Curbside Consultation

The Doorknob Phenomenon in Clinical Practice

Commentary by Justin Faden, DO, and Gregg Gorton, MD
Lewis Katz School of Medicine, Temple University, Philadelphia, Pennsylvania

Case Scenario

A 42-year-old woman returned for a follow-up visit to discuss ongoing management of migraine headaches. She looked somber as I entered the examination room, and she quickly said, "This new medicine is no good, either!" She reported that she had dutifully taken it as prescribed for the past month, yet she had continued to experience headaches on a nearly daily basis. I reviewed her headache log, and we discussed the situation. She was clearly having a very difficult time tolerating her pain. She finally agreed to try a new medication and to follow up soon. As she was leaving, she turned back to me and said in an exasperated voice, "If this doesn't work, I may just kill myself!" Is it appropriate to prolong the session to discuss this comment? Why do patients always seem to say things or ask questions when they are leaving the examination room?

Commentary

By definition, the doorknob phenomenon or doorknob statement occurs when patients wait until the last moment in the clinical encounter—often while the physician is grasping the doorknob to exit the examination room—to utter something that, not uncommonly, provides crucial information. Physicians must then determine whether to pursue this new information immediately or to defer the new issue until the next visit.

The doorknob statement has been called an "exit line" to highlight its dramatic effect. It results in a cliffhanger—a moment of uncertainty about what will happen next.[1] Physicians must decide quickly whether to address this new issue, thereby disrupting their tight schedule, or to say something like, "That sounds very important, but we'll have to discuss it when I see you next. Perhaps we can schedule a sooner follow-up visit." In the initial moment of surprise, there is often a sense of powerlessness because the patient's comment occurs at the edge of the routine clinical visit in both space and time. Physicians' reactions to such unexpected comments may range from frustration to annoyance, resentment, or even anger. Remaining empathetic after being caught off guard will allow physicians to choose an appropriate response.

UNDERSTANDING PATIENT MOTIVATIONS

Doorknob statements generally fall into one of two broad themes: a remark that reflects the patient's ambivalence or an effort to prolong the clinical visit. Doorknob comments are often made with ambivalence, and by sharing them at the conclusion of the visit, patients are compromising between revealing them earlier or leaving them entirely unsaid.[1] These statements are often related to sensitive topics such as substance abuse, sexual function, or emotional symptoms that may reflect mental illness. For example, fewer than one-half of patients with erectile dysfunction reveal their symptoms to their urologist.[2] Also, few things are as fraught with anxiety for patients as concerns about mental illness.

This patient's statement about killing herself could be a dramatic outburst or it could indicate true suicidal ideation. Studies have shown that between 45% and 50% of suicide victims visit their primary care physician in the month before committing suicide.[3,4] Several factors may explain this: patients may wish to say goodbye to a long-time confidant; they may be ambivalent about suicide, and verbally or silently reaching out for help (possibly because the stigma of seeing a primary care physician is less than the stigma associated with seeing a mental health professional); or they may wish to continue seeing someone with whom they have developed a long-standing rapport. The physician-patient relationship is centered on trust, empathy, and respect. Many patients develop a deep trust of their primary care physician and would prefer to speak with him or her about

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This series is coordinated by Caroline Wellbery, MD, Associate Deputy Editor.

A collection of Curbside Consultation published in *AFP* is available at https://www.aafp.org/afp/curbside.

Author disclosure: No relevant financial affiliations.

their mental health concerns, thus making primary care physicians the potential recipient of suicidal statements.

Although ambivalence about asking a question or revealing something personal can be a powerful motivating force behind the doorknob phenomenon, the desire to prolong the appointment can be equally compelling for patients. Reasons for prolonging the appointment may include primary gain (e.g., gratification from assuming the sick role), loneliness (e.g., going to the doctor may be the highlight of the patient's day, week, or month), or anger (e.g., wanting to punish the doctor for a too-brief encounter). Patients may use exit lines to provoke guilt in physicians. This ensures that the physician is thinking about the patient even after the session has ended, thereby prolonging the session through other means. Patients may also view the transition of exiting the room as an opportunity to blur the established professional boundaries, especially when exit lines take the form of asking the physician personal questions, such as about their hobbies, recent vacations, or families.[5] Such questions can serve to shift the paradigm and the dynamic of the physician-patient relationship, and attempt to reshape it into something that patients are looking for in their life (e.g., personal friendship, business advice, even a romantic partner).

PHYSICIAN STRATEGIES AND RESPONSES

Research has focused on how to elicit these statements earlier in the visit to curb the doorknob phenomenon.[6] Physicians are encouraged to ask as the visit is winding down, "Do you have any other questions today?" or, "Is there anything else you would like addressed today?" However, few resources discuss strategies for how to address doorknob comments after they are made.

The appropriate response is predicated on the content of the statement, the physician's knowledge of the patient, and his or her understanding of the patient's motivations. If the concern for urgency is low, an empathetic statement can suffice, such as, "I appreciate you disclosing that to me, but we will need to schedule another appointment to explore that issue in more detail." If the statement triggers something of concern (e.g., an issue that the patient struggled to mention earlier because of ambivalence), we would advocate prolonging the encounter to ensure that the statement can be adequately addressed. Addressing concerns related to depression, self-injury, and suicide is paramount. Whether this entails ensuring that the patient is thinking about hopes and plans for the future, contacting the patient's family for additional information, ordering blood work, or merely reassuring the patient that you will be there to listen and treat—spending this additional time can bolster rapport and benefit patient care.

If the exit line is an isolated occurrence, the physician should allow additional time to address the problem. However, sometimes there may be a pattern—a patient may habitually wait until the last moment to drop a polarizing statement or to ask a critical question. When a pattern is noted, it may be appropriate to defer addressing the doorknob statement until a future visit. For example, "I recognize how difficult that must be to mention, and I would be happy to discuss that with you in more detail at your next appointment." At the next visit, making an observation about the recurrent pattern may be appropriate. It may not only open up a sensitive area for discussion and improve clinical care, but it may also lead to a change in doorknob behavior. This strategy can be employed when clinical concern or suspicion is low; it is advisable to err on the side of caution when there is suggested risk of self-injury or other danger to the patient.

In the scenario presented here with the patient experiencing migraine headaches, it can be easy to brush off her comment as humor or simply frustration. However, if she is clearly in a distressed state, the physician should stop her from leaving the room, prolong the appointment, begin an earnest conversation about how she is truly feeling, and convey, in an empathetic manner, that you both are in this together. Taking the time to do this can be the difference between hope and trust, and despair and isolation.

Address correspondence to Justin Faden, DO, at Justin.Faden@tuhs.temple.edu. Reprints are not available from the authors.

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