HEALTH COMMUNICATION for Health Care Professionals
An Applied Approach
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Health Communication for Health Care Professionals
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Health Communication for Health Care Professionals

An Applied Approach

Michael P. Pagano, PhD, PA-C

With Chapters on Risk Management and Medical Malpractice by
Canera L. Pagano, JD, RN
This book is dedicated to our granddaughters, Caitlin Elizabeth and Scarlett Josephine, with the hope that their futures will be enhanced by more effective interpersonal health communication, collaborative decision making, reduced health risks, and a patient-centered focus on wellness.

And to Dr. Sandy Ragan, professor emeritus, the University of Oklahoma, who took a chance working with a nontraditional health care provider turned graduate student, changed her scholarly focus and taught so many of us the importance of researching, teaching, and writing about interpersonal provider–patient interactions and improving health communication outcomes.
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Foreword

I’ve been teaching both a social science–oriented health communication class and a skills-oriented communication for the health professions class for several years. I have no difficulty finding a good book for the former, but the books that are geared toward skills for health professionals tend to ignore a sophisticated conceptualization of communication processes. They tend to be based more on anecdotal evidence rather than empirical work. As I revised my plan for the course for health professionals a few years ago, I got in touch with Michael P. Pagano, as I was using his case studies book within that class and I wanted his input on the cases that coordinated most effectively with the various chapters in the other text I was using in the course. He provided very helpful feedback, and even created some individual case studies for my students and simulated patients that semester. As we communicated, he shared some ideas that I found useful for my course. This led me to say, “Why don’t you write a better book for me to use as the primary text in my class?” And he did! This book is the product of that conversation and I am delighted to be able to use it in my course. Thus, I am partially responsible for this volume. I’m perfectly willing to share in the credit.

The reader will find the best of both worlds in this book. Michael, with the help of Canera L. Pagano, has a sophisticated understanding of communication processes as well as a thorough understanding of the complexities of the health care process. Most people who write in this area have only one or the other, but a good health communication book that can help health professionals requires both. Both teachers and students will benefit. The communication process and both health and health care delivery are notably intertwined. Communication is directly related to the accuracy of diagnosis and to the adequacy of information communicated by patients and care providers. Health care providers may improve provision of care by understanding and empathizing with patients more completely.

In addition, the reader of this book will find that it is replete with useful and interesting examples, reflections, discussion questions, and exercises.
This is a very interactive volume that will facilitate student engagement and learning at all levels. It focuses on both verbal and nonverbal dimensions of communication and examines the impact of all key audience characteristics on the communicative process. In each case, opportunity is provided to practice and analyze relevant skills. I am particularly pleased with the foci provided within the book on outcomes, ethics, organizational issues, malpractice, end-of-life communication, and cultural concerns. The book is simultaneously well grounded in medical knowledge and in communication theory and research. The reader will appreciate the focus on avoiding communication problems in health care.

I am delighted to be able to use this book in my class, and am proud to have been a part of talking Michael into writing it. It fills an important void in the market for professors, students, and future health care professionals. I think you will enjoy and appreciate it.

Teresa L. Thompson, PhD
Editor, Health Communication
Professor
University of Dayton
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Preface

This text is intended to enhance and stimulate the exploration, effectiveness, and education of the behaviors and skills of health professions students (RN, MD, physician assistant [PA], doctor of osteopathy [DO], advanced practice registered nurse [APRN], physical therapist [PT], etc.) and practicing health care providers related to provider–patient, provider–provider, and provider–organization interpersonal, health, team, and organizational communication. According to a report from the Institute of Medicine, between 40,000 and 100,000 Americans die annually from medical errors. This text is intended to highlight the fact that, at the most fundamental level, all medical errors are communication based.

Therefore, whether you want to better understand the theories that underlie the messages sent via verbal and nonverbal communication, or you want to enhance your listening, speaking, and/or interacting abilities, this book is intended to support your efforts. The primary author has more than 50 years of combined experience/expertise as a health care provider (PA, registered nurse, and army corpsman). Canera L. Pagano has more than a decade of health care/malpractice law and risk-management experience. Their diverse backgrounds cross numerous health care contexts (hospitals, clinics, surgery, OB/GYN, family practice, occupational health, emergency medicine, provider education, malpractice defense, administrative, etc.). They use these experiences to help readers apply the theories and behavioral recommendations discussed in this text to enhance providers’ understanding of health communication and its role in U.S. health care delivery.

This book is intended to serve as a source of information, primarily as a stimulant for interaction, exploration, application, reflection, and self-assessment. Effective health communication is the result of a complex process that begins with understanding the theories related to various interdependent and interrelated communication disciplines (interpersonal, intercultural, small group/team, organizational, health, etc.). To assist you in better assimilating and utilizing these disciplines, each chapter provides real and/or hypothetical
examples that can be assessed and analyzed. Therefore, the authors encourage you not to just read each chapter, but also to apply what you are studying to your daily interactions with patients, peers, friends, family, and so forth. The more conscious you are of how you communicate, verbally and nonverbally, in all contexts, the more likely you are to enhance your effectiveness in the most challenging and emotionally charged communication context of all—health care. Most communication between providers and patients is psychologically affected as a result of a number of predictable factors:

- Patient’s fear
- Health literacy inequality
- Provider power/control (perceived and real)
- Prior experiences (patients with providers and providers with patients)

With these understandings and goals in mind, please begin your journey through this text by asking the simple question “why”? Why study health communication when you have been interacting with friends, lovers, professionals, clients, patients, and so forth for years or decades? We urge you to keep asking that very important “why” question throughout your exploration of this text and your application of the material provided. Perhaps you could seek “why” answers not to a defensive, “why do I need to study communication” query, but rather to a more reflective “why don’t health care providers do more (listening, translating of medical jargon, collaborative decision making, etc.)?” Or “why do health care organizations communicate with (providers or patients or both) in such an authoritarian fashion?” The authors do their best to help you assess these difficult, but very important, questions in an effort to help you become the most effective interpersonal communicator of health care information possible.

In addition to this text, qualified instructors can obtain a PowerPoint presentation and Instructor’s Manual by e-mailing textbook@springerpub.com.

Michael P. Pagano
CHAPTER 3

Interpersonal and Gendered Communication

For the purpose of this text, we are going to use the following as working definitions:

- **Communication competence:** the ability to effectively exchange and process information with others
- **Context:** setting or situation
- **Empathic listening:** letting speakers talk without interruption and demonstrating the listener’s support without evaluating the speaker or providing instruction, instead encouraging the speaker to find a solution
- **Feedback:** using statements or questions to demonstrate listening to a sender or to encourage clarification from a receiver
- **Gender:** gender may not be constant or easily determined by others and is different from a person’s sex; it is demonstrated by how an individual chooses to behave/act, that is, masculine, feminine, or more likely somewhere in between
- **Gender identity:** a person’s perception of his or her masculinity or femininity
- **Goal competence:** the capability to construct goals and choose a plan(s) to accomplish them
- **Interpersonal (also known as dyadic) communication:** interactions between two people who know each other and share common goals (e.g., friends, lovers, family members, professionals, and a provider and a patient); it is not the same as an infrequent conversation between a customer and a store clerk or a restaurant waitperson
- **Interpersonal relationship:** a bond between two people who share common goals requiring effective interpersonal communication for its development and/or maintainence
Nonverbal communication: behaviors that are not word based; messages transmitted via observable or experienced actions (eye contact, touch, vocal volume, tone, etc.)

Role competence: the skill to assume various social/professional roles based on the context and communicators' goals

Self-disclosure: sharing highly personal information with only a very limited number of most intimate friends/lovers

Sex: male or female, generally anatomically obvious to self and others; determined by presence of a vagina in a female or a penis in a male

Verbal communication: literally what you hear or say when in a conversation with one or more interactants

INTERPERSONAL COMMUNICATION AND HEALTH CARE

As you may have surmised from the aforementioned definitions, interpersonal communication is critical to our interactions with friends, family, and lovers, but it is also vital to successful outcomes in our professional lives. Perhaps no profession depends on the effective use of interpersonal communication exchanges more than health care. If you spend a minute to think of a recent visit to your own health care provider, or an interaction you had with a patient, you will likely understand that at the most basic level, almost all health communication is interpersonal. Health care providers and patients are constantly engaging in information sharing to assure effective diagnosis, testing, treatment, and outcomes. But just as critical is the interpersonal communication between health care providers. Regardless of the channel (air waves, electronic, written, etc.), and whether it is verbal or nonverbal, providers needs to share information with other providers (intra- and inter-professionally) in order to achieve their patient goals, minimize risk, and attain successful outcomes.

Reflection 3.1. Thinking about a single interaction (with your provider, a colleague provider, or with a patient), how would you describe the communication exchange? Was it effective or problematic and why?

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Understanding the role of interpersonal communication in health care is critical to the focus of this book. Once we recognize that almost all of our health care interactions are interpersonal, the value of understanding the theories and skills needed to be an effective communicator becomes glaringly obvious. And with that reality comes the recognition that for two people who share common goals (a patient’s health), the importance of developing and maintaining an interpersonal relationship becomes even more paramount. As we know from our personal lives, those friends, family members, lovers, and colleagues, with whom we have an interpersonal relationship are generally the people whom we trust, share information with, and value the most. Therefore, as a health care provider you will benefit greatly if you can strive to develop an interpersonal relationship with your patients, as well as your peers, colleagues, and superiors.

However, we cannot hope to accomplish effective interpersonal health communication and relationship development without a clear understanding of the impact of gendered behaviors on information exchanges, trust, collaboration, and goal planning/attainment. Therefore, this chapter explores how interpersonal and gendered communication in health care are so important to interpersonal relationship development and maintenance. And, as previously mentioned, in this culture we tend to share information more fully, listen to, collaborate with, and trust those with whom we have an effective interpersonal relationship.

Reflection 3.2. Can you recall a situation in which you needed help from someone, or that person offered advice about something? Did/would your reactions to that offer change based on an interpersonal relationship with that person? If so, why? If not, why not?

BUILDING RELATIONSHIPS

For the purpose of this text, we are discussing professional relationships (provider–patient, provider–provider, provider–family member, etc.). As you know from your own relationships, they generally begin when one person becomes aware of another; in health care contexts, this may be the first time a patient goes to a provider, or the first time a provider begins working with another provider, and so forth. Based on the interpersonal communication
of that initial contact, as well as the circumstances (patient’s wellness/illness, health care team, etc.), interactants will make decisions about the other person and future contact/communication. We need to constantly remind ourselves how different health care, as a profession/context, is from other areas of our lives. For example, we tend to have lots of everyday relationships. Some illustrations of these affiliations are the barista at the local coffee shop or the salesperson at the clothing store. While it may be nice to see a familiar face each time you visit, you will likely not change your behaviors if there is someone else who replaces him or her. And although the person in these everyday roles may be friendly, remember your name, clothing size, drink order, and so forth, you do not share common goals. These everyday relationships generally revolve around your desire/need for something versus the other person’s goal to sell something, keep his or her job, or influence the boss. As you can see, for most health care professionals, this is not the type of relationship that makes sense if you are trying to gather/share information. And while health care employees certainly want to keep their jobs and impress their superiors, generally speaking their primary goal is to help patients maintain or reestablish their wellness and achieve the best quality of life possible—which are almost always patients’ goals as well.

Based on this understanding of an interpersonal relationship with shared goal(s), provider–patient and provider–provider interactions need to have some common understandings:

1. There are expectations that each interactant agrees to adhere to
2. Rules are needed to assure both confidentiality and privacy, as well as trust and openness
3. An understanding that both provider and patient must be willing to do the work of not only maintaining the relationship, but attaining the shared goal(s)

In order for the relationship to develop and be most effective, both providers and patients have a right to expect that the information shared is accurate, complete, and effectively communicated. Therefore, if the patient refuses to discuss his or her prior drug use, it needs to be understood that the provider’s decisions, recommendations, and so forth may not be as effective as they would have been if the patient had been more communicative. Similarly, if the provider knows about risks or alternative outcomes, she or he would be expected to share those with the patient. One of the often nonverbalized rules in provider–patient health communication includes the need for patients to fully disclose their present, past, family, and social histories, but providers will not reciprocate. Another rule is that providers will not allow a conflict of interest (financial or professional) to negatively impact the patient’s care, wellness, or quality of life. Finally, the patient has a right to expect that the provider is not only qualified to offer care, but uses continuing education to update knowledge, decision making, information sharing, and so forth.
Now that we have discussed some of the important aspects of developing and maintaining an interpersonal relationship in a health care context, we need to explore the communication competencies needed to help providers effectively exchange information, enhance trust, and encourage collaborative decision making with other interactants.

Reflection 3.3. If you are in a relationship (platonic or romantic) and the other person self-discloses something very personal, what do you think that person expects in return? Why would that reality make it even harder for patients to self-disclose to providers?

VERBAL AND NONVERBAL COMPETENCIES

Verbal Communication

As you can imagine, being an effective interpersonal communicator relies on your verbal and nonverbal competencies. Let us first focus, however, on your understanding of verbal communication. It may seem like commonsense, but when we refer to verbal behaviors we are literally discussing the use of spoken symbols (language) to exchange information. The problem for many health care professionals is the difference in their perception of shared symbols and the reality for their patients and/or family members. We discuss the culture of health care in more detail in Chapter 5, but it helps if we recognize that providers are assimilated into the health care culture (nursing, medicine, physician assistant, physical therapy, etc.) in part by learning a new shared language—medical terminology.

Because most health care providers have a bachelor’s degree at a minimum, their literacy level is already advanced beyond that of the average American. To further understand the problem, we should examine some statistics from U.S. Department of Education, National Institute of Literacy (2015) regarding adult Americans:

- More than 30,000,000 cannot read
- Nearly 50% cannot understand prescription labels
- Nearly 50% are unable to read an eighth-grade-level book
- Nearly 20% of high school graduates cannot read
Although these numbers seem difficult to comprehend, they have remained relatively unchanged for decades (U.S. Department of Education, National Center for Education Statistics, 2015). Therefore, based on these data, there is a high likelihood that many of your patients will have extremely low literacy levels and have difficulty even with everyday American English. As a consequence, health communication becomes even more problematic—patients have limited literacy and providers typically use terminology that is not even remotely part of the patient’s or family members’ vernacular.

The first step then in understanding verbal competency for a health care provider is to recognize the role symbol sharing plays in effective communication. Next, it is critical to recognize the importance of context in communication exchanges. Perhaps if you think about a typical dinner with your family—in that context you communicate verbally using symbols that you know are most appropriate for such an audience. Suppose you go from dinner with your family, to a bar/club to relax with your friends, will your use of language/symbols change with the context? If you are like most Americans they will. Now what do you think will happen to your use of symbols when you enter a professional context? Again, they will likely change, perhaps drastically. As a health care provider, you will need to use the appropriate language/terminology with colleagues and superiors, which requires symbols that are far different than those at your family dinner or your evening out with friends. Like many Americans, you will be able to subconsciously alter your symbol usage based on the context. However, health care is unlike almost any other context because providers must use the appropriate symbols/terminology with their peers and colleagues and a very different level of symbol sharing with patients and family members.

**Reflection 3.4.** Besides literacy, what do you think is another major obstacle in the health care context for effective interpersonal communication and information exchange?

When we think about the differences in health care communication and most other contexts, one major problem seems to transcend all others—patients’ emotional responses. In the current health care system, we tend to have an acute versus chronic care focus—both as providers and as patients. For the most part, adults are not seeking care unless they have a problem. Consequently, patients come to most health interactions with verbalized, or often nonverbalized, concerns (e.g., quality of life, financial implications, pain,
survival). These emotional issues may add an additional layer of difficulty to the provider–patient interaction.

Imagine if you will that you find a lump in your breast—male or female—what is likely the first thing you may assume that lump represents? Even if you are a seasoned health care provider, you are likely to be concerned that you could have cancer. Now, try to consider what it would be like not to be a health care provider with your knowledge of statistics for breast lumps for people of your age group and sex. Patients not only may be terrified that they have cancer, but some may be so concerned that they do not seek care immediately—too afraid to even tell anyone about it. Others may seek care, but not want to disclose all the information the provider is seeking in fear that by talking about a positive family history, or other potential signs and symptoms, they will increase the chances that the lump is malignant. Therefore, one thing that the emotions associated with many health care contexts contribute to provider–patient interactions is a level of “noise” that jeopardizes effective interpersonal communication and relationship development. Noise in this case is hindering the conveyance of information that providers need to help accurately assess the problem/situation. However, emotional issues in health care contexts create another type of noise that can be just as problematic for patients and providers—if not more so.

Reflection 3.5. Can you recall an exam or a lecture during which you had trouble concentrating because of something that had happened in your life? What was causing your distraction (a breakup with a lover, a death of a loved one, other unexpected joyous or sad news)?

Another example of noise that interferes with effective information exchanges is the emotional concerns that distract a patient (or a provider) and decrease his or her ability to listen and assimilate what is being communicated. Think about your response to Reflection 3.5; haven’t we all experienced distractions from outside events that made it very difficult to concentrate on what was happening in the present? Even if you cannot recall such a situation, you likely can understand how the death of a loved one, for example, might make it difficult to focus on a lecture, an exam, or a workplace assignment. Therefore, you should be able to see how a patient who thinks she or he has a serious illness, terminal condition, requires surgery, can no longer work, and so forth, would have a great deal of difficulty listening effectively to a provider who was trying to explain something, or seeking more information or shared decision making. Remember the possible breast lump? What if you’re sitting in the provider’s office and she or he says, “the
biopsy shows that lump is a cancer”—what would you hypothesize occurs at that moment in the patient’s consciousness? Would it be surprising to learn that for many people the word cancer has terrifying connotations (relational meaning, e.g., that’s what killed grandma, or I won’t see my son get married) in addition to the denotative (dictionary) realities that overwhelm the brain’s ability to process incoming information?

In interpersonal communication, verbalized messages generally have two distinct types of meaning—denotative and connotative. The denotative meaning is literally the dictionary definition, cancer is a disease in which cells divide abnormally and can destroy other cells and/or organs. However, the connotative meaning of a message is much more personal, abstract, and/or subjective. So to one person cancer might have a connotative meaning of death, that’s what killed Aunt Helen, or long-term sickness from the chemotherapy. The connotative meaning often has little to do with the denotative meaning—it is much more of an emotional response based on a person’s knowledge, experiences, hearsay, or myth. Thus, a provider may tell a patient that his or her breast tumor is a stage-zero carcinoma, noninvasive—compared to more advanced stages, this would be the best possible news for a patient. However, if the patient’s connotative interpretation of the message is terminal cancer, it is highly unlikely that the patient will hear little if any of the information the provider attempts to communicate about the disease, treatment plans, or prognosis. In this context, the connotative meaning and the patient’s emotional response have created so much noise in the interaction that she or he will not be able to process effectively the rest of the provider’s information.

Reflection 3.6. If you are delivering potentially emotionally charged news to a patient and/or family member, how might you try to overcome that person’s connotative response and obstructive noise in the interaction?

Once we recognize how problematic noise can be to effective interpersonal communication—especially from unrecognized connotative miscommunication—we can begin to find ways to help avoid or deal with the issue. For example, if you have to deliver news to a patient that you think could trigger a negative emotional response, you can either try to verbalize the message in a way that addresses the potential connotative meaning and minimize or eliminate it. Another way to help assure that the patient gets the information she or he needs in spite of the likely noise from the connotative meaning of the message is to ask the patient to bring a relative with him.
or her to the interaction. The patient’s advocate is generally less emotionally impacted because it is not directly affecting him or her, and therefore can listen more effectively, take notes, ask questions, and share the information with the patient at a later time in a different, less emotional setting. Also, it is often very helpful to have a handout that is language specific (English, Spanish, etc.) and written at an appropriate patient reading level that can be taken home and easily understood by the patient and his or her family. The importance of recognizing the potential negative impact of noise and connotative meanings on interactions will help you assess your patient/family member and determine the most effective way to communicate health information to help enhance the patient’s assimilation and decision making.

Listening

Before we move to our discussion of nonverbal competencies, it is very important that we highlight the critical role listening plays in effective interpersonal communication, but also in interpersonal relationships. Listening is different from hearing. Hearing is anatomical and physiological—if you have ears and they are working normally—you can hear. However, listening requires attention and focus on the other communicator and the message. We’ve already discussed how emotional noise can interfere with patients’ abilities to listen. But too often providers do not listen as effectively as they could. Some providers are so concerned with their needs to gather specific information and intrapersonally complete an algorithm based on the patient’s complaints that they do not listen to all that the patient/family member is trying to communicate. In addition, with the use of computers in health care contexts, providers are frequently so preoccupied with completing the electronic document that their focus is on the computer instead of listening to the patient. And, as briefly mentioned earlier, like patients, providers can have extra conversation issues impact their listening. Problems with family, friends, finances, even other patients who are not doing well, all can create noise that can interfere with a provider’s active listening. Finally, some providers may believe that the data they need to gather is more critical than the information the patient wants to share—in those cases the provider may minimize his or her listening and focus only on the responses that meet the provider’s information-seeking needs.

All of these issues are potential obstructions to patient and provider listening and consequently effective interpersonal communication. Armed with this information, providers need to not only understand the importance of effective listening, but also to assure that they are doing all they can to enhance active listening. Some ways to improve your listening include:

- Making the patient’s message your key focus
- Trying not to make your information needs more important than the patient’s
- Waiting to type/write/focus on your computer or paper until the patient has finished speaking
Using eye contact to demonstrate your listening

Providing feedback (restating what you heard or asking questions, even nodding or shaking your head) to demonstrate listening and/or understanding/confusion

The use of feedback is an important tool to assure that you have assimilated what was communicated correctly, but also to reinforce for the patient/family member that you were listening and want to clarify. Feedback can also be used to check that the patient understood what you told him or her. For example, you can ask the patient to restate what you just communicated. Try to avoid simply asking whether she or he has any questions—too often patients/family members didn’t understand what you said, or were unable to process the information because of noise, and they do not know what to ask, or want you to know that they didn’t assimilate what you communicated. As you can tell, the importance of verbally sharing easily understood symbols, recognizing the importance of denotative versus connotative meanings in interactions, and the critical nature of listening are all necessary for competent verbal communicators. However, as valuable as effective verbal communication is to information exchanges, interpersonal communication, and interpersonal relationships—in the U.S. culture, nonverbal competencies are even more critical.

Nonverbal Communication

In American culture, nonverbal communication is extremely important to effective information exchange, interpersonal communication, and relationships. Nonverbal codes are used to express meaning, manage information flow, and contribute to or detract from verbal messages. As you know, we use nonverbal symbols to help receivers recognize whether we like or dislike something (e.g., smile, frown, thumbs-up), agree or disagree (e.g., head movement vertically versus horizontally), or are interested or disinterested in conversation (e.g., eye contact or body position/movements). Nonverbal behaviors also are used to illustrate power and status in this culture. For example, if you have a corner office at work or you are in a cubicle, your status in the organization is immediately recognized by your peers. In health care we use white coats, scrub clothes, and nametags to help patients and colleagues identify us as members of the provider culture and our printed credentials, MD, DO (doctor of osteopathy), RN, physician assistant (PA), advanced practice registered nurse (APRN), physical therapist (PT), to provide nonverbal information about our organizational status.

In terms of combined verbal and nonverbal messages together, interactants frequently use nonverbal codes to evaluate verbal messages. For example, if you are shaking your head from side to side, while you tell someone there is nothing to worry about—the other person is likely going to trust your nonverbal message more than your verbal statement and be concerned. So nonverbals can be used to reinforce verbal messages, contradict them, or highlight certain aspects of them. For example if you say “fire,” others may think it is not a major problem. But if you say “fire!” and your voice rises both in pitch
and volume, people are much more likely to not only perceive a problem, but respond immediately. The verbal symbol did not change, but the nonverbal cues, raising your voice and pitch, alerted listeners that this is not a typical use of the word fire. Be aware, however, that others can use your nonverbals in an interaction to also assess your credibility and interest. How would you feel if a health care provider, during an exam or discussion with a patient, goes to a closed exam room door and puts her or his hand on the knob while asking, “any questions”? In this culture, is there any reason to believe that this provider really wants questions? In fact, most patients would likely assume just the opposite—the nonverbal cue, hand on doorknob, is what the provider intends to communicate—I am leaving; not the verbal message: seeking more conversation. As you can see, our nonverbal behaviors in this culture are extremely important to the effectiveness of an information exchange. But, before we discuss nonverbals in more detail, there are two things that we absolutely need to be clear about:

1. Communication is about the receiver of the message, so it is not about what the sender of the message intends, it is about what the receiver understands. We can assume that in the previous example the provider did not intend to communicate that she or he was ready to close the conversation with no further dialogue, but, based on his or her nonverbal behavior, that is what the receiver (patient) perceived.

2. Everything we do communicates to others. Therefore, if you show up 5 minutes late for your first day of clinicals—whether you intended to or not—you have likely communicated to your superiors (and maybe even your peers) that you did not think it was worth your effort to get to the hospital/office on time.

The importance of these two realities is that a health care provider needs to be constantly aware of patients’ and peers’ perceptions of his or her message (verbal and nonverbal) and pay close attention to what is being communicated and how he or she intended the message to be interpreted.

**Reflection 3.7.** You are discussing a spinal tap procedure with a patient and she asks, “Does it hurt?” You respond, “Not really,” but your eyes are looking away from the patient and you bite your lower lip as you finish speaking. What would you hypothesize a patient in this culture would perceive the answer to her question to be and why?
In order to better understand nonverbal behaviors, it will be helpful to discuss them in the categories in which they are commonly used:

- **Proxemics**—related to the distance between interactants in a conversation
- **Haptics**—how touch is used in nonverbal communication
- **Kinesics**—the use of our bodies to communicate
- **Artifacts**—accessories that contribute to the information exchanged in an interaction
- **Vocalics**—the use of voice characteristics to alter message delivery
- **Chronemics**—the impact of time on message exchanges

While entire books are dedicated to the discussion of these important nonverbal behaviors, we need to explore in some detail how each of these impact interpersonal communication and, therefore, interpersonal relationship development, maintenance, and/or dissolution.

**Proxemics**

Proxemics is an important nonverbal cue for health care providers to understand. In American cultural research, Hall (1959) has shown that we have communication expectations based on very specific distances between interactants. Think about your own conversations and try to recall how far apart you stand/sit from a friend/lover/colleague/professional when you are engaged in an interpersonal conversation. Generally, in this culture, we expect to have about 4 to 12 feet between ourselves and another person in a social situation: restaurant, classroom, retail setting, and so forth. However, if we are talking with friends we are likely to be significantly closer, usually between 2 and 4 feet. Consequently, only our most intimate friends and lovers are generally expected in our private space, between 0 and 18 inches.

**Research Exercise 3a.** You are a social scientist and you want to study proxemics. Go to a retail setting, not a bar or club. Find a stranger of the same sex (very important—do not attempt this with a stranger of the opposite sex) and start a conversation. As you two are talking, slowly inch closer to the other person (very slowly). How close were you able to get? What happened? How did this research project make you feel and why?
Proxemics, as you may have concluded, are extremely important nonverbal behaviors for health care providers to understand and utilize in interactions with patients. Think about your role in health care and how much of what you do involves “invading” a patient’s personal space. From taking vital signs (pulse, temperature, and blood pressure), to auscultating the chest, and exercising joints, almost everything health care providers do involves behaviors that are unacceptable in any other context. Supposing you were on a bus and you approached a stranger and suddenly grabbed his or her wrist and began feeling for a pulse. Or you started doing range-of-motion exercises with his or her knee—do you think that person would respond positively to these nonverbal behaviors? In all likelihood, the person would either scream and push you away, or try to punch you for invading his or her space. Clearly, these actions in the context of a bus, that are done constantly in a health care setting, are made even more unacceptable because they include the use of haptics (touch), which, combined with inappropriate proxemics, compound the miscommunication and misperception of your actions. The question you need to ask yourself is: Do patients give up the right to expect input into this infringement on their personal space in a health care setting versus all other U.S. contexts (except prison)? This book is intended to help you assess the role of communication in such situations, especially in a health care context.

Now, it should be understood that if we are discussing a life or death emergency situation, then the provider should do whatever is needed to aid the patient. However, in the overwhelming majority of health delivery scenarios, providers all too often assume that their needs (to gather data) supersede the patients’ perceptions of personal space and who can enter that domain without approval. In these instances, how much time would it take to acknowledge the patient’s right to his or her space and ask permission to enter it? For example, a simple query like, “Is it alright with you if I pull my chair up closer so I can examine you?” This one-sentence verbal message does much more than just communicate your recognition of the patient’s space. Such a question informs the patient that she or he has power in this interaction and that the two of you are collaborating in the process. When a provider invades a patient’s space without acknowledging the patient’s right to control his or her environment,
the provider has nonverbally demonstrated his or her power as well as the patient’s loss of autonomy and decision making. This single act contributes to a patient’s assumption that the provider is taking an authoritarian role in the interaction and consequently is likely to be more paternalistic and declarative in his or her analysis, diagnosis, and treatment plan than informative, collaborative, and encouraging. Once a provider understands the importance of proxemics in this culture, she or he can make empowered decisions about how she or he wants, or does not want, to acknowledge the patient’s personal space and the provider’s need to access it. However, as noted earlier, proxemics is just one aspect of nonverbal behaviors—even more critical perhaps to patient–provider relationships and communication is the role of haptics.

Haptics

In the United States, touch (haptics) is generally reserved for close friends, family, and lovers. In fact, there are laws governing a person’s right to control who touches him or her socially and professionally. If you recall our example of the aforementioned bus rider who is suddenly touched without his or her permission, you likely had an almost primal response to the thought of a stranger touching you without your permission. And yet, every day in this country health care providers do exactly that to patients. Think of the last time you took someone’s blood pressure or went to draw blood—consider especially this latter behavior—you are going to cause someone pain and yet, if you are like the majority of providers in this county, you didn’t ask to touch the person before you twisted a tourniquet around his or her arm tight enough to constrict the circulation and then inserted a needle into his or her vein (perhaps even without a warning that you were going to do that as well). Now, you can argue that a patient comes to see you for this very nonverbal behavior (to get his or her blood drawn), but does that mean she or he knowingly abdicated the right to say what happens to her or his body? If you recall the earlier discussion of all behaviors communicating—whether intended or not—what would you think a patient might perceive the message to be when a provider grabs his or her arm and performs a venipuncture without asking the patient’s permission to invade his or her space and touch the arm? It seems fairly clear that such a behavior would again communicate that a provider thinks his or her actions are more important than the patient’s autonomy. Once again, you as a provider have to make decisions about how you want to be perceived by patients, but if your actions (not seeking permission to touch) are so different from all other areas of American culture (except prison)—does it not seem wise to take a minute to explain to the patient that you need to draw blood, for example, and you would like his or her permission to touch the arm?

From a patient’s perspective, think about how important it is to have a health care professional acknowledge the right to control what happens to the patient’s body. Nonverbally it communicates the provider’s desire to collaborate, not dictate, to a patient about his or her health care. It is so important to understand how each communication behavior (verbal and nonverbal) can be cumulative in terms of how a patient perceives a provider’s empathy, compassion, and willingness
to share power. As you may have noted, proxemics and haptics are two very important nonverbal behaviors in provider–patient communication, but there are several more, especially kinesics.

**Reflection 3.9.** How would you feel if you were in a classroom or continuing-education conference and the professor/presenter came over to you and grabbed your hand and started helping you write notes? Were you not in that environment to learn? So how is that use of haptics different or similar to the previous blood-drawing example?

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**Kinesics**

Although the term *kinesics* may not be familiar to you, the nonverbal communication behaviors it refers to will be. Some of the common actions included in kinesics include:

- **Body movements**
  - Gestures
  - Gaze
  - Facial expressions
  - Arms crossed on chest
  - Leaning back in a chair
  - Sitting with legs spread out

**Research Exercise 3b.** When you are in a meeting or in a classroom, put on your social scientist “hat” and observe how the speaker uses his or her kinesics to communicate with the audience. How do body movements and artifacts impact your perception of the speaker, the message, and the speaker’s credibility (be as specific and detailed as possible)?

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Body Movements

Body movements refer to a person’s posture and gait. In this culture, we use body movements as one way to determine a communicator’s status, power, and interest. As mentioned previously, some people may not be consciously aware of these nonverbal behaviors, but their actions are nonetheless observed and assessed by others. Therefore, if you are in a meeting and you are sitting in a “closed” position (arms folded against your chest, legs crossed, pushed away from the table/desk), those body movements will likely be perceived as someone who is withdrawn or has little interest in what is being discussed. In contrast, if you are in a meeting and are leaning forward, with your arms and legs uncrossed, this “open” posture communicates your interest in the speaker and the topic and your attention to the material being presented. Similarly, if you are walking down the hall and moving slowly, your supervisor may perceive that you are bored or disinterested. How you move communicates to others and the more you understand that, the easier it will be for you to make decisions about how you want your body movements and gait to be perceived by others.

Another form of body movement that is highly assessed and perceived as a key nonverbal cue in this culture is the handshake. Americans believe that a firm handshake is an expected nonverbal form of greeting, especially between two interpersonal communicators. In general, a handshake is an anticipated communication when meeting someone, either for the first time in a professional context or as a traditional greeting in many interactions with friends, colleagues, clients, or customers. It is in fact one person offering another person the right to touch him or her (haptics). However, this aspect of kinesics is not just evaluated on whether it is communicated (an offer of a handshake or not), but equally for how strongly or weakly a person grips the other communicator if a handshake occurs. A weak handshake in this culture is often perceived as either a sign of disinterest, weakness, or diminished self-confidence.

Based on these expectations, you can not only observe how others use body movements in their interactions with you, but also be aware of how you use these forms of kinesics in your nonverbal communication. For health care professionals, kinesics is especially important as you need to observe your patients’ body movements as part of your physical examination. You will want to determine, for example, whether a patient has a facial droop, or a limp, a weak grip, or an asymmetrical palpebral fissure (distance between eye lids). Although these kinesics may be signs of an illness or injury, they are also nonverbal behaviors that are communicating information about the patient. Therefore, you can use those same powers of health care observation to analyze kinesics (yours and others) during interpersonal interactions and evaluate what the body movements are communicating about the sender and his or her or your nonverbal messages. In this culture, another type of body movement that is perceived as having more credibility than others in the assessment of communication is one’s gaze.
Gaze

In American culture, we highly value a person’s gaze. This form of kinesics is generally theorized to communicate a person’s honesty and/or credibility based on whether that person is willing to make eye contact during an interpersonal interaction. Consider for a moment a male patient whom you are interviewing and he is complaining of dysuria (painful urination). To learn more about his problem, you ask him whether he previously had a sexually transmitted disease (STD). As he starts to respond, you notice that his eyes are not looking at you, but instead, he is looking down at the floor, as he states, “Of course not!” This is an example of contradictory verbal and nonverbal cues. The patient has verbally denied any prior STD history, but his nonverbal kinesics (gaze), have suggested that he may not be telling the truth. Again, in this culture, we expect nonverbal behaviors to “complement” our verbal cues. Therefore, we expect people to look us in the eye when responding to questions—especially sensitive questions like the one in this scenario. When a person in a professional or personal setting does not use his or her gaze as expected in this culture that individual's communication is generally perceived negatively regardless of his or her verbal behaviors. Although body movements and gaze often work together to reinforce nonverbal messages, they also can be cumulative in connection with other forms of kinesics, for example, facial expressions.

Reflection 3.10. You have an interview for a job and go to greet the interviewer. Nonverbally, what are two of the most important kinesics you need to utilize to demonstrate your interest, sincerity, and recognition of cultural expectations for professional greetings?

Facial Expressions

Although in American culture there is an added emphasis placed on the assessment of nonverbal cues based on a communicator’s gaze, the importance of a communicator’s facial expressions in transmitting his or her meaning is also very important to understand. Facial expressions are powerful nonverbal cues, especially in terms of communicating understanding, confusion, and emotions.

If you recall a recent conversation, professional or personal, you can likely remember how a colleague, supervisor/professor, friend, or lover responded during an interpersonal interaction. In this culture, we generally seek
nonverbal feedback in a conversation by observing the other communicator for a smile or a frown, a grimace, or raised eyebrows, and so forth. Similarly, we often assess a person’s facial expression to deduce whether she or he is happy, sad, angry, fearful, surprised, or disgusted. As an interpersonal communicator and a health care professional, you will want to utilize these various forms of nonverbal behaviors to help you better understand your patients’ and peers’ communication, but also to recognize how your own use of kinesics (facial expressions) are being analyzed by others. As mentioned previously, communicators use nonverbal cues to demonstrate and to analyze the assimilation of information, impact of the message on others, and/or the disconnect between a speaker’s verbal and nonverbal cues. A patient who has a pensive look on his or her face (wrinkled forehead, pursed lips, raised brows) may be trying to “unpack” the meaning of what was just heard. Or she or he may be confused about what was stated. In either case, a thoughtful interpersonal communicator might ignore the patient’s verbal ascent of understanding and use kinesics to determine that more clarity and content are needed to better assure effective assimilation of the message. Similar to body movements and gaze, facial expressions offer communicators both an opportunity to share information nonverbally, but also provide a feedback mechanism to help assess a person’s recognition and understanding of the message. However, not all nonverbal behaviors are feedback mechanisms. Specifically, artifacts are more (consciously and/or subconsciously) communicator-centric forms of nonverbal communication.

Artifacts refer to a wide array of nonverbal cues, including body types, clothing, jewelry, and body adornments (tattoos, piercings, and so forth). By their very nature, artifacts tend to be a person’s communication about himself or herself to others (specific or in general). For example, a 20-year-old co-ed wearing bright-pink sweat pants with the word “Party” in big white letters across her butt probably did not consider how that would be perceived by a 60-year-old male professor walking up the stairs directly behind her. It is unlikely that this woman intended, when she got dressed that day, to either invite the professor to “party” or to make him aware of her extracurricular proclivities. And yet, that is exactly what her artifacts have communicated. Similarly, what about an emergency department (ED) provider who walks around in scrub clothes with his tattoos (neck and arms) and piercings (eyebrows, ears, and tongue) visible—do you think patients or even peers might perceive him as less credible a professional because of his body art? And what about the potential risk of hepatitis C from tattoos and piercings—might patients be somewhat concerned for their health? Although such an infection risk from tattoo needles, and so forth may be extremely low, it is a possibility and so is the perception of provider–patient transmission—which could be communicated nonverbally by the provider’s artifacts.
Unlike other forms of kinesics, artifacts are more subjective. For example, in this culture we have research that shows how people generally perceive limp handshakes, down-turned gazes, and frowns versus smiles, but artifacts are much more individualized. If a person is a fan of tattoos or piercings, then another person’s body art might very well be perceived as a positive nonverbal behavior. However, to a different person, who is not a fan of body art, tattoos, and piercings, they could be viewed as negative nonverbal messages. Therefore, health care professionals need to understand both what they are communicating with their artifacts and how they are assessing their patients’ and peers’ artifacts. It is important to not stereotype and certainly it would be a huge communication mistake to evaluate everyone who is obese as uncaring about his or her health. Or to categorize everyone who is thin as anorexic or bulimic. However, at the same time, it is important for providers to understand how patients, peers, family members, and/or organization administrators might perceive the providers’ artifacts. How do you think a 200-pound male patient might assess the verbal versus nonverbal (body type) artifact communication from a female provider who weighs 300 pounds and tells the patient that he needs to lose weight to stay healthy? As stated previously, it is impossible not to communicate (whether intended or not), so in order to be a skilled, thoughtful, interpersonal communicator—you need to understand how your nonverbal cues, including your artifacts, are impacting others’ perceptions and determine whether that is the message you want to be sending. However, not all nonverbal behaviors are silent, in fact, vocalics are an auditory form of nonverbal communication.

**Vocalics**

It may seem odd that there are sounds that are classified as nonverbal communication; however, it really makes sense when you consider how we say things is sometimes more communicative than the verbal symbols we use. For example, “I need some help in here,” may be a simple request for some assistance by one provider to another, but the same symbols—when screamed at the highest volume a person can reach—communicate an emergent level of need. The various nonverbal characteristics (e.g., volume, pitch, and inflection) of our

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**Reflection 3.11.** Why is it that health care organizations have certain dress codes regarding white coats, scrub clothes, uniforms, jewelry, and so forth? What is the organization trying to nonverbally communicate to its members and to its patients and their family members?
voices allow us to alter the way in which our verbal messages are perceived. In addition, communicators can use laughing, crying, and whining as nonverbal behaviors to transmit both physical (tears) and/or emotional feelings. Health care providers need to be aware of how vocalics can be used to impact communication exchanges. Think about how your response to paralinguistic cues (screaming, crying, whining, laughing, and so forth) might impact your communication and/or your feedback to a sender’s message. Another unique form of nonverbal communication is related to the use of time—chronemics.

Reflection 3.12. How do you respond when you are in a conversation with a person who is crying? What if that person is a patient, would you respond differently? If so, how and why is the same nonverbal cue different?

Chronemics
In America, we have some very specific views on how we use time. For example, if you are expected to be at work or in class at 8:30 a.m., arriving at 8:45 a.m. is generally viewed negatively and consequently may impact your pay, promotion, grade, and so forth. In health care, time can be a critical factor, for example, defibrillation that is delayed a few minutes could be the difference between life and death. Medication is usually most effective when provided on a set schedule and, similarly, the amount of radiation exposure is time dependent. However, although these are obvious impacts of time on treatment outcomes in health care delivery, chronemics refers to the use of time as a form of nonverbal communication.

One of the most frequent patient complaints in providers’ offices and hospital settings is related to chronemics. Patients and family members often perceive delayed appointments/visits with providers as nonverbal communication of the power and status differences in provider–patient interactions. Think about meetings or classes you attend, they generally do not begin until the leader/supervisor/professor arrives. Clearly, if she or he is leading the discussion or scheduled the gathering, then the perception is that nothing can take place until the person in charge arrives. Consequently, the audience in this case is aware of the leader’s/professor’s power and control over when things will begin and end. As a person who does not control the timing of these events, how do you feel when you arrive on time, but the featured speaker/leader does not? Or you get summoned to your supervisor’s/professor’s office and when you arrive, you are asked to sit and wait until she or he is ready to see you—what do those nonverbal cues communicate to you (come to the office, wait till I am ready)? If you are like most Americans, and have been
summoned and told to wait until the other communicator is ready, you perceive these behaviors as an illustration of that person’s power and status.

From a nonverbal perspective, being a patient is even more difficult and frustrating. First, the patient is the person who is paying (insurance, copay, Medicare, etc.) for a service—which has its own set of expectations in this culture—but is unlike other contexts (e.g., a retail store where a sales person does not arrive in a timely manner to assist you). Second, the patient may be in pain, or anxious about the reason for the visit. Third, the patient is probably partially naked as she or he waits for the provider. Consequently, it is very difficult in such a scenario for a patient to walk out of an ED or a provider’s office because the patient is unhappy with the wait or being treated less than an equal. Therefore, through the use of chronemics, the provider has reinforced his or her power and/or status vis-à-vis the nonverbal communication that her or his time is more valuable than the patient’s time. If you were in an interpersonal relationship (friend, lover, colleague) and the other person used chronemics to control the start and close of conversations, would you want to maintain or end that relationship?

As we have been discussing throughout this chapter, nonverbal communication is a powerful tool for enhancing or diminishing interpersonal relationships. A provider who schedules a patient visit every 10 minutes but knows that he or she will keep patients waiting is clearly more provider-centric than patient focused and communicates that reality to patients and staff through his or her use of chronemics. Clearly, verbal and nonverbal communications are critically important for effective patient–provider interactions and relationship development and maintenance. But interpersonal communication also relies on communicators understanding their roles, selves, and competencies.

Research Exercise 3c. Ask three people (a parent/grandparent, a peer, and a health care provider) the same question: “Why do doctors so often make patients wait before they see them?” and analyze their answers. What did you learn from the various audience responses/perceptions?

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Role, Self, and Goal Competencies

Part of being an effective interpersonal communicator as well as a successful health care professional is possessing communication competence as demonstrated through your understanding of role, self, and goal proficiencies. Role
competence refers to a person’s ability to take on certain social roles (e.g., friend, parent, professional) and what the expected behaviors for each are, how to maintain them, and when it is okay to ignore those norms.

Think of your role as a health care provider, how does that shape your behavior—especially your interpersonal communication and relationship development? Do you use your role to highlight your status and power (verbally and nonverbally) or do you use your role to help you collaborate, empower, and educate patients? If you see your role as the person responsible for solving patient’s problems, making decisions for them, and being in control—you will likely assume a much more authoritarian position in your interactions with patients and family members. In contrast, if you see your role as participative you will be much more likely to take on a collaborative focus in your communication with patients and families. Therefore, the way you perceive your role in health care is going to have a direct impact on how you communicate. Providers have been often criticized for being disease focused and consequently seeing their role as more problem solving than information- and power-sharing collaborators. Just because you are licensed/certified to be a health care provider your role competency is going to be determined by how you choose to communicate that position to others. However, in addition to your role impacting your interpersonal communication, so does your self-competence.

Self-competence is related to the self-image you choose to present to others. Based on your self-competence you can use interpersonal communication to determine how others perceive you. For example, in your health care provider role, you can decide that you want to be seen as an intellectual, authority figure who knows more than patients and therefore you can unilaterally make decisions for them and share only the information you think is needed. Or you may want to present yourself as a patient-focused partner in health care delivery who encourages a dialogue, information and power sharing, as well as collaborative decision making. However, equally important as role and self-competence is goal competence.

Goal competence is knowing how to attain your communication goals. This means you are able to utilize both your American English-language literacy and your audience analysis to communicate effectively with the intended interactant. Therefore, you must rely on your interpersonal communication and relationship development skills, as well as your self- and role competencies to become goal competent. As this chapter has pointed out, being an effective interpersonal communicator is much more than knowing about health care. Instead, to be successful when interacting with patients, family members, and peers it is critically important to not only assess their needs, literacy levels, and knowledge of the topic, but your own role and self-competence in order to attain your communication goals. However, in addition to assessing the other communicator from a content/capability focus, you also need to be able to determine how a person’s gender may impact his or her communication behaviors.
SEX VERSUS GENDER

In U.S. culture, we frequently confuse the terms sex and gender. However, from a social science and especially a communication perspective—these terms can be very different and yet critically important to effective interpersonal communication and relationship development. As Wood (2015) points out, “sex is a designation based on biology, whereas gender is socially constructed and expressed” (p. 19). This is truly important for health care providers. As you likely have seen, for nearly 100% of the population, sex can be determined based on the presence of a penis (male) or a vagina (female). For the very small minority of individuals who have unique genitalia, the older term hermaphrodite has been replaced with the current classification of intersexed. This text will not be exploring the social, psychological, and communication behaviors associated with being born intersexed. However, it is very important that health care providers recognize that just because an individual has a penis, he may or may not communicate using masculine-gendered behaviors. And the same is true for a female, her sex does not define her gender—like males, her behaviors do.

And because gender is socially constructed, it can evolve and change as a person matures, has new experiences, and is more aware of his or her own feelings. Gender identity is an individual’s understanding of himself or herself. In our culture, we traditionally identify being masculine as strong, independent, aggressive, and unwilling to share many emotions, whereas being feminine is more about physical appearance, nurturing, showing emotions, and an interest in relationship development/maintenance. There are a number of theories regarding these gendered behaviors and how from infancy to adulthood we learn how to be masculine, feminine, or somewhere along that spectrum.

Reflection 3.13. Think about your own gender identity. Do you perceive yourself as more masculine or feminine? What behaviors or feelings do you use to illustrate one gender over the other? Are there contexts in which you may need to behave the opposite of what you feel is the norm for you (more masculine if you see yourself as feminine, or vice versa)? If so, why? If not, why not?

Some of the theories of gender, include:

- Biological
- Psychodynamic
These theories provide us with a breadth of views on how gender is developed, constructed, and evolves. Let’s examine the distinctions among them and how they can help you better understand your patients, peers, and others to be able to communicate more effectively with them.

Biological theory promotes the view that gender behaviors are the result of physiological processes (e.g., hormones, genetics). According to biological theory, hormones like testosterone and estrogen are responsible in part for gendered actions. So changes in testosterone levels, for example, could result in more or less aggression, nurturing, and so forth. But in addition, this theory also proposes that anatomy, specifically brain development, has a role in gender determination. As you may know, males tend to have better developed left lobes and therefore are often more linear, spatial, and abstract in their thinking. Females have increased right lobes, which control imagination and creativity among other cognitive functions. Clearly, there are some reasons to support biological theory, but it is also true that there are other theoretical possibilities for how gender behaviors are developed.

Psychodynamic theory centers around the importance of the mother–child relationship in the child’s gender development. This theory proposes that female children are able to identify more closely anatomically with their mother and therefore tend to identify with their mother’s gendered behaviors. Conversely, boys do not identify as closely with mom and therefore seek a father or other male figure as a guide. However, this theory also suggests that mothers realize the differences in gender and what is expected of males and encourage boys to behave differently than females. For example, boys are sent outside by their mother to play alone or with friends, whereas girls are encouraged to stay inside and help cook. But psychodynamic theory is not the only nonbiologic approach to gender development.

Social learning theory postulates that humans learn how to be masculine or feminine by watching others as children and then, using the feedback they receive for those behaviors to determine whether or not to adopt them. For example, a young boy might see his father watching a football game and enjoying it. Consequently, if he starts throwing a football or tackling his brother or friends and he gets positive feedback from his parents, friends, and siblings, according to this theory, he will likely see those behaviors as being appropriate for his gender. Conversely, if a girl sees a woman on TV fighting and she starts to fight with her sibling, she might get reprimanded by her parents, friends, and/or siblings for not being feminine and decide that those behaviors are incorrect for her gender. Although biological, psychodynamic, and social learning theories all suggest that outside forces are in large part responsible for the development of gendered behaviors, cognitive development theory is more person-centric.

Cognitive development theory suggests that children are not just responding to hormones and/or the directives or rewards of others, but
actively developing their own gender identities. According to this theory, children listen and observe how others communicate with them and then pick which behaviors to continue in order to get the responses they desire (e.g., “a good little boy,” or “a smart little girl”). According to this theory, children develop a sense of their gender very early, before they start kindergarten or first grade at the latest. However, regardless of which gender theory you support, the important aspect for those in health care is that gender shapes our lives, communication, and decision making and it cannot be deduced by merely observing a person’s sex. Therefore, it is very important for you as a health care professional to understand differences in masculine- and feminine-gendered behaviors and not stereotype all males as masculine or all females as feminine.

### Masculine- versus Feminine-Gendered Communication

Although it is crucial for providers to understand the differences between gender and sex, as well as the theories of gender development, it is equally if not more essential that health care professionals recognize the distinctions between feminine and masculine communication behaviors. By doing so, providers can assess how those actions might impact patient information exchange, collaboration, trust, and/or decision making. In America, feminine communication is typically used to nurture and develop relationships (familial, platonic, and/or romantic), whereas masculine communication refers to behaviors that generally support the speaker’s independence, control, goals, and status. One of the key masculine behaviors that demonstrate control is how often masculine-gendered individuals interrupt others. Also, masculine speech is more often to the point and more forceful than feminine-gendered communication. Conversely, feminine-behaviors are more typically cultivating, collaborative, and encourage participation. Once health care providers begin to assess an individual’s communication behaviors, not merely based on his or her sex, they can begin to better determine how to share information, power, and decision making.

By evaluating a patient’s or peer’s gender, vis-à-vis her or his communication, health care providers can determine the most effective communication style needed to meet the patient’s expectations and desires. For example, if a provider is having a conversation with a feminine-gendered individual (female or male), the professional would want to understand the importance of building a relationship from the patient’s perspective: having a provider who listens and offers feedback and is more interested in collaboration than an authoritative style. Similarly, if the provider determines that a patient is masculine gendered, regardless of his or her sex, then the professional would want to encourage more discussion, ask more questions, as well as enhance the patient’s feeling of independence and control.

As we have been discussing, interpersonal communication is intended not just to build relationships, exchange information, and help interactants attain
shared goals—it is also an opportunity to develop trust, promote credibility, and highlight similarities. The more your patients can feel that you are communicating interpersonally with them as individuals (based on their education, health literacy, age, and gender), the more likely it is that you can develop a trusting, collaborative relationship that will allow for the open exchange of information, power, control, and decision making.

It is important to recognize that one of the key aspects of developing and maintaining an interpersonal relationship is the use of self-disclosure. Communicators tend to use self-disclosure (of their most personal information) only with the most trusted people in their lives. Generally speaking, Americans self-disclose their most intimate life stories with a very few (one or two) extremely selective (platonically related, but more frequently romantically related) individuals. In fact, self-disclosure is one way of assessing how an interpersonal relationship is evolving. When one communicator chooses to self-disclose (e.g., I had an abortion or I was arrested, or I love you) in a burgeoning relationship—it is expected to help the relationship continue to grow. However, that expectation is dependent on the other interactant reciprocating with his or her own self-disclosure (building trust and helping ensure confidentiality). This is one of the tools we use in relationships to build reliance—sharing our most intimate feelings and/or experiences.

Reflection 3.14. Think of a relationship you have been in, either platonic or romantic. Can you recall when you or the other person made a self-disclosure and how it impacted the relationship (positively or negatively)? Was there a reciprocal self-disclosure? If so, did the presence or absence of a reciprocal response enhance the relationship or jeopardize it, and why?

If self-disclosure is so key to developing and maintaining interpersonal relationships in the larger U.S. culture, then how does that impact your use of interpersonal communication in health care contexts? As should be somewhat obvious, health care providers do not just need a patient to self-disclose his or her most intimate experiences, they actually seek that information. Therefore, in a culture in which self-disclosure is limited to a communicator’s closest friends and/or lovers, health care expects patients to communicate completely differently—telling providers (often strangers or near strangers), the most intimate details of a person’s life (medical, sexual, psychological, family, etc.). No one in this culture, except health care professionals, routinely asks a person how many people she or he had sex with, if the patient has or had an STD or abortion, how much alcohol she or he consumes, or whether there is a present or past history of drug abuse.
or addiction by the patient or his or her family. But unlike every other interpersonal relationship in American culture, a unilateral self-disclosure by the patient is not only expected but professionally mandated. Therefore, think about how you might help maintain the relationship by explaining briefly the need for such private information, or assuring the patient that you will keep his or her disclosure confidential (keeping in mind that your records will be reviewed by the patient’s insurance carrier, so there is only so much confidentiality possible). The point of this discussion is to remind you that health care occurs in a totally different context and requires much different interpersonal communication for patients than all other experiences in their lives (except perhaps jail).

Interpersonally, health care providers not only ask but expect patients to get naked, or nearly naked, allow themselves to be touched in areas usually restricted to a person’s most intimate lovers, and self-disclose their most private experiences. However, at the same time the provider is trying to encourage the patient to develop/maintain a relationship with a communicator who is fully clothed, not touched by the patient (except perhaps for a handshake), and not reciprocating with her or his intimate personal data. Armed with these major deviations from expected interpersonal communication and relationship development in this culture, it should not be too surprising that there are not only health literacy issues that constrain provider–patient information exchanges and relationship development, but interpersonal communication expectations and experiences as well. As you work to become more effective interpersonal communicators and health care providers, try to remind yourselves of the importance of verbal and nonverbal cues, as well as gendered behaviors in not only assessing your patients’ communication, but your own. In order to enhance patient outcomes and provide a context in which information is exchanged, provider–patient interactions are collaborative and informative and based on power equality and shared decision making, providers need to recognize their key role in assuring that messages are clear, complete, and effectively communicated based on the patient’s health and language literacy, and assimilated appropriately. With such efforts, patients and providers have a much greater potential for attaining shared outcomes (e.g., wellness, and/or illness/injury treatment, goals).

Reflections (among the possible responses)

3.1. Thinking about a single interaction (with your provider, a colleague provider, or with a patient), how would you describe the communication exchange? Was it effective or problematic and why?

When you considered your prior interaction, if you looked at it as a patient, you likely had a completely different response than if you examined the conversation from a provider’s perspective. That is why it is important to think about provider–patient communication from an interpersonal, not strictly diagnostic or treatment, perspective. The more you can attempt to find an equal power/
control viewpoint for your patient interactions the more the interpersonal communication becomes about exchanging information and accomplishing patient-centered goals. The problem with provider-focused communication is that the conversation is not about sharing, but about getting the data the provider needs so she or he can make a diagnosis, determine a treatment plan, and so forth and, therefore, collaborative and participative decision making is hardly possible.

3.2. Can you recall a situation in which you needed help from someone, or that person offered advice about something? Did/would your reactions to that offer change based on an interpersonal relationship with that person? If so, why? If not, why not?

Interpersonal communication research has shown that people are more likely to trust someone they have an interpersonal relationship with and therefore are more likely to carefully consider any recommendations or information from that person. Also, the more we like someone, the more we see that person as similar to ourselves and the more likely we are to share information and decision making with him or her. If a stranger spends 5 minutes with you and then tells you to take a pill and you will be better—are you not less likely to trust that recommendation than if you hear similar suggestions from a provider you have known for a longer period of time, who you like, who cares about you, and has your best interests in mind? If the stranger is seen as just another provider and not someone who cares about the uniqueness of the patient and his or her complaints, it is unlikely the patient is going to value highly, or even follow the provider-stranger's recommendation/advice. Using interpersonal communication (verbal and nonverbal) to develop and maintain a relationship has the most potential for accomplishing both your and the patient's shared health/wellness goals.

3.3. If you are in a relationship (platonic or romantic) and the other person self-discloses something very personal, what do you think that person expects in return? Why would that reality make it even harder for patients to self-disclose to providers?

In American culture, we expect the other person in a romantic or platonic relationship with us to reciprocate when we self-disclose. And yet, in health care contexts for a number of personal, psychological, and organizational reasons, providers are taught not to reciprocate, but instead make sure they get their patients to self-disclose information that no one else save maybe one or two other people even know. Once again, assume the role of patient, if a provider whom you do not know well, or who does not communicate any interest in forming an interpersonal relationship with you, asks you to disclose details of your sex life, alcohol and/or drug use, and will not be reciprocating, would you be as likely to share that information with him or her as you would with a provider you felt you had a trusting/caring relationship with? In most cases,
having an emotional connection enhances trust and encourages information sharing—even when the provider cannot reciprocate.

3.4. Besides literacy, what do you think is another major obstacle in the health care context for effective interpersonal communication and information exchange?

There are many obstacles to effective interpersonal communication and information exchange in health care settings; among the most obvious are the patient’s perceived loss of power and control. Patients often experience a diminished sense of autonomy based on a number of verbal and nonverbal factors in many health communication contexts. First and foremost is the issue of a clothed provider and a nearly naked patient. Second is the fact that many providers choose to stand over a patient (seated or reclining) clearly demonstrating the provider’s power/control. Third, many providers use closed-ended questions to control the conversation—the provider determines what is important information and seeks to minimize any emotional or relational aspects not directly related to the provider’s data-gathering needs. Fourth, providers frequently interrupt patients in order to control the conversation, time, and demonstrate nonverbally/verbally their power in the interaction. Finally, more often than not providers control both the openings (they almost always show up to the conversation after the patient has arrived) and closings—providers decide when their information-seeking/sharing needs are met and decide it is time to close the interaction (e.g., “any more questions?” with a hand on the door knob—mismatched verbal/nonverbal behaviors). Therefore, although health literacy is extremely important to effective provider–patient interactions, the impact of the provider’s communication of power and control can be equally as obstructive to effective information-sharing and collaborative decision making.

3.5. Can you recall an exam or a lecture during which you had trouble concentrating because of something that had happened in your life? What was causing your distraction (a breakup with a lover, a death of a loved one, other unexpected joyous or sad news)?

Most of us have been in situations in which we had trouble concentrating on what was going on around us because of intrapersonal communication—usually unspoken dialogue with ourselves. Therefore, we can understand how difficult it is to listen and assimilate information when we are distracted by these emotional or physical interferences (noise). Consequently, as a health care provider it should not be surprising that many patients, even family members, have similar difficulties concentrating and understanding information presented along with a perceived or real life-threatening or life-changing diagnosis, prognosis, and/or treatment plan. If you are taking a test or listening to a lecture and you get distracted by some emotional or physical event in your life, it is problematic but far less serious than the reality for patients who are told they have a tumor,
cancer, heart attack, and so forth. If you have difficulty concentrating because your significant other wants out of a relationship—imagine what it must be like for a patient who is just told she or he has a malignancy or his or her death is imminent? Health communication differs from all other forms of communication because of the emotional aspects of the context and content. Therefore, providers need to fully consider how to deliver “bad news” or potentially bad news to patients. Perhaps the provider will need to ask the patient to bring an advocate (spouse/family member/friend) to listen, take notes, and/or ask questions. Or the provider will decide to share the news, but request a second meeting the following day to assure the patient not only heard the message but also assimilated it correctly and has a chance to ask his or her questions and gather more information. One thing the provider should try to avoid is giving bad news and expecting the patient to make a carefully considered decision immediately thereafter. Unless the problem is a life or death situation, the provider would be wise to separate the information about the illness or injury from a detailed discussion about possible next steps and/or treatment options.

The impact of “noise” in a communication channel, for example, the emotional fears attached to hearing certain words: tumor, cancer, malignancy, heart attack, stroke, and so forth—should suggest to providers the need to reassess how much information to provide at one time, the need for a patient advocate, the value of a repeat visit and further information sharing, and/or the value of literacy/language-appropriate handouts. The obfuscation created by potentially life-altering diagnoses, prognoses, and treatment options should suggest to providers the need to find alternative ways to communicate with patients and/or family members/advocates. Just being correct in a diagnosis should not be sufficient for a provider—the patient needs to be able to understand what has been determined, assimilate the facts and the options, and make an informed decision. However, without adequate time and appropriate contexts, patients cannot be expected to quickly overcome their initial reactions/fears/uncertainties and address important decision-making options while they are still unable to fully process information and respond appropriately to it.

3.6. If you are delivering potentially emotionally charged news to a patient and/or family member, how might you try to overcome that person’s connotative response and obstructive noise in the interaction?

In such a scenario, a health care provider would be wise to recognize the risk of emotional noise and/or fear in the conversation and do all she or he can to minimize that possibility. As mentioned earlier, you could encourage the patient to bring an advocate (spouse, life partner, friend, etc.) to listen, take notes, and discuss with the patient what had been discussed with the provider at a later time in a different setting. And you might ask yourself whether you are doing all you can to encourage assimilation of information. For example, did you schedule the time to talk about the emotionally charged news when you have time to sit and answer all the patient’s/family’s questions
and provide feedback to determine what the patient/family member heard, understood, and/or had questions about? Are you attentive to your language choices and use verbal messages that are both literacy and language appropriate? Do you need a professional translator? Be sure to pay close attention to your nonverbal behaviors so you are communicating more collaboratively and less authoritatively/paternalistically—sit, maintain eye contact, encourage questions, make sure your nonverbal behaviors are complementary, not contradictory, communicate your empathic listening by allowing the patient/family member to fully express his or her feelings, concerns, and questions. Provide further information in print for later reading, again based on the educational, language, and literacy levels of the patient/family. Offer to answer questions at a later time by phone or in person. Be careful not to provide unrealistic hope or expectations, but focus on quality-of-life issues and empowering the patient to aid him or her in making informed decisions.

3.7. You are discussing a spinal tap procedure with a patient and she asks, “Does it hurt?” You respond, “Not really,” but your eyes are looking away from the patient and you bite your lower lip as you finish speaking. What would you hypothesize a patient in this culture would perceive the answer to her question to be and why?

As discussed earlier, nonverbal communication/behavior in U.S. culture is perceived as more accurate than verbal messages. Therefore, a provider who says one thing, but nonverbally contradicts the statement is most likely communicating the opposite of what she or he said. Consequently, providers need to be keenly aware of the importance of complementing their verbal messages with appropriate nonverbal cues. In the context described in this question it is likely that the provider did not want to scare the patient by honestly communicating the reality: “There will be some pain, discomfort, and/or pressure, but I will inject some medicine under your skin to make the pain less and I will tell you everything I am doing, before I do it.” By communicating what you will be doing and what should be expected, both verbally and nonverbally, not only can the patient increase his or her trust in you, but he or she will be adequately informed of what is about to happen. Providers must resist the impulse to hide facts from patients, verbally or nonverbally, and instead find a way to empower the patient with information that can be understood, assimilated, and assessed. You may not be able to eliminate all pain in health care procedures and diagnostic tests, but you can make sure your patient is properly informed and prepared without having to interpret conflicting verbal and nonverbal messages.

3.8. As a health care provider, why would proxemics be important for you to understand? Have you thought about proximity in visits you have made to your own health care provider, or when you went to the emergency department (ED) or to a new provider? If so, what were your concerns?
Proxemics or the space between communicators is very important to provider–patient communication and relationship development. As discussed earlier, providers—in order to do their work—need to use haptics and proxemics to assess patients’ vital signs, breath and heart sounds, abdomen, skin, and so forth. However, providers can either nonverbally demonstrate their power and control by touching the patient and altering the expected distances between communicators without asking the patient’s permission, or providers can ask to infringe on the patient’s personal space in order to do their exams. Taking a few seconds to illustrate providers’ recognition of patients’ proxemics and their expectations by asking permission to touch prior to doing so, is one small step in affording patients a bit of social/cultural normalcy and control.

3.9. How would you feel if you were in a classroom or continuing-education conference and the professor/presenter came over to you and grabbed your hand and started helping you write notes? Were you not in that environment to learn? So how is that use of haptics different or similar to the previous blood-drawing example?

Not unlike Reflection 3.8, this example seeks to help health care providers understand how touching someone, even if they have chosen to put themselves in the context, can be perceived and treated by the person in charge as a nonverbal permission to touch without asking. However, the act of acknowledging the patients’ rights to control who touches their bodies, just as they do in all other aspects of their lives, demonstrate providers’ recognition of power- and control-sharing in the provider–patient interaction.

3.10. You have an interview for a job and go to greet the interviewer. Nonverbally, what are two of the most important kinesics you need to utilize to demonstrate your interest, sincerity, and recognition of cultural expectations for professional greetings?

Two of the most important kinesics for greeting a stranger, or anyone for that matter, would be eye contact and a smile. Clearly, an applicant for a job wants to demonstrate his or her interest in the position, friendly/positive attitude, and honesty vis-à-vis his or her nonverbal behaviors. In U.S. culture, eye contact is perceived as critical to a communicator’s assessment of the other person’s interest, honesty, and credibility. A person’s smile, or lack thereof, is assumed to reflect the individual’s attitude and enthusiasm. Therefore, if these kinesic behaviors are recognized as being so vital to communicating these nonverbal messages in other aspects of a provider’s life, why would she or he not want to use them also in his or her interactions with patients—both strangers and those who are well known? Try to find a way to use normative communication behaviors of the larger American culture in your microlevel interactions with patients—regardless of the context (ED, office, hospital, etc.)—and patients will likely appreciate your efforts to normalize the interaction.
3.11. Why is it that health care organizations have certain dress codes regarding white coats, scrub clothes, uniforms, jewelry, and so forth? What is the organization trying to nonverbally communicate to its members and to its patients and their family members?

Health care organizations are trying to establish the values, beliefs, and goals for their members, customers, and vendors, as well as meet regulatory requirements. Consequently, many institutions want to assure that their employees’ artifacts: clothes, hair, jewelry, body art, and so forth meet the organization’s, regulators’, and patients’ expectations. The need to find nonverbal ways to build credibility with customers is also a concern. Having standardized artifacts helps to both brand the organization and minimize employees’ and customers’/patients’ distractions. Finally, the more employees/providers appear professional, the more likely the perception that they are knowledgeable, well trained, and dedicated to the organization’s values and goals.

3.12. How do you respond when you are in a conversation with a person who is crying? What if that person is a patient, would you respond differently? If so, how and why is the same nonverbal cue different?

One of the things a health care provider, or anyone for that matter, can do when a person is crying is acknowledge the person’s sadness and encourage him or her to talk about what is causing the feelings. Or, in the case of a patient or a patient’s family member, the provider knows why the person is crying—the provider can acknowledge the cause (fear, sorrow, pain, loss, etc.). Empathic listening allows providers to communicate their understanding of the patient’s situation and feelings. Many times when someone is crying she or he just wants to be able to talk about his or her concerns with someone. The patient does not necessarily expect the other person to fix the problem/situation, but just to allow him or her to verbalize what is causing the feelings and tears. Clearly, if the patient is crying because of pain or a misunderstanding, a provider who listens can provide relief (medication and/or communication/education); however, providers need to be willing to ask questions when they are faced with a crying patient and/or family member and not ignore or avoid him or her. Building an interpersonal relationship in provider–patient interactions is no different from the nonverbal and verbal interpersonal communication required among friends, family, and/or lovers. Providers need to listen and offer patients an opportunity to discuss their situations/problems/concerns.

3.13. Think about your own gender identity. Do you perceive yourself as more masculine or feminine? What behaviors or feelings do you use to illustrate one gender over the other? Are there contexts in which you may need to behave the opposite of what you feel is the norm for you (more masculine if you see yourself as feminine, or vice versa)? If so, why? If not, why not?
In terms of how you think of your gender, do you see yourself as more competitive or collaborative? Are you more independent or participative? Do you strive to be more aggressive or nurturing? These are just some of the behaviors that distinguish masculine- from feminine-gendered individuals. However, as discussed earlier, you likely use a mixture of gendered behaviors and can position yourself somewhere along the gendered communication spectrum from über masculine to über feminine. Nonetheless, there are contexts when more masculine-gendered behaviors (regardless of a person’s sex) may be the most appropriate—for example, in a crisis. If there is a fire and you need everyone to evacuate, you likely will want a more masculine-gendered communication style to assure that whoever is in the dwelling understands that they need to leave immediately and aggressively help anyone who may have difficulty getting out. Or if you are trying to encourage maximum participation in a team that you are leading, you may want to use a more feminine-gendered approach (regardless of your sex) and encourage collaboration and participation instead of using an authoritarian/paternalistic style. These same considerations can be applied to provider–patient and provider–provider interactions. There may be certain contexts in which it is important for you to assume a more masculine-gendered communication style, but in general, a more feminine approach allows for more collaboration, nurturing of the provider–patient relationship, and mutual participation in information sharing and decision making.

3.14. Think of a relationship you have been in, either platonic or romantic. Can you recall when you or the other person made a self-disclosure and how it impacted the relationship (positively or negatively)? Was there a reciprocal self-disclosure? If so, did the presence or absence of a reciprocal response enhance the relationship or jeopardize it, and why?

In most interpersonal communication/relationship scenarios, when one person chooses to self-disclose, the other party in the dyad is expected to reciprocate. However, in health care, patients are asked to self-disclose as part of the information seeking in almost every provider–patient interaction. However, although patients are expected to self-disclose, providers are discouraged from reciprocating. This is antithetical to the norm in our culture and what is expected in all other aspects of interpersonal communication/relationships. As a consequence, it is important for providers to understand how unique this situation is for patients and to use empathic listening to be supportive of patients when they self-disclose difficult or painful information and not just treat the situation as if it is normative for the patient.

**Skills Exercise**

Talk with someone you know well and stand up to talk when she or he is sitting. How does it make you feel not being at eye level? Next, with a different friend or loved one, have a pad of paper or a smartphone or electronic tablet, and while
talking to the person, start looking at and/or writing/typing on the paper or e-device. How does that impact your ability to focus on what the other person is saying? Ask the person how he or she perceived the communication based on your behaviors?

**Video Discussion Exercise**

Analyze the video

- *The Doctor* (1991)

**Role-Play Using These Interactive Simulation Exercises**


- Chapter 5, “Autonomy Is a Myth” (pp. 45–54)
- Chapter 7, “Closings” (pp. 67–78)
- Chapter 20, “The Nurses Paid More Attention to the Computer Than They Did to Me” (pp. 201–208)

**Health Care Issues in the Media**

A doctor’s story

A nurse’s story

**Health Communication Outcomes**

Provider health communication at its most basic level is interpersonal. It is fundamentally diverse, dyadic interaction between providers and patients and/or providers and providers. However, interpersonal communication is generally, in American culture, intended to help develop and/or maintain interpersonal relationships. In health care, however, because of the scientific/biomedical approach of many providers, interpersonal communication becomes more monologue-like, with a paternalistic and authoritarian style that includes health care jargon/terminology, a detective-like inquisition during which patients are peppered with closed-ended questions that serve to verbally and nonverbally demonstrate the provider-centered nature of the interaction. This unique communication style used by many health care professionals is intended to primarily gather the material the provider needs and/or share
information that the provider controls. These verbal and nonverbal behaviors also serve to reinforce the provider’s role and goals, frequently without any effort to assure that these are shared or mutually constructed patient-centered goals. Furthermore, with a disease-focused approach, it becomes even easier for many providers to neglect the impact that gender, not just sex, has on both communication and health care issues. The importance of assessing a patient’s gendered communication preferences, as well as offering carefully considered verbal and nonverbal provider behaviors, can help health care professionals be more effective in their interactions based on the patient’s messages and masculine- versus feminine-gendered communication behaviors.

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CHAPTER 5

Intercultural Communication in Health Care

For the purpose of this text, we are going to use the following as working definitions:

- **Acculturation**: the process of learning to be part of a new culture/coculture
- **Coculture**: a culture within a larger culture
- **Conflict**: differences in viewpoints; can be negative or positive
- **Culture**: the values, beliefs, rules, rituals, language, and behaviors of a group of people who share common goals
- **Diversity**: not just different cultures, but different perspectives
- **Intercultural communication**: information exchanges across cultures
- **Social identity**: how culture helps shape a person’s identity

**HEALTH CARE CULTURE—PROVIDERS**

Perhaps you have not considered it previously, but health care can be viewed as a separate culture. It has its own set of values, rituals, and language. There are artifacts (clothing/uniforms) that are unique to the culture, there is a language that health care students must learn to be part of the culture, there are rituals: education, certification, licensing, continuing education, and so forth as well as values, most obviously, the Hippocratic Oath and caring for others. Think about how various cocultures in health care (MD/DO [doctor of osteopathy], RN, physician assistant [PA], etc.) have their own interdependent values, traditions, norms, and roles with the larger culture. And yet, in spite of role or philosophical differences for health care as a culture to produce positive outcomes and achieve its goals—the cocultures must work interdependently, using the same language to assure that patients receive the most effective care possible.
From a communication perspective, the culture of health care is truly unique. Members of the culture, regardless of their role or discipline/profession, are required to learn the language of health care, which is distinct from the participant’s native language. This medical language is archived in books, taught in courses, and unique to the culture. And although people in certain industries use jargon to help their members adapt to their jobs, health care is one of the very few professions (law is another) in which members must learn an entire language separate from their native one, to become part of the health care culture. Therefore, words like *appendicitis, aneurysm, selective serotonin reuptake inhibitor, lobectomy,* and so on are used to communicate anatomical, physiological, and observational realities. Health care as a culture can be evaluated based on its ability to adapt new members vis-à-vis educational programs such as medical, nursing, and physician assistant schools. Although each of these cocultures teaches its students diverse perspectives on caring for ill and injured individuals as well as maintaining health, they do it using a common health care terminology/language; shared values and beliefs; and an appreciation for the ever-expanding interdisciplinary, interdependent nature of 21st-century health care delivery. As discussed in prior chapters, one of the distinctions between these cocultures centers around the pedagogical and philosophical approaches many nursing education programs take compared to programs for doctors and physician assistants. In the coculture of nursing, the biopsychosocial approach to health care is primarily the pedagogical focus. As compared to medical and physician assistant programs, where education tends to be more biomedically-centric. These cocultural differences have led to a more patient-focused, collaborative value and belief system for those who are nurses versus a more provider-centric, authoritarian approach, especially for doctors. However, as the culture of health care evolves, it appears that a patient-centric, collaborative approach may be gaining acceptance across cocultures. Clearly, that is one of the reasons for this text. However, as we explore the expanding role of intercultural communication (across cocultures and the larger U.S. culture), it is important to understand how the differences in cultures potentially impact provider–patient communication.

**Reflection 5.1.** Why do many medical, nursing, and physician assistant programs have white-coat ceremonies for their students? How does this event help new members develop a sense of acculturation?
Reflection 5.2. Do you perceive the increasing efforts to have health care professionals work more collaboratively across cocultures/disciplines/professions as enhancing or detracting from intracultural and intercultural communication?

Intercultural Communication—Patients and Families

One of the important realizations about health care is that patients and families are not part of the same culture as health care providers. Patients and families are part of the larger American culture, but not the health care culture. Again, for the most part, they do not share the language or have the same education, rituals, roles, beliefs, and behaviors. However, patients do share common goals with the providers who work with them—they all want the patient to be as healthy as possible. Therefore, the interpersonal communication and relationships we have been discussing can now be viewed in light of the intercultural nature of the health care context. In Chapter 4, health literacy was discussed; clearly health literacy is a direct result of the differences in non–health and health care cultures. If you go to a country where you are not a member of the culture, do not speak the language, know the beliefs, rituals, and so forth, you are likely going to feel isolated and insecure. In addition, because of the cultural differences, building trust is very difficult. Therefore, when health care providers recognize how patients can perceive their culture similar to an experience in a foreign culture, they can start to assess their communication—not just language—behaviors in terms of interacting interculturally. This recognition should encourage providers to strive to find ways to bridge the cultural differences to improve interpersonal and health communication and relationship development. As mentioned in Chapter 4, it is important to assess how much health care language a patient understands and can assimilate. Recognizing that behaviors necessary for the health care culture (haptics, proxemics, kinesics, data gathering, emotional restraint, etc.) may be antithetical to the larger patient culture, providers should be aware that common health care behaviors can make them appear uncaring, egocentric, and more focused on the disease than on the patient.

Part of the difference between the health care culture and the larger culture is that patients are accustomed to being the focus of attention when they pay for services. However, in health care, the focus is typically on the disease/injury and peripherally on the patient. In addition, legal issues specific to health care, such as medical records/patient privacy, malpractice risks, adverse events, treatment options, and so on, all impact provider–patient
communication and can appear to patients as the provider being less concerned with them and more concerned with issues they do not know about (as nonmembers of the health care culture) and/or understand. Similarly, health care culture, unlike many other areas of the patient’s culture, must be responsive to health insurers’ requirements and, although the patient may want something different, the provider has little freedom to accommodate the patient based on the 21st-century health care culture’s economic realities. All of these intercultural differences create communication problems for providers and patients and many of them are not even directly related to the illness/injury/health concerns that the provider–patient are addressing. However, the intra- and intercultural differences can impact both patients and providers.

**Reflection 5.3.** What if you have to tell a patient that there is a treatment for his or her illness, but the insurance company will not cover the cost and she or he cannot afford it? How do you suppose that information will impact the patient’s perception of the health care culture generally, and you as a provider specifically? Understanding both sides of this issue from your health care culture perspective, how might you be able to enhance your provider–patient relationship?

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**Social and Cultural Identities**

One of the realities of acculturation is the likelihood that an individual’s social and/or cultural identities will need to evolve. For example, part of membership in most health care cocultures, as well as the overall culture, is the recognition that providers will need to assume new identities. As medical, nursing, and physician assistant students become acculturated, they begin to understand that their new social/cultural identity will require them to behave differently, at least in the health care culture, than in the larger culture. For example, new members of the health care culture are cautioned against forming emotional attachments with their patients—as compared to other interpersonal relationships in the larger culture. As part of the health care culture, members are advised to seek patient disclosure of highly personal information but not to reciprocate, again distancing themselves from patients in spite of the need to form interpersonal relationships with them. Health care providers’ roles may also require them to change their identities related to leadership, paternalistic, or even authoritarian communication behaviors depending on the context and the communication requirements.
Similarly, patients are frequently required to alter their identities based on the culture of health care and their illness or injury. Patients who previously were strong-willed, independent leaders may be forced to become dependent, exhausted, child-like followers of providers’ orders. Or, based on the impact of the illness or injury, patients may undergo various identity responses (Charmaz, 1987):

- Supernormal: the patient does not want to let the illness or injury change himself or herself or their preillness/injury identity
- Restored: less optimistic about getting back to full preillness/injury self, but still won’t believe there has been a change
- Contingent personal: recognizes he or she can no longer do what he or she used to and is starting to recognize changed identity
- Salvaged self: accepts new identity with some aspects of preillness/injury, coupled with current health realities

It is interesting to recognize that for the most part providers choose to become members of a culture and coculture that seeks to acculturate them by changing their social and cultural identities in part. However, patients generally have their identities impacted, often unwillingly, by the health care culture and/or in response to an illness or injury. Therefore, providers should recognize that many instances of patients’ distrust, anger, hostility, and/or frustration may be the result of the impact of cultural differences and illness/injury as much as the specific health communication that appears to be the catalyst for patients’ responses. The impact of changes in a patient’s identity in health care culture versus the larger culture, as well as the shock of an illness/injury to a patient’s sense of self may significantly contribute to problems in provider–patient communication, relationship development, and/or perceived outcomes. These social and cultural identity issues can be explored by examining verbal and nonverbal communication using an intercultural lens.

**Reflection 5.4.** How might a tumor or a cancer impact a patient’s identity and how she or he communicates with a provider? How would you think the differences in culture between a patient and a provider might also be a potential issue?
Verbal and Nonverbal Intercultural Communication Issues

Expanding on the way intercultural communication potentially impacts provider–patient interactions, the differences in symbols/language create the most obvious problems. Most patients do not know or understand the language of health care and—just like when a person travels to a foreign country—many people in one culture do not stop to consider how people from another culture may be able to assimilate and/or understand their language. In health care, it is expected that providers will use health care terminology in their conversations about patients. However, providers must stop and analyze patients and/or patients’ families and their knowledge of health care culture and language. Just as a person in Italy who speaks both Italian and English would need to determine whether someone from another culture could speak Italian and, if not, uses English in order to be understood, so must health care providers do with patients.

Clearly one way to determine whether patients understand the terms that providers are using is to ask patients to describe what they were told. Another way is to observe patients’ nonverbal behaviors to see whether they are expressing confusion or a lack of comprehension. Providers must continually remind themselves that they speak two different languages in two distinct cultures; therefore, providers need to carefully assess the culture and literacy levels of patients, not just use health care language/terminology and assume patients understand. Similarly, providers need to be aware that the nonverbal cues associated with health care are very powerful. Whether it is the artifacts (white coats or scrub clothes), the edifices (hospitals, operating suites, MRI laboratories, etc.), or even the equipment (stethoscopes, examination tables, gloves, stirrups, etc.), these are unique to the health care culture and all remind the patient that she or he is not a member of the culture and thus not similar in many respects to those who are. Because of these dissimilarities, along with the language issues and other intercultural differences (e.g., health care providers are also using their cocultures/professions to earn a living), it should not be surprising to health care professionals or patients that there are communication issues vastly different from other interpersonal and/or professional-consumer aspects of their lives. Consequently, both providers and patients need to recognize the potential for intercultural conflict—both inter- and intraculturally.

Intercultural and Intracultural Conflict

As you know both as a consumer of health care (patient) and as a provider (or soon to be professional), the emotions, economics, and realities of health care delivery affect every aspect of the provider–patient relationship. These various realities can lead to both intercultural (provider and patient) and provider–provider (intracultural) conflict. Although the obvious distinctions from language issues, especially patients who do not speak/understand American English, is the most apparent risk to effective interpersonal and health communication, there are numerous other culturally related potential problems for communicators.
As one of the biggest budget areas in the American economy, the impact of health care delivery and services creates not only hardships, but nearly unimaginable decisions for some patients. And although some of these economic conflicts are easily recognizable for providers (e.g., prescriptions that cost tens of thousands of dollars per year, procedures that are not covered by health insurance), some may not be unless the provider specifically seeks the information needed to assess them.

Research Exercise 5a. Let’s do a little health care economics research. Use the Internet or phone a health care facility (provider office, hospital, pharmacy, insurer, etc.) and find the price of two prescription medications (cash price versus price with your insurance; not the copay but the overall charge) Zithromax (single pills or Z-pack) and Crestor, 10 mg (30 tablets) in your city. Get the prices at two or three very different-style local pharmacies (e.g., CVS versus Costco). Next, look for the national average cost for a single coronary artery stent (total charges, hospital, and physician) procedure with all the needed diagnostic tests and so forth to see whether you can find out what your insurance would pay for this procedure and what your copay would be. Finally, discuss these costs and how they might impact provider–patient communication differently based on a patient having health insurance versus a patient who is uninsured.

As mentioned previously, unless a provider seeks more information it may not be obvious whether the patient is living alone, with family, in a shelter, or on the street. Similarly, without assessment and inquiry, it may not be at all clear whether she or he can afford even modestly priced prescriptions. And the realities of the current American health care system which is clearly economically tiered, may also present severe conflict issues for many patients. Therefore, it is important for providers to frequently remind themselves about how economics affect access to health care in America (see Figure 5.1).

Clearly, the realities of Figure 5.1 for American health care providers and patients are both troubling and critically important to understand. As the pyramid illustrates, for the wealthiest U.S. citizens any health care is possible, from plastic surgery to concierge medicine (a provider who is on a retainer and available for telephone, electronic, or home visits 24/7/365). However, for the overwhelming majority of Americans, this level of health care and its options (access to the most prestigious hospitals and specialists, diagnostic tests, and treatments) are unavailable. For most patients in this country, health care access is based on private
(employer-based or self-insured) health insurance and whether or not they can see a certain provider, have a procedure performed, tests paid for, and so on based on their policy and the amount of copay the insurance requires the patient to contribute to the cost of office/hospital visits, medications, diagnostic tests, and so forth. Therefore, although these patients have less access than those who can pay cash for any type of health care access/delivery, the insured have a number of choices regarding their providers, hospitals, and services. For patients who must rely on government-sponsored health care plans (often administered by private firms but paid in part by the federal and/or state governments), their options for health care access are markedly reduced compared to the top two tiers. Patients in the third tier of the pyramid in Figure 5.1 can generally only see providers who accept government-sponsored health insurance programs. Consequently, many patients who are on Medicare and Medicaid especially are very limited in which providers will accept their insurance. Finally, the 30-plus million Americans who are uninsured in this country have very limited access to health care. Most providers will not see patients who do not have insurance and/or cash to pay for services. Similarly, many diagnostic (not life-threatening emergency procedures/tests) procedures and treatments are unattainable for those in the bottom tier of the pyramid. Consequently, the uninsured typically are forced to use the emergency department (ED) for their health care, regardless of whether it is a toothache or a sore throat. There are very few community-type centers available (from transportation, hours of operation, geographic perspectives, etc.) to the uninsured in major cities and far fewer, if any, in small-town and rural America.
The issues related to health care economics and patient access in this country clearly create communication and relationship development problems for patients and providers. However, in addition to the intercultural problems discussed previously, there are also intracultural conflicts that impact health communication, provider–provider relationships, and health care delivery.

Chapter 10 focuses specifically on provider–provider communication; however, because of the cultural issues related to cocultures in health care working interdependently to accomplish common—patient, organization, and individual—goals, it is important to address the intracultural aspects of health care delivery. As mentioned previously, among the potential intracultural issues in communicating across disciplines/professions are the differences in philosophical approaches, but also the changing organizational approach, from single leader (physician) to a team (doctor, nurse, PA, advanced practice registered nurse [APRN], etc.) perspective, which increases the need for effective provider–provider communication across cocultures. And it requires members of the health care culture, regardless of the coculture, to try to find the most appropriate approach to patient care based on the individual patient, but also the patient’s collaboration and participation in decision making. The potential conflict among providers, especially those from different cocultures, must be recognized and assessed to minimize any potential distractions. Also, within cocultures (e.g., physicians), there can be conflict across disciplines as when the patient’s primary care provider and cardiologist disagree on the diagnosis or the most appropriate treatment plan. Similarly, nursing staff could have a conflict with a nursing supervisor who felt that more time should be spent on documentation than on patient interaction. The intracultural conflicts within the health care culture and/or within health care cocultures need to be recognized by providers—assessed and addressed. Therefore, it is vitally important for providers to recognize the potential communication problems that could lead to untoward diagnostic, treatment, and/or wellness outcomes. However, the barriers to effective health and interpersonal/intercultural communication also contribute to the potential for intercultural conflict.

**Reflection 5.5.** What issues from health communication, information exchange, and intercultural communication perspectives do you see as related to tiered access to U.S. health care delivery from both provider and patient viewpoints?
Intercultural Barriers to Health Communication

Unfortunately, there are a number of intercultural barriers to effective health communication, including:

- Patients and providers who do not use American English as their primary language
- Providers who do not understand or address the issues related to communication with patients who are not members of the health care culture
- Patients whose economic situation negatively impacts their access to care and/or treatments
- Perceived differences in socioeconomic status (SES) between patients and providers

Reflection 5.6. Based on the discussions in this chapter and prior chapters, what are some communication strategies that can overcome some of the barriers to effective intercultural health communication between providers and patients?

It should not be surprising that patients who are not native American-English speakers will have difficulty assimilating, assessing, and utilizing health communication that is not appropriate for their literacy level. However, it is important to also recognize that it may be just as difficult for patients whose first language is American English if they are communicating with a provider who does not use American English as his or her first language. Consequently, providers must also assess their language usage, especially if they are not native speakers. As mentioned earlier, sharing symbols/language is critically important to attaining interpersonal/health communication goals and developing/building interpersonal relationships. It should not be surprising that regardless of whether a communicator is a patient or a provider, intercultural language barriers create enormous problems for all interactants and need to be addressed—vis-à-vis a translator or appropriate literacy level—in order for providers and patients to have the best chance for effective health communication information exchange and decision making.

Similarly, the disparities between the larger culture and the health care culture and cocultures need to be recognized by providers as potential barriers to effective interpersonal health communication. Providers need to assess whether
patients not only understand the health care language that is being used, but the various diagnostic issues and treatment options available—including the differences in roles and responsibilities for various providers/cocultures (specialists, allied health professionals, etc.). It is not uncommon, for example, for some patients to not understand the differences in roles and responsibilities for APRNs and PAs versus MD/DOs and/or RNs. Clarifying who is caring for them, the provider’s role, educational background, supervision, and so on can make it much easier for patients to trust all members of the health care team and feel safe sharing information and collaborating with various members of the health care culture and coculture.

One of the most difficult intercultural barriers is related to economic issues in U.S. health care. Within the U.S. culture, there are various cocultures related to health care access, as illustrated in Figure 5.1. However, this lack of access creates numerous barriers related to both communication and clinical issues. The increased wait in EDs in this country related to uninsured patients, need for chronic care in an acute care setting creates frustration and problems for both health care providers and patients (with insurance and without insurance). Because it is illegal to refuse to see a patient in the ED, everyone who wants to be seen must be examined. Consequently, many EDs have 2- to 3-hour wait times for admission to the ED and everyone—patients and providers—find this a very perplexing situation. Providers generally choose the ED coculture because they want to take care of urgent and/or acute care problems, but are faced with increasing numbers of patients who have nowhere else to go for their chronic or nonacute health care. And patients, whether they have insurance or not, are having to wait and then, because of the prolonged wait times and numbers of patients to be seen, often do not get as much time with the ED provider as they perceive they should—which further impacts their frustration as well as their information exchange, collaborations in decision making, and/or relationship building/trust. Finally, the cost of health care treatments especially can be extremely problematic for patients who need a drug or procedure, but also for providers who want to help patients but have little or no control over the cost of care or what is approved/paid for by insurers. Thus, the economic barriers to effective intercultural provider–patient communication are both pervasive and frustrating for patients and providers alike.

In addition, as discussed in Chapter 4, the differences in SES between providers and many patients also contribute to the problems in effective intercultural health communication. The inability of patients to perceive any similarity with providers who are clearly in different economic, social, educational, and professional contexts makes it less likely for patients to want to develop an interpersonal relationship or cross-cultural trust. Just as with the other barriers to effective intercultural health communication, providers need to realize these potential issues and attempt to address them with patients and overcome them if wellness and/or illness goals are to be attained.
Reflections (among the possible responses)

5.1. Why do many medical, nursing, and physician assistant programs have white-coat ceremonies for their students? How does this event help new members develop a sense of acculturation?

Among the major hallmarks of a culture are the language and traditions that differentiate it from other cultures. In the health care culture, there is a distinctive language/medical terminology used by its members. However, health care also uses unique artifacts to differentiate itself from other cultures—white coats and scrub suits are two of the most obvious artifacts that identify health care providers. In fact, it is rare for a patient to ever question a provider’s credibility/education during an initial interaction; a primary reason for this unusual behavior is that in the larger U.S. culture, the artifacts and contexts (offices, hospitals, etc.) provide the nonverbal assurances for patients that whoever is wearing a white coat and/or scrub clothes is presumed to be a health care provider and no other documentation is required. Therefore, the act of conferring a white coat or a labeled scrub suit on a new member of a culture is part of the acculturation process and helps that student (MD/DO, RN, PA, etc.) adapt to his or her new role, responsibilities, and membership.

5.2. Do you perceive the increasing efforts to have health care professionals work more collaboratively across cocultures/disciplines/professions as enhancing or detracting from intracultural and intercultural communication?

As cocultures collaborate, instead of viewing their roles from a hierarchical perspective, the opportunities for expanding input, information sharing, diverse viewpoints, and enhanced outcomes for both providers and patients become more possible. Working in teams, where all members have not only interdependent roles and responsibilities but also the potential to impact group decision making and institutional as well as patient-centered goals, has the potential to enhance intercultural (across cocultures) communication. For patients and providers, greater collaboration across health care cocultures (specialists, disciplines, professions) offers the opportunity to increase information exchanges, decrease monologues/authoritarian behaviors, enhance relationship development, and improve common goal attainment for all.

5.3. What if you have to tell a patient that there is a treatment for his or her illness but the insurance company will not cover the cost and he or she cannot afford it? How do you suppose that information will impact the patient’s perception of the health care culture generally, and you as a provider specifically? Understanding both sides of this issue from your health care culture perspective, how might you be able to enhance your provider–patient relationship?

One of the most difficult situations a provider can face is having to relate the economic realities of health care to a patient who either does not have the insurance or financial ability to cover the costs of necessary treatment.
options. It would not be surprising for a patient and/or family members in this situation to blame the provider or the health care culture. Although these arguments may have some merit they will not help your patient’s condition or outcome. The patient’s and family members’ frustrations and anger are understandable, but the provider needs to try to help them move beyond the initial responses and find other potential options for care. For example, perhaps the provider could contact a pharmaceutical representative or a pharmaceutical company to see whether there is a prescription assistance program for which the patient might qualify. Or suggest the family contact a local, regional, or national nonprofit association that might have some funding options (e.g., American Heart Association, Susan G. Komen breast cancer fund). Furthermore, the provider can use empathic listening to show support for the patient’s anger and frustration but also to illustrate the provider’s willingness to try and help the patient as much as possible. Often, patients appreciate provider’s efforts, even if they are ultimately unsuccessful, to help them overcome a clinical or nonclinical problem because it demonstrates the provider’s caring and willingness to be more than a member of the health care culture.

5.4. How might a tumor or a cancer impact a patient’s identity and how she or he communicates with a provider? How would you think the differences in culture between a patient and a provider might also be a potential issue?

As discussed in this and prior chapters, communication does not take place in a vacuum. Interpersonal communication is dependent on context, communicator, and culturally dependent. Therefore, as the context for a patient’s health/wellness evolves, the patient’s communication with the provider may be directly impacted. The patient may become more withdrawn (in denial), angry, or resentful. However, the provider needs to understand these responses are related to the patient’s sense of self-identity and how the illness/injury impacts the patient’s self-perceptions. Similarly, the differences in the cultures of patients and providers may also play a role in how the patient chooses to communicate. For example, if the patient perceives the provider, a member of the health care culture, as emotionally detached, uncaring, or operating from a biomedical approach, the patient may feel that his or her concerns will not be important to the provider. Similarly, the patient may question whether the provider’s ability to make money off of the patient’s illness/injury is the major focus for the provider’s role in their relationship. Therefore, it is important for the provider to understand how the communication context is markedly changed by a patient’s illness or injury and to be even more attuned to the patient’s verbal and nonverbal behaviors. The differences in cultures related to illness/injury—especially the routinizing of serious, even terminal illnesses and injuries for members of the health care culture—must be perceived as antithetical to the experiences/expectations of most patients in the larger U.S. culture. Therefore, every effort should be made by providers in such contexts to communicate in a more interpersonal and empathic style.
5.5. What issues from health communication, information exchange, and intercultural communication perspectives do you see as related to tiered access to U.S. health care delivery from both provider and patient viewpoints?

The tiered U.S. health care system creates enormous communication problems for providers and patients alike. Except for the wealthiest Americans, everyone else in this country is striving to understand his or her access realities. Even those with private health insurance likely do not know the ramifications of their policies’ limitations in terms of provider access, diagnostic tests, and/or treatments. In consequence, these issues become part of the provider–patient conversation and impact provider and/or patient decision making. And certainly, for patients who have government-based health insurance or no insurance, their communication with providers is further obfuscated and/or minimized by the limited access they have to care based on their insurance policies’ requirements or the lack of insurance. Similarly, providers may be placed in the difficult position of knowing of a treatment option but trying to decide whether it should be discussed with the patient knowing that it would be cost prohibitive.

5.6. Based on the discussions in this chapter and prior chapters, what are some communication strategies that can overcome some of the barriers to effective intercultural health communication between providers and patients?

Although there are numerous barriers to effective intercultural health communication between patients and providers, most of them can be decreased through active listening, appropriate language choices, interpersonal communication, and interpersonal relationship building. Although there are many distinctions among the health care culture and its cocultures and the larger U.S. culture, providers who are willing to understand these differences and work to overcome them can clearly help diminish many of the barriers. For example, the use of professional translators with patients who are not fluent in American English is one step in improving health communication across cultures. Another is the assessment of a patient’s health literacy level and the level-appropriate intercultural health communication/education. Furthermore, recognizing the issues created by SES differences between providers and patients as well as the economic obstacles created by U.S. tiered health care access—affords providers an opportunity to address these potential problems openly with patients using empathic listening and critical thinking to try to help patients as much as possible.

Skills Exercise

Try to have a conversation with someone who speaks a language that you do not understand. How frustrating is that for you? Was it also difficult for the other person? How might this frustration impact your perception
of the other person and/or him or her of you? Now what if your prescription label looked like this to you, “afjafd ladfjaf;ajfdal;jfdl;k afdajf; afjdf a day?” How would you know what to do with the medication—whether to swallow or chew it? When to take it? How often? What were its side effects? How might a provider help a patient overcome these literacy/language obstacles?

**Video Discussion Exercise**

Analyze the video


**Interactive Simulation Exercise**


- Chapter 37, “No Hablo Español” (pp. 357–366)
- Chapter 40, “Please Take Off Your Clothes and Put on This Gown” (pp. 383–390)
- Chapter 44, “Why Am I Not Seeing a Doctor?” (pp. 415–422)

**Health Care Issues in the Media**

Health literacy

Prescription labels

**Health Communication Outcomes**

As Americans we are members of larger cultures, the world, but also numerous cocultures: Italian, French, Hispanic, your family, school, professional organization, and so on. One of the nonnational/nonethnic cultures is health care. This unique culture is different from American culture in that the health culture has its own distinct language/terminology, values, beliefs, and goals. It has culture-specific artifacts, roles, and traditions. However, the differences in the larger U.S. and health care cultures often contribute to the verbal and nonverbal communication problems that can negatively impact provider–patient interactions. As providers try to manipulate the differences between
these cultures, they often fail to recognize the importance of sharing symbols/language as well as social and cultural identities. Because of differences in culture and SES, there are frequently barriers to effective information exchange, trust building, and collaborative communication and decision making. These barriers contribute to potential intercultural conflict and further create provider–patient health communication difficulties.

■ REFERENCE


■ BIBLIOGRAPHY


