Practitioners' use of non-verbal behaviour in real consultations

P. S. BYRNE, CBE, M.SC, FRCGP
Emeritus Professor, Department of General Practice, University of Manchester

C. C. HEATH, BA(ECON), PH.D
Research Fellow, Department of General Practice, University of Manchester

SUMMARY. Our analysis of real consultations in general practice suggests that eye contact and movements of the body are extremely important in effecting communication between patients and doctors. We have studied non-verbal behaviour in relation to verbal exchanges, and believe that non-verbal behaviour can aid or hinder communication and may sometimes prevent it.

We give examples from general practice consultations and conclude that eye contact and posture are particularly significant when coupled with open questions or silences or when they occur at points in the consultation when the patient has reached a crucial part in disclosure.

We also believe that the doctor's use of medical records during consultations is most important, and we give examples.

We suggest that the non-verbal behaviour of doctors in the general practice consultation is a topic of immense importance and needs much further study.

Introduction

WE present some preliminary observations from a study of non-verbal behaviour in actual general practice consultations. This study extends the range of a previous study from the Department of General Practice, University of Manchester, on verbal behaviour in general practice consultations (Byrne and Long, 1976). This earlier work enabled us to explore some relationships between general practitioners' verbal and non-verbal behaviour.

We concentrate on postural movement or shift, by which we mean changes of position of the body—such as leaning forward in the chair with arms on the desk having previously been leaning back in the chair. Not only do these major changes in position appear at least as significant in their effect as gestures, they are both easier to study and to acquire.

It appears that, used together, some forms of verbal and non-verbal behaviour have a mutually neutralizing or even negative effect, while in other cases positive reinforcement will occur. We give examples of each.

The consultations from which we quote were ethically obtained by videotape recording. One early finding was that doctors whose verbal behaviour was considered patient-centred (Byrne and Long, 1976) changed position significantly more frequently than those with doctor-centred verbal behaviour. A wide range was observed in the number of times an individual doctor changed his position during the consultation. For example, in two consultations lasting about the same time, one doctor changed his position 10 times, the other twice (excluding, of course, movements necessary for examination of the patient). All the parts of consultations quoted are from transcripts, and we have used the term 'doctor' for 'general practitioner' throughout because we believe that our findings relate to all consultations.

The beginning of a consultation

The beginning of a consultation includes everything that happens before and during the time when the doctor asks how the patient is or the reason for the visit.

Examples

Dr: And how is it now—Mr Berger, is it?
Dr: How are you now?
Dr: Now, what is it about?
Dr: Yes. What can I do for you?

The first two examples are taken from return appointments, the last two from new appointments.

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The way the beginning of a consultation is organized, both verbally and non-verbally, is fundamental to its development. As well as establishing the state of their relationship and appropriate organization of their talk, doctor and patient also establish their degree of involvement with each other at this stage, laying the basis for future interaction.

Examples

1. Dr: Yes, Mr Berger?
2. (5·5 seconds)
3. Dr: Mm? Mm?
4. P: { Well, I . . .
5. Dr { We sent you for an x-ray,
6. didn't we?

(Talk in brackets occurs concurrently or overlaps.)

The doctor's opening question (line 1) is designed to find out why the patient has come. The patient's reply is finally begun in line 4, at least 5·5 seconds later, when the doctor interrupts and overlaps his reply. It is not that the patient was incapable of replying: rather, the doctor's body was turned away from the patient—in fact, he was looking for the patient's record. The patient started to reply only when the doctor moved his body to face the patient and eye contact was established.

The last example shows how body movement and glance can affect the patient's talking. There are more polite ways of starting a consultation. Two similar pieces of conversation may be compared:

A. 1. Dr: How's things?
2. (1 second)
3. P: Eh: well, you know, this
4. thing with the social . . .

B. 1. P: Doctor, I've cum wiv me back again.
2. Dr: Er—Mrs Davis?
3. P: Yeah.
4. (16 seconds)
5. Dr: Yes (miss) wh . . .wh . . . when did we see you
6. last? . . .

In A the doctor used a 'broad' question. This was coupled with a movement which resulted in him leaning back in his chair and looking at the patient. This combination of moving his position and asking a broad question showed that the doctor was attentive and prepared to listen: there was a high degree of involvement with the patient. Subsequently, the patient opened up and disclosed relevant personal problems.

In B it was quite the opposite. The patient introduced the first topic after waiting for a long time for the doctor to ask her why she had come. The patient then stopped talking for 16 seconds because he did not look at her and turned away. He then showed his ignorance of the patient in his first question (line 5). Clearly, an alternative would have been to sit back and ask the patient what was wrong.

It appears that:

1. The way a doctor behaves verbally and non-verbally at the beginning of the consultation affects what he will hear from the patient, his relationship with the patient (how did the patient in B feel towards the doctor?) and the degree of involvement that they will both have in the consultation.

2. Movements of the body can be used to great advantage by doctors to generate an early rapport with the patient.

3. It does not save time to disrupt the patient's opening, nor to stop him talking, for it may prevent his real problems from coming to the surface.

Questioning during the consultation

Example

1. Dr: How are you?
2. P: I feel a lot better now . . .
3. less depressed.
4.
5. P: Um, me son was up in court
6. this morning, so that's finished with now . . .

In this example, the doctor moved towards the patient as he asked "How are you?" As in the previous example, it showed the patient the degree of the doctor's involvement in her problems. The patient talked and then when she began to disclose important information about the cause of her anxiety, the doctor moved further forward still looking directly at her. The patient then went much deeper into her problem.

By gearing his body movements to the pattern of the patient's talk so carefully he showed a high degree of attention and readiness to listen—perhaps more efficiently than by using words.

Later in the consultation there was the following exchange:

1. P: Um, doctor. I had to have the
2. doctor out Friday night for the two little boys.
3. Dr: Um
4. P: They were poorly at the time
5. and had a temperature and he gave them penicillin
6. P: but they've still got a very bad cough and
7. they've nearly finished the penicillin that he gave for the two boys . . .

Again, as the patient introduced a problem the doctor leant back and let her talk rather than interrupting. He obtained all the necessary information very quickly. Postural movement, therefore, coupled with appropriate speech are powerful skills. Clearly it is the doctor's prerogative to employ such skills as they seem

appropriate in a particular situation.

The next example comes from one who has a doctor-centred style:

1. P: I've bin very depressed.
2. Dr: Muh, huh
3. P: It's as though all me inside is breakin' up
4. Dr: Um:
5. P: I can't eat and I can't sleep.

Throughout the consultation the patient clearly wished to talk about her depression: she even asked the doctor questions like "Why am I feeling this way?" By direct interruption, closed questions, body behaviour, even examining the patient, the doctor stopped her discussing her real problem and sent her away. In this consultation there were no open questions, no shifts of position, nor any other form of behaviour which might have allowed the patient to open up.

Example

1. P: I have no reason at all, Doctor. I
2. don't know what I'm crying for.
3. Dr: Because you saw me on the 30th and you were
4. quite alright . . .

The remainder of this consultation might have been quite different if the doctor, following the patient's utterance in lines 1 and 2, had leant back and used an open question or even a silence. The patient was bursting to talk and never had an opportunity.

This doctor adapted neither verbally nor bodily to his patient. He paid her very little attention and showed little involvement in her problem. He therefore missed both the open and concealed offers the patient continually made.

The next is an interesting consultation. After three patients (children), the fourth patient (mother) then began to disclose her problems. Twice while she was talking, the doctor tried to close the discussion:

1. P: . . . they seem to be making me more tired.
2. Dr: Rig{ht
3. P: {I could do with something to make me
4. get going more than anything {else you kn}ow.
5. Dr: {Right, well} . . .

Towards the end of the patient's sentence, (line 1) the doctor moved towards the patient, turned away, and said "Right". During the patient's next sentence (lines 3 and 4) he interrupted while looking directly at her.

However, his attempt to stop the patient talking by changing position was unsuccessful. She went on talking and as she started to discuss one of the causes of her problem, the doctor shifted back in his chair and looked directly at her. Later he discovered that the patient was more pleased with his promise of writing to the housing department than with his offer of a prescription.

This doctor constantly seemed to change between a doctor-centred and a patient-centred style. In this instance his more doctor-centred style of behaviour failed and he finally tried one which was more patient-centred. Only then did he start to discover the patient's real problems.

The timing of postural movement

The meaning to a patient of a particular postural shift of the doctor is dependent upon its relationship to what is said in the consultation. It appears that if the doctor moves while the patient is talking he may stop him (unless of course the doctor is intending to interrupt). To avoid any accidental interruption it is therefore better if he moves while he himself is talking or during a silence.

Postural shifts are particularly significant if (a) they are coupled with open questions or silences, and (b) they occur at points where the doctor feels the patient has reached a crucial part in his disclosure, or where there is a change of topic.

On the other hand, moving at other times in the consultation may well have the effect of showing a lack of involvement with the patient.

At the same time, if the doctor wants a movement to be seen to increase his involvement and make the patient feel that he is prepared to listen, then it is important for him to maintain eye contact with the patient at least during part of the movement.

Movements of the body can also be used to mark phases in the consultation, in particular the end of phases. For example, they often occur at the end of the questioning part or at the end of the consultation itself. Hence, they may be used to close the questioning early, get the patient out of the room, stop the patient talking, and so on.

Reciprocal movements

Movements by one person in the consultation can sometimes lead the other person to start shifting also. In other words, there can be a close relationship between the movements of doctor and patient.

Example

1. Dr: What sort of phobia . . .?
2. P: 'Clostophobia' generally (voice fading)
3. Dr: Sorry?
4. P: I find that generally 'clostophobia', but it's, it's
5. not {really
6. Dr: {(yes)

While the patient was talking (line 2) the doctor shifted towards the patient (perhaps the reason for the patient's voice fading). As the doctor moved the patient also started to move, but away, ending up leaning back after having been near the desk.

This exchange of movements shows the care with which doctor and patient may on occasion monitor each other's body behaviour.

Use of silence and reflected questions

These are two of the rare yet useful skills for the doctor to acquire which are characteristic of the patient-centred doctor. They take a long time to learn and we have found that postural shifts and the use of eye contact may be particularly important in leading to success or failure.

Example

1. P: Per[haps, you know . . .
2. Dr: [Yes.
3. Dr: Yes.
4. P: Um . . .
5. (2·5 seconds)
6. P: (cough)
7. (2·2 seconds)
8. P: I wondered if by telling *you* I would tell
9. myself that I'm being stupid. That make sense?
10. Dr: Well, I think it makes sense for us to
11. discuss it . . .

In lines 5 and 7 we find about 4·7 seconds' silence. After the first 1·2 seconds the doctor started to shift his position so that he was leaning back in his chair. He kept his eye contact with the patient. After this, the patient went on to talk further about her problem. Coupled with the use of silence, the doctor's shift in position showed the patient not only that she should continue to speak, but also that he was prepared to listen.

We have seen instances where a doctor has nullified his use of silence and had to go on talking because of the wayward direction of his eyes and lack of movement during a silence.

The success of the doctor's reflected questions also appears to be helped by movement and eye contact with the patient (though we have not yet seen enough instances to support this view). Perhaps this is because only a few doctors appear to use reflected questions and silence.

Use of medical record cards

The various ways in which the doctor reads and writes on the patient's records during the consultation may affect it significantly.

The amount of time spent and timing of handling the record in a consultation appear to vary according to the styles of practice mentioned earlier. For example, more doctor-centred doctors often read or write on the records while the patient is talking, while they are talking, or on each occasion. More patient-centred doctors leave the reading and writing of records to specific times, say, following the questioning of the patient.

Since the type of question which doctors use to start the consultation depends upon whether it is a new or repeat consultation, there is a case for the doctor to read the record before asking his opening question.

Using the record in the opening of the consultation may certainly affect its subsequent progress—less so, however, if frank reference is made by the doctor to his intention to refer to his notes.

Using records while questioning

If the doctor reads or writes on his records while the patient is speaking, this may well affect the pattern of that patient's talk. He may stop talking in mid-sentence, shorten what he was going to say, or speed up his rate of talking.

Example

1. Dr: When do you get that?
2. (0·3 seconds)
3. P: If I've been . . . if I do anything . . . if I'm
4. You know doing anything, uh . . .
5. (0·7 seconds)
6. Out of the ordinary it starts to return
7. (0·3 seconds)

This is a powerful example and there are many similar ones. The doctor asked a question and then began to read the patient's record. The patient began his reply, stopped, restarted, stopped, restarted, and only managed to get out his sentence when the doctor's glance came up from the record to the patient (line 4).

Not only did the patient reconstruct his talk, but the doctor received a different reply from that which the patient first intended.

Example

1. P: No, well, even the training centres for
2. the employment . . . unemployed . . . they
3. don't like them after a certain age to return there 'cos they say its . . . they're too old . . .
4. you see.
5. Dr: I see.
6. P: So . . .
7. (3·5 seconds)
8. P: So I don't think there's . . .

In this example the patient continued with her talk, but on finding the doctor beginning to write (line 6) stopped talking. She only began again when the doctor stopped writing on her record. Sometimes doctors might want to stop their patients talking, and are able to do so. In this instance it was apparently unintentional but it does show the effect of behaviour, which is common among doctors.

Example

Dr: Just hang on a second, I need to look at your records.
(13 seconds)
Dr: Right, now tell me a little more about this pain.

The doctor's announcing that he is about to read the record appears to have a less disruptive effect upon the consultation, and it wastes less time than interrupting the patient by lack of attention. It is worth noting that when the doctor is silent while reading and writing records the patient is often silent too. It seems it is difficult for doctors to appear attentive to the patient while reading or writing.

Furthermore, doctors with more doctor-centred styles tend to interrupt patients more with their use of records than do doctors who are more patient-centred. Here is a further example of the strangeness of patient talk which occurs when the record is being used:

1. P: And um: I just can't pull myself together.
2. (2·5 seconds)
3. P: I've bin so tired and worn out.
4. (3 seconds)
5. Dr: Could you . . .

The doctor wrote while the patient was talking with long pauses between comments. When doctors are handling the records, talk is not relevant if the doctor has said he wants to read or write on them.

Example

1. P: I can't settle, I can't rest at all.
2. Dr: Uh-huh.
3. P: All me body feels . . . as though its breakin' up.
4. (9 seconds, doctor writes records)
5. Dr: Is your husband at work now?
6. P: Yes, he is.
7. (3·3 seconds)

The patient's talk is in two parts (lines 1 and 3). At the start of the second part ("All me body . . .") the doctor looked away from her and began to write. As he did this, she speeded up but her voice faded. Her gesticulations (a stress marker) also faded. The doctor successfully stopped the patient talking, wrote the records, and introduced an extremely closed question (line 5). Such devices allow doctors to maintain a strict control over the consultation, even if they never hear the patient's problem.

Example

1. P: And I haven't had me letter yet, but I've been
2. getting a lot of um (0·2 seconds) hot flushes
3. you know
4. Dr: I see
5. P: And me nerves 'ave bin very bad . . . me
6. fingers are breaking out in rashes
7. (6 seconds, doctor reads records)
8. Dr: Yes, we got a letter from the hospital . . . when did
9. you . . . when did you go to the hospital . . .?

While the patient was speaking (line 5) the doctor began to read the record. The patient speeded up and then stopped. There was then a six-second silence. The use of the record appeared to cause the suspension of talk between doctor and patient, yet it was possible that the patient had more to say. Later in the consultation there were hints as to what this might have been.

Record use may sometimes discourage the patient from talking. By directing his attention elsewhere the doctor closes off the patient. The more patient-centred doctors do not appear to use these cutting-off tactics as often as doctor-centred doctors. Patient-centred doctors avoid interrupting the patient and appear to select special times in the consultation for record use. As we have said, the doctor may state that he is about to read or write on the records; or he may wait till the end of the questioning part of the consultation; or until the patient appears to have finished what he wanted to say.

As with inappropriate movements, the use of silence and reflected questions may well fail if the doctor mistimes his use of records. For example, if he makes use of a reflected question and then turns to the records, he may well not receive a reply, or if he does, it may be brief. Furthermore, a silence will not be seen by the patient as his responsibility if the doctor lets his eyes fall on the records. We found many examples of helpful verbal behaviour being ruined by inappropriate non-verbal behaviour.

Finally, the potential value of movement intended by the doctor to show attention and readiness to listen may also be negated by his trying to use the record at the same time.

Conclusion

We have described some of our preliminary observations about some forms of non-verbal behaviour in general practice consultations. We are attempting to make more rigorous observations and are also gathering information on a wider range of non-verbal behaviour.

Our eventual aim is to demonstrate to doctors, and in particular general practitioners, both the consequences of using some forms of non-verbal behaviour in a consultation, and the wide range of behaviour it is possible to use in everyday consultations.

Reference

Byrne, P. S. & Long, B. E. L. (1976). *Doctors Talking to Patients.* London: HMSO.

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Addendum

Professor P. S. Byrne died between the acceptance and publication of this article. Dr Heath is now Lecturer in the Department of Sociology, University of Surrey.