

Enriching the Doctor-Patient Relationship by Inviting the Patient's Perspective

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■ Doctors and patients alike are saddened and angered by the distance that increasingly interferes with their interactions. Two complementary strategies may enhance the human quality of clinical care and improve outcomes. First, the doctor and patient can undertake a systematic "patient's review" that addresses seven dimensions of care: 1) respect for patient's values, preferences, and expressed needs; 2) communication and education; 3) coordination and integration of care; 4) physical comfort; 5) emotional support and alleviation of fears and anxieties; 6) involvement of family and friends; and 7) continuity and transition. Incorporating the "review" into the clinical encounter encourages both patient and doctor to confront individual preferences and values and offers patients an explicit framework for participating actively in their care. Second, using survey instruments designed to solicit focused reports from patients that address each dimension of care, doctors can gather aggregate feedback about their practices. Such reports move beyond anecdote and can serve as screening tests that uncover areas in doctors' practices that merit improvement. In addition, patients can join doctors in developing solutions to problems uncovered by patients' reports.

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A doctor's job would be so much more interesting and satisfying if he would occasionally let himself plunge into the patient, if he could lose his own fear of falling.—Anatole Broyard (1)

Doctors and patients find themselves drifting apart. As smaller and smaller players in ever growing systems, both we who offer care and those who seek it too often keep a distance from one another. We 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 too are sending 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? For the past 4 years, I have been involved in a project that seeks to evaluate and improve health services by focusing on the needs and concerns of patients as they themselves define them (2). In this article, I draw on that ongoing inquiry but write primarily from my experience as a practitioner and teacher. I am convinced that two complementary strategies could help sustain and enrich the doctor-patient relationship.

First, doctors can incorporate into their clinical en-

counters an organized and systematic consideration of each patient as a unique individual. Based on ideas suggested by Matthews and Feinstein (3) and Baron (4), 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 learned in medical school.

Second, doctors can move beyond their individual patients and use questionnaires that invite patients to report collectively about clinically important experiences, thereby providing valid and reliable feedback about aspects of their individual practices. Patient surveys designed to evaluate systematically how doctors are doing from the patient's perspective can help us both improve our practices and teach us about the clinical epidemiology of patients' experiences regionally and nationally.

Characterizing the Patient's Perspective

In 1988, my colleagues and I set out to learn more about what matters to patients, above and beyond the primarily biomedical aspects of their clinical management. Beginning with a review of the literature, we compiled a preliminary list of those features of care that patients could evaluate and that they judged to be most important. To ensure that the items identified were those most salient, we next convened eight focus groups of patients who had been recently discharged from medical and surgical services in hospitals, as well as groups of family members of patients, nurses, physicians, social workers, health administrators and policy specialists, and lay persons (2).

What did we learn? Patients do *not* focus on prettier waiting rooms, better hospital food, or problems with parking. Rather, they are concerned about issues of clinical significance that have nothing to do with what we think of as the doctor's "image" or the hospital's "atmosphere." They want to be able to trust the competence and efficiency of their caregivers. They want to be able to negotiate the health care system effectively and to be treated with dignity and respect. Patients want to understand how their sickness or treatment will affect their lives, and they often fear that their doctors are not telling them everything they know. Patients worry about and want to learn how to care for themselves away from the clinical setting. They want us to focus on their pain, physical discomfort, and functional disabilities. They want to discuss the effect their illness will have on their family, friends, and finances. And they worry about the future.

Our discussions with patients and clinicians suggest that most patients' concerns fall into seven dimensions of care. Table 1 details the component parts of these

Table 1. Elements of the Patient's Review

Dimension of Care	Focus of Patient's Review
Respect for patients' values, preferences, and expressed needs	What are the patient's short-term and long-term goals? What level of involvement does the patient want in decision making? What does he need, want, or expect from the health care system? What are his feelings about an advance directive?
Coordination and integration of care	Is care delivered by the range of providers effectively coordinated? Does the patient get consistent information from different clinicians?
Communication and education	Does the patient have the information he wants about his clinical status, diagnostic tests, and treatment options? Do the patient and his family know what they need to know to manage on their own to the extent that they are able to do so?
Physical comfort	Is pain alleviated as much as possible? Does the patient have the help he needs with bathing, eating, household chores, or other activities of daily living? Have remediable deficits in functional status been adequately addressed?
Emotional support and alleviation of fears and anxieties	Is the patient worried about his or her illness or its effect on the ability to care for one's self or one's dependents? What are the principal stresses in the patient's life? Is he or she worried about paying medical bills or about lost income due to illness? Does the patient have access to appropriate support networks to help with these worries?
Involvement of family and friends	Are family and friends appropriately included in planning and providing care? Do they have the support they need?
Continuity and transition	Do the patient and family understand medications to take, treatment regimens to follow, activities to pursue or avoid, and danger signals to look out for? Are there clear plans for continuing care and treatment?

dimensions. The following comments by patients I recently interviewed bring each dimension into focus. The studies cited after each comment point to their clinical import, both in terms of the process and outcome of care.

1. Respect for patients' values, preferences, and expressed needs (5-9)

I feel very strongly that the patient has to participate. I mean, I have learned this. This is not a theoretical thing. I have learned that I have to be as involved in my care as the doctors.

2. Communication and education (5, 10-15)

I ask for information when I don't have it immediately. I mean, if they are going to go poking inside my body, I want to know what they expect to find; and then if they find it, what they are going to do about it. I need information. That is my basic food.

3. Coordination and integration of care (16-18)

My experience so far has been that what I tell my doctor does not necessarily go anywhere else. One of the things that drives you crazy is every single person asking you the same questions over and over again.

4. Physical comfort (19-21)

After a while, I began to get nauseated and I didn't feel good and I just felt rotten and I was all upset. A very good friend of mine said, 'Perhaps it's the codeine.' Well, I hadn't been told—I wish I had—that codeine can upset your system. I didn't realize it. As soon as I just took Extra-Strength Tylenol, the pain was adequately controlled. Anyway, I didn't want the codeine, so I made it adequate.

5. Emotional support and alleviation of fears and anxieties (22-24)

If they had told me what I could do, that would have been helpful. I've felt so vulnerable that I think I've been a little timid to do things. There wasn't much I could do, but I wasn't told what I could do, and it might have been encouraging.

6. Involvement of family and friends (25-27)

I have a very strong group of friends. It's made a difference to me. They all tend to be rather inquisitive sorts, themselves. And if for some reason I space out, they will find the doctor and ask, themselves.

7. Continuity and transition (28-30)

It really just seems like, when it's time for you to go home, they more or less push you aside and say, 'Well, you're going home. We have other sick people.'

Focusing on the Individual

How can we incorporate these elements of each patient's unique perspective into our practices? We can discuss them using a format similar to the traditional review of systems (3). I find that incorporating the Patient's Review into my interactions with patients encourages me to address the nontechnical aspects of care in a systematic way (see Table 1). For example, when discussing physical comfort, the patient and doctor review the different components of that dimension of care, just as the doctor has for years asked about certain symptoms when evaluating the cardiovascular system. However, in contrast to the traditional review of systems, which is orchestrated and conducted by the doctor, the Patient's Review often results in a dialogue that promotes sharing of responsibility, an interchange that has been shown to affect clinical outcome favorably (14, 31-34).

Much as decision analysis teaches us to manage biomedical problems with greater intellectual rigor, the Patient's Review helps to tailor care to the individual patient and forces us to make explicit what often has been implicit. All kinds of patients place their own stamp on the Review. Yes, I have always known that patients have their differences. I thought I could judge what they felt and wanted, but the issues that surface during systematic review never cease to amaze me (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 the largest stresses in their lives,

their worries and fears? How well are they functioning? I can find out only if I ask (35-37).

The Review pushes me also to expand my horizons. It encourages both patient and doctor 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 "non-traditional" therapies they may embrace. In turn, we can care for them in a less judgmental way as we learn how they understand and approach their own health and disease.

What will it take for us to lose our "fear of falling" and adopt a more patient-centered approach? The current debate over the value of doctors' time highlights an immediate obstacle: It takes time. I do not suggest that we launch into a detailed Patient's Review during emergent, episodic care; after all, we omit the traditional review of systems during such encounters. However, the additional minutes spent on the Review when we are establishing or strengthening a relationship with a patient pay off in the longer run. It need not be completed during a single encounter. I consciously weave bits and pieces of the Review into my interactions. Similarly, the more extended dialogue I now remind myself to initiate before a patient's discharge from the hospital often seems to improve both the process and the subsequent outcome of care. Anecdote, however, will not suffice. Like other innovations in clinical practice, we shall need to document the effect of incorporating the Patient's Review.

When and how should doctors learn to use the Patient's Review? I believe we should incorporate it into the early years of the medical school curriculum, just as we now teach the traditional review of systems to our students. The Patient's Review could serve as a framework for teaching and learning how to address these highly personal and individualized dimensions of health care. It provides structure: Students learn how to ask questions, to engage patients in dialogue, to educate patients, and to establish a constructive doctor-patient relationship. Moreover, in our clinical teaching, just as we query students and residents routinely about physical signs and symptoms, we can ask them about their patients' values, preferences, knowledge, and support systems. We can also take the next step: We can ask patients themselves for feedback about students' performances (38, 39).

What about patients? Why not adapt the Patient's Review for their use and teach them early on to use it in their encounters with doctors? We are now beginning to model health-promoting behavior and social strategies in primary and secondary school. So, too, could we begin to teach young people to use the health care system more effectively by incorporating the framework of the Patient's Review into their thinking. They could learn to understand and articulate their own values and preferences and address them squarely in their interactions with health care professionals. Why not distribute

an adapted Patient's Review in doctors' offices and hospitals, much as many hospitals now circulate a "patient's bill of rights" (40)? Why not incorporate elements of it into the history forms many patients complete before seeing the doctor? This could both promote shared responsibility and add to the efficiency of its use.

As doctors and patients increasingly use this approach to care, the biggest obstacle the Review faces may erode: the hesitancy of both patient and doctor to be frank. 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 that gap (41-48). A common, systematic framework should vastly improve the prospects for open communication and shared understanding. As one of my patients stated it: "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 the Patient's Review in our approach to *individual* patients, so too can we gather from patients *aggregate* feedback about our practices, using survey instruments designed to solicit their explicit reports. By asking patients selected at random from our practices to answer questions about the component parts of the dimensions outlined in Table 1, we can generate data that will help us improve the quality of our care.

Ernest Avery Codman (49) made the radical suggestion early in this century that we pursue our patients to learn from them the outcomes of their treatment. Avedis Donabedian (50) took a next step by suggesting that patients (and, I would add, their friends and families) are in a unique position to assess important aspects of the quality of the 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."

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 the 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.

Four years ago, my colleagues and I developed and piloted a survey instrument soliciting such feedback from patients who had recently been discharged from hospital. Telephone interviews with almost 6500 patients who had been hospitalized in a probability sample

of 62 hospitals nationwide yielded striking insights into patients' experiences with care (2). Working with a task force of clinicians at the American College of Physicians, we are now developing a similar instrument 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 (51-53).

Using patients' reports about their experience with discrete events in their health care will move us beyond anecdote and certainly beyond the documentation of clinical encounters typically found in the medical record. Moreover, discrete reports are more helpful than global measures of patient satisfaction, because they tell us in a concrete way what patients did and did not experience (51-53). I might be distressed to learn that 25% of my patients are dissatisfied with the care I give them, for example, but a survey that tells me, "Twenty-five per cent of your patients report that they were not told what they could or could not do at home after leaving your office," helps me to take specific action. Annual surveys of 200 patients drawn at random from a doctor's practice will send a clear message about the doctor's determination to learn from their experiences and perceptions. Their reports will serve as useful screening tests, showing doctors the areas of care that they need to examine and improve.

Consider other potential benefits from gathering such systematic feedback. National and regional data documenting patients' experiences would enable us to make comparisons and generate new insights. Who are the clinicians whose patients report first-class care? They could become the exemplars from whom we all might learn. Which patients receive outstanding care, and which do not? For example, our hospital survey found that the chronically ill may be at particular risk for poor communication (2). Might we find in our practices that we give haphazard attention to the values and preferences of certain groups of patients?

Looking Forward

As practices change to involve patients more actively and patients' reports become 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 report on 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 to make choices and set priorities. What a creative activity this would be! What better way to draw closer to our patients!

Incorporating the Patient's Review into our practices and collecting both patients' perceptions and suggestions for change will address clinically significant as-

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

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References

1. Broyard A. Doctor, talk to me. *New York Times Magazine*. 26 Aug 1990;33.
2. Cleary PD, Edgman-Levitan S, Roberts MJ, Moloney TW, McMullen W, Walker JD, Delbanco TL. Patients evaluate about their hospital care: a national survey. *Health Aff*. 1991;10:254-67.
3. Matthews DA, Feinstein AR. A review of systems for the personal aspects of patient care. *Am J Med Sci*. 1988;295:159-71.
4. Baron RJ. An introduction to medical phenomenology: I can't hear you while I'm listening. *Ann Intern Med*. 1985;103:606-11.
5. Putnam SM, Stiles WB, Jacob MC, James SA. Patient exposition and physician explanation in initial medical interviews and outcomes of clinic visits. *Med Care*. 1985;23:74-83.
6. Ende J, Kazis L, Ash A, Moskowitz MA. Measuring patients' desire for autonomy: decision making and information-seeking preferences among medical patients. *J Gen Int Med*. 1989;4:23-30.
7. Strull WM, Lo B, Charles G. Do patients want to participate in medical decision making? *JAMA*. 1984;252:2990-4.
8. Brody DS. The patient's role in clinical decision-making. *Ann Intern Med*. 1980;93:718-22.
9. Linn LS, DiMatteo MR, Chang BL, Cope DW. Consumer values and subsequent satisfaction ratings of physician behavior. *Med Care*. 1984;22:804-12.
10. Brody DS, Miller SM, Lerman CE, Smith DG, Caputo GC. Patient perception of involvement in medical care: relationship to illness attitudes and outcomes. *J Gen Intern Med*. 1989;4:506-11.
11. Wartman SA, Morlock LL, Malitz FE, Palm EA. Patient understanding and satisfaction as predictors of compliance. *Med Care*. 1983; 21:886-91.
12. Hathaway D. Effect of preoperative instruction on postoperative outcomes: a meta-analysis. *Nurs Res*. 1986;35:269-75.
13. Carter WB, Inui TS, Kukull WA, Haigh VH. Outcome-based doctor-patient interaction analysis. II. Identifying effective provider and patient behavior. *Med Care*. 1982;20:550-66.
14. Greenfield S, Kaplan SH, Ware JE Jr, Yano EM, Frank HJ. Patients' participation in medical care: effects on blood sugar control and quality of life in diabetes. *J Gen Intern Med*. 1988;3:448-57.
15. Kaplan SH, Greenfield S, Ware JE Jr. Assessing the effects of physician-patient interaction on the outcomes of chronic disease. *Med Care*. 1989;27:S110-27.
16. Coser RL. Authority and decision making in a hospital: a comparative analysis. *Amer Socio Rev*. 1958;23:56-63.
17. Berwick DM, Godfrey AB, Roessner J. *Curing Health Care: New Strategies for Quality Improvement*. San Francisco: Jossey-Bass; 1990.
18. Palmer RH, Strain R, Rothrock J, Hsu LN. Evaluations of operational failures in clinical decision making. *Med Decis Making*. 1983; 3:299-310.
19. Check WA. Results are better when patients control their own analgesia. *JAMA* 1982;247:945-7.
20. Marks RM, Sachar EJ. Undertreatment of medical inpatients with narcotic analgesics. *Ann Intern Med*. 1973;78:173-81.

21. **Puntillo KA.** Pain experiences of intensive care unit patients. *Heart Lung.* 1990;19:526-33.
22. **Stewart MJ.** Social support: diverse theoretical perspectives. *Soc Sci Med.* 1989;28:1275-82.
23. **Scheier MF, Magovern GJ, Abbott RA, Matthews KA, Owens JF, Lefebvre RC, et al.** Dispositional optimism and recovery from coronary artery bypass surgery: the beneficial effects on physical and psychological well-being. *J Person Soc Psych.* 1989;57:1024-40.
24. **Kulik JA, Mahler HL.** Effects of preoperative roommate assignment on preoperative anxiety and recovery from coronary-bypass surgery. *Health Psych.* 1987;6:525-43.
25. **Doherty WJ, Schrott HG, Metcalf L, Iasiello-Vailas L.** Effect of spouse support and health beliefs on medication adherence. *J Fam Prac.* 1983;17:837-41.
26. **Evans RL, Matlock AL, Bishop DS, Stranahan S, Pederson C.** Family intervention after stroke: does counseling or education help? *Stroke.* 1988;19:1243-9.
27. **Grieco AJ, Garnett SA, Glassman KS, Valoon PL, McClure MA.** New York University Medical Center's Cooperative Care Unit: patient education and family participation during the hospitalization—the first ten years. *Patient Educ Couns.* 1990;15:3-15.
28. **Salz CC, McVey LJ, Becker PM, Feussner JR, Cohen HJ.** Impact of a geriatric consultation team on discharge placement and repeat hospitalization. *Gerontologist.* 1988;28:344-50.
29. **Smith DM, Weinberger M, Katz BP, Moore PS.** Postdischarge care and readmissions. *Med Care.* 1988;26:699-708.
30. **Weinberger M, Smith DM, Katz BP, Moore PS.** The cost-effectiveness of intensive postdischarge care. *Med Care.* 1988;26:1092-102.
31. **Greenfield S, Kaplan SH, Ware JE Jr.** Expanding patient involvement in care. Effects on patient outcomes. *Ann Intern Med.* 1985;102:520-8.
32. **Kaplan SH, Greenfield S, Ware JF Jr.** Assessing the effects of physician-patient interactions on the outcomes of chronic disease. *Med Care.* 1989;27:S110-27.
33. **Starfield B, Wray C, Hess K, Gross R, Birk PS, D'Lugoff BC.** The influence of patient-practitioner agreement on outcome of care. *Am J Public Health.* 1981;71:127-31.
34. **Kaplan SH, Greenfield S, Ware JE Jr.** Impact of the doctor-patient relationship on the outcomes of chronic disease. In: Stewart M, Boter D, eds. *Communicating with patients in medical practice.* Beverly Hills, California: Sage Publications; 1990:228-45.
35. **Bedell SE, Delbanco TL.** Choices about cardiopulmonary resuscitation in hospital. When do physicians talk with patients? *N Engl J Med.* 1984;310:1089-93.
36. **Shmerling RH, Bedell SE, Lilienfeld A, Delbanco TL.** Discussing cardiopulmonary resuscitation: A study of elderly outpatients. *J Gen Intern Med.* 1988;3:317-21.
37. **Calkins DR, Rubenstein LV, Cleary PD, Davies AR, Jette AM, Fink A, et al.** Failure of physicians to recognize functional disability in ambulatory patients. *Ann Intern Med.* 1991;114:451-4.
38. **Matthews DA, Sledge WH, Lieberman PB.** Evaluation of intern performance by medical inpatients. *Am J Med.* 1987;83:938-44.
39. **Brody DS.** Feedback from patients as a means of teaching the nontechnological aspects of medical care. *J Med Educ.* 1980;55:34-41.
40. **Department of Health, Education, and Welfare.** Medical Malpractice: Report of the Secretary's Commission on Medical Malpractice. Washington, DC: U.S. Government Printing Office; 1973:67-81. DHEW publication no. (05) 73-88.
41. **Arnold R, Forrow L, Barker LR.** Medical ethics and patient-physician communication. In: Lipkin M, Putnam SM, Lazare A, eds. *The Medical Interview.* New York: Springer-Verlag; [In press].
42. **Cassell EJ.** *Talking with Patients.* 2 volumes. Cambridge, Massachusetts: MIT Press; 1985.
43. **Lipkin M Jr, Quill TE, Napodano RJ.** The medical interview: a core curriculum for residents in internal medicine. *Ann Intern Med.* 1984;100:277-84.
44. **Stoeckle JD, ed.** *Encounters between patients and doctors: an anthology.* Cambridge, Massachusetts: MIT Press; 1987.
45. **Donnelly WJ.** Medical language as symptom: doctor talk in teaching hospitals. *Perspect Biol Med.* 1986;30:81-94.
46. **Smith RC, Hoppe RB.** The patient's story: integrating the patient- and physician-centered approaches to interviewing. *Ann Intern Med.* 1991;115:470-7.
47. **Kass LR.** Practicing ethics: where's the action? *Hastings Cent Rep.* 1990;20:5-12.
48. **Candib LM.** What doctors tell about themselves to patients: Implications for intimacy and reciprocity in the relationship. *Fam Med.* 1987;19:23-30.
49. **Donabedian A.** The end results of health care: Ernest Codman's contribution to quality assessment and beyond. *Milbank Q.* 1989;67:233-56.
50. **Donabedian A.** Evaluating the quality of medical care. *Milbank Q.* 1966;44:166.
51. **Cleary PD, McNeil BJ.** Patient satisfaction as an indicator of quality of care. *Inquiry.* 1988;25:25-36.
52. **Meterko M, Nelson EC, Rubin HR, eds.** *Patient Judgements of Hospital Quality: Report of a Pilot Study.* *Med Care.* 1990;28(Suppl):S1-S44.
53. **Kaplan SH, Ware JE Jr.** The patient's role in health care quality and assessment. In: Goldfield N, Nash DB, eds. *Providing Quality Care: The Challenge to Physicians.* Philadelphia: American College of Physicians; 1989:25-68.

My life closed twice before its close—
 It yet remains to see
 If immortality unveil
 A third event to me

So huge, so hopeless to conceive
 As these that twice befell.
 Parting is all we know of heaven,
 And all we need of hell.

Emily Dickinson, #1732
The Complete Poems
 Little, Brown, and Co., p. 702

