Communicating with Patients of the Opposite Sex

By Abne Eisenberg

Do you communicate with patients of the opposite sex differently? Perhaps, you do and are not aware of it. The leverage of this column derives from a growing body of evidence suggesting that men and women do communicate differently.

Deborah Tannen, professor of linguistics at Georgetown University, has written extensively on the subject of sex-specific language (Genderlect) -- that is, how men and women communicate differently. While her work does not explicitly address the interpersonal communication common to the healing arts, she does flesh out a number of interesting communicative characteristics relevant to the therapeutic community.

To illustrate some of these gender-linked variables, here are but a few of her indications of the many differences:

- Women tolerate being physically approached from the side better than from the front. Men better from the front than from the side.

- For women, smiling is an interactional phenomenon -- for men, it is an emotional expression.

- Men use more pointing gestures that can be interpreted as being more dominant. Women use more palms-up gestures signifying uncertainty or hesitancy.

Although the aforementioned differences may not tie into specific examples of the overall doctor/patient experience, they do serve to illustrate their existence in a broader context.

In addition to being field-specific, doctor/patient communication is unquestionably modified by gender. Before any of us become licensed and entered private practice, we spent at least a quarter of a century as ordinary men and women. Hanging out a shingle did not alter our gender; only professional jargon was added to our pre-existent language.
Although Professor Tannen appears to give slightly more attention to verbal communication between the sexes than nonverbal, the latter most certainly deserves equal attention. For example, with regard to dress, the first women to enter the field of medicine or chiropractic were observed to de-emphasize their femininity. When this writer did his clinical internship four decades ago, the few female graduates serving their clinical internship wore white slacks, rather than skirts. However, during the intervening years, the feminist movement did much to defuse such an anthropocentric form of dress.

Many female patients still feel uncomfortable presenting themselves in various stages of undress before a strange male who happens to be wearing a white coat, has a stethoscope dangling from his neck, and is called "doctor." What male who is not a doctor wouldn’t delight at the prospect of being able to say to a strange woman, "Get undressed and I’ll be with you in a minute?" Conversely, the contemporary female doctor can exercise the same rite of passage with her male patients. Indeed, the title of "doctor" guarantees some very special gender-linked privileges.

Doctors of both sexes also enjoy the linguistic freedom to ask personal questions. For instance, the male doctor can openly and freely inquire about a female patient’s bowel, bladder, vaginal, and rectal condition. Likewise, the female doctor can ask her male patients about the character and frequency of an erection.

In a Chicago hospital some years ago, a female patient registered a formal complaint against her male physician for unnecessarily exposing her. He entered the room, nonchalantly drew back the sheet covering her, lifted up her gown, and proceeded with his examination. During the inquiry that followed, the physician’s defensive was, "the disease was under her nightgown." While what the doctor did was clinically correct, his manner of doing it remains open to question.

During the course of daily practice, whether the doctor is a male or female, verbal and nonverbal communicative styles will differ. Frequently, patients have been known to continue or discontinue treatment because of such stylistic differences. Moreover, disparate conversational styles may have the capacity to actually make or break a practice.

Do you agree with the following proposition? Sensitivity among male doctors is often judged by female standards, whereas assertiveness is often judge by male standards. The male doctor has a special need to feel in control. When he feels a female patient is trying to control him, he becomes uneasy. Such behavior on his part often causes the female patient to complain of insensitivity. According to Gregory Bateson, a mutually spiraling disapproval of another person’s response provokes a more exaggerated form of divergent behavior.
He colorfully referred to this phenomenon as "complementary schismogenesis." Adapting Bateson’s terminology to the doctor/patient relationship, this phenomenon commonly sets in when the male doctor and the female patient have divergent sensitivities and hypersensitivities. In a like manner, the spiral moves in the opposite direction when the doctor is female and the patient is male.

Another interesting thing happens when male doctors explain things to their female patients. Many male doctors behave as if their female patients are not able to grasp technical explanations as well as men. Professor Tannen illustrates this tendency with the following story:

A woman bought a computer. After reading the manual, she still felt in need of further clarification. She went back to the store where she bought the computer and spoke to one of the salesmen. He used technical language and, whenever she asked him what a word meant, he condescendingly made her feel stupid; even his tone of voice was condescending.

A week later, still confused, she returned to the store except, this time, she was assigned a woman salesperson who explained things very differently.

She didn’t use technical language and, if she had to use an unfamiliar word, she asked whether its meaning was clear. The salesperson’s tone of voice was also very gentle and understanding. Hence, the explanatory styles were emphatically different.

The preceding anecdote should in no way suggest that all male and all female doctors speak to their patients in this manner. In each gender, there are a great many exceptions. All that is being suggested here is that such a practice does appear to exist.

Male versus female doctors are also prone to make different word choices. For example, when it comes to syncope, the male doctor might use the phrase "pass out" while the female doctor might say "faint." Men are not known to faint -- they pass out. Then, there are such words as "nasty" and "bad." A female patient might complain of having a nasty headache, while men would say they had a bad headache.

During any conversation, studies indicate that men interrupt more than women. The act of interrupting appears to have more to do with dominance and control, rather than simply making verbal sounds when someone else is talking. As such, the male doctor who repeatedly interrupts his female patient may be approaching the interaction as a contest. By so doing, he demonstrates an unwillingness to hear the patient out and to lead the conversation in a biased direction.
Patients of both sexes often complain that doctors do not let them fully explain what they think or feel about their condition. While certain situations warrant a doctor interrupting a patient, it should be done with tact and sensitivity. This is particularly important when a male doctor overlaps a female patient’s recitation of symptoms. In the middle of a complaint, a male doctor might either change the topic completely, or superimpose his opinion on the subject while she is talking. The female doctor, in turn, does not perceive her conversational style as a contest and, most likely, has little experience fighting for the right to be heard. Female doctors characteristically show their concern by asking questions; male doctors do so by advancing their opinion and by offering solutions.

When it comes to physical positioning and eye-contact during an initial patient intake, there are additional gender differences. Male doctors tend to make more direct eye contact with female patients and less with their male patients. For instance, while standing in a treatment room, the male doctor is more apt to face his female patients squarely and make direct eye contact, while he will stand at an angle to his male patients and make less direct eye contact. Conversely, female doctors, in a similar situation, tend to face another female patient squarely and make direct eye contact.

Then, there is the matter of seated posture. Elizabeth Aries compared the posture of young men and women in all-male, all-female and mixed discussion groups. She observed that women made more physical adjustments than men in mixed groups. Men, in the opposite direction, sprawled out in “relaxed” positions regardless of the existing gender composition. Might one, then, extrapolate from Aries’ findings that male doctors, in the presence of female patients, assume more relaxed physical postures? Such an assumption represents a positive correlation with the clinical experience of this writer, i.e., female patients display more postural control and “ladylike” demeanor when being interrogated or examined by a male doctor. This physical uneasiness is not, however, as prevalent when both patient and doctor are female. In either direction, postural ease seems to be favorably reinforced when men are treated by men and women by women (again, a cautious generalization).

In a previous column, I spoke of cooperative healing. It stressed the importance of doctor and patient acquiring a more egalitarian status -- one in which a patient’s strengths and weaknesses are seriously taken into therapeutic account. However, to be successful, this objective should be free from any verbal or nonverbal discrimination based upon gender.
Conspicuous in gender-specific studies of how men and women communicate differently is the notion that men approach conversation in a competitive mode -- that they talk to preserve their independence, negotiate, and maintain their status. Women, conversely, communicate by using a cooperative mode. While both techniques can be rationalized successfully, male doctors should defer to the female approach and, whenever possible, communicate cooperatively. Put bluntly, the female doctor is more apt to offer understanding, while the male doctor offers advice. Every patient wants more than just to be heard, but to be understood in terms of thoughts, feelings, and fears. It would therefore, behoove all doctors to adopt the cooperative form of doctor-patient communication.

Another aspect of practice concerns how some male doctors address their female patients. Surely the male doctor who says "Please come in, dear" to a female patient would never say that to one of his male patients. While calling a female patient honey, sweetheart, sweetie, or darling may be acceptable under certain special circumstances, it is generally considered unprofessional.

If the welfare of the patient is the supreme law, it would behoove every doctor of chiropractic to learn from one another, i.e., become familiar with each other’s style of communication. Inasmuch as research is noticeable lacking in this area, I would greatly appreciate any feedback from the profession addressing the question of treating patients of the opposite sex. You may write me at the address given at the end of this column.

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