: each morning, he got up and made rounds.

He did it the old-school way, walking room to room. I caught him a few times, glimpsed the back of his blue cardigan as he shuffled dangerously back to his apartment. His legs had the compliance of ski poles. With motion, he was swept into the inertia that typifies Parkinson's disease. There was no stopping him.

I only heard about the falls severe enough to hospitalize him. After one such episode, when he had been found on his back in the rain, I called. He explained that he was trying to catch the van service to visit a friend hospitalized with a bowel obstruction. There was a rise in the pavement (also known as a curb) that had suddenly gotten in his way. After announcing his idea for redesigning walkers to adjust for curbs he got down to business.

"When are you coming home? We've got work to do."

I wasn't about to let him off that easy: "You're still making rounds, aren't you, Papa?"

"Not really," he lied.

"Papa," I said, "promise to be careful."

"Sure, dear," he said. Then, "Say, you think we got a bestseller?"

In a recent study, the behavioral economist Daniel Ariely and his colleagues gave two groups of volunteers an identical placebo pill.<sup>1</sup> One group was told that the analgesic cost \$2.50, the other that it cost 10 cents. When the patients experienced pain, those who thought they were taking a more expensive pill reported significantly greater relief than those taking the cheaper one.

One could look at such findings and despair: if left to our own devices, will we always seek the most expensive care, regardless of efficacy? But what if we flip these findings around? Rather than assume we are forever dependent upon expensive care to feel good, why not see these findings as an illustration of our control over what we deem valuable? Those pills were assigned prices by people; the amounts assigned were completely arbitrary. What a culture values may be constantly in flux, but it is still up to us to determine. We may choose to value an MRI more than the wisdom and experience of our physicians, but that does not mean that an MRI is inherently more beneficial to our health.

My grandfather practiced without an MRI machine. He lacked the advanced biologics that have revolutionized the treatment of rheumatologic disease. He did not have a computer with an EMR or a drop-down menu with every test you can imagine just a click away. And when his body was no longer his own but he was still making rounds, I have no idea what exactly he offered, but I am certain it is something we have lost.

When my grandfather practiced, the physician, in the cultural imagination, was paternalistic, even stern. But this image was accompanied by an implicit trust in physicians' dedication to patients' well-being. In the absence of all the tools that now forge the bond between patient and physician, words mattered far more. So did touch. A pat on the back and some simple reassurance could satisfy expectations, even make people feel better.

Can we reconsider what it means to “do nothing”? The value of this concept remains ours to determine.

At the end of *A Taste of My Own Medicine* my grandfather writes about attending the funeral of Betty, a patient he had cared for over 30 years. “I feel very depressed,” he writes. “I’ve been at this for so long, yet every time it happens there is the same depression and the same guilt. I am supposed to prevent death. The truth is that I always fail.”

At Betty's funeral, he goes through his ritual. He greets the family. He hugs them. They shed a few tears together, and he is given an honored place in the funeral ceremonies. But at the end of Betty's service, it occurs to him that for so many of his years in practice he had been living under an illusion.

“Patients don't expect me to perform miracles,” he concludes. “They leave that up to the priest. All they ask of me is that I do my best and offer them sympathy when I fail. If I had realized this before, I would have gone to many more funerals.”

At my grandfather's funeral, days before I finished residency, I couldn't believe how many of his patients or their children made the effort to attend. I did not plan to speak. But when everyone else concluded, I found myself walking to the pulpit. I had his book in my hand, and perhaps I read from it, but I can't remember which parts.

What I do remember is being stunned by the sense that I could never adequately convey the way my grandfather had touched people's lives. I was overcome by a feeling of failure. There I stood, with the captive audience he so enjoyed, blowing my chance to fulfill his dream for us. If I could just explain that he wasn't finished, that he was on his way to making medicine right again, that everything would be OK. But I just couldn't. So I looked at the faces of the hundreds who had come to

celebrate his life. And I could see: they already knew. So I just stood there. And I said nothing. And that was enough.

[Disclosure forms](#) provided by the author are available with the full text of this article at NEJM.org.

## Source Information

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## References

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