

educators and researchers in university departments and the Deaneries, and others — to emphasise the importance of the jobs we are doing, to train the next generation of doctors to do them even better, and to provide the evidence on which to base what they do for their patients. The *BJGP* will continue to provide an expanding platform for the best general practice research from across the world, an opportunity for important developments in academic medicine to be widely communicated, and a focus for analysis to lead the debate about the future of health care and of the profession.

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# Doctors' non-verbal behaviour in consultations:

## look at the patient before you look at the computer

**INTRODUCTION**

Verbal communication in medical consultations is well recognised as being important to the delivery of medical care and is usually easy to interpret and analyse. It is discrete with clear endpoints, it occurs in a single mode, it is mostly under voluntary control, and communicates our cognitive thoughts more than our emotions. In contrast, non-verbal communication is less easy to interpret: it is continuous even in silence, can occur in several modes at once, operates at a less conscious level, leaks spontaneous cues, and is the channel most responsible for communicating attitudes, emotions, and affect.<sup>1,2</sup> We should not be surprised, therefore, that non-verbal communication plays a significant role throughout the medical

interview and is an important variable in doctor–patient interactions. Non-verbal communication helps to build the relationship, provides cues to underlying unspoken concerns and emotions, and helps to reinforce or contradict our verbal comments.<sup>3</sup>

Non-verbal communication is at its most significant in the medical interview if it contradicts the message from verbal communication. When the two are inconsistent or contradictory, non-verbal messages tend to override verbal messages.<sup>3</sup> This explains why a closed question accompanied by effective non-verbal communication will often lead to an open answer, and why patients do not necessarily believe a reassuring verbal comment if accompanied by contradictory facial expressions and vocal hesitancy.

Two intimately related aspects of non-verbal communication in the interview require consideration: the non-verbal behaviour of patients and the non-verbal behaviour of doctors. As doctors, we need to recognise and explore patients' non-verbal cues in their speech patterns, facial expressions, and body posture. But we need to be equally aware of our own non-verbal behaviour: how the doctor's use of eye contact, body position and posture, movement, facial expression, and use of voice can all influence the success of the consultation.

The article from Marcinowicz *et al* in this month's *BJGP*<sup>4</sup> reminds us that patients are carefully observing their doctors in consultations and picking up a range of non-verbal cues. In this observational study from Poland, doctors' tone of voice

and degree of eye contact were particularly associated with patients picking up signs that their doctors seemed uninterested in them. Younger and more educated patients were more likely to comment on the doctors' behaviours, either because they were more aware of them or because they were more comfortable with reporting this to the researchers. Unsurprisingly, patients viewed some doctors as more approachable than others and would volunteer different things to different doctors. Thirty years ago, Byrne and Heath, British pioneers of the study of the consultation, carried out a detailed study of the effects of doctors' non-verbal behaviour on their patients and made similar observations.<sup>5</sup> They found that eye contact and the posture of the doctor were influential in determining what the patient revealed in the consultation. They also found the way that the doctor used the medical records (non-computerised in those days) to be very important in influencing the concerns raised by patients.

The non-verbal behaviour of doctors themselves is easily overlooked in communication research. Many instruments for measuring qualities such as patient centredness are designed to be applied to audio rather than video tapes, and questionnaires for patients may not be sufficiently detailed to seek their views on this area. However, an increasing body of work over the last 20 years has demonstrated the relationship between doctors' non-verbal communication (in the form of eye-contact, head nods and gestures, position and tone of voice) with the following outcomes: patient satisfaction, patient understanding, physician detection of emotional distress, and physician malpractice claim history. Although more work needs to be done, there is now significant evidence that doctors need to pay considerable attention to their own non-verbal behaviour.<sup>6-11</sup>

### MODERN-DAY CHALLENGES TO PHYSICIAN NON-VERBAL COMMUNICATION

GPs in the UK face two particular challenges which may affect their non-

verbal behaviour as well as their verbal communication with patients: increased patient participation and computers.

#### *The difficulties of increased participation*

Changes in society as well as medical practice have encouraged the expectation of greater patient participation in consultations. Patients are encouraged to ask questions and expect to be more involved in decision making. One might expect this to lead to improved communication between doctor and patient. However the outcomes of attempts to study the impact of increased patient participation in consultations are largely disappointing,<sup>12</sup> and there is some evidence that doctors respond to increased patient participation with non-verbal blocking behaviours.<sup>13</sup>

#### *The use of computers*

A second challenge for GPs is that they now use computers extensively in their consultations. In the last two decades British general practice has become almost entirely computerised. Furthermore, computers are likely to have had an increased role since the introduction of financial rewards for GPs for recording multiple elements of data about their patients. Bensing *et al*<sup>14</sup> observed that communication between Dutch GPs during the period 1986 to 2002 had become more task oriented, with the doctors less like to engage in building partnerships with their patients, less likely to express concern for their patients, and less likely to provide a structure to the consultation. These findings should be surprising given the emphasis on patient-centred medicine and the focus on communication skills in undergraduate and postgraduate education. But the findings are supported by the evidence that patients still report little encouragement from doctors to manage their own long-term conditions.<sup>15</sup> Bensing *et al* considered that a likely cause of the deterioration in communication observed in their study was as a result of GPs' increasingly using computers.

In contrast, and perhaps more hopefully, Chan and colleagues in a small study from Ireland found that GPs were

able to vary their use of the computer depending on the patient's presenting complaint. For non-psychological problems the computer was used 10–32% of the time but if the problem was classified as psychological this was reduced to 6–16%.<sup>16</sup> However, the design of the study was such that we do not know if those patients with apparently non-psychological problems would have raised additional psychological problems given the opportunity. More research is needed to clarify these issues, but the concern is that the more we use the computer, the less we look at our patients, the less we say to our patients and, in particular, the less we ask about psychosocial aspects of the illness and respond to emotional aspects of their care.<sup>17,18-20</sup>

This would fit with our existing knowledge of the effect of losing eye-contact with the patient by looking at records, whether paper or computer. We know that this behaviour decreases efficiency in the consultation by reducing patient fluency and increasing the chance of doctors missing or forgetting information.<sup>21</sup> Ruusuvaori<sup>22</sup> has shown the importance of the doctor's body position at the beginning of a consultation in affecting patient fluency, with a starting position of the lower body facing the computer, rather than the patient, having a negative effect, even if the doctor provides eye gaze by intermittently turning their upper body to look at the patient.

### IMPLICATIONS OF THE IMPORTANCE OF NON-VERBAL COMMUNICATION FOR TEACHING

Teachers of communication in both undergraduate and postgraduate medical education need to consider how to incorporate these lessons about non-verbal communication into their teaching programmes. Firstly, the evidence underscores the need for video analysis in communication skills teaching so that non-verbal communication can be observed and discussed objectively and, in particular, so that learners themselves can observe their own non-verbal behaviour. Secondly, teachers may need

to become braver about and more skilled at commenting on non-verbal behaviour. Because non-verbal behaviour represents more about our attitudes and emotions, it can be more difficult to comment on sensitively without appearing to criticise the learner's personality and values. This is a particular problem with learners from different cultural backgrounds who may use very different non-verbal behaviour patterns themselves and be used to different doctor-patient relationships and hierarchies.

GPs, practice nurses, and our other colleagues will need to come to terms with the challenge of communicating well with our patients while referring to and recording more data on our computers. In 1984, Heath<sup>21</sup> recommended a variety of strategies to provide appropriate eye-contact, hear the patient's story and concerns, and refer to the patient's record simultaneously:

- deliberately postpone using the records until the patient has completed their opening statement;
- wait for opportune moments before looking at the notes; and
- separate listening from note reading by signposting both your intention to look at the records and when you have finished, so that the patient understands the process (structuring).

Delaying entering some data until after the patient has left the consultation is an option, but the volume of data required for Quality and Outcomes Framework points means that we will almost certainly have to record some data while the patient is physically with us. The skill of structuring the consultation into separate elements, with a deliberate attempt to start the interview by giving full attention to the patient and then explaining to the patient when attention has to be given to the records, is perhaps the most important lesson for clinicians to grasp and to include in modern communication teaching programmes. In this way, we can attempt to overcome a serious issue in medical practice that needs urgent attention. The aim is to reach a happy medium, when the doctor has the skills to communicate well with the patient and is

also able to manage the consultation in such a way as to deliver excellent care and record the necessary data.

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