Does gender matter? An analysis of men's and women's accounts of responding to symptoms of lung cancer

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1. Introduction

Galdas and colleagues note that “much of the empirical literature suggests that stereotypical (or ‘traditional’) gender roles and norms – culturally dominant behaviour considered to be essentially ‘masculine’ and ‘feminine’ – are an important factor that shapes both men’s and women’s health help-seeking behaviour” (Galdas et al., 2010, p19). Public narratives concerning men’s help-seeking for illness have long reinforced beliefs that “rather than seek help, men will be strong, stoical and often silent in matters relating to health” (Robertson, 2003, p112). To some extent, this stereotype has been fuelled by well-known gender differences in use of primary care; analysis of routinely collected data on almost 3.8 million patients in the UK, for example, shows higher mean number of visits to the general practitioner in females than males between the ages of 10 and 65 years (Wang et al., 2013). Furthermore, a qualitative synthesis of patients’ help-seeking experiences and delays in cancer presentation identified men’s ‘reluctance to seek help’ (Smith, et al., 2005, p829) as a ‘third order construct’, concluding that “Men viewed help-seeking as not masculine enough ... and indicated that women found help-seeking easier because of greater contact with health services for themselves and their family” (p828). Such statements reinforce a view that men’s
(under)use of health care is problematic, consulting for serious symptoms at a later stage, while women are presumed to consult more readily, frequently and with less serious complaints (Hunt et al., 2010) and perhaps by implication to be ‘over-users’ of health service resources. But such stereotypes, and the evidence on which they are based, are themselves problematic, as we argue below, and can have far-reaching implications, on men’s and women’s understandings of ‘gender appropriate’ consulting behaviours, on doctors’ interpretations of symptoms according to gender (Arber et al., 2006; Lyratzopoulos et al., 2012; Schoenberg et al., 2003) and potentially on the ways researchers investigate, understand and draw conclusions from evidence relating to help-seeking for illness among men and women. The dearth of studies taking a gender-comparative approach to critically investigate whether or not the available evidence on men’s and women’s help-seeking bears witness to the public narratives has been identified as a clear weakness in the evidence base (Hunt et al., 2010). In particular, Hunt and colleagues argue that “more critical gender-comparative research is needed to understand the ways in which men and women’s help-seeking is similar or different to avoid medical bias in consultations (based on false premises about readiness to consult) and to develop gender-sensitive policy and practice on the most appropriate use of health services” (p253). Similarly, Galdas et al. (2010) argue for a need to go “beyond the masculine-feminine binary of stereotypical gendered constructions of ‘stoic men’ and ‘vulnerable or accommodating women’.

2. Gender identities and help-seeking for illness

In Western cultures, hegemonic masculinity, that is the idealised practices of masculinity to which men are thought to aspire, emphasises stoicism, independence, emotional control and a strong, healthy body (Connell, 1995). The concept of hegemonic masculinity is related to narratives of help-seeking and help-seeking behaviour because, within many current constructions of hegemonic masculinity, acknowledging illness and asking for help are viewed as signs of weakness and men are believed to be less likely than women to seek help when ill so as to avoid jeopardising performances of hegemonic masculinity (e.g. Addis and Mahalik, 2003; O’Brien et al., 2005; Robertson, 2006). Courtenay (2000, p1389) argued that health-related beliefs and behaviours are a means of demonstrating gender, and that dismissing health concerns is a key practice of hegemonic masculinity:

“By dismissing their health care needs, men are constructing gender. When a man brags, ‘I haven’t been to a doctor in years’, he is simultaneously describing a health practice and situating himself in a masculine arena.”

Links between health-related behaviours and performances of masculinity are commonly asserted to: lead to men making less (or inappropriately late) use of health-care services than women; have a detrimental impact on men’s morbidity and mortality; and explain, at least partly, men’s shorter life expectancy compared with women (Baker, 2016; Banks and Baker, 2013; White, 2011). In contrast, it has been argued that ‘feminine ideals’ (in the context of help-seeking behaviour) are typically seen as asking for help, caring about health, nurturing and monitoring partners’ and children’s health and well being” (Galdas et al., 2010) (p18), linking stereotypes of women’s greater ‘propensity’ to visit the GP to their presumed caring roles.

While there is evidence of men presenting themselves as avoiding seeking help for various reasons, including the perceived need to present themselves as traditionally masculine (see Galdas et al., 2005 for examples), research reports that the links between masculinities and help-seeking are not straightforward. Robertson (2003, 2006) argued that men are caught in a dilemma between ‘don’t care’ and ‘should care’, and feel they need to legitimise their health service use to avoid potential emasculation. Others have shown how expressions of masculinity in relation to help-seeking, and the extent to which men justify health service use, can vary by ethnicity, culture (Galdas et al., 2007), age, occupation and medical history (O’Brien et al., 2005). Indeed, others have suggested that help-seeking can be reformulated by (at least some) men as a masculinist act which signifies taking control and responsibility to solve health problems (Farrimond, 2011; Johnson et al., 2012). Such research highlights the importance of destabilising assumptions that hegemonic masculinity precludes help-seeking for all men in all contexts or that help-seeking is always disruptive to hegemonic masculinity. More research is thus needed to investigate the complex and fluid links between gender identities and help-seeking (see also, Galdas et al., 2010).

3. How best can we investigate the links between gender and help-seeking for illness?

A synthesis of research on gender and access to healthcare reported a dearth in comparisons of men’s and women’s responses to the same health concerns, concluding that “[a] full and comprehensive answer to the question of whether access to healthcare is characterised by gendered patterns of advantage and disadvantage is thus not possible” (Annandale et al., 2007, p477). Hunt et al. (2010) called for two types of gender comparative approaches to address this gap: quantitative studies comparing patterns of help-seeking behaviour amongst men and women with similar underlying morbidity; and qualitative studies critically investigating and comparing men’s and women’s accounts of their decisions to consult (or not) when they experience symptoms.

Recent quantitative studies examining GP consulting rates among men and women with comparable morbidity challenge stereotypes of stark gender differences in help-seeking behaviours. A systematic review of consultation for headache and back pain found surprisingly weak evidence of greater consultation amongst women (Hunt et al., 2011). Analyses of a large routinely collected primary care data source revealed small gender differences in men’s and women’s rates of consulting when accounting for underlying morbidity; and qualitative studies critically investigating and comparing men’s and women’s accounts of their decisions to consult (or not) when they experience symptoms.

Findings from qualitative gender comparative research also challenge gender stereotypes. A study of self-management of multiple morbidity in mid-life revealed that men and women accounted for the management of illness within a moral framework, presenting their use of healthcare as a last resort and
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