#Docsplaining

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Last year the Oxford English Dictionary included the word 'mansplaining' for the first time. In case you haven't come across it before, it is a conflation of the words 'man' and 'explaining'. It emerged about ten years ago, when the New York Times defined it as characteristic of 'a man compelled to explain or give an opinion about everything – especially to a woman. He speaks, often condescendingly, even if he doesn't know what he is talking about, or even if it's none of his business.' If you ask most women (in fact, *any* woman) for examples, you will hear countless ones. My favourite is from Trish Greenhalgh, professor of primary care health sciences at the University of Oxford. She tweeted recently about an encounter at a dinner where she explained to a man that she had spent twenty years studying failed IT projects in healthcare.[1] 'Let me tell you why healthcare projects fail…', he replied. Along with her tweet, Professor Greenhalgh posted an algorithm to help men to identify and resist the inclination for mansplaining.[2] It includes questions like 'Did she ask you to explain it?', 'Do you have more relevant experience?', 'Would most men with her education and experience already know this?' and 'Did you ask if she needed it explained?' Unless the answer to the first question is yes, all the other pathways lead to a diagnosis of 'Probably mansplaining', 'Definitely mansplaining' or 'Just stop talking now.'

The past couple of years have also seen the arrival of a parallel term: 'docsplaining'. This is being used to describe equally unwanted, unnecessary or patronising explanations by doctors to non-doctors, whether these are patients or simply members of the general public who suffer from the lamentable lack of a medical degree. Although the word is not yet recognised by the Oxford English Dictionary, it also has a growing presence on social media and its own hashtag on Twitter. If you are feeling full of yourself as a doctor and want to restore a sense of humility, surfing social media for stories about docsplaining is a good way of doing this. Without having the demoralising effect of more controversial hashtags like #doctorsaredickheads,[3] it will help you to become aware of some of the habits of speech that we all seemingly fall into as a profession without being aware of how unhelpful, annoying or ridiculous others may find them.

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VARIETIES OF DOCSPLAINING

Once you become sensitised to docsplaining and begin to be curious about it, you start to hear it everywhere, both in colleagues and in yourself. You notice, for instance, how hard it is for doctors not to opine confidently about matters that have nothing do with medicine even when their knowledge of the topic at hand turns out to be almost non-existent. As with mansplaining, this no doubt comes from an ingrained belief in being clever enough to grasp subjects like politics, history, arts and sciences effortlessly, even when lesser mortals may have had to labour for years to study them. Even more embarrassing, not to say professionally insulting, is the tendency of doctors to explain things to other healthcare professionals like nurses, psychologists or dietitians who may have vastly more experience and knowledge in relation to the patient or topic being discussed.

Most varieties of docsplaining are directed at patients themselves and hence do even more harm. Probably the the most common of these is to express medical conjecture as certainty ('there's absolutely no doubt this is viral') or to frame a trial of treatment as infallible ('these pills will fix the problem'). Then there are all those winsome euphemisms we use to deny causing pain ('this won't hurt', 'just a little scratch'). Such rhetorical tricks are deeply embedded within the culture of medicine itself and sadly we persuade ourselves of their truth rather more than we convince our patients. Another variety of docsplaining takes the form of a failure to calibrate our explanations with what the patient wants or needs to hear at that precise moment. For example, we lecture patients who are already deeply knowledgeable about their own conditions but are too cowed, polite or speechless to upbraid us. Conversely, we bombard people with information about numbers needed to treat, or the latest research findings, on the mistaken assumption that we are being generously patient-centred, at a time when they are in absolutely no emotional state to absorb or use these facts.

Personally, I have a particular distaste for conversational mannerisms such as 'reflecting back' ('so what you are saying is'), reframing ('it sounds to me as if') and naming emotions ('you seem to be very upset'). These techniques are taught religiously on courses in counselling and coaching, but whenever I teach or write about consultation skills myself, I strongly discourage them.[4] In practice they are nearly always used in a spirit of weary automatism, and entirely miss the point of what the patient has said. The most flagrant case I can recall was when a friend saw her general practitioner after her husband had a stroke and was told 'You must be very angry about what has happened'. 'Must I?', she replied, 'I'm actually here to discuss how we can get a stair lift.'

BELITTLING PATIENTS

It is unlikely that any doctor alone can think of all the possible types of docsplaining, so when writing this article, I posted a request on Twitter asking people to suggest others.[5] Many of the responses expanded on the varieties I have described above, but there were additional types, including a particularly toxic combination of docsplaining together with mansplaining. Apparently, one male gynaecologist explained to a postmenopausal woman that she was now effectively a man, while another told a woman how painless her colposcopy would be. (It was not). Psychiatry also seems to be an arena where doctors try to apply benign explanations ('we're keeping you safe') to justify unpleasant procedures such as compulsory admission. Other respondents on Twitter identified the way doctors fail to inquire into the patient's own explanations, offer lifestyle advice when it is neither wanted nor appreciated, or use 'we' in a patronising way ('we do tend to feel that way when we're anaemic').

Across all specialities, belittling patient experience and expertise appears to be the rule, whether this relates to patients doing their own researches, asking questions, or even describing their own pain ('I'm sure it isn't as bad as you think' was one example). Doctors like to keep control of the narrative, and they use docsplaining to disqualify alternative versions. We seem to have acquired an institutionalised addiction to docsplaining, and we now have our work cut out trying to monitor and treat it. Maybe we need more patients to laugh in our presence at the ways we speak to them. Or even better, perhaps we could develop a more advanced capacity to hear

what they are saying about us, and learn to laugh at ourselves as a result.

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