Gender, power, and nonverbal communication

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The importance of communication in cancer care has been well documented. Communication is a challenging process which unfolds between two persons in a particular situation. As such, it has a great variety of determinants. In the present chapter, we propose a summary of the literature on three communication-related factors that have been studied scarcely in the palliative or oncology setting: Nonverbal communication, power, and gender. To approach these issues, we will first discuss findings from the field of general practice on the importance of nonverbal communication in the provider-patient interaction. We will then explore how dominance and power affect the communication process between providers and their patients and how gender affects all of these aspects. Finally, we will relate these findings to the particular setting of oncology and palliative care.

Importance of nonverbal communication in the medical setting

With the growing interest of researchers for the communication process in medical interactions, researchers have paid relatively more attention to the verbal than the nonverbal content of communication (Schmid Mast, 2007). However, depending on the situation, nonverbal behaviour can matter more than verbal messages as a source of information. For example, in the case of an ambiguous verbal message or one of doubtful honesty, nonverbal cues provide key understanding. They become especially salient when they contradict the words being spoken or when the context is highly emotional. Nonverbal cues serve not just to express emotions but also to signal attention orphysical

symptoms like pain, to convey attitudes about friendliness or dominance, and to reveal personality characteristics such as shyness or extraversion (Knapp et al., 2013).

The general definition of nonverbal behaviour is a "communication effected by means other than words" (Knapp et al., 2013, p.8). However, the distinction between verbal and nonverbal communication is not always clear-cut. Sign language, for instance, is nonverbal behaviour through its use of gestures, but it is also verbal in that each gesture has a distinct linguistic meaning. Voice modulation, pitch, and rate, or speech duration are interconnected with the verbal content of the communication, but are considered nonverbal communication because they add information beyond the words alone. Besides such speech-related nonverbal cues, nonverbal behaviours include facial expressions conveying emotions, or eye gaze, gestures, posture, touch, and interpersonal distance (Knapp et al., 2013). One challenging issue in the study of nonverbal communication is that the same nonverbal behaviour can mean different things depending on context. A smile, for example, can mean joy as well as empathy or uneasiness.

Several tools are used to test nonverbal decoding skills. The Patient Emotion Cue Test (PECT; Blanch-Hartigan, 2011) and the Test of Accurate Perception of Patients' Affect (TAPPA; Hall et al., 2014) for instance are both designed for assessing this skill in healthcare providers. In a typical test of this kind, short videos are shown and the test taker is asked to infer the emotions or intentions of the person in the videotape. In the PECT, test takers have to evaluate the emotions displayed by a videotaped actress portraying a patient, and in the TAPPA one guesses the thoughts and feelings of real medical patients during their visits. Research reveals that people can be rather accurate

when assessing what other people feel or think based on nonverbal cues but that there are huge individual differences in this ability. Skill at accurately "reading" others has been shown to be linked to self- and other-rated social-emotional competence, communality, prosocial behavior, and positive personality traits (Hall et al., 2009a). Medical students scoring higher in interpersonal accuracy tests seem also to be advantaged in their relationships with patients and analogue patients (participants asked to put themselves in the shoes of a patient) rated them as having better interpersonal skills (Hall et al., 2014), being more compassionate and likeable, as well as showing more dominant, more engaged, and less distressed behaviours (Hall et al., 2009b).

Importance of patient nonverbal behaviour

How patients behave nonverbally during the medical encounter has scarcely been studied. It is however an important source of information for the provider. In order to diagnose a patient's illness, health care providers use different approaches: Objective measurement (e.g. blood cells analysis), a physical examination, but also the verbal and nonverbal signals of the patient. For example, pain recognition is essential for providers and can be achieved through the observation of patients' facial expressions (Patrick et al., 1986). Also, some coronary illnesses have been shown to be linked to expressing more anger by patients (Rosenberg et al., 2001). So clinicians who are astute in decoding the patient's nonverbal behaviour might be at an advantage for reaching an accurate diagnosis. The correct interpretation of a patient's nonverbal cues by the provider is also linked to other positive medical interaction outcomes. Hall's literature review (2011) concludes that the better health care providers are at accurately decoding nonverbal cues,

the more positive the outcomes in terms of satisfaction, appointment keeping, and evaluation of the physician's clinical skills, and the provider's warmth and engagement.

Importance of provider nonverbal behaviour

The scarcity of studies on the effects of provider nonverbal communication in the medical encounter is astonishing given that existing empirical evidence shows that the clinician's nonverbal behaviour impacts patients' outcomes. A systematic review indeed showed that better patient outcomes (e.g. satisfaction, trust, compliance, adherence, and long-term health effects) are linked to the physician showing more affiliative nonverbal behaviours like nodding, forward leaning, direct body orientation, uncrossed legs and arms, arm symmetry, and less mutual gaze (Beck et al., 2002). In the same vein, the distancing behaviour of physical therapists, such as absence of smiling and looking away from the patient, was related to decreases in patients' physical and cognitive functioning (Ambady et al., 2002a). Also, surgeons with a more dominant tone of voice were more likely to have been sued for medical malpractice than surgeons with a less dominant tone (Ambady et al., 2002b).

The nonverbal behaviours of a provider that convey caring and low dominance are linked to better patient outcomes. This supports findings showing that the provider communication style with the best patient outcomes is patient-centred communication, characterized by high caring (perspective taking and expressing emotions) as well as low dominance. In the next section, we consider the control, power, and dominance distribution in the medical encounter and its impact on patient outcomes.

Power and dominance in the medical encounter

In many ways, the provider can be defined as having more power and control over the patient than vice versa. The provider typically has higher status in terms of social standing and earning capacity. In general, providers have more medical knowledge, thus more clinical competence than patients. Furthermore, help-seeking is fundamentally a position of powerlessness. Discomfort, pain, or anxiety about the prognosis or treatment might contribute to the patient's loss of power and control over the situation. The distribution of power between patients and providers can vary. Roter and Hall (2006) describe four prototypical interaction styles related to the control partition between providers and patients.

- In the *paternalistic* relationship style, the clinician takes control over a passive patient. The provider sets the agenda for the visit, makes the decisions, and does not share much information. The patient's values and treatment preferences are bypassed, while the clinician acts as a guardian.
- The reverse of this pattern is when the patient takes control over a more passive provider and is called *consumerist* relationship. The patient sets the goals and agenda, and takes on the role of a consumer seeking a specific service. The provider becomes the source of information but the patient makes all the decisions.
- In the *default* relationship, both patient and provider exercise 'low-power' and, therefore, remain relatively uninvolved. Neither of them takes responsibility for setting the goals or the agenda so that the patient's goals and the provider's role both remain vague.

- When provider and patient have both relatively high power and value this balance, the relationship is called *mutual*. In this pattern, both are involved in decision-making about treatment, negotiate the goals and agenda for the visit, and the patient's values are respected. The role of the provider becomes one of advisor. This type of relationship is the one the patient-centred approach is based on.

Roter and Hall's classification (2006) is a useful framework for studying communication between a clinician and patient. It indicates also that either medical partner can show a more or less dominant stance. Moreover, even within one type of power relationship between provider and patient, the way the provider behaves towards the patient can still vary in dominance.

Nonverbal indicators of dominance

Hall, Coats, and Smith LeBeau (2005) investigated with a meta-analysis which nonverbal behaviours are related to the perception of dominance in the general population. Their meta-analysis showed that people are perceived as dominant when they display less self-touch as well as more other-touch, when they gesture more and show more body openness, adopt a more erect or tense posture, shift more their body or their legs, use smaller interpersonal distance, lower their eyebrows more, nod more, have a more expressive face, and gaze more. Concerning cues related to voice, the authors showed that louder voice, more voice variation and relaxation, more interruptions, less pausing, faster speech rate, and lower voice pitch are perceived as dominant.

In the medical encounter, Schmid Mast and colleagues (2011) showed that people often use the same nonverbal indicators to judge dominance in clinicians as they do for

the general population in different social settings. Providers' nonverbal behaviours perceived as being dominant included: more indirect body orientation, more gesturing, more forward leaning, less self-touch less gazing at the patient, more gazing at the notes or computer, more frowning, less smiling, less nodding, longer speaking time, louder voice, more voice modulation, and more talking while doing something else. All in all, expansive gestures and less caring behaviours are perceived as dominance cues in the medical setting.

Impact of dominance behaviours on the provider-patient encounter

As one may guess, more provider dominance is usually related to poorer medical encounter outcomes (Ambady et al., 2002a, Ambady et al., 2002b) and it affects how the medical encounter unfolds. Schmid Mast, Hall, and Roter (2008b) found that patients spoke less, provided less medical information, and agreed more when interacting with 'high-dominance' compared to 'low-dominance' providers. The clinician who adopts a dominant style might, therefore, be at a disadvantage because the diagnosis is largely based on medical information provided by the patient.

Interestingly, certain dominance behaviours have been shown to be differently linked to satisfaction when they are displayed by female as compared to male providers. For instance, more interruptions correlate with less patient satisfaction in a male-male dyad, but with more satisfaction in a female-female dyad (Hall et al., 1994). Gender differences seem thus to be an important factor for the understanding of provider-patient communication and its effect on medical outcomes. In the following, we present a review of gender influences on medical encounters.

Impact of gender in the medical encounter

In this section, we will see that the provider gender affects the way they communicate with their patients as well as the way their patients communicate with them. Moreover, we will present how female and male patients are addressed and behave according to their gender.

Provider gender

Female and male providers show some communality in their ways of communicating with patients. They share the same amount and quality of medical information, as well as social conversation (medically irrelevant information) with their patients (Roter et al., 2002). However, female providers talk more about the psychosocial impact of a diagnosis or treatment and use more partnership building (e.g. soliciting expectations from and including the patient in the decision-making processes). Moreover, female clinicians use more positive communication (e.g. encouragement), emotionally focused talk (e.g. emotional probes, empathy), and supportive behaviours such as smiling and nodding. Last but not least, consultations with female providers are on average two minutes longer than with male providers (Roter et al., 2002). All in all, women clinicians seem to display more of the patient-centred typical behaviours. Indeed, compared to men, they show both more partnership building and more warmness through verbal as well as nonverbal communication (Roter et al., 2002).

The gender of the provider also affects patient behaviour. In a meta-analysis, Hall and Roter (2002) showed that patients of female providers talked more and conveyed more biomedical and psychosocial information than did patients seeing a male provider. Patients communicate more positively (e.g. statement of agreement) with a female clinician, use more partnership-building statements, and behave more assertively. In sum,

female clinicians appear to enhance patient participation and empowerment in the medical interaction.

Patient gender

On average, women seek medical advice more often than men. Female patients ask more questions and show more interest during the conversation with the provider than their male counterparts (Hall and Roter, 1995). The provider's behaviour also changes according to the patient's gender. Compared to male patients, female patients receive more emotionally concerned statements and more information from their providers (Hall and Roter, 1998). This is most likely the result of the providers' tendency to ask female patients more questions about their feelings and thoughts (Hall and Roter, 1998). Importantly, clinicians use a calmer and less dominant voice when speaking to a woman (Hall et al., 1994). In sum, providers communicate with female patients in a more emotional and partnership-oriented way.

Gender composition of the dyad

Because both patient and provider gender affect medical communication, studies that consider both aspects simultaneously prove helpful in extricating the role of gender. Female-female interactions seem to follow the patient-centred model with female providers showing more concern about the female patient, her situation and treating her as a partner in decision-making (Roter and Hall, 2004). In female-female dyads, providers and patients talk for fairly equivalent periods of time, whereas in male dyads, the provider typically speaks more than the patient (Hall et al., 1994). The male-male dyads are more hierarchical also in that patients are less included in decision making (Kaplan et al., 1995).

The female clinician and male patient dyads seem to be the most challenging. When female providers interact with men, they adopt a potentially ambiguous style: although they smile more and use less jargon, they convey more dominance and less friendliness through their voices (Hall et al., 1994). The male patients also respond ambiguously to female clinicians in that they make more partnership statements while at the same time they use a more dominant and bored tone of voice (Hall et al., 1994). The ambiguity of the interaction partners' behaviours in this dyad may reflect an uneasiness with a situation in which a woman endorses a high power position and a man a low power position, a constellation that goes against common gender stereotypes. We will come back to the gender stereotypes issue below and try to shed more light on the observed ambiguities.

Gender and patient satisfaction

We just showed how gender can influence providers and patients' behaviours and one may wonder whether those differences can also affect consultation outcomes. Most of the studies on communication in healthcare use self-reported patient satisfaction as a consultation outcome. Patient satisfaction is widely recognized as a valid measure of positive medical interaction outcomes because it is linked to patients' medical improvements (Wickizer et al., 2004).

A meta-analysis by Hall, Blanch-Hartigan, and Roter (2011) showed that female providers have significantly more satisfied patients than male providers, but the effect size was so small ($r < .04$) that the difference between male and female providers cannot be interpreted. The lack of a female provider's advantage in patient satisfaction is surprising because, as we have seen, female providers display a more patient-centred

interaction style than male providers and the female providers' patients seem to respond to it with a more empowered interaction style. Because patient centeredness has been shown to be beneficial for the patients, we would expect female providers to have more satisfied patients as compared as their male counterparts. It seems that somehow female providers are not rewarded for their adoption of the good medical interaction style. One explanation for this astonishing finding could be the gender stereotypes and role expectations that patients bring into the medical encounter. In order to understand this phenomenon, we will now present how gender, power, and stereotypes can influence performance evaluation in the general population before focusing more specifically on the provider-patient situation.

Gender and power interplay

Research shows that women are less likely to be found in leadership positions or to emerge as group leaders compared to men (Eagly, 2007). Women behave less dominantly, are less competitive, and are more interpersonally oriented; they are more communal (Eagly, 2007). Those styles of behaviour are not only descriptive, but they are also prescriptive in that they shape what we expect from women and men in terms of behaviour. Female leaders typically find themselves in a double bind situation. If they behave according to what is expected from women (more communal, caring, or gentle), their behaviour does not correspond to the one expected from a leader and thus these women are devalued (Eagly, 2007, Heilman, 2001). However, if women behave in a role consistent way (dominant, challenging, or entrepreneurial), the expectations linked to their gender are in contradiction to their behaviour. In both cases, female leaders will be

poorly evaluated, because of the lack of fit between gender stereotypes and role expectations (Heilman, 2001).

Gender and power in the medical encounter

Similar to what happens for female leaders, female physicians are in a double bind situation. They are perceived in a negative light if they adopt gender-incongruent behaviours. Burgoon, Birk, and Hall (1991) showed that variations in aggressive communication (non-aggressive, moderately aggressive, and aggressive) affected patients differently depending on the physician's gender. Patient satisfaction decreased with greater aggressiveness in female physicians, whereas patient satisfaction was less affected by male physicians' aggression. Schmid Mast, Hall, and Roter (2007) showed that in male-male dyads, the communication style of the physicians did not influence analogue patients' evaluation of the consultation whereas in female-female dyads less caring physicians received less positive evaluation. In same-sex dyads, female physicians are thus badly evaluated if they adopt an interaction style incongruent with gender stereotypes.

Also, there is evidence that the greater the dissonance between gender stereotypes and job expectations, the less positive female physicians are evaluated. Indeed, the younger the physician and the older the patient, the less satisfied the patient is with a female physician (Hall et al., 1994).

Interestingly, patients expect physicians to show caring and empathic behaviours which are stereotypically female behaviours (Eagly, 2007). And indeed, female physicians are rewarded for endorsing the typically feminine caring style of communication. Schmid Mast and colleagues (2008a) found that patient satisfaction

correlated with stereotypically female behaviours (e.g. more gazing, less interpersonal distance, softer voice) when displayed by women physicians. For male physicians, satisfaction was high when they adhered to stereotypically male behaviours (e.g. more interpersonal distance, greater expansiveness, louder voice) but this link was less pronounced than the one between stereotypically female behaviours and satisfaction with female physicians.

This strong link to behavioural expectations in female physicians might explain why they do not get the credit they should be, given the fact that they use a more patient-centred interaction style. Hall and colleagues compared the evaluation of high and low patient-centred female and male physicians. Analogue patients were asked to evaluate videotapes of male and female actors each displaying either high or low patient-centeredness while interacting with a patient. The results show that low patient-centred female physicians were not evaluated differently from low patient-centred male physicians. However, when the analogue patients watched a male physician displaying high patient-centeredness, they evaluated him much more positively than the female physician displaying exactly the same behaviours. The authors concluded that the female physicians do not get credit for their use of patient-centred care because it is a pattern of behaviours expected from every woman and so female physicians do not get extra credit for it. In contrast, patient-centred male physicians are seen as exceptionally good, because they show behaviours that are not expected from them according to gender stereotypes and the behaviour corresponds to the state of art in physician-patient communication.

Significance in the cancer and palliative care setting

So far we have presented a literature review on nonverbal communication, power, and gender in general medical settings. In oncology or palliative settings, care delivery is different from standard medical settings with respect to the length of the provider-patient relationship, nature of the treatment decisions, and the complexity of medical issues. In this context, the emotional dimension is omnipresent and especially fear and depression are prevalent given that end of life decisions are at stake. Research shows that symptoms of distress are often not detected and go untreated (Ryan et al., 2005). Given that affect is mostly expressed nonverbally, the correct assessment of a patient's demeanour and nonverbal cues is crucial to the provision of responsive care. It has indeed been shown that more interpersonally accurate providers detect more anxiety and depression in their patients with rare false-positive evaluations (Robbins et al., 1994).

In oncology and palliative care, the severity of the illnesses and the related impairments and weaknesses place the patient in an even more submissive and passive role compared to the provider who has the power to potentially alleviate the patients' health concerns and pain and even possibly save their lives. The hierarchical difference between patient and provider are thus most likely intensified by the particularities of oncology and palliative care. It is also important to note that severely ill patients prefer on average more paternalistic and dominant providers (Kiesler and Auerbach, 2006). So we would expect oncology and palliative patients to be more tolerant towards a dominant interaction style from their physicians and maybe even prefer this kind of interaction instead of a more patient-centred one.

The role that gender plays in communication in oncology has been insufficiently explored. But as the power difference between patient and provider is intensified, we

would expect that the dissonance between role expectations and gender stereotypes is exacerbated in oncology and palliative care. Female providers in those settings would therefore be even more negatively evaluated if they showed a dominant interaction style or would receive even less credit when showing a patient-centred interaction style.

Depending on the type of cancer, there might be preferences for one gender or the other which could influence the patient's evaluation of the provider. We know that patients prefer a female obstetrician or oncologist (Plunkett et al., 2002) and that they are on average more satisfied with female obstetricians than with their male counterparts (Roter et al., 1999). It is thus likely that women with cervical cancer, for instance, might prefer a female provider and would also be more satisfied with a female provider.

These reflections are driven by the existing literature, but unless we have empirical evidence, the question of how power and gender affect the particular setting of oncology and palliative care still remains open. Given the importance of nonverbal communication in the patient-provider relationship, providers and especially oncologists might want to consider nonverbal decoding training (Blanch-Hartigan and Ruben, 2013). Oncologists could benefit from a better understanding of their patients' nonverbal cues for the accuracy of the diagnosis, the adequacy of the treatment decisions, and the optimization of the relationship with their patients. Another important factor to consider in oncology training is the different characteristics of providers and patients such as age, gender, and ethnicity because, as the preceding chapter outlined, individual provider characteristics can affect the quality of the medical interaction and the relationship between health care providers and their patients.

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