



# A patient-centered view of the clinician-patient relationship

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## INTRODUCTION

The relationship between doctors and patients is becoming more troubled. As smaller and smaller players in ever growing systems, those who offer care and those who seek it too often feel distant from one another. Doctors are told repeatedly how arrogant we appear, even as we ponder what is happening to the human side of care that attracted so many of us to medicine. Our patients send a clear message as more and more question our motives and the quality of our care.

How can we draw closer to those we serve? Three complementary strategies that focus upon the needs and concerns of patients as they define them could help sustain and enrich the clinician-patient relationship:

- Clinicians can incorporate into their practices an organized and systematic consideration of each patient as a unique individual. A "Patient's Review" that specifically addresses the preferences, values, and needs of each patient can serve as a complement to the organ-specific review of systems we learn in medical school [1,2].
- Clinicians can move beyond their individual patients and use survey instruments and other tools that invite patients to report collectively about their clinical experiences. Feedback of this sort can provide valid and reliable information about important aspects of doctors' individual practices and can be compared with patients' experiences regionally and nationally [3,4].
- Clinicians and patients can share information and join in shaping treatment plans. Facilitated by rapidly spreading electronic health records and secure patient portals that increasingly accompany them, getting on the "same page" is rapidly becoming more feasible.

Patients do **not** focus upon prettier waiting rooms, better hospital food, smiling office staff, or problems with parking. Rather, they are concerned about issues of clinical significance that have little to do with what we think of as the "image" of the clinician or the "atmosphere" of the office or clinic. They want to be able to trust the competence and efficiency of their care givers. They want to be able to negotiate the health care system effectively and to be treated with dignity and respect. They want relief from pain and discomfort, and they worry about functional disabilities. They want to understand how their sickness or treatment will affect their lives, and they fear that their doctors are not telling them everything they know. They worry about caring for themselves away from the clinical setting. They worry about the effect their illness will have upon their family, friends, and finances. And they worry about the future.

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## **PATIENT CONCERNS**

We have defined seven broad dimensions of care of most concern to patients:

- Respect for patients' values, preferences, and expressed needs
- Coordination of care and integration of services within the clinical setting
- Communication between patient and providers: dissemination of accurate, timely, and appropriate information, and education about the long-term implications of disease and illness
- Enhancing physical comfort
- Emotional support and alleviation of fears and anxiety
- Involvement of family and friends
- Transition and continuity from one locus of care to another

**Respect for patients' values, preferences, and expressed needs** — Understanding and respecting patients' values, preferences, and expressed needs is central to first-class practice [5]. It enriches the patient-clinician interaction.

Although disease processes may be described in physiological terms, illness and the experience of illness can only be described as a social and cultural phenomenon. Culture, in the broad sense of the word that includes not only ethnicity but also class, gender, and other social attributes, affects how patients understand their illness, how they respond to and communicate about it, and how their illness affects their lives. Even when patient and provider come from similar social backgrounds, the disparity in their respective understanding of an illness can be enormous; it is all the more so when the social or cultural distance between them is larger. The development of appropriate and effective therapeutic strategies entails a negotiated understanding between the culture of biomedicine, within which health care providers work, and the patient's cultural experience of illness.

Patients vary in their willingness to participate in the culture of biomedicine or take part in their own care. Sickness often makes people more passive than they would otherwise be, content simply to let others take care of them and make decisions for them; they may quite willingly submit to the ministrations of health care professionals. On the other hand, the institutional routines and the technologies that the biomedical world has created often require patients to be passive and submissive, making their attempts at assertiveness or control appear disruptive. But patients who are able to take a more active part in their care may have a better recovery.

Whether or not they want to know every statistic related to their disease or take part in clinical decisions, almost every patient wants honest, accurate information about what clinicians think is wrong with them, what they plan to do about it, and what outcomes to expect. And yet health care providers routinely misjudge how much their patients want to know or do. Providers need to reexamine routine practices and institutional structures that foster a needless, perhaps even harmful, dependency in patients.

Providers may be reluctant to inform patients fully about treatment options, side effects, or outcomes, or to encourage them to take part in decisions, for fear they will make a decision that is not in their best interest. However, informed, rational patients may have a very different view of their "best interest" than the professionals who care for them. They may have a very different idea as to what constitutes an acceptable risk, a tolerable side effect, or an unavoidable disability. Shared decision-making approaches can help clinician and patient, together, clarify options, outcomes, uncertainties, and values [6,7].

**Coordination of care and integration of services within the clinical setting** — Patients and their families are eye-witnesses to the processes of health care delivery. They sense that they are in good, competent hands if the care they receive seems effectively coordinated, integrated into a coherent system of care, and cognizant of their individual needs and circumstances. On the other hand, care that appears uncoordinated or disintegrated, no matter how "good" it might be by some other external measure of quality, does not instill feelings of confidence or trust. Providers face three distinct coordinative tasks in the delivery of care [8]:

- Coordinating access to care and the delivery of care at the "front lines"
- Coordinating clinical care across specialty and professional lines
- Coordinating clinical support and ancillary services.

Sick people often understand very little about the inner workings of the health care system, or about divisions of labor, job definitions, or reporting structures. Sickness may make it hard for them to search out what they need, even though they may need help with even the most mundane aspects of daily living. And yet, health care workers' priorities may bear little resemblance to patients' subjective

needs. Wherever we practice, are we sure that patients have ready access to effective help with their subjective needs and problems, and that staff who come into regular contact with patients have the knowledge, authority, and explicit responsibility to solve those problems and meet those needs [9]?

Coordination of clinical care is complicated by the multiplicity of players involved and the diffuse lines of authority among them. To the patient, it often appears that no one is in charge, and in a literal sense, perhaps no one is. Patients may be left to sort out complicated information and sometimes conflicting messages on their own. Members of the clinical team need to clarify the lines of authority and responsibility, among themselves as well as to the patient. Doctors bear ultimate responsibility for clinical care and must play the central, coordinating role, although members of the team who have closer or more frequent contact with the patient may be appropriate conduits of information. Involving doctors in efforts to improve the clinical processes of care may be more effective than gauging their performance against external norms or standards.

Diagnostic tests and therapeutic procedures are often bewildering to the patients who undergo them, because such services are all too often designed primarily to support clinical decision makers, and only indirectly to serve patients. In the process, patients' more immediate needs and perceptions can be ignored. They often have no idea what to expect. Such services need to be reexamined with patients' needs in mind. Feedback from patients can also be useful in revealing operational problems that might otherwise go unnoticed. When delays, discomfort, and other causes of distress cannot be eliminated or avoided, letting patients know clearly what to expect can ameliorate their negative effects.

**Communication between patient and providers** — In health care no less than in other aspects of life, we live in an era when technology can give us almost immediate access to overwhelming amounts of information. Yet communication entails more than access to information. It encompasses the transmission of information, thought, and feeling, such that it is satisfactorily received and understood in context [10].

Our explorations of the patient's perspective on communication suggest that patients generally seek more information than they get, although individual needs vary significantly with age, gender, and other socioeconomic factors. Informational needs also change over the course of an illness and as a function of the patient's perceived health status. Patients need time to hear, assimilate, and process the information they are given. They receive information from many different sources, compare it, and learn by trial and error whom they can trust for information that is relevant to their circumstances.

However gratifying it is for doctors and other clinicians to help heal not only the disease, but the fear and apprehension that accompanies and amplifies illness, clinicians often perceive that they lack the time to deliver such care. Often such care is devalued by society, by the institutions in which we work,

and even by patients themselves. Both clinicians and patients need to learn efficient and effective communication skills in order to overcome the barrier of the dominant clinician/passive patient default mode of interaction.

In one study, clinicians who participated in an intensive educational program in "mindfulness," communication, and self-awareness demonstrated enhancement in personal characteristics associated with patient-centered care [11]. The mindfulness communication program included didactic material on thought awareness, perceptual biases, managing conflict, preventing burnout, setting boundaries, dealing with suffering, and end-of-life care. It also included meditation, narrative exercises describing personal experiences in medical practice, and appreciative inquiry exercises exploring ways of handling difficult clinical situations.

**Shared decision-making** — Most patients want to consider their individual goals and values when it comes to making decisions about their care. Studies also suggest that patient-provider communication about nontechnical aspects of care improves patient satisfaction and positively affects health outcomes. Too often, however, the traditional model of the authoritative doctor and the passive, receptive patient who complies with medical recommendations dominates the encounter.

Shared decision-making incorporates the patient's values and preferences into medical decisions and puts the patient at the center of care [12-14]. When technical evidence about the relative merits of treatment options is equivocal, the patient's perceptions about the nontechnical aspects of care are particularly relevant to the medical decision.

Analysis of data obtained between 2002 and 2014 from a yearly cross-sectional survey of >20,000 United States adults suggests that patients' involvement in decision-making is improving. Patients reported improvement in all core components of shared decision making, including joint involvement in decisions, sharing information, building consensus, and agreeing on treatment [15].

**Alleviating discomfort** — High among patients' expectations is that health care providers alleviate their discomfort. Assessing pain and pain management must be an ongoing part of patient care. Pain as a sign or symptom can be critical to establishing a diagnosis or monitoring a patient's progress. Individual differences in thresholds, responses, and communication about pain make objective assessment difficult and complicate the task of pain management. Asking them to rate their pain (for example, on a scale of 0 to 10, or with the help of a visual analog device) can help them communicate about it. Assessment and management of pain are described separately. (See ["Prescription of opioids for acute pain in opioid naïve patients".](#))

Although most people can take care of themselves under normal circumstances, illness, medical treatment, and hospital confinement create their own physical dependencies and their own discomforts. Patients may need help maintaining personal hygiene, eating, moving, or walking. Until

these basic human needs are met, people find it hard to function or interact at higher levels. And yet clinicians often give relatively low priority to these basic physical needs in favor of functions that are more technically sophisticated or intellectually challenging. In this regard, hearing patients report firsthand about their experiences can be compelling and instructive [16].

The physical environment in clinical settings can also affect patients' moods and thought patterns in ways that may not be obvious. Perceptions are complicated by the unfamiliarity of clinical environments and the stresses and uncertainties of illness. Modern medicine has created clinical settings designed to accommodate technology, optimize efficiency, and maintain an aseptic environment, often without regard to the patient's perspective. At worst, patients encounter clean lines, featureless walls, and hard and shiny surfaces, all intended to be easily maintained. Patients and staff who use and work in an area can join in finding solutions to problems of environmental design [17].

**Emotional support and alleviation of fears and anxiety** — Illness imposes an emotional and psychological burden on patients and their families that is often as heavy as the physical one. When these needs are acknowledged and addressed, patients suffer less and get better faster. What they need are genuine expressions of concern and caring from those they love and from the doctors, nurses, and others caring for them; the chance to express their own beliefs, feelings, and fears, however extreme or irrational they may seem; information that is accurate, appropriate, and useful; and a sense that they are a continuing and vital part of a social community.

Developing appropriate strategies to address these needs requires sensitivity to variations in individual styles of coping with stress, to the patient's underlying emotional state, and to changing needs over the course of an illness. Most people understand what they want, need, and can handle, if they are asked, but the emotional crisis of illness can seriously compromise their usual resiliency.

Strategies that clinicians can use to help address the emotional and psychological components of illness include eliminating or softening the stressors in the hospital or office environment, training staff in techniques of crisis intervention, developing informational materials appropriate to patients' varying needs and styles of coping, offering programs of relaxation and stress reduction to identified groups of patients, and providing patients with ongoing support outside the hospital through referrals to support groups and self-help groups [9].

Humor, a hug, and open interchange can mean a lot when prospects seem darkest. We should be much less afraid of letting down the professional guard that all too often does little more than distance the clinician from the patient.

**Involvement of family and friends** — Family members, close friends, and "significant others" can have far greater impact upon patients' experience of illness and on their long-term health and

happiness than can any health care professional. Friends and relatives take care of the patient. They offer love and encouragement. They may cook meals, look after children, handle the shopping, pay bills, or take on any of the myriad responsibilities of daily life that a sick person cannot fulfill. They often convince patients to seek medical help and then steer them through the receptionists, triage nurses, doctors, billing and insurance offices, and other hurdles of the health care system. They are the eyes and ears that watch over patients and report what they see to doctors and nurses. They remind patients to take medications and follow treatment regimens. And through their own behavior, they profoundly influence habits that affect the patient's well-being over the longer run.

Patients who are too incapacitated to look out for themselves rely heavily upon friends and family members. Family members are acutely aware of their obligations as the patient's advocate, and at times this function can put them in an adversarial role with health care providers. During the crisis of a serious illness, families place the highest priority upon timely, accurate, and honest information about the patient's condition, daily progress, changes in clinical status, and prognosis. What they complain about most often is lack of information or problems communicating with medical professionals. For their part, clinicians sometimes dread encounters with family members for fear that their demands will be overwhelming.

Serious illness throws a monkey wrench into any family. It makes it hard to carry on as usual, much less provide the extraordinary help and support a sick person requires. Adding to the physical demands of care is the emotional strain that comes from not knowing if, when, and how the patient will recover. Family members may worry that they will be unequal to the task of caring for the sick person, that they will do the wrong thing, or that they will not have access to the resources they need.

Living with patients who have long-term disabilities also places distinctive demands upon family members, demands that have intensified as patients are discharged "quicker and sicker" from hospitals and live for years with chronic illness. Families are often unprepared for this responsibility. Caring for sick relatives may require learning many new skills. It also requires knowing about available services and resources, how to coordinate these services, and how to navigate the health care system.

Clinicians accustomed to thinking of family in terms of "next of kin" must expand the concept to include significant relationships that function as family relationships. Whatever problems family members report in their relations with hospitals and health professionals, the problem is even more pronounced for "significant others" who are not legally or biologically related [18].

**Transition and continuity from one locus of care to another** — No single health care provider is responsible for all aspects of patient care. The hospital's responsibility ends too often at the moment of discharge. The primary care clinician may be unprepared to coordinate the patient's complex home

care and psychosocial needs. Continuity of care is frequently lacking when the patient makes the transition from the hospital to the community or alternative care facility [19]. Patients complain that services are fragmented. They and their families are frequently unaware of available resources or are unable to obtain services because they have difficulty negotiating a complex system. Coordination is essential to ensure that the patient receives the needed information and services with a minimum of aggravation.

Leaving the clinician's office is just as critical a moment but one that has received far less attention. Most encounters are short, stressful, and even traumatic, ingredients whose combination results in the patient remembering little advice or information. It is probably the worst possible setting to educate patients, an observation that may fly in the face of time-honored practice.

Clinicians are learning to provide information and teach before and after the actual office visit. Written materials, tape recordings of the interview, telephone calls after the visit, copies of the office notes, and dictating in front of the patient are all techniques that can help at this critical juncture in the patient-clinician interaction [20].

Health information technology also holds promise to improve the coordination and continuity of care as well as enhance patient education and patient-provider communication. Offering patients access to electronic medical records and e-mail correspondence with clinicians enhances communication and improves the quality of care without raising medico-legal issues that some clinicians fear [21,22]. Studies further suggest that patients welcome access to customized health information and advice via interactive websites and are less concerned about privacy than clinicians often assume [23].

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## **FOCUSING ON THE INDIVIDUAL**

How can we incorporate these elements of care and each patient's unique perspective into our practices? One technique is to address them through a format similar to the traditional review of systems. Incorporating a "Patient's Review" into interactions with patients can encourage the primary care clinician to address the non-technical aspects of care in a systematic way (table 1) [2]. As an example, when discussing physical comfort, the patient and clinician review the different components of that dimension of care, just as the clinician has for years asked about certain symptoms when evaluating the cardiovascular system. However, in contrast to the traditional review of systems that is orchestrated and conducted by the clinician, such review often results in a dialogue that promotes sharing of responsibility, an interchange that has been shown to impact favorably upon clinical outcome.

Much as decision analysis teaches doctors to manage biomedical problems with more intellectual rigor, a "Patient's Review" helps tailor care to the individual patient and forces us to make explicit

what often has been implicit [2]. Patients place their own stamp on the Review. Yes, we have always known they have their differences. We thought we could judge what they felt and wanted, but issues that surface during systematic review never cease to amaze us (and them). How much do they really want to know? What do they want to decide? Would they rather leave decisions to me? What are their worries and fears? How well are they functioning? We can find out only if we ask.

Such explicit review encourages both patient and clinician to confront and express individual preferences and values while offering patients a structured opportunity to participate actively in their care. It forces us to confront our own attitudes and the range of options we offer or control. When patients choose acupuncture, massage, guided imagery, folk healing, or homeopathy, how do we respond if our experiences or values conflict? Patients who are encouraged and invited to do so can tell us more about "nontraditional" therapies they may embrace. In turn, we can care for them in a less judgmental way as we learn how they understand and approach health and disease.

What will it take for us adopt a more patient-centered approach? Debate over the value of doctors' time highlights an immediate obstacle: it takes time. We do not suggest launching into a detailed Review [2] during emergent episodic care; after all, we omit the traditional review of systems during such encounters. However, the additional minutes spent on such review when establishing or strengthening a relationship with a patient pay off in the longer run. It need not be completed during a single encounter. We can consciously weave bits and pieces of the Review into all our interactions.

As doctors and patients increasingly use this approach to care, the biggest obstacle the Review faces may erode: the hesitancy of both patient and clinician to be frank [2]. Is there a common language we can learn to use in our discussions? At the moment, we are often divided by the clinical language of the practitioner and the patient's language of subjective feeling. Today we are witnessing many exciting efforts to bridge the gap. A common, systematic framework can improve the prospects for open communication and shared understanding. As one of our patients exclaimed: "I don't think it should be totally up to the patient to ask questions. The patient doesn't know enough to ask the questions. I think it's up to the caregiver, whoever it is, to lead the patient, draw it out of the patient: 'What are your concerns? What would you like to know?'"

**Soliciting patients' reports** — Just as we can use such in our approach to individual patients, so too can we gather from patients aggregate feedback about our practices, using instruments designed to solicit their explicit reports. By asking patients selected at random from our practices to report about the component parts of the dimensions outlined in the table ([table 1](#)), we can generate data that will help us improve the quality of our care.

Early in this century, Ernest Avery Codman made the radical suggestion that we pursue our patients to learn from them the outcomes of their treatment. Avedis Donabedian took a next step by

suggesting that patients (and, we would add, their friends and families) are in a unique position to assess important aspects of the quality of care we deliver. Consider, for example, the reflections of one patient on the time he spent in the hospital: "I didn't have a whole lot to occupy my mind sitting in the hospital. I really didn't. So I sort of watched, and I watched real hard. And I observed phenomenal differences across the board, just in the way they treat individuals" [2].

Our patients sit looking around our waiting rooms. They lie for hours watching how the wards work. They and their families are eyewitness to hundreds of human interactions, to time-honored "standard operating procedures." Yet few doctors have sought systematic feedback about their practices. Asking patients to join in ongoing review of the components of care outlined above could teach us how well we address their needs and how we can improve their care.

There are rapidly increasing numbers of survey instruments to provide doctors with feedback about their practices from patients. Increasingly, evidence suggests that survey responses can be both valid and reliable, whether elicited through face-to-face or telephone interviews, or through paper-and-pencil or computerized questionnaires. Focus groups of patients, which can be videotaped, edited, and shown to clinicians in a variety of settings, can also provide compelling, first-hand testimony. Using patients' reports about their experience with discrete events in their health care moves us beyond anecdote and certainly beyond the documentation of clinical encounters typically found in the medical record. Moreover, discrete reports can be more helpful than global measures of satisfaction because they tell us in a concrete way what patients did and did not experience. Annual surveys of 200 patients drawn at random from a doctor's practice can send a clear message about the doctor's determination to learn from their experiences and perceptions. Their reports serve as useful screening tests, showing doctors the areas of care they need to examine and improve.

**Looking forward** — As practices change to involve patients more actively and patient feedback becomes integrated into ongoing measures of quality, patients themselves, along with their families and friends, could play a creative part in crafting solutions to problems. They are a varied lot; they bring broad experience and expertise. They also hold an extraordinary personal stake, and many would be eager not only to share their experiences but also to join health personnel in addressing and solving problems. We could convene focus groups of patients to help examine varied aspects of our practice, ranging from the flow through our offices to the way we communicate. They could work with us, helping us make choices and set priorities. What a creative activity this would be! What better way to draw closer to our patients!

Incorporating both patients' perceptions and suggestions for change can address clinically significant aspects of the patient experience, foster the involvement of patients in their care, and help assess and improve the quality of the care we deliver. The electronic medical record and secure patient portals increasingly provide a powerful opportunity to actively promote patient involvement [24,25].

Combining a systematic consideration of patients' individual characteristics in clinical practice with the routine solicitation of their aggregate perceptions can engender a powerful synergism. It can help doctors draw closer to their patients and restore and strengthen public trust. It can both improve the quality of our care and add to the joy of being a doctor.

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## SUMMARY AND RECOMMENDATIONS

- We have identified seven dimensions of care that are a concern to patients: respect for patient values, care coordination, communication with providers, enhancing physical comfort, emotional support, involving family and friends, and managing care transitions. (See ['Patient concerns'](#) above.)
- We propose that a "Patient's Review," analogous to a review of systems, may encourage the primary care clinician systematically to address the non-technical aspects of care ([table 1](#)) [2]. (See ['Focusing on the individual'](#) above.)
- We believe that soliciting feedback from patients, using one of a number of survey instruments, can provide valuable information. Incorporating both patients' perceptions and suggestions for change can address clinically significant aspects of the patient experience, foster the active involvement of patients in their care, and help assess and improve the quality of the care we deliver. (See ['Soliciting patients' reports'](#) above.)

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