

Virtual Mentor
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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 cliché. 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 barbecue 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 cliché, 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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ETHICS CASE

Requests for Care from Family Members

Commentary by Erik K. Fromme, MD, MCR

Martha was at her cousin's house for a family dinner when she was approached by her Uncle John. John was one of her favorite uncles—he'd practically raised her for parts of her childhood and had helped her with her student loans during medical school. Since she'd become a doctor, she noticed he always took a certain pride in introducing her to friends as "My niece, the doctor."

"What's going on, Uncle John?" she asked.

"Well Martha," he said, "I was wondering if I could ask you a couple of questions."

"Sure," Martha answered. "What's up?"

"You see, I don't want to bother you, and I know you must get this all the time, but I've just been having this terrible cough these last few weeks, and I don't know what to do about it."

"That's no good," Martha said. "Have you been to see your doctor yet?"

"No," said Uncle John. "He was away on vacation, and then I called his office, and they said he wouldn't be able to fit me in until next month sometime. I've just been feeling so sick—I could be dead by then!" He laughed. "That was a joke. I don't really know if I want to bother my doctor about this. But I have been feeling pretty sick. I've had this cough, and a really bad headache. And I've been so tired. I just wonder if I've got something going on, and I was hoping you'd give me a quick once-over."

Martha paused, and considered her options. Her Uncle John looked well enough, but he'd been a smoker for most of his life, and had already had one bout with cancer—a small tumor in his colon that'd been caught by routine colonoscopy. "Uncle John," she said, "have you—" but then she stopped. "You know, Uncle John, I'd love to take a look, but I really shouldn't. I think you'd do better to go see someone else. Maybe there's someone else in your doctor's practice who can see you on short notice? Or the walk-in clinic on Water and Main, if no one at the regular practice can see you and things keep getting worse. I'm sorry, but—do you think that would be alright?"

Uncle John looked hurt. “I suppose so, Martha. This has been going on for a couple of weeks—what’s one more night, right? Anyway,” he said, “I should talk to your cousins. I haven’t seen them in months!” He turned away, and Martha couldn’t help noticing that he avoided her for the rest of the evening.

Commentary

Should Martha have examined a family member? This case presents what must be a universal experience for physicians—being asked to get involved in a loved one’s care. Although the case involves a physician, I queried a group of fourth-year medical students this week, and they had all received similar requests. In this case, Martha does the right thing from a professional standpoint, but the narrative gives the impression that her response was personally unsatisfying. Part of the problem is that Martha’s justification, “I’d love to take a look, but I really shouldn’t” isn’t very convincing—to Uncle John, to us, or even to Martha herself. Probably like most physicians she was taught in medical school that it was unprofessional or perhaps unethical to treat one’s own family members. Perhaps she even remembered that the reason was that she might not be objective, but even with that added reason, her justification sounds weak.

I will share the approach of my mentor, Robert Potter, MD, PhD, to evaluating an ethical situation by looking at rules, goals, and roles. The first question is about rules—are there applicable laws, institutional policies, or professional guidelines that can help us here? There are no federal laws specifically prohibiting a physician from practicing medicine, writing prescriptions, or even performing surgery on a family member. Martha could have examined her uncle and even written a prescription for antibiotics for him without breaking the law. If she had written a prescription for a cough medicine containing a controlled substance, she might have broken a state law or violated a state medical board code, depending on which state she was licensed in. Some state laws or medical licensing boards prohibit physicians from prescribing controlled substances or psychiatric drugs to themselves or to family members except in emergencies [1]. However, even in states where it’s not expressly prohibited, medical boards may consider the practice unprofessional. The website Medscape maintains a state-by-state guide to opioid prescribing policies that may be helpful [2].

Professional medical practice also requires that a physician follow the same practices for any patient, meaning performing a physical exam and documenting the encounter in a medical record [3]. So if Martha did examine her uncle, she would need to document the encounter, including her findings, diagnosis, and treatment plan. A quick once-over at a family gathering may not meet this standard and therefore could be subject to disciplinary action by a medical board.

Medical professional ethics explicitly warns physicians not to treat family members. The American Medical Association *Code of Medical Ethics* states: “Physicians generally should not treat themselves or members of their immediate families. Professional objectivity may be compromised when an immediate family member or

the physician is the patient” [4]. Does the use of the word “generally” indicate that there are situations where it might be appropriate?

LaPuma and Priest suggest that physicians can provide family members “acute emergency care and care for most minor recurrent predictable illnesses,” which sounds reasonable, but their justification, that in those instances “care may be given by the physician in the family without overwhelming his or her objectivity or breaching ethical principles, and with much convenience to all concerned” does not make complete sense [5]. Certainly objectivity is not greater during emergencies involving one’s family members, but in an emergency a physician may be compelled to treat a family member to prevent or minimize harm.

For other situations, LaPuma and Priest provide seven questions that physicians should ask themselves before getting involved in a loved one’s care. The questions are: (1) Am I trained to meet my relative’s medical needs? (2) Am I too close to probe my relative’s intimate history and physical being and to cope with bearing bad news if necessary? (3) Can I be objective enough not to give too much, too little, or inappropriate care? (4) Is medical involvement likely to provoke or intensify intrafamilial conflicts? (5) Will my relatives adhere more readily to medical recommendations delivered by an unrelated physician? (6) Will I allow the physician to whom I refer my relative to attend him or her? (7) Am I willing to be accountable to my peers and to the public for this care? These questions are excellent for alerting us to the potential unintended consequences for us and for our loved ones, but physicians whose objectivity is already compromised are unlikely to ask them.

In this case, the rules warn Martha not to examine or treat her uncle, but don’t expressly prohibit her from doing so. This brings us to Dr. Potter’s second consideration: what good goal are we trying to accomplish here? These are easier to see—ideally there are three: (1) Uncle John gets good medical care, (2) the relationship between Martha and her uncle is preserved or even strengthened, and (3) Martha doesn’t put herself or John at risk. It is now clearer why Martha felt dissatisfied. She avoided the risk involved if she were to provide substandard care to her uncle, but failed to see that he got good medical care and may have even weakened their relationship. How could she have accomplished all three goals?

A potential solution arises in considering Dr. Potter’s third consideration—what fitting role could Martha play in this situation to bring about a good or better outcome? There are a number of ways that Martha could be helpful to John, even if she didn’t have a medical degree. She could still show concern for her Uncle’s medical problem (“It sounds like you’ve been feeling pretty ill. Can you tell me more?”) Is this taking a history or simply showing concern? Asking “Can you tell me more” may sound like something a physician but not a nonphysician family member would ask. The point is not for physician family members to pretend they are not physicians, but to notice if they are beginning to slip into the physician role and consider whether that is fitting and necessary given the goals. Here the questions can further both Martha’s goal of ensuring that her uncle gets good care and her goal of

supporting him and strengthening their relationship. She could then follow up and say “It sounds like your symptoms are not going away and are bothering you—I think they’re definitely worth getting checked out.” Is this giving medical advice or encouraging a family member to take his health seriously? Again, both goals are furthered.

To express a desire to help, Martha could say, “It sounds like it’s been hard to get in to see your doctor. Would you mind if I called him to see if I could get them to see you sooner? I could even come with you.” If Uncle John agrees, then Martha will have met all three of her goals; she will have avoided examining or treating her uncle while ensuring that he gets good care and feels cared for.

There is a line (or boundary, if you like) between personal and professional roles, and true professionals feel a twinge of conscience when they think they are crossing it. This twinge is an “early warning sign” that suggests you are entering potentially treacherous terrain. Once you feel such a twinge, the best course of action is to show concern by asking more questions. This shows that you are interested, gives you more information about what the issues are, and gives you the opportunity to think of a way that you can help without using your medical license. I would argue that in most cases, you can help your family members without using your medical knowledge to diagnose and treat their illnesses. Instead, act as a knowledgeable guide and facilitator to help them get the right care from someone else.

Because we know that, despite the rules and warnings, physicians commonly treat family members, in a previous publication my co-authors and I prepared a patient education sheet designed with physicians-in-training in mind [6]. It explains to family members why physicians should not necessarily be involved in caring for their loved ones. Medical students can use this sheet to help establish appropriate boundaries with their friends and family members early in their medical training.

Instead of invoking professional ethics that may not mean much to those who are not health professionals, we frame the issue in terms of risks and benefits. We classify different actions as low-, medium-, or high-risk by assuming that there is greater risk when deciding not to see a treating physician, when physician family members perform services that ordinarily only a treating physician would do, and when physician family members make decisions that are ordinarily made by the treating physician. Using this table, Martha’s examining John and making a diagnosis would be high-risk, but offering to help John get an expedient appointment or to accompany him to his doctor visit would be low-risk and therefore appropriate.

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ETHICS CASE

Responsibility for Patients after the Handoff

Commentary by Robert Macauley, MD

“Is that Mrs. Wilson’s medication list?” Dr. Miller asked the resident, holding up a piece of paper she had found in the chart. It was the first morning of Dr. Miller’s 2 weeks as attending physician on her institution’s hospitalist service. She’d spent some time the night before reviewing the charts of all the patients under her care and gone over their conditions that morning during the handoff from Dr. Jones, the previous attending physician. Now she was meeting them face-to-face. She took a special interest in Mrs. Wilson, an elderly woman with significantly advanced dementia, who’d come to the hospital with pneumonia several weeks before. She’d been treated successfully for the pneumonia, but while she was in hospital, her overall level of functioning had declined.

Where Mrs. Wilson had previously been a kind, if disoriented, woman, she’d become very agitated in the hospital, occasionally acting violently with staff. She’d also developed new pressure ulcers, which were made worse by her agitation: Mrs. Wilson had started rocking herself back and forth in her bed, which made it difficult for the ulcers to heal.

Her agitation made hospital discharge difficult to arrange: Mrs. Wilson would probably need physical therapy at a dedicated rehab facility, but no facility would take her as long as she remained violent and her wounds remained difficult to treat.

In the 2 weeks prior to Dr. Miller’s arrival, Dr. Jones’s hospitalist team had tried to address these problems by instituting a series of measures. First, they’d tried behavioral interventions designed to reduce agitation: letting in light in the morning, encouraging sleep at night, using calendars and clocks to reorient Mrs. Wilson to the current date and time. When these failed, they’d gradually begun to use a combination of antipsychotic and sedative medications, trying several before eventually settling on a combination that seemed to work.

When Dr. Miller began her shift, Mrs. Wilson’s agitation was under good control, and her rocking had subsided. According to her case manager, a rehab facility had agreed to take her sometime in the next several days. But Dr. Miller had just stopped by Mrs. Wilson’s room and didn’t like the looks of her. “She’s snowed. I could barely wake her up,” she told the resident. “And these drugs we’re giving her have been associated with increased mortality in elderly patients. I’m just not comfortable using them without an abundantly clear indication for doing so, and right now I don’t see it. Let’s start decreasing these meds and see how she does.”

Dr. Jones, who was passing by on his way out the door, happened to overhear this conversation, and it made him pause. *Should I step in here?* he wondered? After all, it'd taken some time to get Mrs. Wilson's multiple problems under control, and now the medications that'd seemed to be working were going to be discontinued. *No*, he thought. *I've signed off. Mrs. Wilson is Dr. Miller's patient now.*

Dr. Miller's team began to decrease Mrs. Wilson's sedating medications. Within only a few days, she'd become agitated again and her pressure ulcers had re-opened. Dr. Miller decided they should be brought back up, but by the time they'd taken effect a second time, Mrs. Wilson's spot at rehab had gone to someone else; she'd now have to wait longer in the hospital for another rehab placement.

Commentary

This case highlights some of the clinical and ethical dilemmas inherent in patient handoffs. In this scenario, Dr. Jones's hospitalist service achieved significant improvement in Mrs. Wilson's condition. When Dr. Miller took over the service, however, she modified the medication regimen based on current medical evidence, which resulted in a clinical deterioration and subsequent delay in rehabilitation placement. This case raises important questions related to communication, the limits of evidence-based medicine (EBM), practice variation, professional responsibility, and culture.

Much has been written on the subject of *communication* in patient handoffs, especially since the ACGME limited resident duty hours in 2003 [1]. Handoffs are increasingly common in clinical practice, occurring an average of fifteen times during a 5-day hospitalization, with interns engaging in three hundred or more each month [2]. Given the volume, it is little wonder that 60 percent of the time the most important information isn't communicated [3]. This, in turn, leads to significant clinical implications; studies have shown that 80 percent of serious medical errors involve miscommunication [4].

The question, then, is what information a clinical team must know to provide optimal care for a patient. Not only is it impossible to pass along all accumulated information regarding a patient, it is also not desirable to do so. Too many details can distract the arriving physician from the most relevant issues in a patient's care. Various methods have been suggested to ensure that all *relevant* information is conveyed, with perhaps the most common method being the SBAR—situation, background, assessment, recommendation [5]. In addition to “a standardized approach to ‘hand off’ communications,” there also must be “an opportunity to ask and respond to questions” [6]. While the written scenario does not describe the nature of the information conveyed from Dr. Jones to Dr. Miller, clearly the failure of nonpharmacologic interventions to manage Mrs. Wilson's agitation and the ultimate success of antipsychotic and sedative medications were not included or emphasized.

Without benefit of that perspective, Dr. Miller's decision to decrease the patient's sedating medications was reasonable and consistent with *evidence-based*

recommendations. Here, though, one must remember that EBM addresses population-based trends, and even recommendations with a high level of evidence are not applicable in every clinical situation. For while sedative and antipsychotic medications can be associated with increased mortality in the elderly, one could reasonably defend their use in Mrs. Wilson's case because of the failure of nonpharmacologic measures and the imperative need for physical rehabilitation, which was prevented by her level of agitation. If Dr. Miller had been aware of the specific context—here returning to the fundamental issue of communication—the evidence for weaning those medications may not have appeared so compelling.

This, in turn, raises the question of *practice variation*. A clinical disagreement about a treatment plan may stem from a legitimate difference of opinion (such as whether one antibiotic has a more favorable side-effect profile than another) or from an error in reasoning (as in the case of recommending an antibiotic to which an identified organism is resistant). The first is a matter of style—upon which competent clinicians may disagree—while the other is one of substance. It is appropriate for clinicians to defer to colleagues who make *stylistically* different decisions, but *substantial* errors in treatment must be identified and addressed. In this case, Dr. Jones did not seem to make this distinction, instead deferring to whatever Dr. Miller—in her role as the new attending physician—wished to do.

One might inquire as to the nature of Dr. Jones's *professional responsibility* for Mrs. Wilson. It is true, as he noted, that “I've signed off. Mrs. Wilson is Dr. Miller's patient now.” Yet while he is not officially responsible for her care, he could still play an important role, especially if he is privy to relevant information that the current team is not. His refraining from sharing his perspective about her condition would seem to have more to do with his wish not to offend a peer than his concern for a patient whom he had cared for over the past two weeks. Since one of the core components of professionalism is fiduciary responsibility, determined by the needs of the more vulnerable party in the relationship, Dr. Jones should have been more concerned with Mrs. Wilson's well-being than with Dr. Miller's feelings.

Finally, this case highlights the importance of *culture* within a hospital environment. A great deal has been written about this in the nursing literature because, by virtue of shift work, nurses have accumulated more experience than physicians in the area of handoffs. Unlike physicians, nurses typically dedicate time and space to the process of “signing out” patients, as any physician who has attempted to speak with a nurse during change-of-shift will attest. The nursing literature identifies “social and hierarchical problems” as a major barrier to communication [7].

Even though Drs. Miller and Jones are peers (and thus “hierarchy” *per se* was not an issue) the culture of their hospital—which seems to preclude an off-duty physician from commenting on the care of a former patient—made it more difficult for Dr. Jones to speak up on the patient's behalf. Rather than criticizing Dr. Jones personally, it would be reasonable to address hospital culture itself. Ample evidence exists that culture change results in improved outcomes. For instance, allowing

interactive questions regardless of role or position has been shown to reduce errors in other fields, such as aviation [8]. If Dr. Jones had felt free to engage Dr. Miller in a collegial conversation focused on optimizing patient care, the initial deficits in communication (which led to an indiscriminate application of EBM and a suboptimal outcome) could have been overcome, to the patient's benefit.

Ultimately, this scenario highlights the dangers of increasing fragmentation in modern medical care. The ACGME limits residents' work hours. Lifestyle decisions and reimbursement structures have made the old-style "family physician" who cared for a patient in the office and throughout any hospitalizations a vestige of the past. As handoffs become more and more frequent, optimal communication and collaboration—which may require fundamental culture change within an organization—are increasingly critical if we are to provide optimal care to our patients.

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ETHICS CASE

A University Physician's Duty to Nonpatient Students

Commentary by Cynthia Geppert, MD, MA, PhD, MPH

It had already been a busy day at the student health center for Dr. Smith when Steve came in. Steve was a 22-year-old senior in the biosciences program at the college where Dr. Smith worked. He had asthma and type 1 diabetes, and had been coming to see Dr. Smith about these problems for as long as he'd been a student. However, Dr. Smith noted as he looked at his schedule, today's visit was for something else entirely.

"Hi Steve," Dr. Smith said. "How's it going?"

"Oh, it's okay," Steve replied. "How have you been?"

"I've been well, thanks. I haven't seen you in here lately—your asthma must be behaving itself!"

"It is," Steve assured him. "And I still have refills on the insulin you gave me at my last visit, so I haven't had a reason to come in."

"I'm glad to hear it," said Dr. Smith. "So why did you come by today?"

"Well," Steve started, "my grades haven't been so great lately, and I'm worried that's going to affect my chances of getting a job after graduation."

"Alright," Dr. Smith responded. "Why do you think your grades haven't been so great lately?"

Steve was vague in his answers—he couldn't seem to concentrate, wasn't able to sleep. When Dr. Smith asked what sorts of solutions he had tried, Steve explained that his attempts to drop things from his schedule and get more sleep had failed.

"Hmm," said Dr. Smith. "How can I help?"

"Honestly," Steve said, "last week I took some pills from this guy in my dorm—he says truckers sometimes take them to stay awake for long drives—and they worked really well. I was able to stay awake all night and really get a ton of work done. He's got a bunch, and he says I can just get them from him, but I was wondering if you had anything like that you might prescribe."

“You’re talking about stimulants, I think. Something like Ritalin?” Dr. Smith asked.

“I guess so,” Steve said. “My friend says he gets them his cousin, and I think his cousin has attention deficit disorder or something like that. I’ve never had a prescription for them before.”

“Hmm,” said Dr. Smith. “Do you know if your friend has told his doctor about these drugs?”

“I don’t know,” Steve replied. “He seems like a pretty healthy guy. I’m not sure he even has a doctor.”

“Well,” Dr. Smith explained, “those drugs can be dangerous, and we don’t like to prescribe them without a diagnosed attention disorder to treat.”

“Oh,” Steve said. “I didn’t know that.”

“So I don’t think I can prescribe you that kind of a drug, and I also want to advise you against taking the ones your friend offers,” Dr. Smith said. “But I also don’t want to leave you without a leg to stand on. Let’s talk about other things you may be able to do to get a handle on all this stress in your life.”

“Okay,” said Steve.

They talked for a while, and Dr. Smith was left with the feeling that he’d helped Steve out. But he felt unsettled about Steve’s friend. It sounded like he was in need of medical attention and might not be getting it. Further, Dr. Smith was concerned that he might be supplying his stimulants to other students besides Steve.

Commentary

The situation Dr. Smith encounters with Steve is, unfortunately, played out in many student health centers across the nation. A 2010 study of nearly 500 college students who were prescribed medications showed that 35 percent had diverted their medications at least once and that sharing rather than selling was the more common means of diversion. Not surprisingly in the academic atmosphere of the university, prescriptions for attention-deficit hyperactivity disorder (ADHD) were the class of drugs most frequently diverted [1, 2].

Dr. Smith has a long-standing and trusting patient-physician relationship with Steve. Steve feels safe and comfortable disclosing to Dr. Smith his struggles with school and his use of stimulant medications. Dr. Smith approaches the disclosure nonjudgmentally, giving Steve advice about the dangers of taking other students’ medications and educating him about the risk of stimulants. At the end of the visit, Dr. Smith feels he has done a good job handling Steve’s situation but remains concerned about the student who diverted the stimulants. Dr. Smith wonders whether

he has a professional responsibility not only to the student who diverted his meds but also to the college community he serves.

A practical framework for analyzing ethical dilemmas might help Dr. Smith work through this. There are many readily available models and theories of ethical decision making. Among the most widely used methods is the principlist model of Beauchamp and Childress [3]. Based on four core values—respect for autonomy, beneficence, nonmaleficence, and justice—principlism is an appropriate approach for a pluralistic setting such as a student health center [4]. Dr. Smith should also consider obtaining either informal advice from a respected and wise colleague or a formal ethics consultation to assist him in specifying and balancing the various ethical claims the case presents. Through this moral deliberation, Dr. Smith can translate his laudable and legitimate concern about student welfare into principled actions.

Undoubtedly aware of his professional obligation to respect Steve's confidentiality, Dr. Smith frames his ethical question in terms of his "responsibility as a university physician" even wondering if he should "investigate" the diversion. Dr. Smith's unsettled emotional state constitutes a valid ethical intuition that, honored and reflected upon in a structured manner, can provide insights. Most clinicians reading this case would recognize and sympathize with Dr. Smith's moral distress. The physician has a sense that if he acted he could prevent harm to the student who is diverting medication, to the cousin, and to other students like Steve who are receiving stimulants without consulting a health care professional. Dr. Smith probably also feels he could help the student who is diverting if he could arrange for him to receive "medical attention." If Dr. Smith proceeded with his ethical analysis only to this point, then the *prima facie* obligations of nonmaleficence and beneficence would require him to reach out to the friend, either directly or through the conduit of university authorities.

Herein lies the strength of principlism as a mode of ethical analysis—requiring the balancing and specification of the weight and scope of the core principles through the more particularized and circumscribed moral norms or rules of veracity, confidentiality, and fidelity [3]. The narrative underscores that Steve's friend is not a patient of Dr. Smith's. It is this lack of a sanctioned patient-physician relationship that creates the ethical conflict. Any well-intentioned attempt on the part of Dr. Smith to contact the friend would breach the fiduciary obligation he has to his current patient: to keep in confidence what Steve has told him. The sensitive and stigmatized nature of substance use—understood simultaneously as a disease and an illicit behavior—has led to especially strict federal confidentiality restrictions to encourage individuals to seek treatment and ensure clinicians are not forced into untenable conflicts of interest [5].

Though Dr. Smith is motivated by beneficence, respect for autonomy must be observed. Steve is an adult of 22, and the Health Insurance Portability and Accountability Act (HIPAA) protects his confidentiality, as do applicable state

privacy regulations and student health center policy just as if he were in a private physician's office or a local hospital. Legally, the clinic is required to provide patients with written documentation informing them of these safeguards, and the assurance that his communications with Dr. Smith were confidential is probably one of the reasons Steve felt so comfortable with him. That policy most likely stipulated the traditional grounds on which Steve's confidentiality could be breached: chiefly, a credible threat of serious harm to self or others. Steve's situation obviously does not fall under these lawful exceptions, and any other release of information without Steve's consent fails to honor his autonomy.

The Family Educational and Rights and Privacy Act (FERPA) that governs educational records does permit university officials and faculty to communicate confidential student information necessary to protect the welfare and safety of the student or the community; this is in essence a public health consideration [6]. The Jed Foundation has published a definitive guide to student mental health law that frames Dr. Smith's obligations as clinical and professional, not institutional: "without a student's consent, a clinician is rarely able to discuss information learned as part of the therapeutic relationship with campus administrators or even acknowledge that the student is in treatment" [6].

Is there anything constructive Dr. Smith can do about the serious problem of diversion of prescription medications on college campuses? As a primary care physician, Dr. Smith has already made a positive contribution by working to help Steve find nonpharmacological ways to improve his scholastic performance and manage his stress. Dr. Smith may want to investigate campuswide initiatives to combat diversion through education, counseling, and treatment rather than addressing a single student's misuse.

Dr. Smith may also consider updating his knowledge of university resources for students struggling with academic difficulties, so he can provide appropriate referrals for other student patients. His experience with Steve could lead Dr. Smith to study the literature regarding students at risk of diverting medications and using illicit prescription drugs [7] and review his current patient panel for students who could benefit from more frequent monitoring or a frank discussion of the dangers of diverting and using prescription medications [8]. Dr. Smith might also meet with other clinic staff and revise informed consent procedures for prescription medications to perhaps include controlled substance agreements if these are not already used.

The scenario ends with Dr. Smith feeling good about his interaction with Steve yet troubled that he could not help Steve's friend. The appropriate response to his moral distress is to make constructive changes in his practice that have the potential to benefit many students in the future, fulfilling his ethical duty not only to his patient but to the community as well.

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The people and events in this case are fictional. Resemblance to real events or to names of people, living or dead, is entirely coincidental.

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MEDICAL EDUCATION

A Longitudinal Approach to Handoff Training

Jeanne M. Farnan, MD, MHPE, and Vineet M. Arora, MD, MAPP

Transitions of patient care, or handoffs, between members of the medical team have often been hampered by communication failures, near-miss events, and environmental barriers [1, 2]. Consequently, the handoff has repeatedly been the subject of a Joint Commission National Patient Safety Goal *requiring* hospitals to implement a standardized, structured approach to handoff communication and provide an opportunity for physicians to ask and respond to questions about a patient's care [3]. Meeting this goal is particularly challenging for academic teaching hospitals, given that few medical trainees receive formal training on handoffs [4] and there is more need for communication among a large number of allied health professionals and subspecialty consultants. The Institute of Medicine has therefore recommended that all resident physicians receive formal training in how to execute a safe and effective handoff.

In its most recent (July 2011) iteration of work-hour regulations, the Accreditation Council for Graduate Medical Education (ACGME) further limited shift duration for first-year trainees (PGY-1) to 16 hours, compounding concerns about transitions. But explicit language in the new ACGME regulations also mandates that trainees receive education about handoffs and that residency training programs assess handoff quality [5]. However, there is a lack of both validated tools for the assessment of handoff quality and innovative materials for trainee education. Review of the literature in medical education confirms that the use of video-based education and standardized patient environments increases learner satisfaction and improves the fidelity of the experience.

Combining these strategies with our prior work in this area, we aimed to develop and test a generalizable tool and simulation-based education modules for assessment of handoffs among faculty and trainees. If further reductions in residency duty hours are enacted, the increased frequency of patient handoffs will heighten the need for improved handoff education. The University of Chicago's vertically integrated undergraduate, graduate medical education, and faculty development structure makes it possible to use a case- and simulation-based approach to develop and implement innovative education and evaluation across the continuum of medical training.

Description of Program

Using learner-identified handoff milestones, we developed and implemented a longitudinal education and evaluation curriculum for all levels of learners from medical student through faculty. We developed a multimodal approach with novel

educational tools to engage the learners in the handoff process. Both undergraduate and graduate medical education trainees were asked to identify and define educational milestones.

Undergraduate medical education (UME). A needs assessment was conducted to ascertain clinical students' exposure to and participation in handoffs. Third-year students reported that participation in the verbal component of the handoff during their clinical rotations was highest during their internal medicine rotation, and nearly three-quarters of students reported that handoff training prior to beginning third-year clerkships would be beneficial.

Using case-based workshops and simulations, the program allows third- and fourth-year students to practice giving and receiving handoffs, with a focus on updating information, the transfer of professional responsibility, and effective communication during an interactive, objective, structured handoff experience (OSHE).

The simulated OSHE has two components: (1) providing static information (i.e., a mock history and physical examination transcript based upon an actual clinical case) and (2) dynamic information (i.e., a 5-minute trigger video representing "interval patient events" that occur throughout the day and require follow-up by the covering physician, such as increasing oxygen requirement and pending labs). Trainees are given 10 minutes to complete a written sign-out using a structured template, incorporating the dynamic information from the video with the static information, and then hand off this "patient" to a standardized "receiver."

Receivers at both institutions were housestaff who had been trained on the case and handoff expectations beforehand. They received the handoff and provided feedback using the Hand-off CEX instrument, which asks them to rate overall handoff performance and its components on a 9-point scale (see figure 1).

Figure 1. Sign-out PROVIDER Evaluation

Evaluator: _____ Evaluatee: _____ Ward: _____ Date: _____
 Evaluatee: intern resident student Other: _____ Situation: End of shift Transfer btwn services Admission

Setting (<input type="radio"/> Not observed)	1	2	3	4	5	6	7	8	9	<i>no interruptions; silent</i>
<i>≥ 5 interruptions; noisy, chaotic</i>	Unsatisfactory			Satisfactory			Superior			
Organization/efficiency (<input type="radio"/> Not observed)	1	2	3	4	5	6	7	8	9	<i>standardized signout; concise</i>
<i>disorganized; rambling</i>	Unsatisfactory			Satisfactory			Superior			
Communication skills	1	2	3	4	5	6	7	8	9	<i>face-to-face sign-out; understanding confirmed; questions elicited; responsibility for tasks clearly assigned; concrete language</i>
<i>not face-to-face; understanding not confirmed; no time for questions; responsibility for tasks unclear; vague language</i>	Unsatisfactory			Satisfactory			Superior			
Content (<input type="radio"/> Not observed)	1	2	3	4	5	6	7	8	9	<i>all essential information included; clinical condition described; “to-dos” have plan, rationale</i>
<i>information omitted or irrelevant; clinical condition omitted; “to-dos” lack plan, rationale</i>	Unsatisfactory			Satisfactory			Superior			
Clinical judgment (<input type="radio"/> Not observed)	1	2	3	4	5	6	7	8	9	<i>sick patients identified; anticipatory guidance provided with plan of action</i>
<i>no recognition of sick patients; no anticipatory guidance</i>	Unsatisfactory			Satisfactory			Superior			
Humanistic qualities/ Professionalism (<input type="radio"/> Not observed)	1	2	3	4	5	6	7	8	9	<i>focused on task; appropriate comments re: patients, family, staff</i>
<i>hurried, inattentive; inappropriate comments re: patients, family, staff</i>	Unsatisfactory			Satisfactory			Superior			
Overall sign-out competence (<input type="radio"/> Not observed)	1	2	3	4	5	6	7	8	9	
	Unsatisfactory			Satisfactory			Superior			

Evaluation time: _____ Observing: _____ minutes Providing feedback: _____ minutes

Evaluator satisfaction with evaluation: 1 2 3 4 5 6 7 8 9

Evaluatee satisfaction with evaluation: 1 2 3 4 5 6 7 8 9

Comments: _____

Third- and fourth-year students currently receive training on the necessary components of a handoff, the importance and function of verbal and written handoffs, common barriers to written and verbal communication, and effective communication strategies for verbal handoffs. Senior students participating in the OSHE experience reported significant increases in self-efficacy related to handoff preparedness [6].

Graduate medical education (GME). Additional survey data revealed that incoming interns reached several milestones during their PGY-1 year, including such handoff improvement topics as peer evaluation, performance audit, and feedback. Our GME curriculum currently includes case-based review, peer assessment of handoff performance using the Hand-off CEX tool, and handoff audits using the UPDATED tool (figure 2), an instrument to evaluate the quality of the written sign-out.

Figure 2. UPDATED—Guide to Review Written Sign-out ©

Updated admin data	especially team members, room number, code status
Problem list ordered by importance	Start with acute problems, end with chronic problems.
Diagnosis in one-liner?	e.g., “presumed pneumonia” or “PE” as opposed to “shortness of breath”
Anticipated problems	with directions in “if-then” format
TMI?	Too much information?
Error-prone meds reviewed	i.e., narcotics/IV antibiotics/anticoagulants/insulin
Directions clear	All to-dos have rationale and clarification, not, e.g., “check CBC” without directions on what to do with results

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Housestaff participate in a workshop in which they identify systems issues that prevent effective handoffs and use process improvement to identify solutions. Trainees view a video that stresses the systems-based barriers to the handoff process and debrief about them, which promotes effective handoff communication. Using the UPDATED tool, housestaff evaluate several examples, varying in quality, of the written sign-out. Finally, the senior housestaff are encouraged to provide supervision to their trainees and evaluate their handoff performance in a standardized way, providing feedback on process and performance using the Hand-off CEX tool incorporated into the New Innovations residency evaluation management software, an electronic system used to securely record and track trainee evaluations of performance.

Faculty development. Faculty development focuses on the incorporation of handoff education into teaching rounds and training on handoff quality using the VALID (Video Assessment of Levels of Interactive Dialogue at Hand-offs) workshop and Hand-off CEX evaluation. To train faculty to perform direct observation of trainee handoffs and provide feedback on their written and verbal performance, an

interactive faculty development workshop was piloted this past spring at our institution.

First, faculty received education on the principles of effective handoff communication and the importance of evaluation and feedback in improving handoffs. Instructors also stressed the importance of direct faculty observation of trainee handoffs and feedback on their performance. Following the educational module, faculty participated in interactive practice, where they viewed a gold-standard video-based handoff and discussed the benchmarks of a superior performance. Next, faculty watched six videos that highlight various levels of handoff performance, specifically in the domains of communication skills, professionalism, and environment or setting. In each video, one domain of performance changes while the others remain constant. Finally, faculty identified the factors that encourage or discourage the displayed behaviors and practiced their handoff evaluation skills utilizing the Hand-off CEX instrument.

Upon review of their evaluations, we noted that faculty were reliably able to distinguish the different levels of performance in each domain (e.g., communication skills, professionalism, and setting), and preliminary data regarding the validity and reliability of the Hand-off CEX tool are promising. Participants also commented on the realistic nature of the video-based scenarios, specifically those portraying setting and communication challenges during trainee handoffs.

Conclusions

Using learner-identified handoff milestones, we have successfully created and piloted a longitudinal handoff curriculum, addressing the needs of various learners at their respective stages in training. This curriculum relies heavily on innovative interactive teachings tools that have been easily transported and generalized to institutions other than our own.

This longitudinal, stepwise approach begins with a conceptual model of practical skill development for UME and GME trainees and then moves to a more theoretical, systems-based, and evaluative approach to handoff education. By tailoring to all levels of learners, and diversifying experiences with multimodel educational strategies, the program builds upon prior knowledge as the curriculum moves forward with the trainee.

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MEDICAL EDUCATION

Turfing Revisited

Catherine V. Caldicott, MD

Nearly 35 years ago a sensational fictionalized account of medical residency at a prestigious teaching hospital gave voice to the suffering and sad ironies inherent in medical training at the time. *The House of God*, by Samuel Shem (a pseudonym), gave many medical students, residents, and even practicing physicians permission to lament their often grueling professional lives, and offered useful vocabulary for that purpose [1]. Although Shem did not coin the term “turfing,” his use of it in the novel popularized it within medicine. Ask any medical student or resident what it means to “turf”—even three and a half decades later—and he or she will respond with a common understanding of transferring a patient to someone else’s care for reasons that are not strictly medical. Clearly something about the notion of “turfing” has staying power.

In this article, I will describe my own investigations into the use of this term, why it troubles my colleagues and me, and what we believe it represents. I will present arguments I heard that turfing was a practice unique to teaching institutions and that it would become less relevant—less necessary—over time as work-hour restrictions were introduced. And I will submit that, despite changes in the system of physicians’ training and practice, turfing still exists. I believe that the concept of turfing is less related to the work of taking care of patients and more emblematic of conflicts in medical students’ and physicians’ professional identity and character.

What Is Turfing and Why Should We Care?

Caring for patients is the bedrock of professional roles in medicine. So why would those who are presumably committed to taking care of patients try to get someone else to take certain patients off their hands? Of course, *bona fide* medical reasons justify transfers to other, more appropriate physicians. But in the case of a turf, the patient is one whose medical needs could be met by the initial physician. It’s just that the initial physician happens to prefer not to care for that patient. This is not a rarefied notion. A basic Internet search of “turfing” reveals this definition:

The act of foisting a patient to another service or hospital by manipulating the patient’s history so that the transfer appears appropriate [2].

The act of turfing a patient allows the initial physician to feel relieved, unburdened, perhaps even proud of dumping work onto another physician. The physicians who receive turfed patients may feel burdened, taken for granted, even abused and

powerless. (Curiously, the slang term “a turf” refers to the *patient*, rather than to the physician whose actions caused the feelings of powerlessness and resentment [3].) In response they may find consolation and even satisfaction in having stepped up to the plate and cared for the turfed patient—although in reality they did not have the choice to decline.

Physicians who have received turfed patients believe they leave their resentments toward their turfing colleagues at the door when they begin to care for the patient [4]. But how can they be sure? What concerned my colleagues and me was that the decision to turf a patient seemed to be a decision to benefit the physician, not the patient. We were troubled by the seeming lack of regard for the primacy of patient welfare. We wondered if the negativity felt by the receiving physician towards the turfing physician was ever displaced onto the patient. It seemed crucial to us to assess whether patients could discern an interdisciplinary conflict based on the fact that some physicians did not appear to want to take care of them.

Studying Turfing

My colleagues Drs. Kathleen Dunn and Richard Frankel and I designed a study to interview patients regarding their hospital experiences [5]. We only approached patients who had been evaluated at admission by physicians from two or more services. Some of the patients were transferred from one service to another or declined by one service and accepted by another for appropriate medical and therapeutic reasons. But others fell into the “turfed” category. For example, an elderly woman with hypertension had fallen, broken her hip, and was scheduled for surgical pinning of the fracture. When the orthopedists evaluated her in the emergency room they declined to admit her to their service, stated she could go to a medical service, and agreed to follow her in consultation—which includes taking her to the operating room. This was not a woman with complex or difficult medical problems. She was elderly and had essential hypertension managed well on one medication.

Our study employed qualitative methods suited to exploring issues deeply to generate hypotheses for further investigation. A qualitative study such as ours cannot reach conclusions about the frequency of a phenomenon, but it can yield trustworthy insights into experiences and conditions. Our interviews were semistructured, meaning that we asked a few basic questions of every patient. However, when a patient brought up a unique topic, we explored it as far as the patient could.

We found that the interviews with patients who had been turfed were qualitatively different from those with patients whose doctors did not engage in conflict about patient “ownership.” Patients whose admissions were perceived as appropriate by their physicians offered uniformly positive comments. Patients who had been turfed had complaints and criticisms and picked up on some negativity, although they could not necessarily identify the precise conflicts. Patients who had been turfed were also able to speak well of their hospital care, but their comments were peppered with negativity.

We concluded that, despite their best intentions, physicians who receive turfed patients probably telegraph something to them. Perhaps these physicians are not completely capable of compartmentalizing the discontent they feel towards their turfing colleagues. If that is true, then interspecialty conflicts regarding duties to patients, colleagues, superiors, and self may have unintended adverse consequences on patient care. It may also be the case that feelings about caring for a turfed patient are not limited to physicians. Everyone on a team or hospital unit is busy; an additional assignment of questionable appropriateness may feel burdensome. These hypotheses merit further investigation.

Is Turfing Unique to Academic Medical Centers?

Criticisms leveled at the study of turfing include the point that, in private practice and community hospitals, physicians of all specialties gratefully accept referrals and consultation requests from colleagues. One's professional and financial success depends on this. By contrast, in an academic medical center (particularly in the 1980s and 1990s) faculty physicians were typically salaried and did not derive financial incentives for taking on additional patients—nor did they experience financial penalties for declining patients. Fewer patients on a service allowed faculty to spend more time in their laboratories or outpatient practices.

Perhaps there were other good reasons to keep a team's census down. Using the example above of the elderly woman with the broken hip, one might accept the orthopedists' rationale that caring for fewer patients would allow them time to focus on those whose conditions were more complex or unstable. (The same, however, would be true of internists.) If an attending physician urged the residents to be extremely judicious in admitting patients to their service (i.e., to be "a wall"), the residents may readily internalize that message and convey it to the rest of the team. And if the differing financial set-ups truly distinguish private from academic medical settings, then the criticism that turfing is unique to academia sounds plausible.

And yet situations exist in which physicians in private practice turf patients to academic medical centers. Since 1986, federal legislation has outlawed "dumping" of unstable patients or women in labor from private hospitals to public ones based on the patients' ability to pay [6]. In the nonacute setting, however, it is not unusual for private practices to decline patients with Medicare, Medicaid, or no medical insurance and refer them to the nearest academic center. Faced with a disproportionate share of un- and underinsured patients, academic centers suffer financially, and academic physicians feel burdened, even though, increasingly, they are compensated according to their productivity. Patients turfed for inability to pay endure overcrowded offices, long waits for appointments, and the indignity of being rejected by certain practices.

Other reasons exist to try to move the care of certain kinds of patients to other physicians.

Turfing refers to a physician's culling sick patients out of the practice to make the utilization profiles look better—in other words, transferring the sickest patients to other physicians for care to look like a low-utilizing provider. Turfing can occur in any plan with an undue emphasis on low utilization [of medical services] and when the compensation and reward structure for physicians is heavily weighted toward individual physicians having low utilization profiles.... Turfing refers specifically to physicians trying to “dump” their high-cost patients on to other physicians [7].

Work-Hour Restrictions and Turfing

A second criticism of studying turfing pertains to student and resident work-hour restrictions in the United States. Since these restrictions designate a predictable time for medical students and housestaff to stop working and go home, one might think that any imperative an initial physician might feel to turf a patient would be diminished by the predictability of the end of his or her own shift. In this new system, an additional patient no longer represents quite the same burden as he or she did when work hours were open-ended. For the same reason, receiving a turfed patient also should not feel as burdensome as it did when the end of one's workday was unpredictable. If these suppositions are true, then one would expect turfing to decrease over time.

Nevertheless, those who receive turfed patients care for more patients than they might otherwise, potentially creating difficulty wrapping things up at the end of a shift, and a higher census necessitates a larger and more complex handoff to whomever comes in next. Despite the absence of hard data, anecdotal reports substantiate that turfing persists. Attending physicians are not subject to work-hour restrictions in the United States. They go home when their work is done, not when they have worked a prescribed number of hours. So to the extent that attending physicians support the turfing of patients from their own services, the practice remains.

Ethical Issues in Turfing

I contend that the concept of turfing is less related to the work of taking care of patients and more related to conflicts regarding professional identity. Some members of certain specialties have adopted into their professional identities—and have become known for assuming—the authority to make patient disposition decisions based on nonmedical related criteria. They may even value and cultivate that professional identity, as suggested in the example of the resident “wall” above.

By contrast, recipients of turfed patients assume a professional identity of passive accepters. This is not an identity they relish [8]. Some recipients may find professional virtue in caring for a patient other physicians do not want; altruism, compassion, and conscientiousness are among the many virtues that are expected in health care professionals. But physicians who receive turfed patients may balk at feeling that their professional role is to do the bidding of other physicians. When a

patient is turfed, the interdisciplinary relationships take on the characteristics of a power play. In medicine, duties to patients are paramount, and yet in a turfing situation one group of physicians appears to consider themselves in some ways exempt from that duty.

Other professional responsibilities, including duties to one's teammates and colleagues, to the mission of one's institution, to one's professional code of conduct, to society, and to oneself and loved ones, are expected of physicians and, hence, emphasized. If it were possible to honor all these duties simultaneously, physicians might not feel the need to turf patients to others. More commonly, though, a physician feels pulled apart by competing duties. For example, how does one demonstrate a duty to patient care (assuming the patient is medically appropriate) when one also feels a duty to comply with the wishes of a superior, or behave as a "team player," or prepare for an exam by studying or sleeping?

Part of what exemplifies a physician's or medical student's professional character is how he or she prioritizes these worthwhile but conflicting duties.

The bread and butter of morality in medicine...is in acting rightly when the right path is clear before us but other pressing needs and desires pull us away from that path in the midst of day-to-day medical routine.... Professionalism in training means taking the time and making the effort to do the right thing when the path of least resistance would be to take an easier way out, allowing the demands of, say, the next half hour, or one's hunger or anxiety or fatigue or desire to leave the hospital, to override moral considerations [9].

Rather than pointing fingers at physicians who turf or comforting the overworked physicians and students who receive turfed patients, medical educators, administrators, faculty, and trainees can respond in more productive ways. Here are some ideas.

- Institutional leaders can agree among themselves to act as role models for medically sound patient dispositions. Some patients who are critically ill or whose care is more complex than that of others require careful triaging at the faculty level.
- Patients whose care is particularly complex can be treated collegially and collaboratively by more than one specialist. If the elderly woman with the fractured hip had had more challenging medical problems, it would have been appropriate for the medicine service to care for her and work closely with the orthopedists during the pre- and postsurgical course. Otherwise, a general medical consultant could serve as a sufficiently supportive and involved resource so that the orthopedists would feel confident about keeping her on their service.
- Departmental educational conferences could provide opportunities to examine subspecialty professional views of medical care and articulate what

- Students and residents should freely solicit the advice of chief residents, attending physicians, and ethics faculty about how to choose between worthwhile but conflicting duties and to reason through and anticipate the consequences of various choices.

Inculcating professionalism in medical training is a task that “may be harder than we think and may require of medical educators a degree of personal virtue and involvement with trainees that most of us perhaps do not really contemplate, let alone achieve” [8]. Doing the right thing is harder when a novice professional believes he or she must take matters into his or her own hands. Rather, it becomes easier when the novice professional turns to leaders, mentors, and advisors—in other words, experts—for guidance that will build a capacity to act professionally going forward.

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THE CODE SAYS

The AMA *Code of Medical Ethics*' Opinion on Physicians Treating Family Members

Opinion 8.19 - Self-Treatment or Treatment of Immediate Family Members

Physicians generally should not treat themselves or members of their immediate families. Professional objectivity may be compromised when an immediate family member or the physician is the patient; the physician's personal feelings may unduly influence his or her professional medical judgment, thereby interfering with the care being delivered. Physicians may fail to probe sensitive areas when taking the medical history or may fail to perform intimate parts of the physical examination. Similarly, patients may feel uncomfortable disclosing sensitive information or undergoing an intimate examination when the physician is an immediate family member. This discomfort is particularly the case when the patient is a minor child, and sensitive or intimate care should especially be avoided for such patients. When treating themselves or immediate family members, physicians may be inclined to treat problems that are beyond their expertise or training. If tensions develop in a physician's professional relationship with a family member, perhaps as a result of a negative medical outcome, such difficulties may be carried over into the family member's personal relationship with the physician.

Concerns regarding patient autonomy and informed consent are also relevant when physicians attempt to treat members of their immediate family. Family members may be reluctant to state their preference for another physician or decline a recommendation for fear of offending the physician. In particular, minor children will generally not feel free to refuse care from their parents. Likewise, physicians may feel obligated to provide care to immediate family members even if they feel uncomfortable providing care.

It would not always be inappropriate to undertake self-treatment or treatment of immediate family members. In emergency settings or isolated settings where there is no other qualified physician available, physicians should not hesitate to treat themselves or family members until another physician becomes available. In addition, while physicians should not serve as a primary or regular care provider for immediate family members, there are situations in which routine care is acceptable for short-term, minor problems. Except in emergencies, it is not appropriate for physicians to write prescriptions for controlled substances for themselves or immediate family members.

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STATE OF THE ART AND SCIENCE

The Patient, the Physician, and Dr. Google

Bradford W. Hesse, PhD

In July of 2002, I watched as my wife, a practicing obstetrician/gynecologist, was deluged with telephone calls as scores of her patients began processing the news that the National Heart, Lung, and Blood Institute had halted the combined estrogen and progestin arm of the massive Women's Health Initiative clinical trial because of concerns of risk over invasive breast cancer. What was perplexing about the experience, I recall, was that many of the women calling had already downloaded a preprint of a *JAMA* article explaining the institute's decision a full week before the print issue had arrived at my wife's desk. Naturally, the callers were filled with questions. One of my wife's more innovative solutions was to invite interested patients to a journal club review of the online article, so that they could go over and digest the new information together.

What I was watching firsthand was playing out in physicians' offices around the country. In 1999, a study of online information revealed that health-related concerns dominated much of what people were looking for on the newly opened "information superhighway" [1]. Patients were doing an end run around traditional medical sources and were beginning to search online for answers to their health-related questions. What they found, though, was a hodgepodge of medical information, from cutting-edge study data to dubious advertisements for miracle cures [2].

Often it was difficult to tell what the source of information on a web site might be, and many ostensibly credible web pages were actually masking a spate of ulterior motives. Direct-to-consumer advertisers were especially prevalent in this space, with new online companies making it easy to skirt local jurisdictional restrictions on the sales of pharmaceuticals. Phishing (i.e., the fraudulent practice of sending people to a bogus web site that collects their personal account information) and "pharming" (i.e., the tactic of enticing consumers to download malevolent software in the guise of updating antivirus software) added to the lack of trustworthiness [3].

In spite of the obstacles, online patients were able to navigate their way to trusted medical organizations. In 2001, for example, worries about bioterrorism following the national anthrax scare drove an unexpected amount of traffic to the Centers for Disease Control and Prevention's web site. What readers found was presented in a highly technical way and was difficult to interpret. Accessing journal articles only added to the confusion, as patients tried to make sense of a specific field's jargon and complex statistical treatments of findings [4]. There was a prevailing sense that patients appreciated being able to get at original source material easily through the web, but that they needed help interpreting it.

Seeking an alternative to more formal sources, patients also began using the Internet to find similarly diagnosed others through listservs and discussion groups [5]. It wasn't long before these groups of online patient communities became their own sources of information about side effects, solace from others who were experiencing similar disease trajectories, and advice on how to navigate the complexities of a fragmented health care system [6]. Some commentators wondered whether the "disintermediating" influence of the web (that is, the ability to bypass traditional information gatekeepers) would signal a "crisis in trust" of the medical profession as it had for the financial and travel industries [7].

To understand what these changes in the information environment meant for health and health care, the National Cancer Institute launched the Health Information National Trends Survey (HINTS) in 2001. The HINTS program was created as a biennial, general population survey of adults 18 years and older to monitor the public's use of a changing health information environment to improve their own health. Data files, reports, top-line briefs, linked lists of published papers, and a method for comparing variables within the dataset over years are all on the NCI's website [8]. The results have been enlightening.

Rather than signaling a "crisis of trust" in physicians, the HINTS survey suggested that the American public was continuing to place its greatest degree of confidence in its doctors [9]. That trust actually increased with the proliferation of online health information [10]. But regardless of the growing trust in their doctors, patients continued to say that the Internet remained their "first source" of health information when reporting what happened the last time they looked. That is, because of its simple convenience, the Internet was the starting point for most people's questions about their health. "Dr. Google" was clearly entering into the picture as an invisible part of the patient's solution strategy [11].

As more and more medical information went online, patients reported increased confusion about what the abundance of online medical information meant for their own health [12]. The public experienced what journalist David Schenk called "data smog," bombarded by constant health scares, raw data, and impenetrable scientific language [13]. Lastly, as some medical organizations began experimenting with secure e-mail channels and compensated physicians for time interacting with patients, HINTS data portrayed a slow but steady rise in the number of people who interacted with their physicians through e-mail [14]. There is some evidence that these new online channels may save medical costs and patients' time by allowing nonurgent inquiries to be addressed without an office appointment [15].

What, then, does this mean for the ethics of clinical practice? Health systems researcher Edward Wagner suggested that health must be a product of an activated patient working in collaboration with a prepared health system [16]. In this sense, the rise in number of patients going online to seek information for the "vital decisions" [17] they make in their lives can be viewed as a positive trend. What patients find in

the unfettered, unregulated environs of the global web, however, will continue to vary in quality and reliability.

In this environment, the role of clinical systems in improving the educational experience of patients may actually become more important, not less so. Many highly reputable health care systems and government agencies are creating informative patient portals that invite engagement and support an active approach to preventive care. Credible online sites can even serve as a type of “information prescription” to patients who are seeking to learn more but do not know which information to trust [18].

These efforts are a start, but may not be enough. Information technology and patient brochures are only part of the solution. To create a prepared and responsive health system, designers should look for ways to protect—not obliterate—time for the personal counseling patients may need to make sense of an overwhelming information environment. From a thorough review of the patient communication literature, Arora et al. recommended that in addition to exchanging information a responsive health care system should also find ways to: (a) enable patients to manage their own care; (b) foster healing relationships with the care team; (c) support patients in making sound decisions, taking evidence-based medical knowledge and personal values into account; (d) manage the uncertainty associated with medical diagnoses and probabilistic treatment recommendations; and (e) help patients deal with and respond to their own emotions [19].

Unlike other sectors, the health care sector must rely on a shared understanding of complex processes to be optimally effective [20]. According to the Institute of Medicine, that shared understanding can and should be extended to patients [21]. Online supports for patient engagement may eventually become an integral part of the process [22]. In fact, new data from the Livestrong Foundation suggest that patients do better at self-management once they begin to feel comfortable with their ability to search for and find medically relevant information from a variety of sources [23].

Rather than creating an environment of “disintermediation” (information in the absence of an intermediary), then, the Internet may be creating an environment of “apomediation” (information “surrounding” all parties) [24, 25]. In this world, the ethics of sound health care will likely put the medical team in the position of interpreter or guide, while patients continue to hone their information-seeking abilities and to polish their health problem-solving skills. More to the point, health systems engineers and administrators should strive to create an atmosphere in which physicians and their patients are fully supported in their ability to digest new data and process new information together [26].

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HEALTH LAW

When Is a Patient-Physician Relationship Established?

Valarie Blake, JD, MA

From day one, medical students are taught that their primary obligation is to patients. But defining who their patients are is another matter. Who counts as a patient is a complex legal question that has major implications for determining when a physician has a duty to treat, when a physician can be sued for malpractice, when a physician has “abandoned” a patient, and other serious matters. The legal definition of a patient and the corresponding duties of the physician have been debated in state courts for over a century, and many aspects of the question are still being resolved. This article will explore a number of important legal cases that have helped to define the patient-physician relationship generally, as well as some key exceptions to the general rule.

When Is a Patient-Physician Relationship Established?

Hurley v. Eddingfield. In 1901, the Supreme Court of Indiana heard the tragic case of Charlotte Burk [1]. Dr. Eddingfield was the local general practitioner and Burk’s family physician, but when Burk suffered complications during childbirth, her husband sent a messenger to Dr. Eddingfield, and Dr. Eddingfield refused to treat Burk [1]. She and her unborn child died. Dr. Eddingfield was not considered obligated to provide care for Ms. Burk because “the State does not require, and the [medical] licensee does not engage, that he will practice at all or on other terms than he may choose to accept” [1]. The court distinguished doctors from innkeepers who are required to serve anyone who comes to their door.

Ricks v. Budge. Several decades later in Utah, a patient saw a Dr. Budge for an injury to his hand [2]. When he visited again several days later, the hand had become severely infected, but Dr. Budge refused to treat it because the patient had unpaid bills. Budge told the patient to go to a nearby hospital [2]. The hospital physician immediately operated, but the hand was eventually amputated [2]. In this case, the court decided that a patient-physician relationship had been established when the patient saw Dr. Budge at the first visit because it is “well settled that a physician or surgeon, upon undertaking an operation or other case, is under the duty, in the absence of an agreement limiting the service, of continuing his attention...so long as the case requires attention” [2]. A withdrawal is permitted even where the patient requires additional attention but only if the patient is given “sufficient notice...[to] procure other medical attention” [2].

Childs v. Weis. In this Texas case, the court held that Dr. Weis did not have an established relationship with Daisy Childs, 7 months pregnant, who presented to the emergency room, bleeding and with labor pains [3]. The physician had never seen or

treated Daisy Childs. When called by the nurse, Dr. Weis told the patient she needed to go to her own physician in Dallas. During travel, she lost the baby [3]. The court stated that “a physician is not to be held liable for arbitrarily refusing to respond to a call of a person even urgently in need of medical...assistance provided that the relation of physician and patient does not exist” [3].

Mead v. Adler. In Oregon, an on-call neurosurgeon was consulted by an ER doctor who suspected a severe neurological disease was causing a patient’s low back pain [4]. The neurosurgeon examined the patient and recommended that she be admitted but said that surgery was not needed [4]. Four days later it was determined that the patient did require the surgery, following which she was permanently impaired [4]. The patient sued the neurosurgeon who was originally consulted for damages but he defended that he owed her no duty because a patient-physician relationship had not been established. The court held that “in the absence of an express agreement by the physician to treat a patient, a physician’s assent to a physician-patient relationship can be inferred when the physician takes an affirmative action with regard to the care of the patient” [4]. A patient-physician relationship was formed because the physician took an affirmative action in rendering an opinion on the course of the patient’s care.

General Rule

As the cases above demonstrate, states vary in how they define a patient-physician relationship. Physicians should consult with their local medical boards to determine the law for their particular state. As a general rule, physicians are under no obligation to treat a patient unless they choose to. (Exceptions are made when emergency care is needed and when refusal to treat is based on discrimination). However, a patient-physician relationship is generally formed when a physician affirmatively acts in a patient’s case by examining, diagnosing, treating, or agreeing to do so [5]. Once the physician consensually enters into a relationship with a patient in any of these ways, a legal contract is formed in which the physician owes a duty to that patient to continue to treat or properly terminate the relationship.

Special Exceptions

HMOs. In *Hand v. Tavera*, Dr. Tavera was the physician responsible for authorizing admissions when the patient, a member of the Humana HMO, went to the HMO-approved hospital and complained of a 3-day headache, the severity of which fluctuated with blood pressure [6]. The patient was sent home and suffered a stroke several hours later [6]. When Dr. Tavera was sued, he argued there was no established patient-physician relationship because he had never seen the patient [6]. The court held that a relationship did exist because the patient had essentially “paid in advance for the services of the Humana plan doctor on duty that night, who happened to be Tavera” [6]. “When the health care plan’s insured shows up at a participating hospital emergency room, and the plan’s doctor on call is consulted...there is a physician-patient relationship” [6].

On-call physicians. In *Mead*, the on-call physician formed a patient-physician relationship because he took the affirmative act of recommending a course of care [4]. In a similar case in Texas, a physician was held not to have established a patient-physician relationship when he was the on-call doctor supervising residents during an emergency caesarean section [7]. In another case, a patient-physician relationship was held not to be established until a physician sees the patient during rounds [8, 9]. In contrast, a recent Ohio Supreme Court case held that a patient-physician relationship can be established between a physician who “contracts, agrees, undertakes, or otherwise assumes the obligation to provide resident supervision at a teaching hospital and a hospital patient with whom the physician had no direct or indirect contact” [9, 10]. The issue turned on whether and to what extent the physician was expected to take an active role in the care of the patients and whether the physician was considered to be the attending doctor of the patient [9]. The issue is still a developing area in the law, with different state courts coming to different conclusions about the duty of the on-call physician. The safe course of action is for on-call physicians to consider everyone whose care they are supervising a patient.

Consultations for benefit of a third party: curbside consultations. Where a physician provides an evaluation of a patient for the benefit of a third party, or as a professional courtesy for a colleague, a patient-physician relationship is typically not established. In *Mead*, the on-call neurologist was held to have a duty that the court contrasted with “curbside consults,” in which a physician provides a professional courtesy to another physician and no duty to the patient exists [4]. Likewise, examinations conducted at the behest of a third party, such as an exam for an employer, insurance company, or court (independent medical examination) do not typically entail the establishment of a patient-physician relationship because the intent is to inform the third party, not to treat or diagnose the patient [11, 12].

Obligations to third parties. A closely related question asks to what extent physicians owe duties to third parties arising from their patient-physician relationship? In a famous case, a psychiatrist was found to have had a duty to warn a readily identifiable victim who was subsequently murdered by his patient [13]. In another case, a physician who had treated the plaintiff’s father for colorectal cancer was held to have an obligation to warn the patient’s daughter of the risk of genetic transmissibility of the illness [14]. Yet, in a Texas case, a physician was found not to have a duty to third parties, when he wrongly concluded a child patient had been sexually abused by the father, who sued. The court indicated that, in some instances, a duty might exist to third parties (here, the father), depending on the type and foreseeability of risk and the magnitude and consequences for placing that burden on a physician [15].

Termination and Abandonment

Where a patient-physician relationship is established, the physician has an ethical and legal duty to continue care and not to abandon the patient. A summary of court cases relating to abandonment posits that, in general, abandonment occurs when the relationship between physician and patient is terminated either (1) at an unreasonable

time or (2) without affording the patient time to find a qualified replacement [16]. “Absent good cause...where the doctor knows or should know that a condition exists that requires further medical attention to prevent injurious consequences, the doctor must render attention or must see to it that some other competent person does so” [16]. A physician must notify the patient and give him or her time to seek care elsewhere. A physician who does not do so can be ethically and legally responsible for abandoning the patient.

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POLICY FORUM

Assignment, Attribution, and Accountability: New Responsibilities and Relationships in Accountable Care Organizations

Harold S. Luft, PhD

The Patient Protection and Affordable Care Act of 2010 (ACA) includes important features that are likely to change how medicine is delivered in the United States. The Supreme Court will rule this summer on various aspects of the act's constitutionality, especially the individual mandate provisions, but it is unlikely to strike down the entire act. In section 3022 of the act, the Secretary of Health and Human Services is authorized to recognize arrangements between Medicare and collections of physicians and other providers as accountable care organizations, or ACOs [1]. If the costs to Medicare for people "assigned" to an ACO grow at a slower rate than costs for patient populations with similar patterns of medical use, *and* if the ACO meets certain quality targets, the implicit savings will be shared by Medicare and the ACO. These savings can be allocated by the ACO to reward its participating clinicians, build infrastructure to facilitate care, or pay for services not ordinarily covered by Medicare.

Several features of the Medicare version of ACOs and similar arrangements developed for the privately insured market (PACOs) are important. The first is that patients in ACOs and PACOs keep their traditional coverage, e.g., Medicare, rather than enrolling in an HMO-style health plan that significantly limits their choice of providers. (I use the term "provider" to include both physicians and other clinicians, such as nurse practitioners, who may be the patient's usual source of care, and entities such as clinics and hospitals.) Indeed, some patients may be in an ACO or PACO without even knowing it. This brings us to the second feature—patients are attributed (ACA uses the term "assigned") to an ACO based on their patterns of primary care use. The next section will explore this in more detail. The third feature of ACOs and PACOs is that they are held accountable for all services received by the patients attributed to them, even those received outside the ACO.

One might ask, "why would clinicians want to form an ACO or PACO and be held accountable for the quality and costs of care that they do not provide for patients who are not formally enrolled and have no financial incentives for receiving care *within* the organization?" Indeed, initial response to the concept was mixed, but it seems to be gaining traction, especially after CMS revised its initial regulations [2].

Perhaps the short answer is that many believe the current payment and incentive system leads to so much wasteful care and so many missed opportunities for quality improvement; the incentives and flexibility of the ACO/PACO model may

encourage them to “do the right thing” more frequently and save money in the process. The lack of control inherent in the ACO/PACO structure (compared to an HMO) makes cost saving more difficult, but has the advantage of engaging providers and patients not willing to be in HMOs. More importantly, it requires and supports a different relationship between clinicians and patients.

Attribution versus Assignment

The “assignment” terminology in the ACA does not reflect an attempt to assign patients to providers, but instead reflects the origins of the accountable care organization concept in what were essentially epidemiological studies [3]. The term “attribution” better fits what is actually being done. Although the details for attribution to Medicare ACOs and various PACOs differ, the notion is that a person can be attributed to a specific primary care provider (PCP) based on a list of the providers from whom he or she receives care. Readily available insurance claims data allows one to “crunch the numbers” to do this attribution without ever asking the patient. Attribution is intended to be a feasible, rather than an ideal, methodology.

Even in a Medicare population with a large number of visits per person per year, it is difficult to attribute patients to individual PCPs [4]. Problems arise, for example, when a patient has an equal number of visits to two PCPs, or when so many PCPs are seen that no one accounts for a majority of the visits. Attribution typically focuses only on visits to PCPs, so problems arise when, because of a dominant chronic condition, a patient largely has his or her care managed largely by a specialist. The attribution challenge is exacerbated with younger adult populations because many have no visits to a PCP in any one year. Does this mean they do not have someone to whom they could go, or who should be monitoring their care? Such concerns are mitigated substantially if one merely needs to attribute people to a set of PCPs affiliated with one ACO/PACO; the problem of “ties” usually disappears if the attribution is to “any PCP within the ACO/PACO.”

The key aspect of attribution, however, is that it reflects a relationship between patients and their provider organizations that is fundamentally different from patient-HMO relationships. An HMO takes responsibility for an enrolled population, meaning that the premiums it receives each month allow it to know exactly for whom it is responsible. The HMO contract with its enrollees, moreover, generally says it has no financial responsibility for medical care obtained outside its system, except in emergency situations or via explicit referrals. In contrast, ACOs and PACOs do not have monthly enrollment lists, and their attributed patients have comparable coverage for care from non-ACO/PACO providers. The challenge for them is to be so attractive to their patients that patients don’t want to seek care elsewhere.

Accountability

HMOs typically bear full financial risk for their enrollees; in an ACO/PACO part of that risk will be borne by Medicare or private insurers. This is a necessity given the

highly skewed nature of health care costs, in which a small number of patients account for a large share of overall expenditures. Risk sharing does not, however, allow ACO/PACOs to ignore the costs of the care received by their patients. The insurer can capture information on all the patient's care, regardless of the providers' affiliation, and the ACO/PACO shares in savings only if overall patient costs are lower than those for comparable patient populations. If it meets such targets, however, the ACO/PACO will receive lump-sum payments from the insurer (Medicare) *not* tied to the services of any particular provider. This flexible pot of money allows the ACO/PACO to focus on developing standard processes for the efficient management of the problems its patients face.

Efficiency in this context does not mean shaving a 12-minute primary care visit to 10 minutes and ending the session with two prescriptions and a referral to a specialist. On the contrary, it may mean spending 20 minutes to thoroughly understand the patient's problem and working through treatment options, perhaps with a phone call 3 days later to see how the patient is doing. Even if the insurer does not pay for the extended visit or the time to call the patient, the ACO/PACO could compensate for that time with the savings achieved.

Balancing the incentives to reduce expenditures are quality metrics. Initially, these may focus on the standard preventive screening and process measures, but they will rapidly move toward clinical and patient-reported outcomes. The latter are not the oft-maligned "generic patient satisfaction" measures but specific patient assessments of their functional status, understanding of their condition, and experience of care—that is, measures patients care about.

Physicians and other professionals deliver medical care, but organizations create the infrastructure to ensure high quality. Quality care may begin with the face-to-face encounter, but it requires the ability to transfer information efficiently among all the clinicians involved, to delegate mundane tasks so the most skilled clinicians can attend to clinical cues, to know when a patient *hasn't* come in when he or she should. Large medical groups already provide much of this. ACO/PACOs seeking to include providers such as independent or small group practices will need to create such infrastructures.

ACO/PACOs and the Patient-Physician Relationship

It is too soon to know how ACO/PACOs will function, but the logic behind them is quite different from that of a standard insurance plan or an HMO. Insurers are typically passive payors of claims after events have occurred. They focus primarily on tweaking benefit packages to create patient-focused incentives to reduce expenditures. HMOs (and managed care plans) sometimes act as if they "own" the patient—at least for a time—and exercise the right to say they will not cover certain services even if the physician thinks they may be needed. They typically also have more data about what is and is not done for their enrollees.

Most physicians in independent practice know just what they do for their patients, but have little or no information on their patients' care from other providers. Because fees do not adequately compensate for time spent with patients, financial pressures discourage the development of close and trusting connections between patients and physicians. Well designed and effectively implemented ACOs should help those who deliver primary care become trusted elicitors of informed patient preferences and knowledgeable coordinators of care. It will take a few years, however, to know if they successfully seize this opportunity.

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POLICY FORUM

Physician Assistants and Their Role in Primary Care

James F. Cawley, MPH, PA-C

In the mid-1960s, the need for greater patient access to general medical services was a principal motivator for establishment of the physician assistant (PA) profession. Since then, PAs have effectively helped to deliver primary care services in many settings. But the supply of clinicians in this field remains a major issue. While the absolute number of primary care physicians, nurse practitioners, and physician assistants is expected to rise in the coming years, the increases are not expected to meet the demands of an aging population, changes in service use, and trends connected with a major expansion of insurance coverage. The best estimates continue to indicate that there will be significant shortages in primary care clinicians. According to the DHHS Agency for Healthcare Research and Quality, only about one-third (208,000) of American physicians practicing in 2009 [1], 43.4 percent (30,300) of PAs practicing in 2010, and 2 percent of nurse practitioners (NPs) practicing in 2010 worked in primary care [2]. It is believed that these numbers are insufficient to meet current and future demands for these services [3].

PA's: Definition and Scope of Practice

Physician assistants are health care professionals licensed to practice medicine with physician supervision. PAs conduct physical exams, diagnose and treat illnesses, order and interpret tests, counsel on preventive health care, assist in surgery, and write prescriptions. A PA's practice may also include education, research, and administrative services [4].

Utilization in Practice

There appears to be increasing reliance on PAs and NPs to deliver primary care services. Recent data from the National Center for Health Statistics attests to this trend based on information from hospital outpatient departments. According to the data brief, hospital outpatient department visits handled by PAs and advanced practice nurses (including APNs and NPs) increased from 10 percent in 2000 and 2001 to 15 percent in 2008 and 2009 [1], indicating greater use of PAs and other nonphysicians, particularly in settings where a good deal of primary care is delivered.

The same study found that PAs also more often delivered care in clinics associated with nonteaching hospitals and handled a higher percentage of Medicaid, Children's Health Insurance Program (CHIP), and uninsured patients, as well as younger patients [1]. These data suggest that PAs are used to a greater degree in smaller facilities located in nonurban areas to serve populations that may otherwise be

medically underserved, trends that are consistent with the intentions of the profession's creators [1].

Of particular interest to some is the finding that PAs saw a higher percentage of preventive care visits (17 percent) than visits for routine chronic conditions or pre- and postsurgical care [1]. It has long been speculated that PAs (as well as NPs) have the potential to provide care that is more prevention-oriented than physician care, and it appears that they may be fulfilling this potential. Further delineation of this trend is warranted. Practicing preventive medicine may offer justification not only for the widespread use of PAs and NPs in primary care but also for policy changes leading to greater levels of reimbursement for preventive services by third-party health payors.

Longer-term trends point to a future for PAs and NPs as the principal front-line deliverers of primary care with physicians assuming more managerial and executive functions and a greater focus on inpatient specialty practice. One physician and professor of medicine at Yale School of Medicine recently observed that “in the decades ahead, it is likely that the main role of the generalist physician will be to supervise those providing primary care and to personally care for patients with complex illnesses who are hospitalized, an idea already well established as the hospitalist movement” [6].

In 2012, 34 percent of practicing PAs reported that their specialty was one of the primary care fields: family/general medicine (25 percent), general internal medicine (7 percent), or general pediatrics (2 percent) [5]. The percentages of PAs working in these primary care fields has been steadily declining, down from fully 50 percent in 1997 and 43.1 percent in 2002 [3]. Although the proportion of PAs choosing primary care has declined, the absolute number of PAs in primary care has continued to increase due to the rapid growth in the number of PAs overall. For example, while the number of PAs in primary care grew only about 45 percent between 1997 and 2006 (from about 16,000 to 23,000), the total number of PAs practicing in America doubled [5].

Increasingly popular specialties for PAs include general surgery/surgical subspecialties (25 percent), emergency medicine (12 percent), the subspecialties of internal medicine (11 percent), and dermatology (4 percent). More than 9 percent work in orthopedics; only 2 percent are in obstetrics/gynecology.

Education, Accreditation, and Certification

Because of the close working relationship they have with physicians, PAs are educated in graduate-level, medical-model programs designed to complement physician training. There are 164 accredited programs in the United States, the majority of which offer master's degrees. The Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) is the accrediting agency responsible for establishing the standards for U.S. PA education and for evaluating programs to ensure their compliance with the standards.

The curriculum is rigorous, comprising basic science, behavioral science, and clinical courses. The required content areas of the preclinical curriculum are anatomy, physiology, pathophysiology, pharmacology and pharmacotherapeutics, and genetic and molecular mechanisms of health and disease. The average U.S. PA program takes 26.5 continuous months of study to complete.

In essence, PA education more closely resembles a condensed version of medical school than does any other health professions curriculum. Clinical education is required in a variety of settings, including outpatient and inpatient settings as well as emergency and long-term care facilities, typically in academic teaching settings. Inpatient clinical rotations are usually conducted in an experiential team format consisting of PA students, medical students, and residents, led by a staff attending physician. The required areas for clinical education are emergency medicine, family medicine, general internal medicine, general surgical care (including operative experiences), geriatrics, pediatrics, prenatal care, and women's health.

Economic Aspects

Data from the Medical Group Management Association's (MGMA) 2009 Physician Compensation and Production Survey supply estimates of the amount of care provided annually by primary care clinicians [7]. (The MGMA statistics reflect productivity at larger group practices, which are not necessarily representative of productivity in smaller group settings [7].) Each year, PAs in family practice have 42 percent of ambulatory encounters with patients (physicians have the other 58) [7]. Using relative value units (RVUs; indicators of service effort used for Medicare reimbursement) that reflect personnel time and level of skill involved with care, PAs have almost as many RVUs as family practitioners (48 percent, to physicians' 52). Use of average, annual patient encounters as the productivity measure may be leading to underestimation of the contribution of PAs because, though in some practices the PA might provide the majority of the care during a patient visit with the physician participating only at the end (e.g., to prescribe medication), these encounters are typically coded as physician encounters [7].

These numbers suggest that hiring a PA in a large practice could be the equivalent of having 0.73 to 0.96 of a full-time (FTE) family practice physician. For general internal medicine and geriatrics, the percentages are somewhat lower (ranging from 70 to 85 percent [7])—perhaps reflecting the complexity of adult cases. For NPs, average annual ambulatory visits and RVUs are lower, possibly reflecting greater use of NPs for administrative and other non-patient-care activities. Although primary care practices differ in how they use certified nurse practitioners (NP-Cs) within a team, these numbers suggest that an NP-C offsets the work of 70 percent to 90 percent of an FTE primary care physician, on average. Additional research on the implications of greater use of NPs and PAs on demand for physicians would be useful.

Conclusions

PAs are likely to continue to be used increasingly in a wide variety of medical practice settings in American medicine, including primary care. They have been shown to be clinically versatile and cost-effective clinicians, extending the services of physician practices and improving delivery of care to underserved populations, and have thus become an important component of the U.S. health care workforce.

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MEDICINE AND SOCIETY

Individualism, Solidarity, and U.S. Health Care

James E. Sabin, MD

Why has it been so difficult for us in the United States to provide health insurance to every citizen? I believe we can get close to answering that question by examining the bitter divisiveness over President Obama's effort at health system reform.

To a significant degree, the impediment to achieving universal coverage and the bitter political standoff arise from poorly handled tension between two basic values: individualism and solidarity [1]. This tension, a classical "good-versus-good" conflict, has been with us since Revolutionary War times. It undergirds American political and moral thinking the way tectonic plates undergird the earth's surface. In 1782 our founding fathers chose *e pluribus unum* ("out of many, one") as the national motto. But as of the twenty-first century, at least with regard to health policy, their optimistic aspiration is not being realized.

In 2009, in an effort to articulate the ethical dimensions of the health reform debate, the Hastings Center published a collection of essays: *Connecting American Values with Health Reform* [2]. The essays on liberty and responsibility highlight the underlying tension between individualism and solidarity. When we examine these values in depth, it becomes clear that they contain antithetical elements.

Appeals to "liberty" have been a central part of the opposition to health system reform [3]. In public discussion of health reform, liberty shows up most prominently as a fear that reform means "loss of choice," "government takeover," and "socialized medicine." These reactions arise from the concept of *negative liberty*—the cherished right to do as we wish and be free from external control as long as we are not harming others. In the U.S. political tradition, negative liberty is enshrined in the Bill of Rights, the first 10 amendments to the Constitution.

But the concept of liberty has a *positive* meaning as well, exemplified in the Preamble to the Constitution, in which "We the people of the United States" commit ourselves to "promot[ing] the general welfare." The First Amendment makes freedom of speech a fundamental negative right. But in order to make use of that right in a way that strengthens rather than divides our society, we must be able to speak effectively and reasonably—we need access to education; hence, state and national laws that protect our positive right to basic education. Individualism demands freedom of speech, but for individuals to speak together reasonably, to deliberate respectfully, to make laws—to act in solidarity—demands education.

Without the *positive liberty* of access to basic education, the *negative liberty* of freedom of speech has little social worth.

The tension arising from our underlying commitment to both individualism and solidarity gives two meanings to the concept of “responsibility” as well. In movie after movie, macho heroes in the tradition of John Wayne take individual responsibility for solving problems, often breaking the law of the land to do so [4]. Superman and Spiderman take the image of the responsible solitary hero up a notch. But movies also portray responsibility as collective action, as in barn raising on the frontier or loving teamwork among soldiers. Superman and Spiderman can take responsibility on their own for catching criminals, but the day-to-day work of raising children in safety and imbuing them with our values takes community.

Healthy societies need *both* individualism and solidarity. True liberty requires both freedom from external constraints *and* developed capacity to use that freedom constructively. As individuals we need to take responsibility for ourselves *and*, at the same time, recognize and act on our interdependence with others. The fact that fundamental values like liberty and responsibility contain antithetical meanings doesn’t represent inconsistent ethical thinking on our part. Rather, the dual meanings ask us to understand and tolerate complexity and to work constructively with moral tension—good-versus-good conflicts.

This is what the U.S. was able to do in 1965 when Medicare was created. There was just as much conflict about health reform in 1965 as there was before passage of the Affordable Care Act in 2010. But what happened in the political sphere was dramatically different.

In 1965 the House and Senate *deliberated* about the complex issues and devised a compromise that received bipartisan support. In the Senate, 12 percent of Democrats voted against the Medicare bill and 43 percent of Republicans voted for it. In the House, 20 percent of Democrats voted no and 51 percent of Republicans voted yes [5].

But since the mid-1970s, our capacity for democratic deliberation [6], constructive compromise, and bipartisanship, has steadily diminished [7]. Although the Affordable Care Act represents a more limited change in health policy than Medicare did, the Senate vote was 100 percent on party lines, while in the House 13 percent of Democrats voted no and no Republicans voted yes.

The fact that the ACA’s legislative proposal to authorize Medicare payment for conversation between patients and their doctors about the values to guide end-of-life care elicited an entirely unfounded fear of government “death panels” shows how rigid ideological divisiveness impedes rational thought [8]. Every medical school teaches its students about informed consent and the ethical imperative for physicians to understand their patients’ values, especially for end-of-life care. But a proposal to

reimburse physicians for these time-consuming, compassionate conversations triggered a firestorm of panic and outrage.

The impediment to guaranteeing universal access to health insurance results more from our diminished capacity for democratic deliberation than from a failure of ethical reasoning. Simply marshalling ethical arguments on behalf of universal coverage won't solve the problem of the uninsured. Those who are primarily moved by solidarity values will continue to see their opponents as "uninformed, uncaring rednecks." Those who are primarily moved by individualism values will see their opponents as "government takeover radicals."

Health professionals can't change U.S. political culture singlehandedly, but there's a lot we can do. We're the group the public trusts most. When Gallup asked how the public would rate the "honesty and ethical standards" of different groups, nurses (84 percent), pharmacists (73 percent), and physicians (70 percent) were the top three, with lobbyists (7 percent), members of Congress (7 percent), and car salespeople (7 percent) at the bottom [9].

We health professionals must become leaders in constructively managing the unavoidable tension between individualism and solidarity. In practical terms, this means moving beyond our traditional responsibility for the *quality* of care and taking responsibility for the *cost* of care because sharing in the cost of care for others is a flash point for those who value individualism above community solidarity. If we continue to make "us" (health professionals) responsible only for care and "them" (public and private insurers) responsible only for cost, we will add to the ideological rigidity that has stymied health reform [10].

The clearest statement of the roadmap we health professionals should follow is the "Triple Aim"—simultaneous pursuit of (1) improving the patient's experience of care, (2) improving the health of populations, and (3) reducing the per capita cost of health care [11]. In order to support pursuit of the triple aim, the Affordable Care Act authorized Medicare to enter into Shared Savings contracts with Accountable Care Organizations—systems that coordinate physicians, hospitals, and other health professionals, to make sure that patients get the care they need in an efficient manner. ACOs that meet quality standards will share in the savings they generate.

When solidarity and individualism—tectonic underpinnings of our political and moral thinking—live together in a state of creative tension, the political landscape is vibrant and innovative. When they move into polarized opposition—as has happened in health policy—our national capacity to achieve universal access to health insurance is stymied.

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MEDICAL NARRATIVE

A Medical Student-Cadaver Relationship

Helena Winston, MSc, MPhil

“Human Anatomy”—two simple words that launch the medical education of almost all future doctors in the United States. Bland words, words that are obvious. Of course. Medicine concerns the human body on the most basic level. But behind the lexis, woven into its etymology, is a darker side. Anatomy is more than just the structure of the human being; its origin is from the Greek: “*anatome*, from *anatemnein* to dissect, from *ana-* + *temnein* to cut” [1].

To cut—a verb that has so many meanings and relies on many contexts. We all know what “to cut” is...it is to wound, to pull apart, to injure. This is what all medical students *know*. The sanctity and completeness of the body will be repeatedly breached by needles, tests, blood draws, operations, and exams. We will wound again and again. But we are blessed, because the first wounding is blunted, as the first patient is no longer among the living.

The cadaver is a deferred shock. One day we are meeting new classmates, trying on our white coats and stethoscopes, and playing dress-up in front of loved ones who proudly photograph us at our white coat ceremonies. Though none of us is a child, at least some of us feel childlike again, both giddy and naive. And then suddenly...“Human Anatomy.” Although as students we don’t know in all certainty why it is that we start dissection within the first week, we speculate: it is done so that we don’t have time to worry about it, to ponder what it will be like. We just *do* it. I once saw a sticker plastered to the side of a pharmacy counter in Tanzania; it was slightly frayed and had a stylized figure jumping off a cliff. The text read: “Jump First. Get the Courage After.” That’s what anatomy is...you get it *done*, and after you’re done, you realize you can do it. In a way, this experience prefigures and gives us insight into what we will soon learn about some aspects of cognitive behavioral therapy: confront your fear, emerge on the other side, and only *then* realize you can live through and with it.

I was not in favor of naming the cadaver, a practice that some dissection groups commonly adopt. I went to see the body before we began, and it was terrifying, lying in its black body bag. It was something dead that should be put away, below the ground or out at sea or in the air, not on the top floor of an educational building lying rigid in its bag in a steel humidifier coffin. There was a party that night, and I talked to a fellow student I had never met. I cried a little, probably at the disconnect between a celebration of the beginning of med school, full of young and middle-aged men and women dancing and chatting excitedly before the start of class, and the image of that

remnant of life. Not naming it seemed prudent, appropriate, distancing. There was a line between life and death.

But weeks later, our group, four women, had somehow named her Gertie. We didn't know her real name, but we knew she was elderly—her skin was weathered. I think we all pictured our own grandmothers. We are of different ethnic backgrounds, but somehow Gertie looked like all of us. I'm not sure how it happened, but we were protective of her. Dead object had been born again as something in-between, something that could instruct and give to the living. Although none of us ever consciously discussed it, I believe that through dissection we came to terms with the four major principles of medical ethics.

We are taught the elements of the Belmont Report (nonmaleficence, respect for autonomy, beneficence, and justice) with respect to living persons. We examined a sample clinical trial proposal and analyzed it to see if it accounted for all of the principles adequately. The process seemed rather sterile: follow the four principles and apply them to clinical and laboratory research, experiments, and trials. Read, follow, read, follow. The report and the qualities detailed within it are guidelines to engender proper behavior and to (re)create the principles themselves through adherence to them. But with Gertie, the principles were *embodied* and became material.

In anatomy, we did harm to the body but no one was hurt. Whether or not one believes she had a soul—and I do—it had departed. Gertie's will, her intent to give her body—her autonomy—were preserved. Of course, it is unknown whether her family and close friends approved of her decision, and whether we, through dissection, offended or harmed them psychologically in some way—an externality never intended or wished for. But we knew that Gertie was never alone. She was always a node in a network, and we imagined her family and hoped they approved.

In our haste to complete assignments, we occasionally lost ourselves in conversation and Gertie again became just an object, something we were all working on while thinking of something else. But we constantly returned to beneficence. She was covered and kept safe in her sleeping bag. We made sure to do the best we could at finding all the structures we needed to know. Strangely, we always said “Hi, Gertie,” and “Bye, Gertie,” and even “Goodnight, Gertie!” Of course we knew that there was no need to talk to such a being, but she came to exist in a liminal ground in which destruction was done, but life was acknowledged.

But we hit a snag with regard to justice, for there is no fairness of distribution of benefit (or burden) in the gift of dissection. Gertie herself will never receive the benefit of what we learned. And this presents an ethical problem: what do we do when benefit is unidirectional and *cannot* be directly returned? Anthropologist Marcel Mauss's treatise *The Gift*, published in 1954 and mainly concerning the gifting activities of the peoples of the Melanesian Islands, provides insight. Mauss noted that two different types of objects (necklaces and armbands) always circulated

in opposite directions as gifts, and that these objects are seen as extremely important; “Mere contact with them passes on their virtues” [2]. Just so with Gertie. Instead of being a taboo, she became a friend, who had unique things to teach.

Mauss observed that a gift must always be accepted, always returned, and always reciprocated. It serves as a tie between two people or groups of people, and binds them together. The receiver of a gift both *cherishes* and *abhors* the present, for it represents the fact that the receiver is now in debt to the giver. This *debt*, an ethical and monetary term, *necessitates* that one pass on the gift in order to be free of it and to honorably repay the debt. Gertie represents both a gift given freely and a gift that is never without strings. We must act to pass on our knowledge or use it to benefit others. Why Gertie donated her body we will never know. In her gift she willingly became an object, and objects mediate, enact, and pave the way for *social* activities, for the doctoring we must now do.

And so I return to that directive of Human Anatomy, “to cut.” Beyond wounding, perhaps deeper, to cut can be to create, as we do when we are children, cutting construction paper into shapes and gluing them together into less perfect, but more meaningful patchwork wholes. We each carry with us images of the structures of the human body that we learned *from Gertie*. Every future patient, every diagram in a book, will in some way always refer to her. She has become a mother, a progenitor, and a gift that extends ever outward.

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OP-ED

Follow-Up after a Health Fair

Carolyn T. Bramante, MPH, and John Song, MD, MPH, MAT

Health fairs are paragons of goodwill: generally free, they are usually provided by well-intentioned individuals and organizations with the goal of improving the health of a community, often one that is underserved. For example, a group of health professions students screen for high blood pressure at a homeless shelter, intending to improve the health and lives of an underserved and disenfranchised group. This health fair is conducted by volunteers, free to participants, and held in the common room of the shelter after clients have checked in for the night; they are free to participate or ignore the students.

On the surface, health fairs like this one appear to be ideal public health interventions, all benefit and little or no harm. As such, however, they warrant a certain degree of scrutiny to ensure they are ethical—that is, that the anticipated benefits outweigh any anticipated harms. Had the students who conducted the fair intended to improve the health of the shelter's clients—that is, had they intended the event to be a public health intervention—they should have addressed the ethical consequences of the fair before holding it.

This homeless shelter scenario raises the question of whether in fact these fairs ought to be viewed as public health programs or interventions rather than as student training or recruitment activities, community relations events, local business promotions, or any number of activities with a range of other motivations and objectives. There are several compelling arguments for viewing them as public health interventions. First, the students in question clearly intended to use their skills to improve the health of the homeless participants in some manner. This is true of most fairs; they are directed toward some community with the intention of improving its health through interventions such as education and screening.

Another reason to view fairs as public health programs is that they often fill that need for many groups of people; the health fair at the shelter, for example, may be the only contact with health care professionals for some of the people who sleep there and perhaps even the first time they have had their blood pressure measured. Perhaps the most important reason for treating health fairs as public health interventions is that those who attend them view them as such. Some of the participants in the shelter may drop by because they are curious or bored or to pass time, but many attend because they believe it will provide something of value to their health.

If the students' event at the shelter is a public health intervention, intended to improve the health of the residents, then standards such as those Nancy Kass proposes in "An Ethics Framework for Public Health" ought to guide its development [1]. And, if these students are well-intentioned and very much desire to improve the health of their target population, they might consider providing services that will increase the impact of the health fair.

One such service is follow-up after the event has concluded. Kass asserts, moreover, that ethical scrutiny of a public health intervention ought to be proportional—the greater the possible benefits and burdens of the intervention, the greater the scrutiny warranted [1]. Thus, adding follow-up to this health fair to improve effectiveness of the event also necessitates greater attention to the ethical concerns raised by the additional services.

We will examine what these concerns might be and how to best balance the benefits and potential harms that providing follow-up at a community health fair might include.

Potential Benefits and Harms of Follow-up to Health Fairs

One potential benefit of follow-up from a health fair is simply the act of reminding a participant of what he or she saw and learned at the fair. Behavior change is difficult and not likely to be successful with a one-time exposure to the recommendations at a health fair [2, 3]. A recent prospective study analyzed brief, personalized follow-up counseling for 15 months after a health fair [4]. The counseling involved four calls over 3 months to discuss and set health goals, check progress and provide assistance, and evaluate progress. These short follow-up calls reduced the percentage of participants who were obese or overweight and improved self-reported health status, dietary choices, and exercise habits [4]. The study also noted that these improvements occurred after the initial follow-up phone calls, suggesting that the one-time health fair had not been effective in producing the desired changes.

Beyond reminding participants of healthy behaviors introduced at the fair, follow-up gives them individualized attention that is particularly important if the participant does not have access to regular health care and preventive health resources or a trusted health care provider. Event participants can check a box or sign up if they are interested in receiving follow-up, which is what was done in this study, so that follow-up is a voluntary option and not an undesired intrusion.

A third benefit of follow-up is connecting fair participants to resources and information. If a participant needed a health care resource about which the health fair did not have information, someone from the fair could get back in touch with that participant to give him or her the details. This happens often at screenings at homeless shelters in Minneapolis, such as the one mentioned earlier.

More than one study has found that follow-up after health fairs improved disease outcomes by providing referrals to appropriate care. Lucky et al. found that a one-

time follow-up phone call to participants with high blood pressure (HBP) increased the percentage that made appointments with their primary care physicians (PCPs) [5]. Of those who saw their primary physicians, 30 percent required BP medication or changes to their current BP medication, suggesting that even participants who are already seeing a PCP benefited from the screening and prompting [5]. Another study found that health fairs were integral in referring participants with elevated BP to primary physicians [6]. These participants who saw a PCP after the health fair averaged a fifteen-point decrease in their blood pressure.

Possible drawbacks of follow-up after health fairs include the time and money spent on a small percentage of fair participants who indicate they want further contact, as these resources could be used for screening a large number at another fair. The studies cited above require far more resources than a 1-day health fair. For example, the follow-up in the study by Dong-Chul Seo involved four calls for individualized counseling from a public health nurse to each participant over a 15-month period [4]. This is a significant commitment of time and resources. Similarly, in the study by Lucky et al., all participants with high blood pressure readings received a follow-up call, with interpreters as needed, to prompt them to see their PCP [5].

As the level of health-fair services increases, so does concern that participants view the health fair as a substitute for regular health care. Participants might feel that having their blood pressure taken at a health fair means they do not have to continue visits to their PCPs. This concern might be heightened if the health fair involved follow-up that imparted a false sense of fully individualized care and comprehensive care.

Most important, follow-up adds another level of care and thus of participant risk, including many of the risks that come with any kind of health care and range from issues such as inaccurate results and measurements to the loss of privacy or confidentiality. (Where, for example, does a homeless person receive confidential health information?) Introducing these risks carries with it a greater need for the protection of the participant's autonomy and rights. This protection is best provided through informed consent, which, we believe, ought to be a part of a health fair if follow-up is provided. Benefits and risks should be discussed as in any health care encounter, and consent obtained.

Going through the informed consent process during a health fair seems particularly cumbersome, however, and somewhat impractical, given the number of attendees at many of these events. Informed consent also introduces volunteer training requirements, literacy and decisional capacity issues, and myriad resource issues.

It seems, then, that one of the central assertions of Kass's thesis—that of proportionality—is appropriate in approaching health fairs. Adding follow-up adds great benefit to the effectiveness of the fair, but raises corresponding concerns that must be addressed in evaluating the full program. The most important concern raised

is that providing this additional service carries patient risks and thus requires a consent procedure.

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Suggested Readings and Resources

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Valarie Blake, JD, MA, is a senior research associate for the American Medical Association Council on Ethical and Judicial Affairs in Chicago. Ms. Blake completed the Cleveland Fellowship in Advanced Bioethics, received her law degree with a certificate in health law and concentrations in bioethics and global health from the University of Pittsburgh School of Law, and obtained a master's degree in bioethics from Case Western Reserve University. Her research focuses on ethical and legal issues in assisted reproductive technology and reproductive tissue transplants, as well as regulatory issues in research ethics.

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