Establishing rapport: the GP without a smile

> "Not being able to smile meant that I was forced to hone all those other elements of non-verbal communication, which proved to be far more important than a non-specific smile."

The Royal College of Paediatrics and Child Health gives a seemingly simple piece of advice: *'Doctors should treat children with a big smile.'*[1]

After all, a smile is a cornerstone of good non-verbal communication and it is arguably the most important tool we have for establishing rapport with a patient. However, if a smile really is so important for a doctor–patient interaction, where does this leave the GP who cannot smile? I found this out the hard way.

Last summer, I woke up one morning with excruciating ear pain and looked in the mirror to be confronted by a face that I barely recognised. My left cheek hung heavy and motionless, dragging the corner of my mouth down with it. My left eye, meanwhile, was fixed wide open, unblinking and staring. There was something seriously wrong, and 4 hours later I was hooked up to intravenous acyclovir, having been diagnosed with Ramsay Hunt facial palsy.

After a week in hospital and a week at home trying to come to terms with my newly paralysed face, I found myself back at work in a busy inner-city GP practice. Every 10 minutes, I faced another patient, and with each patient another exhausting round of introducing myself and trying to establish rapport. Without being able to smile, this felt impossible. The patient would approach me, smiling, and I would begin to smile back. Each time, though, my facial muscles failed me and all I produced was a strange, twisted expression that didn't resemble a smile at all. I would look away, embarrassed, and spend the next 10 minutes trying to prop up my heavy, droopy cheek with my hand, while staring at the computer screen.

Over the following weeks, my smile showed no sign of improvement. I began to realise, though, that patients were not really looking at my 'smile' anyway. They were looking at my eyes and listening to what I said. Their own problems weighed more heavily on their minds than the subtleties of my facial expressions. Sixty-five-year-old Mrs Smith was more bothered about her sciatica, 32-year-old James's depression was at the forefront of his mind, and little 3-year-old Tommy would have cried his eyes out during examination whether I smiled at him or not.

Without being able to smile, I had to learn to show friendliness and establish rapport in other ways. I became acutely aware of my posture and body language. I consciously turned away from my computer screen and faced the patient front-on. I carefully considered my gestures and paid close attention to what I was doing with my hands — a simple thumbs-up turned out to be an unexpectedly useful little sign of friendly approval. Instead of a smile, I used my tone of voice to convey openness and a willingness to listen. And, to my great relief, as I became braver about making eye contact, not one patient ever commented on my contorted face with its non-blinking eye. Many patients, however, commented on how nice it was to be listened to for once. Not being able to smile meant that I was forced to hone all those other elements of non-verbal communication, which proved to be far more important than a non-specific smile.

Now, my face is almost fully recovered and my friends and family (apparently with complete sincerity) say they see nothing wrong with my smile. I am sure that this is the case with my patients, too. However, I now know that it doesn't really matter anyway. I have learnt that establishing and maintaining rapport with a patient is about so much more than activating your facial nerve and contracting your zygomaticus major.

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DOI: https://doi.org/10.3399/bjgp18X699149

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