Italian doctor-patient interactions: 
A study of verbal and non-verbal behavior leading to miscommunication

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Abstract

This study discusses aspects of doctor-patient communication and presents a preliminary analysis of doctor-patient interactions in Italy. The aim is to gain information on how (mis)communication between doctors and patients may affect the doctor-patient relationship and may lead patients to lack trust in their doctors. The authors use a corpus of existing audio-video materials on Italian doctor-patient interactions, and analyse doctors’ use of verbal and nonverbal expressions in their exchanges with their patients. The analysis is aimed to identify which features may engender communication problems –leading to misunderstandings and the perception of doctors as distant or unreliable. The preliminary findings reveal that patients’ lack of trust in doctors may also be the result of doctors’ use of culture-specific patterns of verbal and nonverbal expressions, for example certain sentences used for minimizing patients’ fears, specific postures and gestures signalling distance or closure. These findings will be used for planning future investigations of doctor-patient interactions based on the collection and analysis of audio-visual material. Having a detailed knowledge of what patterns mostly affect communication in natural settings will provide important information to be implemented in digital devices.

Keywords: doctor-patient communication; verbal and nonverbal communication

1. Introduction

In the past patients had high levels of trust in health care professionals. Interpersonal doctor-patient relations were characterized by a sort of blind reliance in doctors; this developed as a result of a longstanding relationship between the patients and their personal physician as well as the patients’ recognition of the physician’s knowledge and medical expertise.

This relationship has been transformed by changes in the culture of health care. Public attitudes towards professionals and their authority as medical experts are changing and there is a decreasing deference to authority and trust in doctors and institutions. The lack of trust in doctors may be the result of various factors such as the increasing competence and confidence of the patients in their own personal judgment of risk (Beck, 1992; Hall, Roter and Rand, 1981), a wider level of education, and a growing level of available information (i.e. through media such as television or the internet). These factors allow patients to doubt what their personal physician says and, consequently, demand more. The change in the institution of medicine may be another cause for the decline in patients’ trust in doctors: technological progress and the continuous search for a higher efficiency and rapidity of treatments lead patients to expect more of the health care providers and justify less any possible mistake. This is one of the leading causes for the rise of the so-called ‘defensive medicine’, referring to the doctor’s practice of recommending treatments that are not necessarily the best option for the patient, but that mainly serve the function to protect the physician against the patient as potential plaintiff.

One of the effects of the complex changes in the culture of health care is that, as compared to the past, doctors generally adopt a more detached approach to their profession. That means, they bring an increased distance in the personal relationship with the patients and therefore a decreased sensibility and empathy for their patients during their encounters. Thus, even though the doctor-patient relationship has traditionally been recognized as a central aspect of medical care (Roter, 2000), with the rise of modern medical science doctors’ ability to communicate with patients has been lost to a greater attention to the technical, purely biomedical detail. In fact, it has been suggested that medicine care has changed the nature of its communication culture: while before it was characterized by an attention to emotions, the unstated or the nuanced, it is today based on the verbally explicit. In other words, it has shifted from being a ‘high-context’ to a ‘low-context’ communication culture (Roter, Frankel, Hall and Sluyter, 2006).

Good communication seems to be the basis of an effective relationship between doctors and patients. Patients consistently articulate their desire for a physician who they trust, has their best interests in mind, and understands and takes their feelings into consideration (Calnan and Sanford, 2004; Golin, Thorpe and Di Matteo, 2007). Good communication in doctor-patient interactions prevents misunderstandings, builds trust between physicians and their patients and, above all, brings better health outcomes. For example, patient-doctor interactions based on good communication have been shown to influence a variety of outcomes including adherence to treatment, recall and understanding of medical advice, and health improvements. On the other hand, the lack of trust in the

1 These terms are used in anthropology to describe differences in people’s cultural behavior as it relates to communication.
3. Preliminary Findings

The analysis was made on a variety of different communicative instances of both verbal and nonverbal communication between Italian doctors and patients. Three main categories of communicative barriers occurring during the analyzed medical encounters were identified. The categories were the following:

- external interruptions
- verbal barriers
- non-verbal barriers.

3.1 External interruptions

The first and most easily recognizable communication barrier observed was the presence of external interruptions occurring during the doctor-patient exchanges. Typically, these were personal phone calls received by the physician during the interaction with the patient, or people (for example, medical staff) entering the room where the physician was speaking with the patient. These interruptions caused a break in the conversation and in the flow of information exchange between the patient and the doctor. They represented a source of distraction for both people involved in the exchange, and at times made it difficult for the patient and/or the doctor to recall exactly what was said prior to the interruption. However, most importantly, it is possible that these interruptions may contribute to the patients’ feeling of frustration: if the doctor does not switch his/her phone off and lets staff enter the consultation room when he/she is speaking with the patients, these may feel that the doctor is not respectful of their needs and is not taking their case in due consideration.

3.2 Verbal Barriers

Another important communication barrier in the doctor-patient interaction was identified in some aspects of the language used by the doctors in their conversations with the patients.

Most noticeably, doctors often used language that was too technical. If a doctor uses technical definitions to describe possible diseases, he/she is using a high level of verbal dominance (Bertakis and Roter, 1991; Kiesler and Auerbach, 2003) and the patients will not be able to fully understand what is being said to them. Patients will also probably feel not satisfied with the way they are being approached, and this will decrease their level of trust in the doctor.

The second relevant communicative barrier identified in the analysis was doctors’ strategies for addressing the patients’ reactions after the latter were told about their disease. The Italian physicians observed in the video clips often used sentences that minimized or involuntarily underestimated their patients’ worries and fears. For example, as a strategy to cheer up the patient, the physicians would use sentences like: “Come on! Take it easy, it’s not that bad! Try not to think too much about it!” or “You worry too much!” These sentences, far

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2 The original sentence was: “Su con la vita. Non è così grave.”

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from having the effect the doctors were hoping to achieve, i.e., to cheer up the patients, work in the opposite direction, that is, they make the patients feel judged or isolated in their fears. Once patients feel the doctor’s lack of empathy or that their fears are not taken seriously, their trust in doctors decreases irremediably.

Studies have shown the advantages of patient-centered communication, that is, communication that takes the patient’s individual factors (such as age, gender, race, past experience, costs and familiarity with the disease) into consideration and incorporates the patient’s perspective and experiences in care planning and decision-making (Wissow et al., 1998). When adopting patient-centered communication physicians provide information, both biomedical and psychological, to patients spontaneously and in response to their concerns. By having a better understanding of the diagnosis and treatment and feeling actively involved in the decision-making process concerning their own health, patients feel that their needs and desires are being met and respond better to care managing their own appointments, filling prescriptions, taking medications, etc. (Hakim, 2011). The style used in patient-centered communication needs to be positive, and aimed at engaging patients in a shared decision making process, eliciting their preferences and understanding their perception of risk and benefit (Hakim, 2011). On the other hand, doctors’ using a critical and judgmental attitude towards their patients during a medical consult can lead to problems of miscommunication and affect the relationship of trust and reliability between the two parts.

3.2 Non-Verbal Barriers

The last barrier to good communication and trust between doctors and patients identified in the analysis was represented by doctors’ use of nonverbal language (and particularly their use of body language).

It has been claimed that 80% of communication between individuals is nonverbal (Mehrabian, 1968). Thus, doctors’ nonverbal behavior and what they communicate to their patients through their bodies is very relevant in highly socio-emotional exchanges such as doctor-patient interactions (Pawlikowska et al. 2012). In general, specific physician behaviors viewed favorably by patients include eye contact, less time looking at medical charts, forward leaning, open body posture, head nodding, use of open hand gestures, and the maintenance of a closer interpersonal distance (Griffith, Wilson, Langer and Haist, 2003; Roter and Rand, 1981; Hall, Harrigan and Rosenthal, 1995).

In our analysis, the observation of doctors’ nonverbal communication focused on their posture, hand gestures, gaze and facial expressions. The effect of any physical object that might work as a barrier, such as the doctors’ desk, medical charts, etc., increasing the distance between the doctor and the patient, was also taken into consideration.

The analysis revealed that Italian physicians are generally unaware of the meanings of non-verbal language in their interactions with the patients. The physicians’ were sometimes leaning backwards, increasing the distance and lack of empathy with the patients and communicating little interest in the patients’ complaint. In addition to leaning backwards on their chairs, doctors might use other gestures that can be interpreted as lack of empathy or participation, as well as perplexity, evaluation, or closure. For example, while listening to the patient or the patient’s relatives, they might use a variety of chin-stroking gestures, signs indicating that the listener has negative thoughts, is evaluating or is being critical about what the speaker is saying. Also, the physicians might often have their hands clenched in a raised or middle position, signaling—again—a negative attitude or little openness towards the interlocutors. The physicians might also often have their hands joined as in prayer, a typical Italian gesture used to express frustration—a sign that can have the same effect as the use of language minimizing the patient’s feelings and fears. Finally, Italian physicians showed little awareness of the importance of gaze and eye-contact in communication: In their interactions they might use a top-down gaze to address their interlocutors, a gesture that may be interpreted as a signal of dominance and does not support a relationship based on partnership and empathy.

As for physical objects that might work as barriers in doctor-patient communication, all videos showed that Italian health care practitioners hold their consultations with their patients, or with the patients’ relatives, sitting behind their desks. Doctors also often hold medical charts for extended periods of time while talking to their patients. Studies have shown that seating arrangements are an important factor in determining the patients’ evaluation of the physician and that objects that are interposed between the physician and the patient may work as a distancing device to the detriment of communication (i.e., Griffith, Wilson, Langer and Haist, 2003; Roter and Rand, 1981; Hall, Harrigan and Rosenthal, 1995). In countries like the US health care professionals tend to avoid interacting with their patients across their work desk to reduce their distance from their patients; in Italy, on the other hand, the space in the doctor’s office is still arranged in the traditional fashion, so that the physician and the patient speak at each other by sitting at the opposite sides of the desk, which amplifies the distance between the speakers.

4. Discussion and Conclusion

This preliminary analysis of the corpus of short videos on Italian doctor-patient interactions was aimed to identify and categorize health care providers’ use of linguistic and non-linguistic strategies that might create communication barriers in the doctor-patient relationship. The purpose of this analysis was to gain information to plan a more systematic investigation of the verbal and

La prenda con filosofia, e cerchi di pensare ad altro”.

3 Translated from the original phrase: “Lei si abbatte troppo”.
non-verbal communication strategies commonly used by health-care professionals in Italy as compared to the strategies used in other countries.

This analysis shows that a number of factors, both verbal and non-verbal, contribute to the transmission of meaning in doctor-patient interactions. Some of the strategies used by doctors when speaking to patients may result in unsuccessful communication, with detrimental effects in many aspects of the management and provision of health treatments. Some of the dynamics observed in this study may, in fact, be specific to the Italian culture and need to be investigated in depth. Our data suggest that the Italian doctor-patient communication is often univocal, and characterized by the doctors’ dominance in both verbal and nonverbal behavior; also, doctors appear not to take into proper consideration patients’ feelings and ideas.

These characteristics clearly do not favor a trust relationship. At the same time, while Italian doctors may be relatively unaware of the consequences of poor communication in their interactions with patients, Italian patients may have lower expectations, as compared to patients in other countries, from their communications with doctors, as they have generally not yet been exposed to communication that is less traditional, more patient-centered. At the same time, communication between doctors and patients might be successful—to some extent in spite of doctors’ poor communication skills, as it has been shown that in conversations, and particularly in certain contexts of urgency, collaborative processes are at work between the participants aimed at making communication flow and avoid miscommunication (Vogel, 2013). In fact, it has been recognized that the social process of interaction in conversation plays a central role in the cognitive process of mutual understanding. Listeners who participate in a conversational interaction go about understanding and thus trust their interlocutor much more than those who are excluded from it (Schober, Michael and Herbert, 1989). However, more needs to be known of the dynamics of doctor-patient interactions.

Future investigations of doctor-patient interactions will be carried out based on the analysis of audio-visual material collected on purpose. Having a detailed knowledge of what patterns mostly affect communication in natural settings will also provide important information to implement in digital devices.

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6. References