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Non-verbal communication during the consultation

When this subject was suggested to me, my first reaction was to say to myself: what a strange question, since everything that happens when we consult with a patient is part of a natural train of events…

On further thought, and trying to see how I myself behave during consultations, I came to understand the reality and importance of this question.

How can we study non-verbal communication during a consultation?

The first step would have been to make a film during a consultation, and then to erase the sound track in order to analyze the role of non-verbal communication. This seemed to me relatively difficult to do in the context of a conference and, without completely abandoning this idea, I tried, throughout the year, to observe and to note down the steps and elements which are part of non-verbal communication during consultations.

I would therefore propose that we look at the various moments in a consultation, along with my remarks, and this will serve as a point of departure for our discussion. If, during the debate that follows, we limit our discussion of the non-verbal aspect to my own observations, we will have neglected the perception of the patient. So this must be enriched by the comments of other people.

The dimension of non-verbal communication in consultation can exist on a number of levels:

- The organization of the consultation
- Attitudes
- How one looks at the patient
- Gestures
- Architecture

For each one of these steps, I will distinguish the elements that correspond to the non-verbal part of the consultation.

I – The patient comes into the consulting room: is it the physician or someone else who lets the patient in? If it is the physician, is he or she alone or with a colleague? And where does the colleague stand, or is he told to stand in a specific place (at his side, for example) by the physician?

What does the physician look at? Does he concentrate on his list of patients (and say he is running late) or does he look at the patient him/herself?

From the beginning of the meeting, what is the climate and environment?

- Do patient and physician shake hands?
- Is the patient encouraged to come quickly into the consulting room while the physician looks away, or is the patient told to sit down right away?

What is the physician wearing? Classic clothes or sporty clothes? Does the clothing indicate an attentive attitude on the part of the physician, or does it appear to indicate neglect? What about wearing a lab coat?

Consulting room set-up:

- How is the physician seated? Behind his computer or a stack of files? Or facing the patient, unencumbered by equipment?
- If there is a stack of files, do these reveal the names of other patients who have appointments, or have the files been placed so that these names are not visible?
- Does the physician seem interested in the patient? Does he/she ask the patient to speak before consulting the file, or does he/she immediately look at the file?
- Is the physician seated in an armchair that is more elevated than the patient's chair, or is he/she at the same level, and is the patient as comfortably seated as the physician?
- During the conversation between physician and patient, do the questions leave time for the patient to express him/herself and find his/her own words? Are the following objectives evident to the patient?
    - To reveal the real motivation behind the consultation, which is not always the complaint that led the patient to consult;
    - To bring forth from the patient the elements that will allow the physician to make a diagnosis of the patient's condition, rather than asking the patient to make this diagnosis.

This non-verbal part is the most essential element of the patient's reaction to the questions that the physician asks.

The physical examination is an important step, in that every gesture can make the patient feel secure or insecure.

In my field, which is gynecology and obstetrics, I have an examination room adjoining my office, with a dressing room separated by a movable screen.

When asking the patient to undress, has the physician thought to put in place this screen so that the patient can feel secure, and to let the woman open the screen herself if she wishes?

A good examination does not necessarily entail the patient is being entirely undressed. It is essential to adapt procedures to the patient and to let the patient understand that a complete examination can be performed while respecting the patient's wishes to keep some clothes on (for example, a shirt).

A clinical examination begins with a general exam and not immediately the exam of the lesion; the patient is shown that the physician is interested in the whole person. Prior to the examination, there is a period of explanation, which takes into account previous exams.

Gestures, as well as the eyes and words, are part of the pelvic exam.

The way the physician looks at the patient is essential when a patient comes in for a mammary or pelvic lesion. The physician should not look surprised or worried or contemptuous or reproachful. In effect, the patient knows her own pathology and expects a professional opinion. A worried or surprised look for a major prolapse could, for example, destabilize the patient to the extent that her future care would be compromised, and her image of her body and of herself as a woman would be adversely affected.

In effect, an isolated lesion can be presented as a handicap or can have repercussions on the patient's body and personality. A worried or desperate look will be "heard by the patient as such, whatever is the quality of the follow-up, and the result will never be satisfying."

There are words that kill and looks that kill!

The way the exam continues is important, because it is indispensable to pay close attention to the zone being examined but also to the patient herself, her face, and her reactions. Movements of the skin, the face, the eyelids and the mouth speak well before there are words, and it is important to know how to interpret and question these in order to allow the patient to speak and say what she feels or thinks. In exchange, the physician agrees to respect the patient's expectations.

When an exam is painful it must be stopped, but also explained in order to find the most pernicious cause.

There is the look and there are the gestures:

- The pelvic exam, whether done with the speculum or not, must never be painful;
- In touching the pelvis, there should never be an association with naked fingers touching the perineum or the inside of the thighs or the flat of the belly. This is a medical exam. If the exam is difficult, gloves can be used.

Words can help and reinforce gestures to explain the steps and procedures of the exam.

The patient is then asked to come back to the consultation room.

If words are necessary to comment or explain, they can never be seen in isolation. It is indispensable that two elements come to bear:

1. The use of diagrams to help the patient understand;
2. A vocabulary lesson, in order to give the patient the medical terminology that corresponds to her descriptions.

It is indispensable in this context that the diagrams allow the physician to give information not only about the disease and its treatment and medical supervision, but also about the conditions under which the patient will be cared for, concerning emergencies or difficulties that may arise from the various therapies.

This imposes a certain number or architectural constraints, such as the quality of the reception room, the waiting room, the sound-proofing of the consultation room (either by insulating the walls or by masking sounds with music, television, etc.)

Beyond the consultation in a consulting room, there is a non-verbal part of the consultation of a patient who is hospitalized. We can observe here a number of seemingly unimportant but in reality very important signs:

1. The act of knocking on the door before entering the room, addressing the patient directly and not the medical team, not lecturing the patient about things that do not interest her, but rather concentrating on her specific case and waiting until out of the room for the discussion of general matters.
2. If an exam is necessary, it should be done in private or with one or two persons to accompany the patient ; care should be taken so that the exam is done in a room with no other patients present. If need be, the patient should be seen in another room.
3. When the physician finds it important to see the patient, the physician should ask to see her alone or with a person of her choice. This is to allow information to be given to the family not by the physician but rather by the patient, who decides to whom to give the information.
4. If need be, a patient can be seen with the persons of her choice. The patient can also wish that the physician speak to these people rather than she, and that the physician give them the information in her presence or in her absence.
5. As far as hospital consultations are concerned, the simplest gestures are the best, for example: if there is time, sit on the edge of the bed and put one's hands on the patient's hands or on the sheet, to signify that one is there to accompany her. This is particularly important.
6. In the same vein, if one feels that words can be hard to understand or misunderstood, one has to know when to stop and begin again in another, more private space (office, etc.).

Non-verbal communication is a dimension that has been too long overlooked and not taught or taken into account in the evolution of our practices.

Yet it has an essential role, which is to allow patients to feel respected and listened to it allows them to speak because they are recognized and validated by an expert. Moreover it gives the patient the impression of being part of the therapeutic decision that is taken, and of being treated as an equal with the physician in human terms.

In effect, there are words that kill ; looks that discredit definitively, gestures that are aggressive. But there can also be looks and gestures that say: "You are valuable, you are important in my eyes, and I can, if you wish, accompany you with whatever competence I have."

Thus, the way we use words and listen to patients (and alternate between the two), allows us to detect the reality of the question that has brought the patient to us, realizing all the while that the official question and the question that is not dared asked (such as pain that hides a sexual problem) are often quite separate.

This attitude is essential in looking for medical violence hidden in the words we use every day, and re-expressing these words for our patients.

Non-verbal communication in the relationship between caregiver and patient is for me a new issue and an obligation; one could even say a new ethical space that imposes reflection and education.

This was perhaps an underlying part of the French law of 2002 relating to the patients' rights.

Fundamentally, one can say that non-verbal communication is, at bottom, an attitude, a way of looking, a way of thinking, and it gives the person we are dealing with the feeling of being recognized, listened to, respected, and, if possible, accompanied.

It thus becomes an essential support for the words of the professional, because it makes these words credible and respectable.

I believe one can say that today, non-verbal communication poses the question of the ethics of communication and relationships.