

**KEYWORDS:** health and wellbeing; masculinity; identity; health practices

# Men managing health

Men face a dilemma between showing they ‘don’t care’ about health issues and realising they ‘should care’. The ways men resolve this dilemma, how they justify caring for their health and engaging with health services has implications for practice. It is important that health professionals take the time to understand how this dilemma impacts on men’s health practices in order to generate opportunities for effective health work with men.

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Historically, men’s health has tended to focus on how men don’t take health seriously and continue to take more risks with their health than women. Frequent emphasis is placed on men’s poor use of health services, particularly primary care. Having to be strong, not show weakness, and taking risks are the attributes often associated with masculinity that are identified as being responsible for men’s negative health practices and outcomes<sup>1,2</sup>.

Those researching in men’s health have begun to recognise that how men attend to their health, or not, may depend as much on other aspects of identity – such as sexuality, ethnicity and disability – as on masculinity, and therefore sex differences in GP attendance are not as straightforward as once thought<sup>3,5</sup>.

This article reports on part of the main findings from a larger NHS funded Research Fellowship project, conducted in the North West of England, that aimed to examine the links between ‘masculinity’ and men’s understanding of preventative health. Specifically, this article will highlight how health is understood by the men who participated in the study and what processes were utilised by the men to justify engaging with health services.

## METHODOLOGY

A combination of four focus groups, in-depth interviews with eight community health professionals, and in-depth interviews with 20 men, each interviewed twice, was used to generate the qualitative data set. The specific findings presented

here are part of those emerging from the focus groups and interviews with the men themselves. These men included seven gay men, accessed with help from the local health promotion unit, six disabled men, accessed through a contact in the local authority leisure department, and seven none-gay, none-disabled men, accessed through two local GP practices. All the men were aged between 27-43 years and were chosen to represent a diverse range of masculinities; in this sense they were seen to represent what is known as a ‘purposive’ rather than ‘representative’ sample<sup>6</sup>.

**“Men often understand health as it relates to their functioning in everyday life, rather than as an abstract concept”**

Data analysis involved identifying the main themes that emerged from the transcribed interviews and undertaking a more detailed coding of this data for each of these themes. The relationships between these codes was then examined to allow for theoretical ideas to be developed. This article looks at the data and theoretical ideas from one of the main emerging themes, that of justification for engaging with health services.

## FINDINGS

When asked what they understood ‘health’ to mean, a clear tension presented itself to

## WEB LINKS

Fathers Direct  
[www.fathersdirect.com](http://www.fathersdirect.com)

## KEY POINTS

1. Men face a dilemma between showing they ‘don’t care’ about health issues and realising they ‘should care’.
2. The most common way that the men resolved this dilemma was by making a clear distinction between health and illness/disease.
3. Men need to legitimise or explain in some way ‘healthy’ behaviour or engaging with health services.
4. Stereotyping men as only being unconcerned about health matters stifles health professionals’ ability to create practical opportunities for health work with men.

the men. On the one hand, they expressed the view that men didn't care or think about their health:

"Yes, health's important to women ... but blokes don't really bother about it."

Yet, at the same time, there was a feeling that as an individual, you should be responsible for maintaining your own health:

"I don't feel that the NHS should have to help me out to keep myself healthy and balanced."

There is a strong public narrative, or discourse, about health being 'women's business'. This was apparent in the men's interviews, leading to expectations that rather than seek help, men will be strong, stoical and often silent in matters relating to health and wellbeing. Yet from the evidence of the men's own experiences this was not necessarily how the men actually behaved in daily life. Whilst the men were all aware of this 'macho' aspect of male identity, nearly all distanced themselves from it in direct discussion:

"... men have been taught from a child that ... 'you're a man, you're supposed to be big and nothing bothers you' and all that, but it's not true ..."

Given that health is often associated with that which is feminine, that part of asserting male identity involves expressing a lack of concern with health issues. Yet the idea of 'health' today carries moral connotations and identifying yourself as a 'good citizen' means also showing at least some concern with your health. Men may therefore face a dilemma in having to balance these two contradictory demands: a dilemma between 'don't care' and 'should care'. Whilst health professionals are good at recognising the 'don't care' elements of men's relationship to health and wellbeing, they are not quite as good at recognising the 'should care' elements and how and where these create opportunities for health work with men.

## MEN TAKING CARE

The most common way that the men resolved this dilemma was by making a clear

**TABLE 1 Ways men legitimise healthy behaviour and engagement with health services and the implications for health professionals.**

<ul style="list-style-type: none"> <li>■ Distinguishing between health, that doesn't require health service input, and illness/disease that does</li> </ul>	<p>Practical implication – There is a need to provide information and support for men to recognise when illnesses or diseases are present particularly those with minimal symptoms in the early stages eg. hypertension, testicular cancer</p>
<ul style="list-style-type: none"> <li>■ Life changes such as marriage, fatherhood, relationship breakdown, can lead men to re-evaluate issues of mortality and lifestyle (positively or negatively)</li> </ul>	<p>Practical implication – Such changes often involve a reassessment of identity, of what it is to be a man, and as such provide an opportune time to discuss changes in lifestyle practices including those that relate to health</p>
<ul style="list-style-type: none"> <li>■ Family history of ill-health, death, or susceptibility to particular conditions</li> </ul>	<p>Practical implication – Particular family histories of ill-health/death can and do lead men to consider taking action about certain aspects of their health and wellbeing. These may also provide opportunities to discuss wider health practice changes</p>
<ul style="list-style-type: none"> <li>■ Using other aspects of identity, (sexuality, are impairment etc) as a means of explaining particular health-related actions</li> </ul>	<p>Practical implication – If time and thought is given to specific identity issues these can be used as levers to facilitate more appropriate and effective ways to engage with particular groups of men</p>

distinction between health and illness/disease. All the men interviewed were able to recount times when they had sought help from a health professional. This was when they had been unwell or injured and they expressed no reservations about doing so:

"There are certain doctors that I'd prefer to see, but I haven't got any qualms with going to see a doctor at all."

As other research has also shown, men can and do take ill-health seriously and are not necessarily more prone to delay in seeking help than women for the same condition and level of symptom<sup>4,5</sup>. Yet when the concern is about preventative health, most men felt that they would be wasting the doctor's time in attending. This was evident in the discussion on whether the NHS has a role in helping men to stay well:

"You're wasting their time, they could be sorting someone out who is poorly. Someone needs an emergency appointment and you go in and there's nothing wrong with you, you could be holding them up ... the less I go to the doctors, the better off everyone else is that's poorly. I know I'm not taking up his time."

It is clear that care has to be taken when considering health promotion work with men as certain approaches, particularly those seen as more 'medical', may be perceived of as removing scarce resources from where they should be best used.

Given that men often understand health as it relates to their functioning in everyday life, rather than as an abstract concept', it is no surprise that their health practices change over the course of their life as circumstances change. For example, settling into family life was seen as a significant factor in influencing how men understand health:

"I was one of the beer swilling types not that long ago. But now things have changed and we [as a couple] still enjoy ourselves, but we enjoy ourselves wanting to know that we are able to put up with any emergency that may occur. We will take it easy until she's [the baby] of an age when she can look after herself."

There was often a reassessment of values as men settled down into long-term partnerships, including gay partnerships, and into fatherhood. This reassessment was usually associated with reductions in excesses

(of going out, drinking, smoking, sexual promiscuity for example), an improvement in dietary habits (usually facilitated through a female partner), and a desire to live a long life (often in order to provide for and see the children grow up). The reassessment of male values that occurs during such life changes presents positive opportunities for health work with men and this is beginning to be recognised in work with young fathers, particularly in 'Sure Start' initiatives. Similarly, divorce and relationship breakdown could be further explored in practice, as such life changes can have a significant detrimental impact on men's health and wellbeing.

### **“Stereotyping men as not wanting to take responsibility for their health and of consistently delaying seeking help cannot be sustained”**

Many of the men interviewed had experienced the ill-health and even death of family members or of close friends and this was also used as a means of legitimising caring for health:

“My father died of skin cancer when I was very young. So, if I've got a scratch on my back I think 'is that a mole?', I always get my mum to check it out. She says, 'right you ought to go and see a doctor'. So certain things like that I'm very cautious about, I always run it by them.”

Recognising that such issues do generate concerns about health for men, and that they are willing to act upon such concerns, again creates opportunities for health work with men. Stereotyping men as only being unconcerned about health matters stifles our ability as health professionals to maximise the opportunity afforded by such events.

A further means of legitimising access is the role that others can play in encouraging men to seek help. Health professionals have long been aware that female partners and relatives are active in helping men to seek help for health problems and this was confirmed by the men inter-

viewed. One man recalled a recent doctor's appointment:

“Jane phoned up to make the appointment, she always phones the doctors and tells me when I have to be there ... I'm not very good at that kind of thing.”

Yet this may not mean that men are unwilling to go, as is often suggested, but rather that they need a means of legitimising their visit so that they can maintain face, or keep their male identity intact, by claiming to be pressured into attending. Care must be taken that health professionals do not rely too greatly on promoting men's health through female partners/relatives, as this serves to reinforce the impression that real men are not concerned about health matters and it means that women continue to carry the burden of all the family's healthcare concerns.

Drawing specifically on particular aspects of identity can also help men explain why they care about health and engage with health services. The gay men interviewed used their alliance with, supposedly, feminine ideals about 'looking good' as a way of distancing themselves from 'straight' men and explaining certain positive health practices:

“I think gay men are more aware of their health than straight men – on the whole I think that gay men are more health conscious. I mean, I've seen some men, same age as me, and they're huge, fat, because they haven't looked after themselves, whereas gay men don't tend to do that.”

Likewise, the disabled men used their specific impairment as a means of justifying engaging in 'healthy' behaviour:

“I think, since I've been in the chair, I've watched what I've eaten because I can't lose it ... I'm worried about getting a belly and not being able to get rid of it.”

If we can take the time to understand how specific aspects of identity impact on men's health practices we can generate more opportunities for engaging in effective health work with men, identifying the right triggers that can facilitate change.

## CONCLUSION

It is clear that stereotyping men as not wanting to take responsibility for their health and of consistently delaying in seeking help from health professionals and services cannot be sustained. However, it became apparent from the men surveyed, that caring for their health and wellbeing and engaging with health services needs to be legitimised or explained in some way. Not to legitimise or explain such behaviour risks being emasculating, leaving men open to ridicule and even violence from others through association with that which is seen as feminine or gay (ie caring).

As health professionals we need to pay more attention to how we can help men legitimately care for their health and engage with health services whilst minimising such risks. Linking into times of life change, recognising specific aspects of family history that may cause concern about health issues, acknowledging the importance of third parties in facilitating access to health services, and utilising identity specific concerns, all represent levers and therefore act as opportunities for helping men to legitimately care for their health and wellbeing.

## REFERENCES

1. Griffiths S. Men as risk takers. In: Kirby RS, Kirby MG, Farah RN (Eds.) *Men's Health*. Oxford: Isis Medical Media, 1999.
2. Banks I. No man's land: men, illness and the NHS. *BMJ* 2001; **323**: 1058–60.
3. Robertson S. Men's health: present practice and future hope. *Br J Community Nursing* 1998; **3**(1): 45–49.
4. Macintyre S, Hunt K, Sweeting H. Gender differences in health: are things as simple as they seem? *Social Science & Medicine* 1996; **42**: 617–24.
5. Hunt K, Ford G, Harkins L, Wyke S. Are women more ready to consult than men? Gender differences in family practitioner consultation for common conditions. *Journal of Health Services Research and Policy* 1999; **4**: 96–100.
6. Silverman D. *Doing Qualitative Research: a practical handbook*. London: Sage Publications, 2000.
7. Watson J. *Male Bodies: health, culture and identity*. Buckingham: Open University Press, 2000.

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