# Engagement: The Grout of the Clinical Encounter

*J. Gregory Carroll, PhD, and Frederic W. Platt, MD*

## Introduction

In 1989, the Bayer Institute for Health Care Communication introduced a model of doctor-patient communication designed to enrich current practice. To the traditional "find it, fix it" ("F-2") model of the clinical encounter, the Institute added four complementary steps: engagement, empathy, education, and enlistment. Combined with F-2, the "4-E" model enables the physician to address both the biologic and psychosocial needs of the patient and provide more complete medical care [1]. Engagement, the first of the four complementary steps, is the foundation on which all subsequent steps are built.

As defined in the model, engagement is the process by which doctor and patient initiate and maintain an effective working relationship. It is based on mutual trust and respect and a clearly articulated and demonstrated concern by the physician for the patient's welfare. Minuchin and Fishman [2] coined the term "joining" as a metaphor for this process in family therapy. They describe joining as more of an attitude than a technique and define it as "letting the family know that the therapist understands them and is working with and for them." For Minuchin and Fishman, "Joining is the glue that holds the therapeutic system together."

As taught in Bayer Institute workshops, engagement is both an attitude that can be learned and a set of skills that can be mastered. But regardless of the clinical scenario, the physician's essential underlying task is to cultivate an atmosphere of mutual trust and respect and to demonstrate a commitment to the welfare of each patient. To extend Minuchin and Fishman's metaphor, engagement is the grout in the mosaic of clinical encounters that depicts the physician-patient relationship.

Over the past 9 years, Bayer Institute faculty have taught the 4-E model to more than 20,000 clinicians in half-day workshops. From these workshops, we have learned the following:

- More than half of the frustrations physicians encounter in communicating with their patients can be categorized as missed opportunities in doctor-patient engagement.
- Most doctors and patients blame each other for failures in engagement.
- Physicians cite lack of time as the primary reason for their failure to achieve engagement with patients.

Every physician can learn to build engagement with a patient and to repair the relationship when engagement goes awry. When engagement fails, the doctor and patient usually find the interaction equally frustrating. Mutual engagement goes far toward avoiding frustrations.

## Disengagement: Some Examples

**1. *"My doctor doesn't have a clue about who I am or what's important to me. All he cares about is the condition of my liver (or kidneys or blood tests or echocardiograms . . .)"***

This complaint is frequently heard from patients whose otherwise competent physicians describe their interviewing technique as "getting right down to business." Such a doctor rarely leaves the biomedical sphere during the interview and seldom demonstrates to the patient that he understands her concerns, beliefs, and worries.

**2. *"My patient tells these terrible long stories."***

This physician related the following dialogue:

**Doctor:** *How long have you had this chest pain?*
**Patient:** *Well, I think it was since my trip to London. You know they had to route us through San Francisco and it was really rainy. Anyway, I went out to take a walk between planes and . . .*

**3. *"Another patient with a laundry list!"***

French doctors call this "le malade du petit papier."

**Patient:** *Doctor, I made a list (*takes out a scrap of paper with 12 items on it and guards it closely).
**Doctor:** *Can I see it?*
**Patient:** *Well, I don't think you can read it, Doctor. I wrote it in shorthand.*

**4. *"By the way, Doctor . . ."***

**Doctor:** *OK, I guess we're done for today* (gets up and reaches for the doorknob).
**Patient:** *Oh, by the way, Doctor, there's one more thing. What do you do if someone vomits up blood?*

*J. Gregory Carroll, PhD, Director, Bayer Institute for Health Care Communication, West Haven, CT; and Frederic W. Platt, MD, Clinical Professor of Medicine, Univeristy of Colorado School of Medicine, Denver, CO, Regional Consultant, Bayer Institute for Health Care Communication, West Haven, CT.*

**5. *"There's no talking to him!" "It was like pulling teeth, trying to get any information from him."***

This patient and physician have very different opinions about the quality of their interaction. Can both be right? Sure. Here's how the conversation actually went:

**Doctor:** *What brought you to see me?*
**Patient:** *Well, I was pretty sick, Doc. Lots of trouble with my chest.*
**Doctor:** *Were you hurting?*
**Patient:** *Hurting? Yeah, I guess so.*
**Doctor:** *Where?*
**Patient:** *Where?*
**Doctor:** *Yeah, where were you hurting?*
**Patient:** (points vaguely to anterior chest)
**Doctor:** *So how long were you hurting?*

In the above exchange, the doctor did not let the patient initiate or participate much, and as a result the patient became passive and monosyllabic. The doctor experienced further communication as "pulling teeth."

### Techniques to Facilitate Engagement

The process of engagement begins any time that physician and patient meet. The following techniques are useful in establishing an effective working relationship with a patient at each encounter.

- Begin and end interactions with a brief focus on the patient as a person. For example, with a new patient, begin the encounter by asking the patient to say a little about himself [3]:

  **Doctor:** *Before we get to the medical details, I'd like to know a little more about you. What would you like to tell me about yourself?*

- Express interest in hearing the patient's story. Encourage the patient to give you a narrative, at least for a minute or two. Avoid a high-control, interruption-filled, or interrogatory interview style, especially in the opening minutes of the interview. Use open-ended inquiry instead of close-ended questions to help facilitate the patient's narrative [3–7].
- Be sure that you and your patient agree on the agenda. Ask "What else is bothering you?" "Besides the chest pain, what other concerns do you have?" "What else did you want to accomplish here today that we haven't yet dealt with?" Use of "what else" questions will greatly reduce the "Oh, by the way, Doctor" syndrome because these questions act as review-of-systems emptying devices. The rule of thumb is to keep asking "Anything else?" until the patient can report nothing else.
- Demonstrate an eagerness to discuss roles, boundaries, and communication rules during the encounter. This can be done without rejecting or condemning the patient. It may be necessary to take some ownership of the problem in these discussions:

  **Doctor:** *I'm having a little difficulty here. I see that you have 12 items on your list, but we have a time limit. We have about 15 minutes today, so we'll only be able to attend to two or three of the items. Where would you like to begin?*

- Recognize that physicians and patients speak somewhat different languages and have somewhat different goals. Physicians have a large biomedical vocabulary that most patients do not share, and patients would rather tell their story than produce "facts." When we interrupt or sidetrack that story early in the interview, most patients will feel frustrated. And once they are interrupted, patients usually will not return to the same story, even though it may contain their main reason for seeing a doctor that day [4,8,9].
- Attend to nonverbal communication that may contradict the verbal channel of your engagement messages (eg, incongruous facial expressions, too much eye contact with the patient's chart, sitting behind a desk, looking out the window).

### Restoring Disrupted Engagement

Physician and patient can become disengaged at any time during their relationship and at any time in the clinical encounter. Some engagement problems originate with the physician's behavior (eg, interrupting the patient or asking close-ended questions). However, many engagement disorders result from the patient's assumptions and communication style. To communicate effectively, it helps for the patient to understand how the doctor works, what the doctor expects from the patient, and what the doctor's needs and limitations are (eg, the need to hear a symptomatic history, the need to reach a diagnosis before prescribing treatment). The usual perception that the doctor-patient relationship represents a power imbalance often masks this reciprocal need for understanding [10].

White and Keller [11] describe five techniques for getting "derailed" interviews back on track: acknowledging the communication problem; discussing boundaries or ground rules for the doctor-patient discourse; showing compassion for the patient's situation or dilemma; discovering the meaning of the illness and the meaning of the visit for the patient; and extending the treatment or communication system beyond the doctor-patient dyad when appropriate (eg, making a referral to a community agency). The acknowledgment techniques from this model are especially useful for reestablishing engagement with a patient once it has been disrupted [12].

Acknowledgment begins with the physician's awareness that something is wrong. Signs that communication has gone offtrack are frequent interruptions or repetitions by

either the patient or the doctor, a global sense of dissatisfaction, or a feeling on the part of the doctor that she is stereotyping the patient or situation [Korsch BM, personal communication 1998]. When the physician becomes aware that something in the interview has gone wrong, she should stop the process. It is important to stop talking, but this may not be easy.

**Patient:** *And so on and on and on and . . .*
**Doctor:** *Wait a minute, Mr. S, I need to stop and think about this.*
**Patient:** *And on and on and on and . . .*
**Doctor:** *No, Mr. S* (touching the patient's elbow). *I really need to stop and think about what you've been saying. Please let me think.*

This peremptory request usually will have a dramatic result.

At this juncture, it is helpful for the physician to identify and reflect on the emotion she is feeling. What is causing her to feel this way? Is there a disagreement about roles? boundaries? ground rules? the agenda? What is going wrong? It is important to remember that the physician is not searching for a biomedical or psychosocial diagnosis for the patient, but for a diagnosis of what went wrong in the interview.

In certain cases, a doctor may decide that she cannot continue to care for a particular patient (eg, a patient is actively pursuing malpractice litigation against her). In such cases, the physician must make arrangements for the patient to receive care elsewhere. However, if the physician decides to continue with the patient, she must take time to deal with the disengagement. Further progress will be difficult, if not impossible, until the disengagement issue is confronted. Part of repairing engagement is deciding whether to share the problem with the patient. The physician may be able to act unilaterally to improve the situation, perhaps by moving closer to a whispering patient or turning off a distracting TV. However, more often the patient must become part of the solution:

**Doctor:** *I'm having some difficulty here. You seem to have quite a few problems on your list and we only have about 15 minutes today. Could I ask for your help? We'll probably have time for only two or three problems today. Could you pick your most worrisome two and let me pick one? Then we'll set up another visit to talk about the rest.*

Of course, one must be prepared for the frustrated patient:

**Patient:** *But Doctor, I waited 3 weeks for this appointment!*

To such a patient one could reply:

**Doctor:** *That sounds really frustrating* (pause). *But we're still stuck with this time limit. What are you hoping we can accomplish today?*

## Conclusion

Engagement problems in the clinical setting are common. Restoring disrupted engagement requires that the physician diagnose the communication problem, express some ownership of the problem, and generate solutions, often with the patient's help. Based on research and clinical observation, this process can reduce the frustrations of physicians and patients alike, thereby leading to a better working relationship and, potentially, to a higher quality of care.

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