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Citation:

Witty, KR and White, AK and Bagnall, A and South, J (2011) Male frequent attenders of general practice and their help seeking preferences. *Journal of Men's Health*, 8 (1). 21 - 26. ISSN 1875-6867
DOI: <https://doi.org/10.1016/j.jomh.2010.09.228>

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Male Frequent Attenders of General Practice and Their Help Seeking Preferences

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Background

Frequent attenders of general practice have been shown to place undue pressures upon GP services, accounting for between 21% and 67% of all consultations [1]. Literature on frequent attenders reveals this group to contain a disproportionate amount of women, reflecting the wider literature showing a greater use of health services by women. Indeed sex has been found to be a strong indicator of health service usage in a range of different populations, with women being more likely to access health services than men [2-5]. Men are commonly seen as reluctant users of health care, and engaging men in health services has been highlighted as a problem for those working within the field [6]. Such that, whilst frequently attending men are a relatively small grouping, their apparent subversion of traditional masculine norms of indifference towards health provides a potentially rich resource for researchers and policy makers.

Traditional notions of masculinity and masculine help seeking behaviours evoke images of men who are reluctant to seek help for medical conditions, delaying attendance of service until a problem is too severe to ignore [7]. There is a broad body of evidence to show that these stereotypical patterns of behaviour are based upon truths. Studies conducted in a variety of different populations of men, in varying states of health have found men to be hesitant in seeking health care [8, 9]. There is also evidence showing lower levels of service use by men, compared to women [10, 11].

There is however, a second body of literature which refutes the idea that sex plays a determining role in help seeking behaviour and questions the value of illustrating help seeking behaviours using the broad brush strokes of male or female. Shapiro and colleagues [12] analysis of health and mental health service utilisation found that whilst women were more likely to visit mental health services, men were more likely to visit mental health specialists than women. Furthermore, Macintyre and colleagues [13] conducted research on the general population of Scotland, finding no evidence that women were more likely to report 'trivial' or mental health conditions. What's more, the study found no evidence that men were more reluctant to seek help. Complimenting these findings, there is an increasing body of literature highlighting a more nuanced and flexible masculine identity [14-16]. Such accounts reject monolithic notions of hegemonic masculinity in favour of a more reflexive approach to masculinity.

This paper reports findings from extended analyses performed on a sub-section of data from a large scale evaluation study of a self care intervention delivered to frequent attenders of general practice within three areas, Self Care in Primary Care (SCinPC). The primary aim of the extended analysis was to explore, help seeking preferences of men using a sample of men who frequently attend general practice. The paper examines men's self reported health service use preferences and provides a reflexive analysis of attitudes towards current health service provision.

Method

The Self Care in Primary Care Evaluation Study

The parent SCinPC study adopted a multi-method approach. Quantitative data was collected from all 1,454 frequent attenders using structured questionnaires delivered at baseline and followed up at six months and 12 months. The questionnaire collected data relating to participants' demographic attributes, self reported health status and current service use. Acknowledging concerns over the validity and reliability of self report data, patient findings were supported by qualitative data collected using a series of telephone interviews conducted prior to the implementation of the SCinPC intervention and routinely collected service use data,.

Sampling and Recruitment

The parent sample was drawn from 11 practices within four PCT areas across the UK (PCTs A,B,C & D). PCTs were selected due to their economic and social diversity. The intervention

programme was introduced in PCT areas A, B & C a fourth PCT (D) acted as a control which did not receive the intervention programme. The SCinPC sample was drawn from those people who were identified as higher users of health services (defined as 8 - 11 GP consultations in a year) and included men and women aged 16 years and over. An upper limit was applied to exclude very frequent attenders (VFAs) a group which has been described as displaying high levels of physical and psychological ill health and therefore unlikely to be amenable to change.

The following groups were excluded from the SCinPC study and therefore not included in the analysis:

- Those with a terminal illness or receiving terminal care
- Pregnant women
- Those with severe mental illness

The SCinPC sample consisted of 1,454 frequent attenders, 497 of whom were men and 957 women. Sample size calculations were based upon a primary outcome of a 20% reduction in consultation rates, and an estimated attrition rate of 30% at each of the two follow-up points.

From this parent sample a total of 80 qualitative interviews were conducted at baseline. Interview participants self selected after declaring their willingness to be interviewed at time of recruitment.

For a full description of methods used in the parent study see White and colleagues [17]

Ethics

Full ethical approval was obtained from the National Research Ethics Service.

Extended Analysis

The current paper uses data from the baseline interviews only. All interviews were recorded with the participants informed consent and transcribed using critical listening techniques. Interview transcripts were imported into the qualitative data management software NVivo 8. An initial coding tree was developed based upon interview schedules. Thematic analysis was employed with dominant themes and sub themes elicited, as well as responses which conflicted to normative themes.

Results

Data reported in this section are presented in the form of anonymised quotes from participants, all of whom are men. The age of participants are provided underneath each quote in order to illustrate the age range of the respondents.

Participant details

Thirty-four frequently attending men from the parent SCinPC study are included in the extended analysis. Ages of interviewed men ranged from 16 to 72 with the mean age being 51. Ethnic diversity in the sample was low, with 31 (91%) of the 34 men stating that they were White British. Of the remaining three men, two (6%) stated that they were Black-African and one (3%) stated that they were Mixed, White and Asian. Just 13% (n=4) reported having no qualifications, 91% (n=31) stated that they had a current health condition, 24% (n=8) stated that they lived alone and 74% (n=25) stated that they had children under the age of 16. The majority of men interviewed 59% (n=20) were from PCT A with 29% (n=10) being from PCT B and 12% (n=4) from PCT C.

Help-seeking preferences

Evidence from the interviews showed that many frequently attending men viewed the GP as the preferred, first port of call when experiencing a health concern. A number of men stating

this preference added precursors to their declarations in order to justify or rationalise their attendance of the GP surgery. Other men appeared to be more emphatic in their help-seeking preferences in simply stating that they would attend their GP surgery should they have any health concerns.

"If it persists I might go to the GP and inform him that I'm having this back pain... I get worried easily"

Aged 27

"It doesn't bother me – if there's owt wrong wi' me I go to t' doctor"

Aged 44

"I would go to the GP first, he's the first port of call"

Aged 50

The pharmacist was also cited by men as a key source of health support within the study. Interview data showed the majority of men to have a positive attitude towards the pharmacy, particularly as a source of support for minor ailments. A number of men did however express negative perceptions of the pharmacy. There was a belief amongst some men that pharmacists were not qualified, or did not have the required expertise to provide them with an adequate level of health care support.

"I don't know, I still generally think of them as the people who hand out what the doctor tells them to... I don't personally perceive them as the experts in, in my condition"

Aged 52

There was a relatively low proportion of men who reported use of other services such as walk in centres, social workers, occupational health services and charity groups. There was however a notable theme within interviews relating to use of the physiotherapist, generally related to managing backache.

"I do all the exercises that my physio. tells me and if I get similar kind of thing, I'll try doing those exercises myself before I go back and see him."

Aged 16

Information Sources

Findings from the interviews showed men's perceptions of NHS Direct and the advice provided by NHS Direct to be less positive. A number of men interviewed were not aware of the service, or did not believe they had cause to use the service. There were a number of men who suggested they did not use the service because of a lack of confidence in nurses ability to diagnose over the phone or in contrast a lack of confidence in their own skills and knowledge as a patient. A small proportion of male interviewees did report more positive opinions or experiences of using the NHS Direct service.

"First thing is, when you're speaking to somebody over the phone they can't see you, therefore they cannot make a... proper diagnosis of what you're talking about, because when I say something, I could be saying what I believe not what is correct... there is absolutely no way that I would use NHS Direct for absolutely anything what-so-ever, if I have a problem major or minor, I go to my GP"

Aged 71

"Being a man...I might be working away or going to the doctors impinges on my work schedule... I'll probably ring up NHS Direct"

Aged 52

A small number of men reported using the internet to assist with management of their health. Data revealed that men who did use the internet were likely to use the resource as a tool for initial investigation into symptoms experienced, or for general lifestyle advice. However,

similar concerns arose over the quality of information provided and the patient's skills in interpreting the information.

"I look up healthy eating on the internet I was looking at garlic on the internet today"
Aged 54

"I always kind of, if I've got a few symptoms, always look it up on the internet, partly just for interest and partly just to get an idea what it possible could be"
Aged 16

"Because then, the thing is I would be presupposing that I know what is wrong with me, what the symptoms mean... If I started deciding what I think is wrong with me then I would be acting as a GP and I am not qualified"
Aged 71

Interview data revealed that a considerable proportion of men were cautious about using lay knowledge for example friends or work colleagues in managing a condition. Further to this a number of men suggested that they would not turn to their family through fear of burdening them. There were however some men within the sample who stated the value of family and friends in assisting with management of their health. For some men drawing upon family and friends own experiences of illness management enabled themselves to gain a better understanding of their condition and for some, simply sharing their concerns with a family member aided or initiated health care management. There was also evidence to show that some men were to varying degrees reliant on female members of the family to assist with their health care needs, however this did not emerge as a strong theme.

"If it's a medical problem, you go to a medical practitioners you don't go to... somebody and say whatever, because they're not qualified."
Aged 71

"[S]he panics for me, but I think she goes too far sometimes"
Aged 44

"Well it depends how bad it was, the first thing I'd have a moan to the wife and she'd then probably say, 'well, if it doesn't get any better' you know."
Aged 68

Whilst some men reported high levels of confidence in their ability to manage their own health, talking about 'knowing' their bodies and 'knowing' when something was wrong, this knowledge was commonly linked into their decision to seek external help.

"I'm more than confident, the thing is I either know there's no problem, or I'm in doubt and I go to my GP"
Aged 71

"Very confident... I know myself physically, and I can tell when something is out of kilter and, and if I listen to myself, I can tell what I think I need to get back to it, even if the help that I need is I need to go to the GP with this, even if it takes me ages to do it"
Aged 52

Discussion

The extended analysis reported in the current paper highlights both the diversity and complexity of men's help seeking behaviour, with the identification of a group of men whose help seeking behaviour runs contrary to traditional notions of masculinity [8, 9]. Whilst some men within the study attempted to rationalise their frequent attendance of general practice by drawing on the traditional masculine traits of tolerance and delayed help seeking, others illustrated the presence of a very different masculinity, embracing professional help seeking and explicit in their intentions to visit the GP, should they experience any ill health. At the

crux of this delineation is the complexity of factors which informs the construction of male help seeking preferences. Supporting findings from George and Fleming's [18] study of male help seeking in the early detection of prostate cancer, the current study suggests the influence of both biological and social factors in men's help seeking preferences, moving beyond what Möller-Leimkühler calls 'bipolar' constructs of masculinity and femininity [19].

Galdas and colleagues review of male help seeking behaviours also exposes the complexities of male help seeking preferences [11]. Galdas et al's review asks whether delayed help seeking in men can be found in their own masculine attitudes. The current study would indicate that masculine attitudes do not in themselves prevent help seeking. There was indeed some evidence, that in the current sample masculine attitudes were drawn upon by men and promoted help-seeking, for example in an apparent display of independent thought exemplified in the statement *"It doesn't bother me – if there's owt wrong wi' me I go to t' doctor"*. For Smith and colleagues this independence may be both health enhancing as well as health damaging..

Given the population under study, it is unsurprising that for many men the GP was described as the primary source of support for healthcare; however men's attitudes and decisions to use, or not use other sources of support was less clear in men's accounts. There was evidence that some men were willing to seek help from a range of sources, including the pharmacist, physiotherapists and the internet, once again questioning the broad generalisations and negative stereotypes associated with men's engagement with health services [13]. However, potentially of more interest in the context of the current paper is the lack of awareness other men reported about alternatives to the GP. The current drive in men's health, to deliver services where men are, for example in the workplace [20, 21] or sporting venues [22] must therefore be complimented with drive to raise men's awareness of other available services, with a view to catch men for whom current health services do not meet their help seeking needs and preferences.

Whilst there was some evidence that frequently attending men were willing to consult information sources such as the internet or NHS direct for routine health management and initial investigation there were also accounts which highlighted some of the concerns which men may experience, potentially acting as a barrier to engagement. A theme emerged around men's anxieties in using the NHS direct phone-line and other sources of help, however, there was little evidence that these accounts were based upon lived experience. Linked in with this frequently attending men also presented anxieties about their own abilities to interpret the information presented to them by health professionals and health information resources. This finding highlights the challenge for practice to not only deliver services to men, but also empower them to use the services.

Results of the study must however be interpreted with caution. A fundamental problem with the study emerges with the use of frequent attenders and the lack of an established definition of the term. Secondly a lack of questions relating to the identification of a men's perspective on masculinity and help seeking within the original interviews has resulted in a limited resource for the current study. The lack of consistent responses concerning gendered health behaviours proved to be a strong barrier to the development of existing knowledge of men's help seeking preferences. Further to this there were relatively few men recruited as frequent attenders, therefore limiting the generalisability of research findings. However, withstanding these limitations, the data provided opportunity to gain insight into a rare group of men, offering insight of value to both research and practice.

Conclusions

The detection of a group of men explicit in their willingness to engage with services provides some evidence of the inaccuracy of broad statements claiming men's lack of help seeking activity, and evidencing that a 'one size fits all' approach to male service provision is not feasible. Whilst examples of compliance with traditional male norms were found, a number of men interviewed indicated that they were willing to consult health care services which included the GP, the pharmacy and NHS Direct for serious and minor ailments. Further to this the anxieties which men presented in using these services suggest that greater focus must be

placed upon empowering men to seek help, complimenting the current drive to improve male accessibility to health services.

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