Getting the Most out of the Clinical Encounter: The Four Habits Model

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Medical interviewing is the foundation of medical care and is the clinician's most important activity. A growing body of evidence suggests that clinicians use distinctive, describable behaviors to conduct medical interviews. This article describes four patterns of behavior that we term Habits and reviews the research evidence that links each Habit with both biomedical and functional outcomes of care.

The Four Habits are: Invest in the Beginning, Elicit the Patient's Perspective, Demonstrate Empathy, and Invest in the End. Each Habit refers to a family of skills. In addition, the Habits bear a sequential relationship to one another and are thus interdependent. The Four Habits approach offers an efficient and practical framework for organizing the flow of medical visits. It is unique because it concentrates on families of interviewing skills and on their inter-relationships.

Introduction

Medical interviewing is the foundation of medical care[1] and the clinician's most important activity. Physicians conduct a mean of 120,000 to 160,000 interviews in a practice lifetime.[2] Even a modest improvement in efficiency, diagnostic accuracy, and adherence can greatly affect outcomes, satisfaction, and cost.

A growing body of evidence suggests that clinicians behave according to distinct, describable patterns. What was once called "bedside manner" and considered a matter of etiquette and personal style has now been the subject of a large number of empirical studies. The results of these studies suggest that the interview is integral to the process and outcomes of medical care, supporting Engel's view that "the interview is the most powerful, ... sensitive and versatile instrument available to the physician ..."[3: (p 115)] Apparently, patients are less concerned with how much their physicians know than with how much they care.[4]

Recently, several conceptual models of the medical interview have also been proposed.[5-10] These models have been quite helpful in laying out the basic tasks or functions of the interview. What has been lacking to date is a conceptualization of how the elements of the encounter relate to one another during and across encounters.

We describe a new approach to the medical interview called "The Four Habits Model." It is derived from previous empirical and conceptual work on the interview and represents a synthesis of the available research literature on interviewing effectiveness plus our own clinical and teaching experience. The advantages of the Four Habits Model are that families of skills known to be related to outcomes of care are organized together into Habits and that the relationships among the Habits are made explicit.

We use the term Habit to denote an organized way of thinking and acting during the clinical encounter. 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, facilitate the effective exchange of information, demonstrate caring and concern, and increase the likelihood of adherence and positive health outcomes.

Numerous studies show that both patients and physicians derive considerable satisfaction from interpersonal aspects of care and suggest that certain clinician behaviors affect the likelihood of achieving desired outcomes. Fortunately, growing evidence indicates that clinical communication skills can be taught, learned, and practiced[11] (Table 1). However, many practicing physicians receive little or no training in this area.

Overview of the Model
Four Habits Grid

In the Four Habits Model (Table 2), the various communication tasks that make up each Habit are organized into families of skills, techniques, and payoffs. In addition, the Habits are seen as nested and interrelated. For example, failure to elicit the full spectrum of concerns at the beginning of the encounter and to assess their importance from the patient's point of view leads to premature hypothesis testing, misplaced empathy and support, and the emergence of hidden concerns at the end. In contrast, eliciting and prioritizing all of 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 encounters. The importance of

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the skills associated with each Habit relates not only to their support of that Habit but to their support of the other Habits as well.

Habit 1: Invest in the Beginning

Three tasks must be accomplished at the beginning of the interview: creating rapport quickly, eliciting the patient's concerns, and planning the visit.

Creating rapport quickly. The first few moments of the medical encounter are often overlooked by physicians as a pleasantry or as preliminary to the clinical "business" of the interview, but they are key elements for establishing a trusting relationship and often affect the outcome of the visit.

Entering the examination room ready to engage the patient and using the first few seconds to establish a welcoming atmosphere can give the patient a sense of safety. For new patients in particular, a handshake during the introduction indicates an egalitarian stance and initiates touch. 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. Adapting voice tone, language level, and posture in response to the patient early in the visit underscores the clinician's attentiveness and caring and can further set the patient at ease.

Issues of power and authority as reflected in the greeting can inhibit communication and rapport. To achieve trust and respect, the principle is to match terms of address by using the same terms with which the clinician would like to be addressed. For example, to greet a patient as Mary Jones or Mary and to refer to oneself as Dr. Baker is to select terms with different levels of formality. Patients thus addressed often feel that the relationship is being established on an unequal footing with the patient in an inferior position. This is avoided if Dr. Baker introduces herself as such and uses the formal term, "Ms. Jones," in addressing the patient.

Physician preparedness has been associated with professionalism by Inui and Carter[20] and with patient satisfaction by Frankel and Treger (Frankel RM, Treger N, unpublished material).[a] In both studies, patients rated physicians who were unfamiliar with their cases or repeatedly referred to the chart during the encounter as less professional and as providing less satisfying care. Reviewing the case and planning the visit before entering the room is good practice. Saying explicitly, "I've reviewed your record," conveys some familiarity with the patient's history.

When the clinician has kept the patient waiting, it is effective to address this directly. Comments like "Thank you for waiting," or "I'm sorry for keeping you waiting. I'm here now and you have my full attention," can usually diffuse the patient's irritation. Lengthy explanations about the reason for the delay, unless requested, reinforce the power differential and may worsen the patient's resentment.

Eliciting the full spectrum of concerns. The second initial interview task is to accurately determine the reason(s) a person seeks care. Two strategies are recommended. The first involves drawing out the patient's concerns with open-ended questions like "I'd like to begin today by getting a good idea of what concerns you'd like me to address" or "What would you like help with today?" or "I understand you've been having pain in your foot. Could you tell me about that?" After the first concern, saying "That's an important concern which I'll come back to in a moment. Before I do, is there anything else?" is useful. This statement can be followed by asking "Anything else?" until the patient either says no or a silence of more than three seconds elapses.

The second strategy is to draw upon a set of linguistic devices known as "continuers." These include vocalizations such as "uh huh," phrases such as "I see," "Go on," and "Tell me more," and nonverbal behaviors such as silence, vertical head shaking, and an engaged listening posture. Continuers encourage the patient to elaborate.

Traditional medical education teaches that a single chief complaint exists and that this complaint is either obvious or the first thing the patient mentions.

Table 1. How important are interviewing skills to satisfaction and medical outcomes?

A study of primary care patients by Brody and colleagues[12] showed that educating, stress counseling, and negotiating during visits predicted patient satisfaction, whereas doing examinations or tests or providing medication did not. Similarly, when physicians were surveyed after office visits,[13] their overall satisfaction most closely related to the quality of the patient-physician relationship. As far as medical outcomes are concerned, an early study by Wasserman et al[14] showed that physician empathy was related to overall visit satisfaction and reduction in concerns. In contrast, reassurance and support, which were both used more frequently in the visits studied, had no relation to outcomes of care. In a series of studies, Greenfield et al[15] found that a single 20-minute coaching intervention to enhance patient participation in care improved both biomedical and functional outcomes in patients with hypertension, diabetes, and ulcers. A review article on communication and health outcomes concluded that "most of the studies demonstrated a correlation between effective physician-patient communication and health outcomes. The outcomes most impacted were patients' emotional health, symptom resolution, functional status, physiologic measures, and pain control.[16] Finally, several recent studies[17-19] established a link between absence of supportive, empathic communication and medical malpractice suits.

Table 2. The Four Habits Model

Habit	Skills	Techniques and Examples	Payoff
Invest in the beginning	Create rapport quickly	• Introduce self to everyone in the room • Acknowledge wait • Convey knowledge of patient's history by commenting on prior visit or problem • Attend to patient's comfort • Make a social comment or ask a nonmedical question to put patient at ease • Adapt own language, pace, and posture in response to patient	• Establishes a welcoming atmosphere • Allows faster access to real reason for visit • Increases diagnostic accuracy • Requires less work • Minimizes "Oh, by the way ... " at the end of visit • Facilitates negotiating an agenda • Decreases potential for conflict

	Elicit patient's concerns	• Start with open-ended questions:
		  – "What would you like help with today?"
		  Or, "I understand that you're here for ... Could you tell me more about that?"
		  – "What else?"
		• Speak directly with patient when using an interpreter	

	Plan the visit with the patient	• Repeat concerns back to check understanding • 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 tests/ways to treat this? Sound OK?" • Prioritize when necessary: "Let's make sure we talk about X and Y. It sounds like you also want to make sure we cover Z. If we can't get to the other concerns, let's ... "	

Elicit the patient's perspective	Ask for patient's ideas	• Assess patient's point of view:
		  – "What do you think is causing your symptoms?"
		  – "What worries you most about this problem?"
		• Ask about ideas from significant others
			• Respects diversity
			• Allows patient to provide important diagnostic clues
			• Uncovers hidden concerns
			• Reveals use of alternative treatments or requests for tests
			• Improves diagnosis of depression and anxiety

	Elicit specific requests	• Determine patient's goal in seeking care: "When you've been thinking about this visit, how were you hoping I could help?"	
	Explore the impact on the patient's life	* Check context: "How has the illness affected your daily activities/work/family?"	
Demonstrate empathy	Be open to patient's emotions	• Assess changes in body language and voice tone • Look for opportunities to use brief empathic comments or gestures	• Adds depth and meaning to the visit • Builds trust, leading to better diagnostic information, adherence, and outcomes • Makes limit-setting or saying "no" easier
	Make at least one empathic statement	• Name a likely emotion: "That sounds really upsetting." • Compliment patient on efforts to address problem	
	Convey empathy nonverbally	• Use a pause, touch, or facial expression	
	Be aware of your own reactions	• Use own emotional response as a clue to what patient might be feeling • Take a brief break if necessary	
Invest in the end	Deliver diagnostic information	• Frame diagnosis in terms of patient's original concerns • Test patient's comprehension	• Increases potential for collaboration • Influences health outcomes • Improves adherence • Reduces return calls and visits • Encourages self care
	Provide education	• Explain rationale for tests and treatments • Review possible side effects and expected course of recovery • Recommend lifestyle changes • Provide written materials and refer to other resources	
	Involve patient in making decisions	• Discuss treatment goals • Explore options, listening for the patient's preferences • Set limits respectfully: "I can understand how getting that test makes sense to you. From my point of view, since the results won't help us diagnose or treat your symptoms, I suggest we consider this instead." • Assess patient's ability and motivation to carry out plan	
	Complete the visit	• Ask for additional questions: "What questions do you have?" • Assess satisfaction: "Did you get what you needed?" • Reassure patient of ongoing care	

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Table 3. Provider assessment of initial patient concerns

In a study of the opening moments of 74 routine ambulatory patient encounters, Beckman and Frankel[21] found that only 23% of patients fully completed their statements in response to the physician's request for a description of concerns. Further, they were interrupted a mean of 18 seconds after beginning to speak. Most interruptions (54%) came after the patient's first stated concern. Once interrupted, only 1 of the 51 patients added additional concerns after the beginning of the visit.

This study also found that patients with multiple concerns do not necessarily list them in order of priority, suggesting that physicians who interrupt patients are less likely to elicit a complete and accurate picture and are more likely to be faced with a patient's hidden concerns at the end of the visit. This relation was confirmed in a follow-up study by Beckman et al.[22] In terms of accuracy, a recent study of elderly diabetic patients by Rost and Frankel[23] showed that the patient's first stated concern is not a reliable guide to its importance. When patients were asked to list their range of concerns, most identified the third concern as most important. Yet nearly 70% never got past their first concern during the encounter.

In addition to facilitating accurate data collection, eliciting the full spectrum of patient concerns has been shown to relate to outcome. A study by the University of Western Ontario Headache Study Group[24] found that resolution of chronic headache symptoms was best predicted by the patient's perception of having been listened to completely by the physician.

Costs of eliciting the full spectrum of concerns mainly stem from the additional time required. Beckman and Frankel[21] found that no patient took more than 2-1/2 minutes to completely state their concerns. This cost is frequently offset by gaining a full and accurate understanding of the patient's agenda early in the visit and by using that information to negotiate how the remaining time can be used most effectively.

"This strategy is used to state the amount of time allocated for the visit and asking the patient to state the issues of highest concern."

This assumption causes tremendous difficulty during primary care visits if patients have a concern which may be socially stigmatizing or difficult to disclose, even though it may be the most important one they have. The technique and sensitivity with which the provider assesses patient concerns at the beginning of the visit are crucial (Table 3).

Planning the visit. Repeating the concerns to check understanding and letting the patient know what to expect establishes a clear agenda for the rest of the visit. A summary statement like, "So you've had shortness of breath, weight gain, and trouble sleeping. Is that right? ... What I'd like to do is to get more details about those symptoms, do an exam, and then we'll talk about a plan together," also signals a transition into a deeper level of information-gathering.

A common source of frustration for many clinicians is the mismatch between number and type of concerns a patient may bring to a single visit and the time they have to address those concerns. As a result, many providers limit themselves to established problems and exclude problems of a psychologic or social nature. Such an approach at best confuses the patient and at worst erodes the covenant of trust which is the heart of the physician-patient relationship. Two strategies are suggested for handling this frequent dilemma: prioritizing and time-framing.

Prioritizing involves using positive language to set limits on what can be accomplished. For example, "In the time we have today, I want to make sure we talk about your chest pain and weight loss. You also mentioned your desire to get a cholesterol test. How about if we start our next visit discussing the other issues you mentioned?" This kind of respectful limit-setting reduces the chance that the patient will feel short-changed. If the patient presses further, it can be useful to use "I wish" statements. "I wish we had time to talk about all your concerns today" conveys a sense of alliance, whereas a rebuttal like, "I just don't have time today for all those issues" risks alienating the patient.

Time-framing is another strategy which allows the physician to negotiate the agenda with the patient. This strategy is used to state the amount of time allocated for the visit and asking the patient to state the issues of highest concern. For example, "Mr. Smith, you are scheduled for a 15-minute visit. What are the concerns you most want us to cover today? ... If we are unable to address some issues, I will schedule a follow-up visit." Using good clinical judgment about extending a visit should outweigh scheduling considerations. However, in general, being explicit about time saves time and distress.

Habit 2: Elicit the Patient's Perspective

Habit 2 is used to assess the patient's point of view concerning the meaning of symptoms and the request for care. It serves at least 2 important functions: showing respect for the patient's experience and individuality and gathering clinical information in an efficient way. Eliciting the patient's perspective during this phase of the encounter consists of three skills: assessing patient attribution, identifying patient requests for care, and exploring the impact of symptoms on the patient's physical, psychological, and social well-being. Eliciting the patient's perspective is not limited to Habit 2. It is useful in discussing treatment options and issues of nonadherence, for instance. Our focus in Habit 2, however, is on the context of understanding the meaning and impact symptoms have for the patient.

Assessing patient attribution. Assessing patient attribution consists of determining the patient's perspective about what caused the problem. This approach requires asking directly, "What have you been thinking might be the cause of these symptoms?" or "What are you worried about most?" Patients frequently engage in a process quite similar to differential diagnosis; that is, they exclude certain causes and

include others. Knowing specifically what meaning the patient is giving to the symptoms allows the clinician to frame the rest of the dialogue accordingly. For example, a patient with a mild headache who is worried about a brain tumor is more likely to leave the visit reassured that the diagnosis is benign if the discussion includes consideration of a tumor. Assessing the patient's attribution thus reduces the potential for miscommunication and misunderstanding. Tuckett et al[25] found that patients who were able to fully explain their illnesses recalled more information and were more committed to treatment.

Arthur Kleinman, who is both a physician and an anthropologist, refers to the sense-making practices patients use to understand the experience of illness as an "explanatory model." According to Kleinman,[26] explanatory models allow patients to place an experience in a personal and cultural context which is often overlooked in the clinical interview (Table 4).

Exploring the patient's explanatory model provides the clinician with a "context of meaning" for the actions and actors participating in a patient's experience of illness. In the example, if Dr. Phelps or the emergency department physician had asked what Mrs. Lue's symptoms meant to her, they might have saved her additional distress by explaining that anniversary reactions frequently include experiencing the same symptoms as the person who died. A deeper exploration of the meaning Mrs. Lue's symptoms had for her might have saved valuable medical resources. The cost of a thallium stress test is several hundred dollars; the cost of exploring Mrs. Lue's explanatory model was two minutes of physician time.

Identifying patient requests. Unmet expectations for care occur in about 18% of visits according to one study.[27] Factors which influence patient expectations include the nature of their somatic symptoms, perceived vulnerability to illness, past experiences, and knowledge acquired from the media and other sources. Soliciting the specific reason(s) the patient is seeking care can help reduce the extent of unmet expectations. To address this problem, Lazare et al[28] described what they called "the customer approach" to providing care. They theorized that, as customers, patients bring to the encounter both problems and expectations or desires about how they should be dealt with. They coined the term "patient requests for care" to characterize these expectations and desires and suggested using variations of the question, "How were you hoping I could help you with your concern?" to improve clinical effectiveness. For ex-

ample, if the concern elicited in Habit 1 is the "what" of the visit ("I have pain in my knee"), Habit 2 helps define the "how" ("I was hoping for a referral to Physical Therapy and medication for pain").

Consequences for patient satisfaction and adherence relate to this skill area. Eisenthal and Lazare[29] found that patients whose requests were fully listened to were more satisfied with their care, regardless of whether the requests were granted. Likewise, Froehlich and Welch[30] showed that physician humanism rather than ordering expected tests correlated with satisfaction. A large number of studies of adherence to medical recommendations have shown that 40% to 80% of patients who receive recommendations do not follow them.[31] Some patients do not follow recommendations because the advice may not fit the question, need, or priority they bring to the encounter. Therefore, finding out not only what the full spectrum of concerns is but also what, if anything, the patient wants the clinician to do about them is important.

Exploring the impact. The final skill in Habit 2 is determining the impact of the patient's symptoms or illness on daily activities, work, and family. Many clinicians hesitate to explore the impact of illness on activities of daily living for fear of initiating a lengthy

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Table 4. Eliciting personal and cultural context in the patient interview

Mrs. Lue, a native of Tonga, was seen after an Emergency Department visit by her primary care physician, Dr. Phelps inferred from a chart note "chest pain, rule out MI" that she should order a thallium stress test. However, when one of us (RMF) met Mrs. Lue while visiting Dr. Phelps' clinic, a different diagnosis was revealed:

Dr: Dr. Phelps tells me that you continue to have chest pains even though all of your tests show that your heart is fine. Can you tell me a little bit about what was happening when you first noticed them?
Pt: Well, it was the night I went to the ER. My in-laws had called me earlier and cursed me out for not sending my nephew a birthday gift [a strong tradition in Tonga]. It really upset me, because they know that I lost my husband a year ago that day.
Dr: That must have been difficult for you. What happened next?
Pt: Well, my chest began to ache and I was afraid I was going to die just like my husband did. He died of a heart attack in an ER two hours after getting into an argument with his father.
Dr: So you were afraid the same thing might be happening to you?
Pt: Yes.
Dr: Have things resolved between you and your in-laws?
Pt: No.
Dr: And have you continued to feel heartache?
Pt: Yes.

Two separate issues converged in Mrs. Lue's explanatory model, the first relating to the occurrence of this incident on the anniversary of her husband's death, triggering an "anniversary reaction," in which she experienced the same symptoms her husband had died from exactly one year earlier. She continued to report "heartache" due to the lack of resolution of conflict with her in-laws.

discussion of problems for which they may have few solutions. The benefit of asking this kind of focused question is that it 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 addition, information on functional status is useful in planning treatment and negotiating realistic expectations of outcome. Knowing that a widow with severe degenerative joint disease is prevented from opening cans and jars to cook helps the clinician assess whether treatment and assistive devices are viable alternatives to nursing home placement.

Habit 3: Demonstrate Empathy.

"... to know and understand, obviously is a dimension of being scientific; ... to feel known and understood, is a dimension of caring and being cared for."[3: (p 125)]

Caring and compassion have characterized the doctor-patient relationship throughout history. In the modern era, great technological advances and economic pressures have led to a relative de-emphasis on the therapeutic benefits of caring and compassion both in training and practice. Nevertheless, researchers have linked the presence or absence of caring to medical outcomes such as satisfaction, adherence to medical recommendations, and propensity to sue. If caring and compassion form the core conceptual basis of the doctor-patient relationship, empathy is the core skill for enacting it (Table 5).

Although building rapport and empathy may be employed at any point in the medical encounter, the use of empathy in Habit 3 relates to responding to the core of the patient's concern(s). In terms of the flow of the visit, this response usually occurs after gathering data about the full spectrum of patient concerns.

Being open to the patient's emotions. One barrier to clinicians' ability and willingness to show empathy toward patients can be the sense of practicing medicine in a highly time-pressured, stressful environment. How is it possible to experience empathy while feeling overwhelmed with patient care duties? One strat-

egy is to look for brief "windows of opportunity"[33] for responding to patients' emotions, a skill noted in "outstanding" clinicians. Often a patient's appreciation of an empathic response is sustaining to the clinician and adds meaning and depth to the relationship. Research at the University of Western Ontario by Stewart et al[34] showed that physicians who are sensitive to and explore patients' emotional concerns take a mean of one minute longer to complete visits compared to physicians who do not.

Accurately identifying emotions begins with observing nonverbal behavior such as facial expression and body posture and listening closely to the patient's description of the experience. For example, in describing the impact of having a tremor, a patient with multiple sclerosis may avoid using hand gestures to illustrate comments. Careful observation of the patient's gestures and comments is useful for identifying the feelings of shame and embarrassment the symptom has caused. Physicians sensitive to nonverbal expression of emotion have more satisfied patients.[35] Physicians who establish good eye contact are more likely to detect emotional distress.[36]

Often patients only hint at an emotion. Statements such as "I'm considering retirement" or "My child is moving out of state" do not directly express an emotion. Suchman et al[37] define these occurrences as "potential empathic opportunities" and suggest that they are often used by patients as "trial balloons" to test whether it is safe to talk about the underlying emotion.

Conveying empathy. Two general options are available when responding to a potential empathic opportunity. The clinician can sidestep the opportunity by shifting the topic, by ignoring the potential emotion, or by offering premature reassurance; or he or she can encourage the expression of the emotion by using open-ended continuers such as "I see," "Go on," or "Tell me more." Patients for whom an issue is emotionally charged generally express their feelings at this point. For example, in response to a "go ahead" signal from the clinician, the patient who mentions retirement would characteristically add a statement such as, "You know, retirement is really scary."

The final step in helping the patient move from hinting at an emotion to fully expressing it is to show empathy. The patient's response to the question, "Is there something in particular which scares you?" might be, "I've been very successful in business and don't really need the money. But I'm not really sure what I would do with myself if I retired. After my wife died last year, it's been hard to focus on the future."

> "... physicians who are sensitive to and explore patients' emotional concerns take a mean of one minute longer to complete visits compared to physicians who do not."

Table 5. What is empathy?
According to Rogers,[32] empathy is one of the most potent therapeutic interventions. Empathy allows the physician and patient to join in constructing a shared understanding of the illness experience. Cohen-Cole and Bird offer a more specific definition, stating that, "Empathy is a term indicating one person's appreciation, understanding, and acceptance of someone else's emotional situation."[10] In the context of the clinician-patient relationship, empathy requires identifying a patient's emotional state accurately, naming it, and responding to it appropriately.

Several empathic responses are possible at this juncture. Cohen-Cole and Bird[10] identified five types of empathic responses and suggest a generic format for each. They are:

- Reflection—"I can see that you are ... "
- Legitimation—"I can understand why you feel ... "
- Support—"I want to help."
- Partnership—"Let's work together ... "
- Respect—"You're doing great."

Returning to the example, it is possible to analyze the emotions elicited by the clinician and decide which empathic response best fits the situation. The primary feelings experienced by the patient are loss and fear. The accuracy of the assessment may be tested by using a statement of reflection such as, "It sounds like your wife's passing has made the future look uncertain for you." If this is an accurate statement, the patient will agree. Assuming that this occurs, the next step is to determine which need in the patient's hierarchy of needs is most important. A supportive statement such as, "I am sorry you are faced with such uncertainty and such a difficult decision. I would like to help if I can ..." is likely to be most useful. The result of using empathy is that patients feel known and understood.

Researchers have begun to focus on the potential link between perceived lack of caring and dissatisfaction, including the decision to litigate for medical malpractice. Three recent studies, by Lester and Smith,[17] Beckman et al,[18] and Hickson et al,[38] support the assertion that lack of empathy is a risk factor for dissatisfaction and malpractice suits in the event of a negligent outcome.

Investing in the relationship and getting to the heart of the problem by showing empathy is a rewarding strategy which can be learned, taught, and practiced.[39,40] The time required to implement this strategy is minimal—a mean of <1 min.[34] Including expressions of empathy during medical visits can add depth and meaning to clinical practice. Francis Peabody's famous dictum that "the secret of the care of the patient is in caring for the patient" captures the essence of Habit 3, its importance for the relationship, and its potential for healing.[41]

Habit 4: Invest in the End

Unlike the first three Habits, which primarily require information gathering, the last, Habit 4, requires information sharing. This difference in emphasis is reflected in the tasks of the end of the encounter: delivering diagnostic information (giving good news, bad news, or no news); encouraging patients to participate in decision making; and negotiating treatment plans and probing for adherence.

Delivering diagnostic information. Patients generally seek medical care with at least two questions in mind: "Why am I experiencing these symptoms?" and "What can be done to relieve them?" Because the patient's frame of reference and experience initiate both the search for care and what they are likely to do with answers to questions, the most important principle of delivering diagnostic information is to use the patient's original statement of concerns to frame information to be shared.

Table 6 is an example of an actual encounter that shows information sharing that fails to incorporate the patient's original statement of concerns.

Table 6. Need to incorporate patient's initial concern

Ms Jane Fox, a 47-year-old mother of three who came to the general internal medicine clinic complaining of unrelenting headaches, was seen by Dr Greg Antonio, an internist new to practice. Ms Fox's initial statement of concerns to Dr Antonio appears below.

Dr: What brings you here today?
Pt: Spasms in my neck and shoulders ... It's gotten so bad it's giving me headaches, vomiting ... I'm really concerned about it. I can't think; I can't work.

A review of the patient's opening statement contains multiple references to suffering. Fifteen minutes later, Dr Antonio delivered his diagnosis to the patient. Note the lack of responsiveness of the diagnostic news to Ms Fox's initial statement of concerns.

Dr: First of all, it's a fairly normal physical exam. I found only one abnormality—the tenderness over your spinous processes of your upper vertebrae. [pause] Your muscle strength and nerve exam—all within normal limits.
Pt: Okay.
Dr: That's good. I managed to review the laboratory results that they obtained from the ER, particularly for tests of arthritis or something called lupus. Those tests all came back negative.
Pt: Okay.
Dr: They also measured to see if you had some muscle disease—whether there was nerve breakdown occurring. Those all came back negative. Your blood counts were within normal limits. So where to go from here ... Because of the tenderness, let's get an x-ray of your cervical spine. There's probably a few more blood tests we can get.
Pt: (interrupting) What do I do for my pain in the meantime? What do I do for my head and my nausea and my numbness?

Until the patient interrupted him, Dr Antonio had been engaged in a classic report of his findings. From a strictly biomedical perspective, Dr Antonio's report could be viewed as "good news" in the sense that no serious underlying disease could be associated with Ms Fox's symptoms. However, her response is a strong repudiation of Dr Antonio's "wait-and-see" strategy. The consequence was a protracted discussion. The visit took 50 minutes, and neither Ms Fox nor Dr Antonio felt satisfied.

For the busy clinician, nothing is more important than framing conclusions by using the patient's initial problem statement: a suggested alternative strategy follows:

Ms Fox, I know you've been experiencing some unpleasant symptoms which have affected your ability to think and work. I do know that it may take a while before we can get to the bottom of this. What I'd like to do is continue talking with and testing you. I'm also aware that you're in pain, so we'll need to try different techniques to deal with your symptoms in the short run. How does that sound to you?

"The importance of checking patient comprehension cannot be overemphasized."

Traditional teaching about the logic of the clinical encounter suggests that delivering diagnostic information should be followed by prognosis and treatment planning with the patient. Abundant anecdotal evidence indicates that, once given a diagnosis, especially if the news is bad, patients' ability to retain information is limited. One suggestion that has been tested successfully by Ley[42] and his colleagues is to deliver prognostic information first followed by the diagnosis. This approach might mean making a statement such as, "After reviewing all the information, I feel confident that you have an excellent chance (95% or better) of making a full recovery from the problem(s) you've been experiencing, and those problems we've diagnosed as prostate cancer."

Involving Patients in Decision Making

A number of research studies have confirmed that increasing patient participation in decision making leads to positive functional and biomedical outcomes. Patient participation is particularly important at the conclusion of the visit when clear understanding and agreement on courses of action to be pursued become operative.

The importance of checking patient comprehension cannot be overemphasized. In addition to sharing decision making responsibilities, using this tactic provides the opportunity to educate patients about the condition and to correct misinformation or misunderstanding. Grueninger et al[43] suggested several helpful questions for use in educating patients and testing for comprehension. These include:

- What do you know about this condition?
- What have you tried in the past to help you deal with this problem?
- What has worked? What hasn't?

These authors suggest that many patient requests or demands can be met with education instead of confrontation. For instance, the patient who comes to the office complaining of headaches and demanding a computed tomography (CT) scan can present a daunting challenge when confronted. An alternative approach is to explore what the person knows and has experienced regarding the demand. A constructed example (Table 7) illustrates this approach.

Completing the visit: negotiating a plan, probing for adherence. Unlike the inpatient setting, where patient activities can be monitored, ambulatory patients are solely responsible for implementing recommended treatment and lifestyle changes. The therapeutic alliance between the physician and patient becomes the basis for negotiating realistic management and treatment plans. Key skills required at the end of the visit are providing a clear rationale, exploring potential barriers to implementation of the plan, and offering support.

Providing a clear rationale. A key concept in establishing a partnership with patients is ensuring that they understand not just that the clinician is proposing a diagnostic or therapeutic plan but why. Like so many other aspects of effective clinical communication, providing a rationale depends on the patient's level of comprehension and interest in the information. At minimum, providing a rationale should include a statement of intent, eg, "I'd like to spend a few minutes discussing your treatment plan so you will understand what I'm suggesting and why," and an invitation to the patient or family to use memory aids (written notes, tape recording) and pre-existing information (pamphlets, videotapes, brochures) to optimize comprehension. Memory aids provide patients and family members with a resource which can be reliably consulted after the visit and are likely to increase information retention and adherence between visits.

Exploring potential barriers to implementation of the plan. After providing a clear rationale for the plan, checking with the patient to determine what barriers to its implementation exist is important. A question such as "What might prevent you from carrying out the treatment plan?" is often useful. For example, a highly visible advertising executive may be concerned about excusing himself or herself from meetings with clients to comply with 24-hour urine testing. Unless

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Table 7. Drawing on the patient's experiences

Pt: Doctor, I'm having awful headaches. I know I need a CT scan, but I also know you make more money by not giving me the test.

Dr: It sounds like you're very concerned about your headaches, and so am I. Before we make any decisions, however, can you tell me what you know about CT scans?

Pt: Well, I know they can detect brain tumors. My next-door neighbor died last week of a brain tumor. He had bad headaches like mine, and they never did a CT scan.

Dr: So you're concerned that the cause of your headaches might go undetected without a CT scan, is that right?

Pt: Yes.

Dr: It's true that CT scans can detect brain tumors, but other procedures may work better for you.

Pt: I'm listening.

Dr: The reason I want to use the right procedure in diagnosing your headaches has less to do with cost and more with making sure the test is appropriate for your needs. Are you aware that a CT scan poses some small health risks?

Pt: I wasn't aware of any risks from a CT scan.

Dr: Let's meet again next week. In the meantime, here is some information for you to read and think about. We can continue the discussion once you've had a chance to do that.

Pt: That sounds like a good plan.

this concern is identified and an alternative testing strategy is negotiated, this patient may not comply with the plan.

Providing support. Acknowledging the difficulty in following a plan or making lifestyle changes and then providing support are critical. Patients are gratified to know that the physician understands and cares about the path they have embarked on. Viewing the physician 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.

In a busy office practice, in which time is short, doctors may be tempted to "cut corners" by giving patients their diagnosis, recommending a treatment plan, and moving quickly to closure. As is true for the beginning moments of the encounter, investing in the end ensures that genuine partnership exists between doctor and patient and that both parties know and understand each other well enough to minimize the potential for misunderstanding and miscommunication.

Conclusion

An extensive body of literature on the medical interview and related skills already exists,[44] and a number of elements of the interview known to relate to satisfaction and outcome have been identified.[16] The Four Habits Model builds on previous empirical and conceptual contributions to the field by focusing attention on the sequence of events that typically takes place during a medical encounter and the influence communication in one Habit or domain has on others. In this respect, the Model is an attempt to respond to the challenge identified by Inui and Carter[20] to address the gap between associations of individual, isolated behaviors and the broader context of social interaction and meaning in which physicians and patients encounter one another.

We have found the Four Habits Model to be both practical and understandable to practicing physicians. Experienced clinicians intuitively understand that they must seamlessly blend the logic of clinical decision making, which is the basis for making an accurate diagnosis, with the logic of social interaction, within which successful relationships are established and which often determines how effective treatment and satisfaction with care will be (Vanderford ML, unpublished material).[b] Investing in the Four Habits provides a stepwise approach to enhancing patient

relationships, optimizing the amount and quality of information available for making clinical decisions, and making the practice of medicine more mutually satisfying for doctor and patient. ❖

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