DISCUSSION

Practical Implications

The data from this study reveals several practical applications worthy of future study. First, it would be valuable to further examine how society constructs images of masculinity and femininity and how this impacts health care procurement. This study suggests that males do not seem to place value on regular health check-ups and early detection of disease even though they frequently listed these characteristics among healthy role models. The reason for this ideology, it seems, is that some men are functioning from outdated constructs of masculinity. Characteristics such as aggressiveness, fearlessness, and competition lead young boys to a construct of invulnerability as a grown man. This ultimately prevents them from acknowledging that being vulnerable, specifically being vulnerable to poor health and disease, is a natural part of life. Thus it would be helpful to examine how males develop the construct of masculinity and how this is translated into a denial of vulnerability. By making an annual physical part of the masculine construct, steps can be taken to acknowledge vulnerability and perhaps head off debilitating illness and disease as a result.

Similarly, women are held to equally archaic and outdated images of femininity. Women are often portrayed as passive, weak, and emotional. This affects how women interact with the health care system and how health care providers interact with female patients. Women are frequent targets of both physical and sexual assault. Homicides and assault related injuries have increased since 1990 (United States Department of Health and Human Services, 1995). As such, women account for nearly two-thirds of medical visits and are recipients of most medications prescribed (Hoffman, 1995). Although
women currently live approximately 7 years longer than men, the quality of their lives may be vastly diminished (Verbrugge, 1989). Over the past 30 years, the death rate is rising rapidly among women for lung cancer, women are developing AIDS at a faster rate than men, and cardiovascular disease is now the leading cause of death among women and men (Litt, 1993). Contributing to the problem, women are less likely than men to have adequate health insurance coverage (Stanton & Gallant, 1995). Despite these grim numbers, women place a far greater value on preventative health and have greater success in gaining an annual preventative check-up. Women perceive a healthy role model as one who seeks regular care and most could name a role model who modeled this behavior for them.

To change society’s view of masculinity and femininity is not a small undertaking. Pervasive messages supporting the traditional view of masculinity and femininity undermine efforts to increase and improve men and women’s health. Certainly the advertising industry and the media in general would need to support efforts to change the perception of gendered stereotypes. Subsequently adolescent peer group pressures to accept new constructs of gender roles would need to be reinforced. It would mean breaking the cycle of images that are relayed from generation to generation about traditional masculine and feminine roles and replacing them with images that support, enhance and promote health in constructive ways for each gender.

In addition, messages, which support health promotion, must be dispersed by many different sources including health care providers, schools, religious institutions as well as other groups in the community. Without the mutual understanding and support of
a variety of sources the risk of losing the message in the wake of contradictory gender health related messages is great. It cannot be accomplished by one sector alone.

Secondly, an area that deserves immediate attention is the opportunities that exist for men to become educated about health and healthy lifestyles. There is an extreme deficit of information between male and female related health issues. A recent search of the Medline database, the most widely used database in the field of medicine, listed 4,394 entries for “women’s health” and 94 entries for “men’s health.” during the period from 1959-1998 (Good, Sherrod & Dillon, 2000). Men’s health as a category of health has not been adequately addressed or researched.

A health class in middle school or high school is likely the only source most developing young men have for health related subjects. Coupled with a male’s tendency to use less talk, and use talk as a means to establish status and independence rather than form a solid support network (Tannen, 1990), men operate with less information and support to make truly informed decisions about their health care. This is inadequate to help males form behavioral patterns that should exist over the life span. Optimally, health courses should address the role of masculinity on health. Specifically, to debunk the myth that being proactive and taking preventative measures with one’s health does not make one weak or vulnerable would be helpful. Ideally, by creating opportunities for health education to address the implications of gender roles on health, we could effectively change the health care practices of a generation.

Thirdly, changing how health care messages are framed could help support society in their attitudes and behaviors toward their health. In the immediate future until cultural images about masculinity and femininity are altered, health care professionals
might create campaigns to capitalize on gender related images. We know conceptions of masculinity influence men’s health seeking behavior. By taking a well-known masculine image such as the Marlboro Man, for example, and framing a message that supports the need to check one’s cholesterol or blood pressure we could capitalize on the current construct of masculinity. Another approach could focus on men’s bodies needing regular service much like the “once-over” men’s hot rods receive before the first ride in the springtime.

Similarly, women could benefit by gender related image campaigns. From this study, and gender communication literature, we have learned that women stay connected to other women and form communities in which information is exchanged. Similar to the “Belt Someone you Love” campaign from the National Highway Transportation Safety Administration, a health promotion campaign could be directed toward women that capitalizes on a woman’s tendency to look out and nurture family and friends of both genders. We know that the health of children and adolescents is directly impacted by the closeness of the relationship between a woman (not necessarily the child’s mother) and child (Parker, Boulet, & Atrash, 2006). Close proximity allows them to share patterns of healthy behaviors. Values are exchanged on the benefits of exercise, mental wellness and self esteem as well as good eating habits. Clearly, the female role model is underutilized in health promotion.

Fourth, providing incentives to individuals practicing healthy lifestyles should also be considered. Auto insurance companies have begun rewarding those drivers who drive accident and ticket free. They also provide monetary incentive for new drivers who present good grades and reflect credits in the premiums that are charged. Perhaps health
care companies could do the same by incentivising health plan participants to seek regular preventive care, weight loss goals, and exercise regimens.

Employers could provide work environments that are healthier by providing workplace interventions. Onsite workout facilities, healthier food choices in cafeterias and vending machines and even programs that encourage people to walk or bike to work could be offered. Even lectures offered over lunch hours on the benefits of a healthy work force could provide support to large portions of the work force. As part of its Healthy People 2010, the federal government could offer incentives to companies large and small who are actively seeking to monitor and improved the health of its workforce. This could also provide an important tool of analysis for Healthy People 2020.

In 2002, the Centers for Disease Control and Prevention’s Office of Genomics and Disease Prevention, in cooperation and collaboration with the National Institutes of Health began an initiative to encourage the use of family history for the purposes of assessing a person’s risk for common diseases and influencing early detection and prevention strategies. In 2004, the CDC along with the Surgeon General’s Office and the NIH and the Health Resources and Service Administration collaborated on a campaign to promote the use of family history for health promotion and disease prevention. They have designated Thanksgiving Day as National Family History Day, where families can share important health history information on a day when families traditionally gather. Tools are available to help facilitate the gathering of information from the campaign’s website (www.hhs.gov.familyhistory) Unfortunately, this has not been promoted to large sections of the population.
At the heart of this research is a need for all of us, women and men, to adopt the ethic of prevention in our personal lives and to encourage our family and friends to promote their own health as well. The key is in changing individual behavior in a way that makes health care promotion and disease prevention a natural course over the life span which does not hinge on one’s personal gender construct.

**Implications for Future Research**

In addition to the practical implications, this study has also revealed implications for future research. Qualitative approaches have proven to be a rich foundation to discover gender related health care issues. This study focused on individual interviews to discover in-depth attitudes of health care and role models. A suggestion for future study would be to introduce a new instrument such as focus groups to provide information on the dynamic between men and women as it relates to health care. This instrument would become centered on gender relations instead of gender roles and could help further illuminate gender differences in seeking preventative health care and the reasons behind those differences.

Other directions could include comparing gender samples from the United States with gender sample from countries with different health care structures such as the socialized medical program in Canada. The Canadian system of health care has been a work in progress since its inception. Reforms have been made over the past four decades and will continue in response to changes within medicine and throughout society. The basics, however, remain the same - universal coverage for medically necessary health care services provided on the basis of need, rather than the ability to pay (Health Canada,
Future studies could analyze the utilization of the health care system on the basis of gender from the perspectives of universal and privatized medical structures.

**Theoretical Implications**

When applying the CMM framework to the data, we see many helpful outcomes. CMM tells us one’s varying meanings are coordinated in conversations (Pearce, 1989). Through constitutive rules, or the rules used by communicators to understand an event or meaning, and regulative rules, rules used by communicators to determine how to respond or behave, individuals interpret appropriate ways of being. The data reveals that men and women apply constitutive rules and regulative rules differently to their health care. While men acknowledge annual check-ups can enhance one’s health and contribute to a longer, healthier life overall, their regulative behavior is stunted due to current structures of masculinity. Women, on the other hand, also acknowledge the need for an annual preventative check-up and utilize this when possible but are inhibited due to a lack of adequate health care coverage and outdated portrayals of femininity. As we turn our attention to a relational understanding of health care procurement and the social reasons and issues surrounding preventive health care, CMM would pose new kinds of questions.

Rules of meaning and action always operate within a context or frame of reference (Pearce, 1989). CMM could provide a theoretical framework to facilitate dialog within various contexts such as intercultural or intergenerational contexts. Pearce and Pearce (2001) have developed SHEDD, an acronym for the five phases of a public dialogue process model (S - starting, H - hearing all voices, E - enriching the conversation, D - deliberating the options and D - deciding how to move forward together). By applying this framework to health communication we would gain valuable
date toward understanding the contextual factors that influence health promotion and disease prevention. CMM and the SHEDD process model could illuminate the motivating factors that lead men and women to be more behaviorally inclined (or uninclined) to seek preventive medical care based on the constructs of rules that are shared between cultures and generations.

Additionally, intergenerational and intercultural life scripts, or the ways in which communication shapes an individual’s self perception, could be studied utilizing a CMM lens. By analyzing intergenerational and intercultural conversations, new theories might emerge based on the social constructs that are unique to generations and cultures and contribute to the construction of gender and its influence on health care procurement. Each generation brings forth certain values and ideologies that typify its place in time. By acknowledging these unique attributes we can begin to perturb the patterns that are transferred and learned by subsequent generations. Similarly cultures are defined by the values and ideologies that bind a certain group of citizens. Exposure to differing cultures and ways of being could cause re-evaluation and a reconstruction of health care practices and the gender practices within those constructs.

Archetypes, or our understanding of speech acts, life scripts, episodes and contracts shared by a particular group such as men or women are also ripe for study. As gender is constituted in conversation and discussion, society needs to weave alternative realities that allow for multiple interpretations of masculinity and femininity. Through the perturbance of the current conversational logic by men, “I’ve never been sick therefore I don’t have to go to the doctor,” we have the potential to move society from a position of
reaction to a position of action by procuring preventative healthcare in pursuit of healthier lifestyles.

The frameworks of coherence, coordination and mystery also provide a rich background for theoretical implications on health care and gender. When a subject or idea is coherent to an individual, it makes sense to them. When it comes to health care, when a notion is coherent, it would seem ridiculous not to practice it. Making “meaning” is not an optional activity for human beings. Where theoretical application is lacking is the connection between making health communication so compelling that it becomes a powerful impetus to health practices. Beliefs and actions must go hand in hand to make meaningful changes to the health and well-being of the population. Through our own resources to make the world coherent, such as the institutions of friends, family, we need to develop the stories to reinforce the importance of health maintenance. From a communication perspective, stories will function to enable groups of persons to achieve coherence, and ultimately, greater health conditions. Simply put, we are what we tell ourselves we are and this comes from many sources.

As young children, we begin to coordinate and form our opinions and approaches to many different social structures, primarily influenced by our parents. Theoretical development would benefit by exploring the impact of earlier intervention and exposure to health related topics, and specifically the gender constructs that influence health care approaches from a variety of sources. By incorporating messages from parents, schools, and religious institutions, new theories could be designed to influence life long practice of health maintenance. New theories about coordinating opinions and belief systems
when one is in the formative years deserves attention to change the health behaviors of generations to come.

One’s interpretation of mystery, or the faith one may use to interpret the world around them can have a profound impact on one’s health outlook. Religion explanatory systems should be one of the more powerful influences on believers who undergo health procedures (Miner & McKnight, 1999). What we have yet to explore is the connection between one’s successful health maintenance and the impact of faith on health care procurement. Specifically, does mystery, or those who acknowledge some higher power, affect health maintenance behavior? Are men or women more likely to be influenced by faith when undergoing health treatments? How does prayer influence health outcomes by gender? Theoretical development of the impact of mystery on health care procurement is an area where further development is needed.

In summary, many factors influence the procurement of preventive health care. By understanding the gender-specific constructs of masculinity and femininity we can better address the objections and obstacles these populations face in attaining optimum health. Further, by developing an understanding of the importance of health care role models, we can begin to raise the consciousness of society on how individual actions influence the well being of those around us. As health care expenditures in the United State continue to grow at a pace faster than inflation, the importance of disease prevention and health care promotion cannot be over-emphasized. Ultimately, flexibility in gendered behavior is important for optimizing health (Watkins & Whaley, 2000).