



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



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ABSTRACT

Men are often portrayed - in research studies, 'common-sense' accounts and popular media - as reluctant users of health services. They are said to avoid going to the GP whenever possible, while women are portrayed, in presumed opposition, as consulting more readily, more frequently and with less serious complaints. Such stereotypes may inadvertently encourage doctors to pay greater heed to men's symptoms in 'routine' consultations. Although previous research has challenged this view with evidence, and suggested that links between gender identities and help-seeking are complex and fluid, gender comparative studies remain uncommon, and particularly few studies (either qualitative or quantitative) compare men and women with similar morbidity. We contribute here to gender comparative research on help-seeking by investigating men's and women's accounts of responding to symptoms later diagnosed as lung cancer. A secondary analysis of qualitative interviews with 27 men and 18 women attending Scottish cancer centres revealed striking similarities between men's and women's accounts. Participants were seen as negotiating a complex and delicate balance in constructing their moral integrity as, on the one hand, responsible service users who were conscious of the demands on health care professionals' time, and as patients who did not take undue risks with their health, in the context of an illness for which people are often held culpable, on the other. In accounting for their responses to symptoms, men and women drew equally on culturally-embedded moral frameworks of stoicism and responsible service use. Regardless of gender, the accounts portrayed participants as stoic in response to illness and responsible service users; and as people seeking explanations for bodily changes and taking appropriate and timely action. Our analysis challenges simplistic, 'common-sense' views of gendered help-seeking and highlights that both men and women need support to consult their doctor for investigation of significant or concerning bodily changes.

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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 3.8million 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

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(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 straight-forward. 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 masculine 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, such as depression and cardiovascular disease (Wang et al., 2013), and that, in relation to three non-sex specific cancers (colorectal, lung and malignant melanoma), there is little evidence that men are being diagnosed at a later stage than women and very little evidence of gender differences in GP consulting in the 24 months prior to diagnosis (Wang et al., 2014). The authors assert that their analyses provide little support for the hypothesis that gender differences in mortality might be explained by men presenting later or less to primary care. A study which examined the number of GP consultations prior to hospital referral for cancer found the probability of making three or more pre-referral consultations was greater for women than men (Lyratzopoulos et al., 2012), and particularly marked for bladder cancer. The authors highlight an apparent danger of GPs "misattributing urinary tract symptoms in women to a benign cause" (p363) and suggest GPs' readiness to suspect cancer varies by cancer type and gender, meaning that, for some cancers, women may have to make more visits to their GP before cancer is considered as the possible cause of 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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