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FROM THE EDITOR
The Patient-Physician Relationship: Classic Questions and New Directions

The importance of the patient-physician relationship (PPR) is emphasized so frequently in medical school that it's almost a medical-education cliche. But there's a reason for this emphasis: solid PPRs are the foundation of successful medical practice. With them, you can move mountains; without them, any headway you make with patients will be slow and hard-won. Because of their importance, they've been a frequent topic of discussion in this publication (most recently, our October 2011 issue explored how certain facets of physicians' personal lives may spill over into their professional relationships with patients).

This month, we revisit the patient-physician relationship in a series of cases and articles focused on answering two general questions. First, under what circumstances should a physician enter into the relationship? And second, how has the way medicine is practiced in the twenty-first century changed our understanding of the PPR?

Our first two cases explore perennial questions about the boundaries of the PPR. The first commentary, by Erik K. Fromme, MD, MCR, centers on a dilemma frequently encountered by students and physicians at all stages of their careers: a physician at a family barbeque is taken aside by a family member who has questions about his medical problems. Does she offer advice? Treatment? Or does she decline to offer an opinion?

The third case commentary, by Cynthia Geppert, MD, MA, PhD, MPH, examines a university physician's sense of duty to nonpatient students in the setting of medication diversion. Is the entire student population under the doctor's care, or must care be restricted to students who come in for treatment?

In the health law section, Valerie Blake, JD, MA, reviews legal cases that describe how patient-physician relationships have been defined by courts over the last century and explains other situations in which legal establishment of a PPR isn't as straightforward as we might wish.

Other articles in the issue consider how the PPR is changing in the twenty-first century. In the "State of the Art and Science" section, Bradford W. Hesse, PhD, tackles the subject of online health information. This information has had a profound leveling effect on the PPR by offering patients access to knowledge formerly possessed, in large part, only by physicians. The downside, however, is that the majority of it is incorrect, incomplete, or misleading. Dr. Hesse argues that the role

of the physician is to serve as a trusted guide, helping patients navigate the flood of online health information.

As patient-centered medical homes become the de facto model of medical practice, a significant portion of care is provided by nonphysician team members. The patient-physician relationship of old, exemplified by the mid-twentieth century solo practitioner, is being replaced by the patient-*team* relationship. One of the team members providing patient care in this setting is the physician assistant, or PA. James F. Cawley, MPH, PA-C, sheds some light on the PA's place in today's health care team and discusses how the role of the PA may evolve in the coming years.

Building on the topic of team-based care are several articles and a case commentary on hospital-centered team-based care. Historically, when patients were admitted to hospital, they were under the care of a single physician. Today, the "hospitalist" model of care, in which a rotating team of clinicians cares for a shared patient list, is gaining ground.

With a rotating team of physicians comes an increased frequency of patient handoffs, in which critical information about a patient's care is transferred from the departing to the arriving physician. The more frequently handoffs occur, the more opportunities there are for potentially harmful miscommunication. In his case commentary, Robert Macauley, MD, considers whether an off-duty hospitalist—who technically ceded responsibility for his patients when he handed them off—has a responsibility to intervene when his successor may not fully understand a patient's medical condition.

In the medical education section, Jeanne M. Farnan, MD, MHPE, and Vineet M. Arora, MD, MAPP, describe an innovative handoff curriculum that the University of Chicago is using to improve training for team members at every stage of their medical education. In the same section, Catherine V. Caldicott, MD, takes a hard look at "turfing," the practice of inappropriately foisting patients onto other services or hospitals, which may have negative consequences for patient care and interdisciplinary relations.

New legislation influencing how health care teams are paid may also affect the way health care team members view patients. Accountable care organizations (ACOs), which are a central feature of the Patient Protection and Affordable Care Act, are held "accountable" for patients' outcomes through financial carrots and sticks, in the hopes that this will encourage them to provide high-quality, cost-effective care. But, as Harold S. Luft, PhD points out in a policy forum article, there are various ways of deciding which ACO should be responsible for a particular patient—and that decision has real implications for an ACO's bottom line.

In addition to addressing the PPR head-on, this issue of *Virtual Mentor* concludes with three articles that approach it indirectly. For example, does a PPR exist if the "patient" in question is deceased? In a reflective essay, Helena Winston, MSc,

MPhil, applies the four principles of medical ethics—nonmaleficence, autonomy, beneficence, and justice—to her medical school's anatomy lab, suggesting that the PPR is just as relevant here as elsewhere. Carolyn T. Bramante, MPH, and John Song, MD, MPH, MAT, offer an interesting take on community health fairs, arguing that, while generally beneficial to the populations they serve, these fairs may be ethically questionable if their organizers don't think critically about following up with the participants.

Finally, in his "Medicine and Society" piece, James E. Sabin, MD, considers the question of why the economic structure of the American medical system makes it difficult for some patient-physician relationships to be established in the first place. He argues that one reason universal health care has had such a bumpy ride in the United States is an underlying tension between solidarity and individualism that has been with us since revolutionary times.

Where do we go from here? Even though the PPR is something of a cliche, we hope this issue of *Virtual Mentor* will show that it remains relevant to reexamine from time to time, as old questions may prompt new answers, and new problems may require reimagining of old roles and responsibilities.

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