CHAPTER 4
Greasing the Wheels
Promoting a Working Alliance with Patients and Families

The relationship between families and their physician is the most powerful vehicle for influencing patients about issues regarding health and illness. Physicians influence their patients and patients influence their physicians. The doctor–patient relationship is an essential subsystem of the biopsychosocial approach to treatment. As such, it deserves special thought and consideration, and careful assessment when this alliance is problematic. The way the physician handles his or her part in the doctor–patient relationship can affect a patient’s sense of well-being and the likelihood that a patient and family will cooperate with any given treatment plan, not to mention the physician’s own sense of job satisfaction. For these important reasons, we will now turn to some pragmatic suggestions for promoting a constructive working alliance between physician and family members. We will focus on the physician’s side of this equation because that is what we can alter. Three fundamental interviewing skills enhance the potential for an effective partnership to develop between physician and family: building rapport, structuring the interview, and converting resistance into cooperation.

Building Rapport

Early in an interview both physician and patient test each other. Physicians look for whether a patient will be a clear and reliable source of information about the presenting problem. Physicians also look for some sense of cooperation from the patient: Will the physician and patient easily understand each other and work together, or will this alliance require more attention to succeed? While physicians scrutinize
their patients, the patients, of course, are checking out their physicians. First and foremost, patients generally assess the physician: Does the physician seem to ask the right questions, order the right tests, prescribe the right medicine, provide some information about the presenting complaint? Does the physician listen attentively and empathize with patient concerns? In this way the patient decides if the physician is competent and understanding.

During this phase of the interview, it is important to focus, almost exclusively, on building rapport. The term used by family therapists to characterize this early phase of rapport-building is joining (1). Joining with each individual patient and family member is like oiling an important piece of machinery. If it is well-oiled, the machine is likely to run smoothly and effectively when it is needed. If not, the machine will grind, make a lot of noise, and run inefficiently or sometimes not run at all. Joining, like oiling, is a maintenance task that in and of itself will not produce the desired outcome, but the absence of which threatens the outcome of the interaction.

Joining occurs most consciously in the socializing phase of an interview or conference. It begins with greeting, making contact, and establishing rapport with each person. From an individual perspective, this process involves searching for a common wavelength or language with which to communicate. Searching for commonality may involve commenting on the weather, on a common heritage, or inquiring about the patient’s employment. It is finding a respectful way to make a connection, person to person, before beginning the central business of the interview. For example:

- Hello, Mrs. Jones, I’m Dr. Brown. How did you manage to get here today through all that snow?
- Hello, my name is Dr. Brown. Mr. Mancini? That’s Italian isn’t it? My wife’s family came over from Italy.
- I’m glad to meet you, Mr. Hammer. I see from your chart that you are a carpenter. I did some construction work while I was in college. That’s tough work.

It is in these beginning interactions that a physician may consciously or unconsciously use different parts of his or her own history or behavior to connect with a given patient. This may be done at the level of content, as in the above introductions, or it may be done at a process or nonverbal level. For example, with a depressed woman, the physician may speak in a low, soothing voice. With a loud, anxious man who just had a myocardial infarction, the physician may speak with strong conviction. With a particularly difficult patient, part of establishing rapport may involve matching behavior, such as sitting in the same position, using similar speech cadence, or mirroring some of the patient’s gestures until the patient has relaxed enough to have productive exchange.