



# TALKING WITH PATIENTS

## Using the Four Habits Model

Terry Stein, MD  
Edward Krupat, PhD  
Richard M. Frankel, PhD

# THE FOUR HABITS MODEL

## Introduction

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High quality mutually satisfying medical care depends on conversation. This is true in the exam room, at the bedside, and increasingly on the telephone and via email. The degree of open exchange and partnership in each conversation influences the accuracy of diagnoses, the level of trust in the relationship, patient follow-through with recommended treatments, and symptom improvement<sup>1-5</sup>.

Many medical schools and residencies now include courses on interpersonal skills. Yet practicing clinicians face daunting challenges in communicating effectively with patients—time constraints resulting in the frequent need to multi-task, meeting clinical guidelines and quality goals, mastery of computer documentation and order entry, and the ability to interact with patients from diverse backgrounds and with low health literacy—to name a few<sup>6,7</sup>. Patients face challenges as well. The anxiety generated by illness compounded by the pressure of talking with a harried clinician can lead to frazzle, a neurophysiologic state in which both providing and taking in information can be impaired (8-10).

Fortunately, growing evidence indicates that clinical communication skills can be taught, learned, and practiced, and that using desirable interpersonal behaviors can mitigate some of the challenges of a busy practice<sup>11-13</sup>. The importance of communication between clinicians and patients is recognized in one of the Institute of Medicine's most widely cited and influential reports.

This document asserted in 2001 that patient-centered care, based on patients' values, wishes, and cultural beliefs, is one of six domains of quality in medical care (the others being safety, effectiveness, timeliness, efficiency, and equity). The report adds that the absence of patient-centeredness in the physician-patient relationship is associated with negative outcomes such as lower patient satisfaction, poorer adherence to medical recommendations, higher blood pressure and hemoglobin A1C levels, and greater propensity to sue for medical malpractice in the face of an adverse event<sup>14</sup>.

This monograph describes a patient-centered approach to conversations between clinicians and patients called The Four Habits Model. This

approach represents a synthesis of the available research literature on effective communication behaviors plus recommendations based on clinical and teaching experience. The Four Habits Model has been taught to thousands of clinicians at Kaiser Permanente since 1995 and is currently used in many healthcare settings across the US and internationally<sup>15</sup>. The model has also been used in a growing number of research studies as a framework for analyzing both clinicians' and patients' communication behaviors<sup>16-19</sup>.

We use the term Habit to denote an organized way of thinking and acting when conversing with patients. Key advantages of the Four Habits Model are that families of skills are organized into a logical structure and that the relationships among the Four Habits are made explicit.

The Four Habits are: Invest in the Beginning, Elicit the Patient's Perspective, Demonstrate Empathy, and Invest in the End. The goals of the Four Habits are to establish rapport and build trust rapidly, to facilitate the effective exchange of information, to demonstrate caring and concern, and to increase the likelihood of adherence and

positive health outcomes. This monograph will present an overview of the basic model, provide strategies for using this framework in the exam room, and offer tips for applying the skills on the telephone and in the hospital setting.

## OVERVIEW OF THE FOUR HABITS MODEL

In the Four Habits Model, the communication tasks that make up each habit are organized into families of skills, techniques, and benefits. In addition, the Four Habits are seen as nested and interrelated. For example, eliciting and prioritizing a patient's concerns, exploring the patient's perspective, and showing appropriate empathy set the stage for successfully engaging the patient in joint decision-making and education. Understanding each of the skills individually and how they work together is important for creating mutually satisfying and effective conversations. While the model is patient-centered, it also provides structure and a clear roadmap for busy clinicians.





## HABIT 1

# Invest in the Beginning

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The beginning of an interaction involves three key tasks: creating rapport quickly, eliciting the full spectrum of patient concerns, and planning the visit.

### CREATING RAPPORT QUICKLY

The first few moments of the conversation are essential for establishing a trusting relationship and setting the patient at ease. In his book *Blink*, Malcolm Gladwell describes an array of common settings, such as the doctor's office, in which decisions about how to act are made virtually in the blink of an eye<sup>20</sup>. Patients look for subtle non-verbal clues and cues from their clinicians. This is especially true if they are meeting for the first time, or if patients are concerned about sharing information on "sensitive topics" like smoking, substance abuse, high risk sex, or about receiving bad diagnostic or prognostic news.

Being aware of and consciously using non-verbal clues and cues such as facial expression, tone of voice, and proximity requires no extra time and yet can rapidly create an atmosphere that reduces patient anxiety. A study using "thin slices" of physicians' speech filtered voice tone successfully discriminated between physicians who had been sued and those who had not<sup>21</sup>.

For new patients in particular, a handshake and eye contact during the introduction, if culturally appropriate, indicate an egalitarian stance and a sense of caring. A study exploring patient preferences on greetings in medical encounters found that nearly 80% of the respondents, regardless of their gender, educational level, or ethnicity, wanted the physician to shake their hand<sup>22</sup>. For returning patients, a warm greeting conveys familiarity and continuity<sup>23</sup>.

For both primary care and specialist visits, finding out the names of each person in the room and their relationship to the patient also creates a personal connection without taking much extra time. While this social gesture seems self-evident, in half of the videotaped interactions in the study on greetings, the physician did not mention the patient's name at all, suggesting that this basic step is often a missed opportunity<sup>22</sup>.

Another study examined preferences for ways the clinician can successfully acknowledge having kept a patient waiting<sup>24</sup>. Study participants strongly preferred an apology in which the physician took ownership for the problem, such as, "I apologize for the long wait" (rather than "I'm sorry you've been kept waiting"). An apology combined with a brief explanation of the reason for the delay and then moving on with the visit was the over-all preferred approach. Another alternative that many clinicians have found effective is "I'm sorry for keeping you waiting. I'm here now, and you have my full attention." Lengthy explanations about the reason(s) for the delay, unless requested, reinforce power differentials and may increase the patient's distress.

For an initial visit with a primary care clinician, a brief description of one's approach to providing care is extremely useful for orienting patients and for defining mutual roles. Saying something like, "Since we are meeting each other for the first time, let me give you some information about my style of working with patients and see how that fits for you" can clarify essential logistics as well as offer a range of partnership roles, from highly active to passive. It can be helpful to hand out a business card and/or a short biography during the



first visit and later to agree on the best modes of contact between visits (eg, email or phone). A specialist seeing a patient in consultation can establish rapport quickly by briefly summarizing the reason for the appointment, asking the patient, “Did I get that right?”, having the patient add details, and then clarifying how the consultation fits into the patient’s care plan.

Some clinicians wonder whether sitting or standing influences a patient’s perspective about the interaction. One study in an emergency department found that patients overestimated the time spent by seated clinicians and underestimated the time spent by standing clinicians, suggesting that taking a seat may have subtle benefits<sup>25,26</sup>.

## ELICITING THE FULL SPECTRUM OF CONCERNS

Communicating to patients what to expect in a medical visit is a key to building trust. This is particularly true at the beginning of the interaction when discussing the reason(s) the patient has sought care. While the mechanics of this task may be straightforward, they may also present competing demands for the clinician’s time and attention. For example, a clinician may simultaneously need to listen to the patient’s concerns and type information into the computerized medical record. To maintain rapport it is important to be explicit, with a comment such as, “I have your complete medical record on the computer here. If it’s OK with you I will take some notes as we talk.” Being clear and transparent about what is occurring (and why) during the visit keeps the pace of the conversation moving forward and reduces patient anxiety. Maintaining frequent eye contact while typing, if possible, helps to sustain the rapport created in the beginning of the interaction. Looking at the patient intermittently is particularly important if the computer screen is positioned so that the clinician’s back is toward the patient.

The initial strategy to draw out the patient’s concerns is asking an open-ended question like, “What concerns would you like us to address today?” or “What would you like help with today?” When the reason for the visit has been solicited by an assistant, it is a good idea to restate the reason and ask for elaboration by a prompt such as, “I understand that you injured your leg playing basketball. Tell me about it.”

Research on the opening of the clinical encounter shows that physicians interrupt patients, on average, 18-23 seconds after they begin speaking and usually after their first stated concern<sup>27,28</sup>. Once interrupted, patients almost never raise additional issues at the beginning of the visit, which often leads either to concerns not being expressed at all or being expressed in the last moments of the encounter.



After the first concern is raised it can be useful to encourage the patient to bring up any additional symptoms or questions. Many patients will not mention their most worrisome concern right away, especially if it may be socially stigmatizing or embarrassing. In the past, clinicians may have learned that there is only one “chief complaint”. Research has shown that patients have on average 3 concerns that they would like to discuss with their clinician and that those concerns are not necessarily stated in order of their importance from the patient’s perspective<sup>29</sup>.

Soliciting the full agenda can reduce the likelihood of the “by-the-way” syndrome, when the patient brings up a new issue near or at the end of the visit. One study found that new problems were raised by the patient at the end of the interaction in 39% of the observed encounters<sup>30</sup>. This last minute phenomenon may be only the tip of the iceberg since many patients never raise concerns unless they are asked directly about them<sup>31</sup>. A study to test interventions to address this issue in primary care visits found that asking “Is there something else you want to address in the visit today?” was nearly 80% effective for reducing unmet concerns whereas asking “Is there anything else you want to address in the visit today?” was the same as not asking at all<sup>32</sup>.

## PLANNING THE VISIT

Many clinicians find that summarizing what they have heard, checking for accuracy, and then explicitly planning the rest of the visit is efficient and reassuring to the patient. This step signals a transition to more focused questions or to the exam. After a brief agenda-setting workshop, patients of the trained physicians were more likely to indicate that all of their problems were addressed during the visit<sup>33,34</sup>.

The first step in planning the visit is summarizing what the patient has stated and assessing for

accuracy: “So, if I’ve understood you correctly, you’ve had a sore throat for 4 days, started to cough up green phlegm, and you are wondering if you need an antibiotic. You also would like to discuss your cholesterol medication. Is that right?” The second step is proposing a simple plan for the rest of the interaction and checking for agreement, such as, “What I would like to do is ask you some more detailed questions, do an exam, and then we can talk about how best to treat your symptoms and review your cholesterol medication. How does that sound?” Pausing and looking at the patient after asking this question conveys the clinician’s interest in checking for mutual agreement with the proposed plan.

Frequently the number of concerns the patient raises exceeds the allotted time. Prioritizing involves using positive language to set limits on what can be accomplished. For example, asking, “What concerns do you want to make sure we talk about today?” followed by, “Let’s get as much done as we can today. If we can’t address all of your concerns in the time we have, we’ll plan our next steps at the end.” Respectful limit-setting reduces the chance that the patient will be disappointed. If the patient presses further, it can be useful to use “I wish” statements followed by an option for follow-up<sup>35</sup>. “I wish we had time to discuss all of your concerns completely today. After you go to the diabetes class, how about if you send me an email with any questions you still have.” In some cases, educational materials may be available on a clinician’s or a healthcare organization’s website that can address patient needs and serve as an adjunct to the visit.

The benefit for Habit 1 is that patients feel welcomed, safe, and listened to within a framework and organization for the visit that is clear and explicit. The skills to invest in the beginning create a sense of trust and help to determine the plan for the rest of the visit.







## HABIT 2

# Elicit the Patient's Perspective

Patients' perspectives on what's distressing them can yield important clues about cause and effect, or 'attribution'. The skills in Habit 2 enable the clinician to improve diagnostic accuracy, clarify the patient's underlying concerns or worries, and show respect for the patient's experience and culture. Eliciting the patient's perspective consists of 3 components: assessing patient attribution; identifying requests for care; and exploring the impact of symptoms on the patient's well-being. Drawing out the patient's perspective is also useful toward the end of the interaction in discussing treatment options and aiming for adherence. Our focus in Habit 2, however, is on the conversation about the meaning and impact that symptoms have for the patient.

### ASSESSING PATIENT ATTRIBUTION

Assessing patient attribution consists of determining patients' perspectives about their symptoms or illnesses. Unless the clinician asks about patients' views directly, this information surfaces in only about one quarter of medical encounters<sup>36</sup>. Habit 2 requires asking directly, "What have you been thinking might be the cause of your symptoms?" Some patients who are unfamiliar with being asked such questions may respond, "I don't know; you're the doctor." A useful response at this point is to say, "I know you may not know for sure what is causing your symptoms, but it would be helpful if you could tell me any ideas that may have crossed your mind." One study exploring the impact of the media on people's ideas about their illnesses

found that using a prompt such as, "Today, people hear, see, and read a lot about health problems. I wonder if there is anything that you may have seen, read about, or heard someone mention that you connected with your symptoms," resulted in the disclosure of additional concerns without adding significant time to the interaction<sup>36</sup>.

Patients frequently engage in a process similar to differential diagnosis, by considering certain causes and excluding others. Knowing specifically what meaning patients are giving to their symptoms allows the clinician to frame the rest of the dialogue accordingly. For example, a patient who has a strong family history of cancer may seem unusually worried about symptoms that appear vague or minimal to the clinician. Finding





out the source of the patient's concerns by eliciting the belief or assumption that cancer is the explanation for the symptoms allows the clinician to speak directly to the underlying fear.

In one study conducted at Kaiser Permanente, physicians who scored highest on patient satisfaction (compared to low scoring physicians) were more likely to elicit patient worries about medical problems, including concerns about the meaning of symptoms<sup>37</sup>. Responding to patient attribution is also associated with better information retention and treatment adherence. For example, patients with headaches who were able to fully explain their illnesses to their physicians recalled more information and were more committed to treatment<sup>38</sup>.

## IDENTIFYING PATIENT REQUESTS

Requests or expectations in Habit 2 refers to specific actions or services the patient seeks from the clinician, such as a medication for pain relief, a note for work, a referral to a specialist, or a

particular test. A study on expectations found that patients had unmet requests for care in a fifth of their visits. In 9% of visits they never had the chance to mention their requests<sup>39,40</sup>. In this study, factors which influenced expectations included the nature of patients' somatic symptoms, perceived vulnerability to illness, past experiences, and knowledge acquired from the media and other sources. Asking directly, "How were you hoping I could help?" or "What were you hoping we could accomplish today?" can help surface patient requests.

Several studies relating to this skills area have shown an impact on patient satisfaction. Patients whose requests were fully listened to were more satisfied with their care, regardless of whether their requests were granted<sup>41</sup>. Physicians' elicitation and attention to the psychological and social dimensions of patients' concerns (humanistic care) rather than ordering tests (technical care) correlated with patient satisfaction<sup>42</sup>. Even after a request for a



medication was denied, patients had higher satisfaction when the physicians elicited their perspective during the conversation compared to when they only cited biomedical facts<sup>43</sup>.

## EXPLORING THE IMPACT

The final skill in Habit 2 is determining the impact of the patient's symptoms or illness by asking, "How have your symptoms affected your daily activities (or your work or family)?" Many clinicians hesitate exploring the impact of illness for fear of initiating lengthy discussions of problems for which they may have few solutions. Yet asking this kind of focused question can enhance rapport, efficiency, and clinical quality. This inquiry often provides important diagnostic information about the patient's functional ability and mental health while conveying interest in the broader context of the patient's life. In response to the patient's reply, saying something like, "It sounds as though there are a lot of things going on in your life right now, perhaps even some

things we may not be able to completely address at the moment," lets the patient feel heard without the clinician proposing to act on the issues directly. Also, information on functional status is useful for planning treatment and negotiating realistic expectations. For example, discussing the decision to prescribe an expensive medication provides an opportunity to assess potential barriers to adherence, consider treatment alternatives, and to optimize the care plan to suit the patient's medical and economic needs.

The information gathered in Habit 2 about patients' perspectives on their symptoms or illness, on the requests for care, and on the impact of symptoms on function almost always creates empathic opportunities. It need only take a moment to ask about the patient's greatest worry and to respond briefly, "No wonder you've been feeling scared." This linkage of habits 2 and 3 is one of the most powerful and efficient ways to get useful clinical details, personalize care, and convey compassion.

## EIGHT QUESTIONS THAT HELP ELICIT THE PATIENT'S EXPLANATORY MODEL OF ILLNESS

Arthur Kleinman, who is both a physician and an anthropologist, refers to the practices that patients use to understand the experience of illness as an "explanatory model." According to Kleinman, explanatory models allow patients to place an experience in a personal and cultural context of meaning, a step which is often overlooked in the clinical interview<sup>44</sup>.

To help patients present their own explanation of their illness, clinicians may find several questions useful:

- *What do you call the problem?*
- *What do you think caused the problem?*
- *Why do you think it started when it did?*
- *How does the problem work, and what does it do to you?*
- *How severe is the problem, and how long will it last?*
- *What kind of treatment is needed, and what do you hope it will achieve?*
- *What difficulties has the problem caused for you?*
- *What do you fear most about the problem?*







## HABIT 3

# Demonstrate Empathy

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In the context of a busy practice, clinicians sometimes forget that patients seeking medical care are often under considerable emotional stress. Feelings of vulnerability, anxiety, anger, and fear are common reactions to the uncertainties of new symptoms or the anticipation of undergoing tests or procedures. When clinicians recognize and acknowledge these emotions and help patients to identify and deal with them as part of their conversation, patients feel heard. When clinicians miss or disregard cues to emotion or offer premature reassurance, patients may wonder if their doctors genuinely understand and care about them<sup>45</sup>.

In order for empathy to be expressed effectively, at least three conditions need to be present: 1) recognition that the clinician's role includes responding to patients' emotions 2) the ability to discern opportunities for empathy across individual and cultural differences 3) a set of verbal and nonverbal skills for expressing empathy<sup>13</sup>. In learning to use the skill of empathy with each patient, clinicians might ask themselves what emotions they would likely experience if they were facing the same difficulties as the patient<sup>46</sup>.

### RESPONDING TO PATIENTS' EMOTIONS

Evidence shows that medical trainees are often instructed to maintain clinical distance from their patients in order to remain objective. Empathy can decline over the course of training as many clinicians learn to regulate their emotional reactions to pain and suffering. A recent study demonstrated this tendency. When lay subjects viewed contrasting images of a person being

pricked by a needle or touched by a cotton swab, their functional MRIs showed cerebral blood flow to differing areas. In comparison, physicians' blood flow patterns were the same as they observed the two images, suggesting an ability to control their natural responses to pain in others<sup>47</sup>.

Perhaps because of this acquired modulation of physiologic response to suffering, clinicians may have a tendency to miss "windows of opportunity" presented by patients. In a recent study of visits between patients with lung cancer and their clinicians, patients presented 384 empathic opportunities. Clinicians responded empathically only 10% of the time<sup>48</sup>.

In another study in the primary care setting, unannounced standardized patients presented specific empathic opportunities such as "Do you think this could be something serious?" For every empathic response offered, twice as many expressions of reassurance were offered, and almost six times as often patients were either asked a biomedical question or given a medical explanation without reassurance<sup>49</sup>. This is notable in light of a study conducted in the pediatric setting, which showed that statements of empathy are more effective in reducing anxiety and distress than reassurance and support<sup>50</sup>.

Confusion sometimes exists about the differences between empathy (naming or supporting another's distress) and sympathy (experiencing the same emotions as expressed by the other person). The former is under conscious control and can be used mindfully and strategically in relationship-building, while the latter is largely an autonomic response which may have therapeutic potential but is not under conscious control.



Clinicians in training and new to practice often fear the loss of control that sympathy produces and don't explore the benefits of empathy. Research in this area has shown that responding effectively to patients' emotions can be taught, learned, and successfully used in practice<sup>13,51</sup>.

## DISCERNING EMPATHIC OPPORTUNITIES

A potential barrier to empathy for busy clinicians is a concern that acting empathically may take too much time. However, in one study physicians who were sensitive to patients' emotions and trained to respond empathically took only a minute longer to complete their visits than physicians whose responses were exclusively biomedical<sup>52</sup>. Another study showed that when physicians failed to respond empathically to emotionally charged statements, patients tended to repeat and intensify their concerns, often leading to longer but not more satisfying visits<sup>45</sup>.

Empathic ability begins with sensitivity to nonverbal behavior. Body posture, facial expression, and tone of voice are important clues to patients' feelings. Physicians who are sensitive to patients' nonverbal expressions of emotion

have more satisfied patients<sup>53</sup>. Likewise, physicians who establish good eye contact are more likely to detect and treat emotional distress<sup>54</sup>. In order to appreciate the appropriate norms of interpersonal distance and non-verbal behaviors across cultures, it can be useful to review the relevant literature or consult with someone who is from or very familiar with the norms of cultures other than one's own.

## EXPRESSING EMPATHY

Clinicians' non-verbal behaviors are essential components of effective empathy. Touch, gaze, facial expressions, voice tone, and body posture all convey important information about the quality of the clinician's attention. In one study, the use of an accepting tone of voice by clinicians was highly associated with whether patients followed up on referrals to a treatment program for alcohol abuse<sup>55</sup>. As mentioned in Habit 1, brief snippets of surgeons' tone of voice differentiated surgeons who had never been sued for malpractice from those who had been sued at least twice<sup>21</sup>.

The final critical step in demonstrating empathy is conveying in words what has been understood from observing and listening to the patient. Effective options include encouraging the expression of emotion, naming the likely feeling, and legitimizing the emotion. For example, empathic responses to a patient who states, "I don't like it that my blood pressure is so high. My father had high blood pressure and he had a stroke when he was 50," include the following:

"I'm glad you told me about your father. Tell me more..." (Encouraging)

"It sounds to me that you are worried this could happen to you as well." (Naming)

"If I were in your shoes, I think that I would feel the same way." (Legitimizing)



## KEEPING EMPATHY FROM GOING ASTRAY

Although it may seem counterintuitive, empathy is often helpful in the context of conflict or disagreement between patient and clinician. Making an empathic statement that demonstrates appreciation of the patient's perspective (as noted in Habit 2) is an essential step in working through differences in values, attitudes, and readiness for change. For example, if a patient is insisting on an antibiotic prescription for viral symptoms, saying something like, "I can see how uncomfortable you are feeling and how much you are hoping that an antibiotic would help". This kind of empathic statement helps the patient feel understood and enhances the likelihood of resolving the issue collaboratively.

A growing body of evidence shows that empathy can prevent unnecessary visits and treatments, uncover diagnoses that might otherwise be missed, and can lead to greater trust and adherence to medical recommendations<sup>56</sup>. While some clinicians feel uncomfortable and mechanical when first learning the skills involved in demonstrating empathy, evidence does show that empathy can be practiced and improved, with highly positive results<sup>57,58</sup>.



It can be helpful to know effective alternatives to some common expressions of empathy that may result in patients and clinicians feeling misunderstood.

- In an attempt to be receptive to a patient's emotions a clinician might be tempted to say, "I know just how you feel" or "I understand completely". Some patients may find this kind of comment offensive and may question how the clinician can presume to know what they are feeling. A better alternative would be to say something like, "I can see how difficult this experience is for you."
- In wishing to reassure their patients, some clinicians say, "I see you're upset, but there's nothing to be worried about." This response can be experienced as trivializing the patient's concern and attempting to move quickly to a solution rather than hearing and exploring the source of the patient's emotions. A more effective strategy is to say, "You sound very upset. Tell me what worries you most."
- Another common tendency is to respond to an emotionally charged moment by presenting biomedical facts or education ("The treatments work by..."). When patients feel frazzled, their cognitive ability to take in information can be limited. The mismatch between the patient's emotional state and the clinician's need to convey information can seem dismissive and uncaring. Using brief silence or making an empathic statement followed by a pause before delivering facts can give the patient the time to regain composure: "I know there is a lot for us to discuss. Right now I can see that you look very stunned by this news".
- Emotionally reflective statements are more accurate when phrased as perception rather than as fact, saying "It sounds like you are worried that with your wife gone..." rather than, "You are anxious about how you will function now that your wife..." When stated tentatively as a perception, this expression of empathy comes across as an acknowledgement and an invitation to correct or expand.





## HABIT 4

# Invest in the End

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The conversation at the end of the medical visit represents an opportunity for clinicians to explain their findings and to collaborate with patients and other family members or caregivers in making treatment plans. Unlike the first three habits, which primarily involve gathering information, Habit 4 involves information sharing, the “pay-off” from the patient’s point of view. This difference in emphasis is reflected in the tasks that characterize the end of the encounter: delivering diagnostic information, providing education and engaging in joint decision-making, and completing the visit.

The most significant challenge for busy clinicians in Habit 4 is to maintain focus on the patient given the competing demands of documentation and electronic order entry. Explaining the purpose of entering data in the computer (“I’m ordering your lab tests now”) can help the patient feel involved when the clinician needs to attend to the keyboard. Inviting the patient to move from the exam table to a chair after conducting the physical exam, and even to look at the computer screen together if appropriate, is another way to indicate that the focus is on the relationship and to signal the shift from information gathering to information sharing.

### DELIVERING DIAGNOSTIC INFORMATION

Patients generally seek medical care within a personal and cultural context that fits together in what has been termed “the narrative thread”. The patient’s story of illness typically begins in Habit 1 with a response to the clinician’s questions about presenting symptoms. Thus, one important principle of delivering diagnostic information is to use the language of the patient’s original

statement(s) of concern to frame the information to be shared. For example, if the patient stated at the beginning of the visit, “I’ve been having an aching feeling in my chest,” it is valuable for the clinician to say, “We began this visit with your saying that you have an aching in your chest. I’d like to discuss with you what I think is causing this problem...” Connecting patients to their illness narratives by using their own language creates a context in which diagnostic information and treatment recommendations are more likely to be understood and followed.

### PROVIDING EDUCATION AND ENGAGING IN JOINT DECISION-MAKING

Despite time pressures, clinicians often feel compelled to be comprehensive in educating patients about symptoms and treatments. It is important to remember that a significant percentage of the US population has limited literacy skills, which manifests in healthcare settings as difficulty understanding written and verbal language, especially information that includes both words and numbers<sup>59</sup>. Even with adequate literacy, patients and family members may become overwhelmed with information and be unable to comprehend what they are hearing and seeing. Studies have shown that patients remember 50% of what they are told in a typical medical visit and significantly less when hearing bad news<sup>60,61</sup>. Checking frequently to make sure information is understood and limiting the number of messages during the visit can help improve the efficiency and effectiveness of the visit.



**Skills for delivering education effectively and efficiently include the following:**

- Choose a few key points to emphasize during any single interaction.
- Use plain language as much as possible, or follow a technical term with a simple alternative: “Hematoma means a blood clot.”
- Ask the patient to summarize or “teach back” to ensure that essential information has been understood and any errors corrected: “What will you tell your spouse about what we discussed today?” or “I want to make sure I have been clear. Could you please tell me what you heard?”

The past half-century has seen a steady increase in the rights of patients to be informed about medical decisions. More recently, research has shown that active engagement of patients in determining options, identifying potential barriers, and encouraging the patient’s voice to be heard lead to more satisfying encounters with better functional and biomedical outcomes and improved patient adherence<sup>3,62</sup>. Joint decision-making means providing information and then asking about the patient’s opinion and preferences. It may also involve assessing patients’ readiness to change when discussing sensitive topics such as weight, smoking, drinking, or exercise. A question like, “On a scale of 1 to 10 — with 1 being not at all ready and 10 being ready today — what number represents how ready you feel right now to make this change?” gives patients a chance to determine and then express their level of motivation. Clinicians can then offer the appropriate type of assistance if readiness is high or leave the door open for future conversations if readiness is low<sup>63</sup>.

Acknowledging the difficulty in following a plan or making lifestyle changes and then providing support are critical steps. Patients are gratified to

know that the clinician understands and cares about the path they have embarked on. Viewing the clinician as a “coach” — that is, as someone who is interested in and understands the intricacy of the “game plan” and has the skills and commitment to help the patient achieve the goals--also reinforces patient autonomy<sup>64</sup>.

Another aspect of joint decision-making is exploring barriers. A question such as, “What might prevent you from carrying out the treatment plan?” is often useful. For example, an advertising executive may be concerned about excusing herself from meetings with clients to comply with 24-hour urine testing. Unless this concern is identified and an alternative testing strategy is negotiated, this patient may not follow through with the plan.





Finally, providing education and engaging in joint decision-making includes supplementing the interaction with written materials, such as an after-visit summary, or recommending the physician's own home page or other relevant websites. Giving patients a print-out of their instructions and the key points of their visit can enhance patient satisfaction and understanding<sup>65</sup>.

Memory aids also provide patients and family members with a resource that can be reliably consulted after the visit and are likely to increase information retention and adherence between visits<sup>66</sup>.

## CLOSING THE VISIT

The final moments of the conversation include 3 skills: asking for additional questions, confirming next steps, and ending on a personal note. Rather than posing a general question about further questions the patient may have, a better option is to ask, "What questions do you have about what we just discussed?" This query, followed by a review of next steps, acknowledges the fact that patients may still not be clear, allows for any necessary clarifications, and may avoid later phone calls or emails. If a referral is part of the treatment plan, making a comment at this point about having confidence in the specialist's expertise can relieve the patient's anxiety as well as convey the message that the patient's care is thoughtfully coordinated. Finally, the very end of the interaction offers the opportunity to close in a personal way. Handing the patient a business card, making sure that important contact information is clear, thanking the patient for coming in, and/or making a personal comment ("Have a great vacation") are options for reaffirming the relationship at the end of the visit.

## TIPS FOR DELIVERING BAD OR SAD NEWS

Clinicians may find the following practices helpful when delivering potentially distressing news<sup>67,68</sup>:

- Prepare key points and goals of the conversation ahead of time.
- Find an appropriate time and place to deliver the news.
- Use clear, unambiguous language, and be brief in delivering the news.
- Once delivered, let the patient absorb the impact of the news before continuing.
- Elicit the patient's perspective before providing clinical or personal viewpoints.
- Limit goals of the visit to a minimum once the news is delivered.
- Check for patient (or patient and family) comprehension.
- Plan next steps (consider short-, medium-, and long-term time frames as appropriate).





# THE FOUR HABITS MODEL

## Conclusion

The Four Habits Model provides busy clinicians a stepwise approach for having productive and mutually satisfying conversations with patients. The Model is based on an extensive body of literature on the medical interview and on 15 years of use in Kaiser Permanente and in other healthcare settings in the US and internationally.

The Model emphasizes the importance of the beginning and end of interactions, and of paying attention to the verbal and nonverbal details that can set the patient at ease, create a positive care experience, and aim for understanding, safety, and adherence. It also underscores the value of eliciting the patient's perspective and expressing empathy as ways to solidify the clinician-patient partnership and to combine compassion with efficiency.

In an era of increasing use of technology in medical care, maintaining the essential human connection between patients and clinicians can be challenging. The Four Habits Model provides a framework for using the brief moments of a patient-clinician interaction to share information, deepen the trust in the relationship, and make decisions that result in better health outcomes.

### TIPS FOR APPLYING THE FOUR HABITS MODEL

#### In the Hospital:

- Ensure that the patient and accompanying family/friends know the names of the key members of their care team (clear introductions, names on business cards or white boards, explanation of roles).
- Summarize short- and long-range steps at each interaction, including timing of tests and treatments and tentative discharge date, and check for understanding.
- Use empathic statements with patients as well as with their family and friends.

#### On the Telephone:

- Use a slower pace of speaking than in person.
- Be aware of vocal tone, voice modulation, and facial expressions, because without visual cues, patients have to rely on less information to establish trust.
- Summarize frequently to convey listening and check for accuracy.
- Look for opportunities to express empathy.
- Deliver information 1 or 2 points at a time and then check for understanding.
- Clarify next steps and what to do if the symptoms worsen.

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# THE FOUR HABITS MODEL

HABIT	SKILLS	TECHNIQUES AND EXAMPLES	BENEFITS
<b>INVEST IN THE BEGINNING</b>	Create rapport quickly	<ul style="list-style-type: none"> <li>• Introduce self to everyone in the room</li> <li>• Refer to patient by last name and title (e.g., Mr. or Ms.) until a relationship has been established</li> <li>• Acknowledge wait</li> <li>• Make a social comment or ask a non-medical question to put patient at ease</li> <li>• Convey familiarity by commenting on prior visit or problem</li> <li>• Consider patient's cultural background and use appropriate gestures, eye contact, and body language</li> </ul>	<ul style="list-style-type: none"> <li>• Establishes a welcoming atmosphere</li> <li>• Allows faster access to real reason for visit</li> <li>• Increases diagnostic accuracy</li> <li>• Requires less work</li> <li>• Minimizes "Oh by the way..." at the end of visit</li> <li>• Facilitates negotiating an agenda</li> <li>• Decreases potential for conflict</li> </ul>
	Elicit the patient's concerns	<ul style="list-style-type: none"> <li>• Start with open-ended questions: "What would you like help with today?" "I understand that you're here for... Could you tell me more about that?"</li> <li>• Speak directly with patient when using an interpreter</li> </ul>	
	Plan the visit with the patient	<ul style="list-style-type: none"> <li>• Repeat concerns back to check understanding</li> <li>• Let patient know what to expect: "How about if we start with talking more about ..., then I'll do an exam, and then we'll go over possible ways to treat this? Sound OK?"</li> <li>• Prioritize when necessary: "Let's make sure we talk about ___ and ___. It sounds like you also want to make sure we cover ___. If we can't get to the other concerns, let's..."</li> </ul>	
<b>ELICIT THE PATIENT'S PERSPECTIVE</b>	Ask for the patient's ideas	<ul style="list-style-type: none"> <li>• Assess patient's point of view: "What do you think might be causing your problem?" "What concerns you most about this problem?" "What have you done to treat your illness so far?"</li> <li>• Ask about ideas from loved ones or from community</li> <li>• Express respect towards alternative healing practices</li> </ul>	<ul style="list-style-type: none"> <li>• Respects diversity</li> <li>• Allows patient to provide important diagnostic clues</li> <li>• Uncovers hidden concerns</li> <li>• Reveals use of alternative treatments or requests for tests</li> <li>• Improves diagnosis of depression and anxiety</li> </ul>
	Elicit specific requests	<ul style="list-style-type: none"> <li>• Determine patient's goal in seeking care: "How were you hoping I could help?"</li> </ul>	
	Explore the impact on the patient's life	<ul style="list-style-type: none"> <li>• Check context: "How have your symptoms affected your daily activities/work/family?"</li> </ul>	
<b>DEMONSTRATE EMPATHY</b>	Be open to the patient's emotions	<ul style="list-style-type: none"> <li>• Respond in a culturally appropriate manner to changes in body language and voice tone</li> </ul>	<ul style="list-style-type: none"> <li>• Adds depth and meaning to the visit</li> <li>• Builds trust, leading to better diagnostic information, adherence, and outcomes</li> <li>• Makes limit-setting or saying "no" easier</li> </ul>
	Make an empathic statement	<ul style="list-style-type: none"> <li>• Look for opportunities to use brief empathic comments: "You seem really worried."</li> <li>• Compliment patient on efforts to address problem</li> </ul>	
	Convey empathy nonverbally	<ul style="list-style-type: none"> <li>• Use a pause, touch, or facial expression</li> </ul>	
<b>INVEST IN THE END</b>	Deliver diagnostic information	<ul style="list-style-type: none"> <li>• Frame diagnosis in terms of patient's original concerns</li> </ul>	<ul style="list-style-type: none"> <li>• Increases potential for collaboration</li> <li>• Influences health outcomes</li> <li>• Improves adherence</li> <li>• Reduces return calls and visits</li> <li>• Encourages self care</li> </ul>
	Provide education	<ul style="list-style-type: none"> <li>• Explain rationale for tests and treatments in plain language</li> <li>• Review possible side effects and expected course of recovery</li> <li>• Discuss options that are consistent with patient's lifestyle, cultural values and beliefs</li> <li>• Provide written materials in patient's preferred language when possible</li> </ul>	
	Involve the patient in making decisions	<ul style="list-style-type: none"> <li>• Discuss treatment goals to ensure mutual understanding and agreement</li> <li>• Assess patient's ability and motivation to carry out plan</li> <li>• Explore barriers: "What do you think would help overcome any problems you might have with the treatment plan?"</li> </ul>	
	Complete the visit	<ul style="list-style-type: none"> <li>• Summarize visit and review next steps</li> <li>• Verify patient's comprehension by asking patient to repeat instructions</li> <li>• Ask: "What questions do you have about what we discussed today?"</li> <li>• Give the patient a written summary of the visit</li> <li>• Close visit in a positive way: "It's been nice seeing you. Thanks for coming in."</li> </ul>	

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