Soc Sci Med. Author manuscript; available in PMC 2016 December 07.

Published in final edited form as:

Soc Sci Med. 2010 July ; 71(1): 18–24. doi:10.1016/j.socscimed.2010.03.006.

Help seeking for cardiac symptoms: Beyond the masculine–feminine binary

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Abstract

Empirical and theoretical literature suggests that stereotypical gender roles shape men's and women's health help-seeking behavior, and plays an important role in the treatment seeking delays of cardiac patients. We were interested in exploring the ways in which gender informs the experiences and help-seeking behavior of men and women who experienced the symptoms associated with acute cardiac events. We undertook 20 in-depth interviews between October 2007 and July 2008 with 11 men and 9 women recently diagnosed with an acute coronary syndrome in British Columbia, Canada. Participants were encouraged to tell their 'story' of the event that led to hospitalization and diagnosis, with a focus on the symptoms and decision making processes that occurred before and during the activation of health services: seeking the advice of others including colleagues, family members and healthcare professionals; calling 911; and attending an emergency department. Although we anticipated that distinctive patterns of help-seeking behavior aligned with stereotypical masculine and feminine ideals might emerge from our data, this was not always the case. We found some evidence of the influence of gender role ideology on the help-seeking behavior of both male and female participants. However, men's and women's experiences of seeking health care were not easily parsed into distinct binary gender patterns. Behavior that might stereotypically be considered to be 'masculine' or 'feminine' gender practice was shared by both male and female participants. Our findings undermine simple binary distinctions about gendered help-seeking prevalent in the literature, and contribute towards setting the direction of the future health policy and research agenda addressing the issue of gender and health help-seeking behavior.

Keywords

Canada; Gender; Femininity; Masculinity; Cardiovascular disease; Cardiac symptoms; Health-seeking behaviour

Introduction

Women's and men's health-seeking behavior are purported to be closely tied to stereotypical/traditional ideals of femininity and masculinity. Within Western culture, the

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predominant stereotype of women has placed a heavy emphasis on beauty, youth, and physical attractiveness (Avsec, 2006; Baker-Sperry & Grauerholz, 2003; Beben, 2002; Cole & Zucker, 2007; Stankiewicz & Rosselli, 2008; Wu, Rose, & Bancroft, 2006). This stereotype is accompanied by the traditional gender role ideology of women as primary care givers and the perception that women are gentle, emotionally expressive, reluctant to bother others with their problems, sensitive and sociable (Prentice & Carranza, 2002). Accordingly, women are typically viewed as possessing a desire to have and raise children, as nurturers who have domestic skills, take care of their own and others' health, and have a need for intimacy, connectedness, and self-disclosure (Barnett, 2006; Cole & Zucker, 2007; Emslie & Hunt, 2008; Kristofferzon, Löfmark, & Carlsson, 2003; Wood, Conway, Pushkar, & Dugas, 2005). Thus, in Western cultures, feminine 'ideals' (in the context of health help-seeking behavior) are typically seen as asking for help, caring about health, nurturing and monitoring partners' and children's health and well being, and pressuring male partners to see a physician if they are reluctant (Courtenay, 2000b; O'Brien, Hunt, & Hart, 2005).

By contrast, the espoused masculine ideal in Western culture emphasizes toughness, controlled emotions, decisiveness, heroism, and independence (Seem & Clark, 2006). Men are typically viewed as risk takers who possess a high threshold for pain or discomfort, enjoy challenges, are self-reliant, and are responsible for the family's economic protection. Rather than emotional, 'real' men are considered to be stoic and rational, and typically suppress the need for self disclosure, intimacy, and connectedness (Connell, 1995; Courtenay, 2000a; Emslie, Ridge, Ziebland, & Hunt, 2006; Mahalik, Levi-Minzi, & Walker, 2007; Wu et al., 2006). Although recent work has identified differences and diversity among men and masculinities in the context of health and help seeking (Galdas, Cheater, & Marshall, 2007; O'Brien et al., 2005; Robertson, 2006), these culturally-dominant masculine ideals have been implicated to play out in some men's reluctance to seek health care promptly (Galdas, 2009). Indeed, despite variations in how gender has been understood and conceptualized by social scientists and health researchers, the aforementioned (Western) gender roles and stereotypical ideals of masculinity and femininity have been widely used to inform a variety of studies of health behavior.

Mahalik, Lagan, and Morrison (2006) found that men who reported greater conformity to the 'masculine norms' of sexual promiscuity, self-reliance, and violence were less likely to engage in health-promoting behavior, and were more likely to engage in health risk behavior. Regardless of nationality, conformity to traditional norms was associated with unhealthy alcohol use, neglect of preventive health care, such as health screenings and skin cancer protection, entering into fights, and taking general as well as specific risks related to sexual behavior and the use of cars. Parslow, Jorm, Christensen, Jacomb, and Rodgers (2004) reported that being married or in a relationship was positively associated with men making an initial family physician visit, and also with making further visits, indicating that, for married heterosexual men, women were monitoring and successfully ensuring that their male partners sought health care. However, men are less likely to discuss mental and emotional problems with their primary care providers, and spend less time in office visits than do women (Smith, Braunack-Mayer, & Wittert, 2006). When the use of reproductive services have been accounted for, Western men use health services less often than do women, especially after the age of 16 years, and are twice as likely to have gaps of two or

more years between physician visits (Mansfield, Addis, & Mahalik, 2003; Mason & Strauss, 2004; Smith et al., 2006). The reasons for these differences may include perceptions of invulnerability and espousing the masculine 'ideals' of independence, self-reliance, stoicism, and fear of discrimination for mental or physical health problems (George & Fleming, 2004; Smith et al., 2006; White, Fawkner, & Holmes, 2006). Mahalik, Burns, and Syzdek (2007) found that men who rated themselves as having higher 'traditional masculinity' scores reported more health risk behavior and less health promotion behavior, and were less likely to consult a mental health professional if feeling sad or depressed for longer than a month, or to consult with a health care provider when having unfamiliar symptoms.

According to the popular press, women are seen as experts in terms of diet and health (Gough, 2007), which is framed as women's work, with a caretaking role expected of them (Barnett, 2006). Similarly, compared with men, women have been found to have more positive overall attitudes toward professional help-seeking, a greater willingness to recognize the need for help, and a greater tolerance for any societal stigma associated with help seeking (Ang, Lim, Tan, & Yau, 2004; Krogh, 2007). Hunt, Lewars, Emslie, and Batty (2007) reported that higher 'femininity' scores in men were associated with a lower risk of coronary heart disease death, while no such relationship was observed with the women in their study. Thus it would seem that traditional gender roles and stereotypes exist and influence the health behavior of men and women. Moreover, researchers continue to rely on these notions to explain health behavior.

The literature concerning help seeking and cardiac care is conflicting in that some researchers have reported that women delay seeking help, compared with men's responses (Ottesen, Dixen, Torp-Pedersen, & Køber, 2004; Ting et al., 2008), and others have reported that there is no sex/gender difference in the interval between the onset of cardiac symptoms and seeking care (Løvlien, Schei, & Hole, 2007; Moser, McKinley, Dracup, & Chung, 2005). Those who have reported that there is a sex-based difference (anatomical or physiological in nature) have postulated that women do not recognize their cardiac symptoms because health educators' characterizations are based on men's experiences when women's symptoms are different from the "hallmark" symptoms – they are "atypical" and consequently not recognized as serious (O'Keefe-McCarthy, 2008). Canto et al. (2007) however hypothesized that this apparent difference is more likely the result of differences in age at the time of a cardiac event, rather than being a sex difference (women are generally older than men when they first experience an acute coronary syndrome and age influences the symptom experience). Others have suggested that there are gender differences in help-seeking behavior and they are social in nature. For example, Moser et al. (2005) reported that being concerned about troubling others led to delay for women but not for men. They argued that the importance placed on their numerous social demands may cause women to ignore their own health needs. Galdas et al. (2007) reported that some men need to portray high tolerance for pain and to avoid appearing weak or hypochondriacal, which influences their help seeking.

Whether there is a difference in the timing of help-seeking, much of the empirical literature suggests that stereotypical (or "traditional") gender roles and norms – culturally dominant behavior considered to be essentially "masculine" and "feminine" – are an important factor

that shapes *both* men's and women's health help-seeking behavior. Indeed, these masculine and feminine gender roles are purported to play an important role in treatment seeking delays in cardiac patients. We were interested in exploring the ways in which gender informs the experiences and help-seeking behavior of men and women who have symptoms of an acute cardiac event.

Methods

Sampling and data collection

We used purposive sampling to recruit a heterogeneous sample in terms of gender, age, socio-economic status and health status. Participants were invited to be interviewed based on the following criteria: an admitting diagnosis of chest pain suspected to be of cardiac origin or confirmed Acute Coronary Syndrome (ACS); completion of a survey questionnaire while in an acute care facility for ACS; an expressed interest in participating in a qualitative interview once discharged home and medically stable; and the ability to communicate in English. Ethics approval was obtained from relevant ethics committees, and written informed consent was obtained from all participants. Participants continued to be recruited and interviewed until nothing new emerged from the data about the themes being explored, and 'conceptual density' was deemed to have been achieved (Strauss & Corbin, 1998). Twenty interviews were completed in British Columbia, Canada (see Table 1).

An interviewer's and participant's gender likely affects the dynamic and information shared in a qualitative interview: participants tend to gauge interviewers' orientations and opinions and consequently develop their responses within a gendered context (Schwalbe & Wolkomir, 2001; Williams & Heikes, 1993). To ensure consistency, one (female) researcher conducted all 20 interviews and ensured the accuracy of all the transcriptions.

Data were collected between October 2007 and July 2008 using in-depth semi-structured interviews that took place at a time and location convenient to the participant. Each participant was provided with a $25 honorarium. Interviews were digitally audio-recorded and transcribed verbatim. The initial interview guide consisted of open-ended questions that encouraged participants to tell their 'story' of the event that led to their hospitalization and diagnosis of ACS, with a focus on the symptoms and decision making processes that took place before and during the activation of health care services: seeking the advice of others, including colleagues, family members and healthcare professionals; calling emergency services; and attending an emergency department. When participants discussed or alluded to delays in their help seeking, the interviewer sought clarification and a deeper understanding of the context and influencing factors surrounding such delays. Further, the interviewer sought to understand the influences of being male or female, married or single, location of the event(s), and the role of previous cardiac events or co-morbidity on the actions taken. The interview guide underwent several revisions based on insights that emerged from the analysis of completed interviews.

Sample characteristics

The sample was composed of 20 people (11 men and 9 women; see Table 1). These participants ranged in age from 48 to 89 years; 15 were marriedand5 were eitherdivorced,widowed,or nevermarried, and hence lived alone at the time of the event. Sixteen participants were either retired or worked part-time; 2 participants worked full-time, and 2 participants were on long-term disability leave owing to non-cardiac health issues. One participant reported no previous health problems of any kind. For those 8 participants with a previous cardiac history, the problems reported were: one or more previous myocardialinfarctions; a pacemaker insertion;hypertension;angina; and angioplasty. The remaining 11 participants reported various non-cardiac chronic conditions, such as asthma, arthritis, trigeminal neuralgia, cerebral aneurysm, diabetes, *Helicobacter pylori*, and end-stage renal failure. All 20 participants communicated in English.

Data analysis

The data were analysed using an inductive thematic approach that occurred concurrently with data collection. The analytical process involved grounded theory methods of coding and constant comparative analysis as described by Strauss and Corbin (1998); ‘tools’ which have been widely used in exploratory qualitative research studies seeking to explore and describe social situations and to understand social phenomena (Charmaz, 2000). Transcripts were entered into the qualitative data management software *NVivo* (version 8.0) and initially subjected to a line-by-line analysis. First-level coding involved making comparisons between transcripts, searching for similarities and differences, and then labelling similar phenomena as open codes. Second-level coding involved making propositions about connections between open codes and reassembling them into ‘tentative themes’ to form a more precise and complete explanation of the phenomena (Strauss & Corbin, 1998). The ‘tentative themes’ were discussed by the entire research team on several occasions until a consensus on the interpretation of patterns in the data was reached. A key feature of this process involved each member of the research team testing themes against individual transcripts and the entire data set, and reformulating them where necessary, in an iterative process of constant comparative analysis that led to the generation of the final themes (Strauss & Corbin,1998). The final themes were considered to represent a level of patterned response or meaning in the data that described the phenomena taking place in the participants’ experiences of seeking help for cardiac symptoms (Attride-Stirling, 2001; Braun & Clarke, 2006).

Findings and discussion

Although we anticipated that distinctive patterns of help-seeking behavior aligned with stereotypical masculine and feminine gender roles might emerge from our data, we found that this was not always the case. Indeed, our findings reveal that men’s and women’s behavior is not easily parsed into distinct binary gender patterns. Behavior that might stereotypically be thought of as “masculine” or “feminine” was shared by both men and women. We begin by discussing the responses of men and women that tended to fit the stereotypical gender-role pattern of help-seeking behavior, themes we conceptualized as “stoic men” and “vulnerable or accommodating women”; before going on to address those

participants whose narratives were not reflective of stereotypical gender ideology: a theme we conceptualized as “beyond the masculine–feminine binary”.

Stoic men

For several of the men we interviewed, from the onset of their symptoms to their decision to seek help they described what could be considered to be ‘stereotypical’ masculine help-seeking behavior: being extremely reluctant to relinquish control of their situation to a health care professional, and attempting to manage their condition independently. For some, retaining control and independence meant continuing with a planned schedule involving work or leisure activities. For instance, one 54-year-old male participant experienced recurrent exercise-induced chest tightness and arm weakness over a period of two days, which prompted him to research his condition on the internet. Despite suspecting he had angina, he decided to delay visiting a physician so that he could continue with his planned work schedule. An additional striking feature of his account was his great reluctance to admit to colleagues that an appointment with a physician was the reason he could not attend a pre-planned game of golf. Instead, he offered a work-related excuse to avoid being seen to be ‘bailing out’. He was later diagnosed with an acute myocardial infarction (AMI).

> I felt brief spells when I was walking, exerting myself, of this sensation. So, during the weekend, I poked around on the internet to see, ‘What is this that’s going on?’ I suspected it was angina….I had meetings all day Monday …so I didn’t have an opportunity to go to the doctor…. So, the next day, I was actually supposed to play a game of golf with some of my colleagues…and I was looking for an excuse not to do that because I was thinking, ‘I better go see the doctor and see what this is about.’ As it turned out, I got a phone call from the office…saying, ‘We need you here to meet with some people at 3 o’clock on Thursday afternoon.’ So, ha! My perfect excuse, I didn’t have to bail out totally. I had an excuse to leave on Thursday morning, which I did.
>
> [P#19, 54-year-old man, first time AMI]

Similar stories were told by several other male participants who recounted their reluctance to accept the potential severity of their condition. These men’s accounts of stoicism and self-reliance clearly align with the assumed stereotypical pattern of male help-seeking and masculine gender role ideology (Seem & Clark, 2006), and echo the findings of other qualitative studies of men’s cardiac disease related help-seeking behavior (Galdas et al., 2007; White & Johnson, 2000). Consistent with this pattern, several men in the study also frequently spoke of having ‘played down’ or denied their symptoms to continue with their daily activities. One participant was skiing at the time of his symptom onset and minimized the suggestions of his friends that his symptoms might be indicative of a ‘heart attack.’ He vowed to continue with his ski trip. Even though some of these men had been informed by their family physicians that their condition was serious and required immediate emergency care, many admitted that they remained extremely reluctant to forgo their independence and self-determination. For instance, one participant with a history of previous AMI described his determination to view the end of a theatre show he was attending during the onset of his symptoms – despite suspecting he was having a ‘heart attack’ at the time. It was clear from

these men's accounts that they were determined to engage with health care services on their own terms.

> I had gone a thousand miles to see two operas and, by God, saw them…. I was not going to allow myself to be sick. Even though, in retrospect, I realize I was a having a heart attack during Samson and Delilah.
>
> [P#11, 68-year-old man, fourth AMI]

Vulnerable or accommodating women

Along the same lines as the 'stoic men' theme, several of the women we interviewed recounted stories that could be considered to be a 'stereotypical' health help-seeking pattern that was consistent with female gender role ideology (Prentice & Carranza, 2002). The key aspects of these women's accounts were associated with self-disclosure and asking for help promptly, caring about health matters, monitoring partners' and children's health and well being, and nurturing the family. The features of the participants' stories cohere with previous literature that has highlighted the often deleterious impact of 'femininity' and feminine gender roles on help-seeking for the symptoms of an acute cardiac event (Lockyer, 2005; Rosenfeld, Lindauer, & Darney, 2005; Turris & Finamore, 2008). For instance, one woman in our study, who had realized she was having a heart attack at home, talked of her fear that she might die with an unkempt appearance and be found by her sister.

> [I had] no makeup on, nothing, I think my hair was brushed. My hands were washed and my face was washed, but still….You just feel like…ugh…I hadn't brushed my teeth either, that was the thing that really bothered me.
>
> [P#18, 67-year-old woman, first time AMI]

A 59-year-old woman spoke of her relief when paramedics arrived at her home. In her narrative, she indicated her willingness to surrender control of the situation and let others 'take charge' and take her to hospital, despite thinking throughout the process that her condition was not serious. Another female participant, a 69-year-old married woman with two children and with a history of previous AMI, clearly positioned herself as a mother and care giver in her narrative. She described being preoccupied with caring for her husband and children before tending to her own needs despite experiencing several days of 'typical', often severe, AMI symptoms. Later in her interview, she described how she felt the need to straighten up the house before going to seek help:

> I got up and walked around and thought, 'Oh, I feel just awful.' And I didn't want to bother K., my youngest, because she's got two babies and you know, she didn't need that, and C. and J. [the participant's other children] were away somewhere that weekend, or they had something else on…[later in interview]…I guess I thought I had to make the bed, I had to make the place tidy, loading the dishwasher and stuff like that.
>
> [P#13, 69-year-old woman, second AMI]

Beyond the masculine–feminine binary

Although many aspects of our participants' stories fit with the stereotypical pattern of masculine and feminine gender roles in the context of help-seeking behavior, several participants reported responses that were *not* reflective of their respective gender roles. Indeed, several participants explicitly positioned some of their behavior during their cardiac event as atypical of their gender. For female participants, this was most often displayed through accounts of behavior that would more commonly be aligned with masculine ideals embodied by stoicism, control, the denial of weakness, and endurance. For instance, in describing her symptoms, one woman explained,

> I was playing badminton. I had no idea, and everyone was extremely shocked, because I've always been active, that I would have a heart attack. I was playing badminton, and had the pain in my chest. Fortunately, it was the crushing pain, the deep pain, so I knew what it was, not like a lot of women who really, their sense is so different.
>
> [P#7, 69-year-old woman, first time AMI]

It was also apparent that a large proportion of the men's responses contrasted with stereotypical, stoic masculine ideology. For these men, 'atypical' responses were often characterized by accounts of explicit concern for their health, relinquishing their control to healthcare professionals, and overt displays of vulnerability during their cardiac event. For example, one man took pride in facing his symptoms 'head on', rather than trying to 'wait it out', he took immediate action.

> This was a little more serious, and then I started thinking to myself, "Am I going to let this go because it seems to be passing already?" And, I thought to myself, "No, this has been, this is probably the most pronounced thing I've ever felt, so I'm doing to do something about this." And, I turned around behind me, two steps away was the foreman's doorway to his office, and I backed into his office, sat down on a chair and I said, "I have to go to the hospital now, I'm not feeling good." They know me at work, that I have a heart problem; have been on some medications, and have had ups and downs at times…been going over the last couple of years. I think that's kind of been good for me, in the fact that I've never run from this, I've always faced it face on. I'm not going to hide; I want to try and be around as long as I can, to put it that way. Nobody wants to die or anything like that. But I have a positive outlook too, from my own personal experience.
>
> [P#15, 54-year-old man, first time AMI]

The above accounts serve to illustrate that many men's and women's responses to their acute cardiac symptoms were not simply a reflection of assigned gender roles and expectations. It was clear in the data that contextual factors (most notably the time and location of the event, and the people present) frequently influenced the participants' behavior and responses to their symptoms. The circumstances persons found themselves in when they first experienced their symptoms were powerful moderators, as were the nature and severity of their symptoms.

The reticence of some participants to relinquish control to healthcare professionals was often compounded by a sense of ambiguity about the seriousness of their condition. The transient nature of their symptoms, including chest pain, was frequently confusing for the participants. These findings accord with those of a previous investigation that showed the help-seeking decision-making process of people admitted to hospital with an AMI to be a complex interaction of knowledge and experience, beliefs, emotions, and the context of the event (Pattenden, Watt, Lewin, & Stanford, 2002). Pattenden et al. (2002) found that patients experiencing the symptoms of AMI were often reluctant to relinquish control to healthcare professionals, and frequently attributed their symptoms to a benign, non-cardiac cause. As other researchers have described (Clark, 2001; Dracup et al., 1995; Galdas et al., 2007; Pattenden et al., 2002;), several participants in our study had waited until their attempts at self-treatment had failed, or their symptoms were viewed as being persistent or more severe, until they decided that their condition was serious and they required health care. This observed pattern of behavior is consistent with Clark's (2001) analysis of the role of the body and self as an important part of the interpretive frames used to understand the meaning of AMI symptoms and the action to take thereon. Clark (2001) drew a distinction between individuals' interpretations of the body (symptoms, including chest pain) and self (perception of level of risk to health) in the context of experiencing an AMI; with the latter seen as more influential in prompting help seeking. He also found that it was only when numerous and often lengthy attempts to alleviate symptoms failed and symptoms appeared to be more severe that participants saw the self as being at "high risk" and sought help. Akin to the participants in our study, it was the view of the self at risk as opposed to the body in great pain that appeared to prompt individuals' decisions to seek medical help.

> I waited to see if the pain would go. You always try to ignore things, you know? But even though I sort of knew what it was, I just waited about 15 min or so, and the pain didn't go. That's when I phoned him.
>
> [P#7, 69-years-old woman, first time AMI]

The narratives in our study show that gender is not simply a matter of identity and role, but that it is constructed and lived in a social and cultural context. The men and women we interviewed were responding to the gendered expectations that were subtly and not so subtly cuing them to respond in certain ways depending on the context of their event. Simply put, their construction of health and gender did not occur in isolation from other forms of social action (Courtenay, 2000b); a perspective in keeping with the insights of gender-relations theory, which positions gender as a socially produced practice with attention to how it is accomplished vis-à-vis "norms" of femininity and masculinity (Connell, 1995). This is important to note because it highlights gender as being both fluid and reciprocal. The findings presented in this final theme serve to illustrate the fluidity of gender, refuting much of the recent work that has explored men, women, and heart disease (Emslie, 2005), which has suggested that women predominantly respond one way and men another when experiencing the symptoms of an acute cardiac event. The discourses of several men we interviewed exemplified what could more commonly be considered to be 'feminine' gender roles/behavior, and several women spoke of 'masculine' gender roles/behavior. Furthermore, several participants recounted behavior that could be aligned with both 'masculine' (stoical)

and ‘feminine’ (vulnerable/accommodating) gender ideals in the context of seeking health care, as seen in this excerpt:

> I made a doctor’s appointment, and at the beginning of March, my son, he had a stroke. But it turned out to be, he got over it in a couple of weeks … anyway, so I thought, “I’m not going to say anything to anybody [about cardiac symptoms] because I don’t want … Let’s let him get over his problem first and then I’ll deal with this.” There’s always family things that seem to, and I’m not one to complain about everything like that … I think my symptoms, I tended to put onto other stuff. I’m pretty sure, somewhere back there, I knew there was a problem long before that, that I didn’t acknowledge until late February [her first symptoms developed in December].
>
> [P#16, 68-year-old woman, first time AMI]

Clearly, men and women can and do behave in ways that both cohere with and contradict their respective gender role ideologies and ‘normative’ gender behavior when seeking health care for the symptoms of an acute cardiac event. The participants’ stories illustrated that gender was not a ‘stand alone’ variable that determined their help-seeking decision making and behavioral patterns. Yet, the complex, fluid, and often contradictory nature of gender evident in the narratives of our study participants does not necessarily mean that gender is not an important and useful construct in exploring help-seeking behavior. Rather, we argue that the way in which gender interplays with men’s and women’s health behavior is highly complex and our treatment of it in empirical work – and in the study of health help-seeking behavior in particular – has often lacked the sophisticated approaches it deserves. Much of the work in this field has built on an oppositional, binaried approach. As a result, the key practices of masculinity and femininity in the context of seeking health services have been somewhat essentialized as either a masculine or feminine gender role or trait. A more nuanced investigation of the intersection of gender and help-seeking behavior is required to develop a progressive and more diversified conceptual lens that disrupts the ontological assumption of binaried categories.

The call to move beyond a binary conceptualization of gender is not a recent or novel insight. In the mid 1990s, authors such as Lorber (1996) called for a reconsideration of traditional gender categories. Lorber (1996) commented that in research “variations in gender displays are often ignored: A woman is assumed to be a feminine female; a man masculine male” (p. 144). Furthermore, a questioning of binary conceptions of gender is influencing other areas of health research such as HIV/AIDS (Dworkin, 2005). What is interesting to consider is why those working in the field of cardiac sciences have continued to reify these stereotypical typologies. Perhaps part of the problem is that there has been little opportunity to ask whether there are similar expressions of reluctance or willingness to seek health care amongst women and men because most recent insights from research on gender and health have arisen from empirical studies of single sex samples (Hunt, Adamson, & Galdas, 2010). Because of an often (perhaps unconscious) tendency to highlight distinctions rather than similarities between male and female ‘gendered’ behavior, it is often presumed, for instance, that because some men adhere to the masculine ideals of stoicism and self-reliance in certain help-seeking contexts, women do not; or, that because some

women may prioritize their domestic and family responsibilities over their own health, men do not. Our study clearly undermines these binary gender distinctions and suggests that, consistent with relational theoretical perspectives (Connell, 1995), masculinity and femininity are not polar opposites on a single gender continuum. As has been discussed elsewhere (Courtenay, 2000b; Robertson, 2007), a key feature of gender-relations theory concerns the understanding of gender as neither a character typology nor an isolated act, but as a configuration of social practice that is generated in particular situations in a changing structure of relationships. In this way, gender practices, such as those manifested by the participants of our study, can be understood as being historically and culturally contingent, but also open to change and not essentially determined by biology or processes of socialization (Robertson, 2007). Our findings suggest that this relational concept of gender fluidity may be a useful starting point in re-examining current binary assumptions about gender and help seeking. Further research using samples of both men and women will be crucial to avoid overly simplistic and binary assumptions about gendered behavior.

Conclusion

Our findings contribute towards setting the direction of the future health policy and research agenda addressing the issue of gender and health help-seeking behavior. Previous research has largely focussed on single sex samples and emphasized the differences between men's and women's help-seeking behavior for acute cardiac symptoms, when it is apparent that there are many important similarities. Our findings illustrate that men's and women's decisions to seek or delay seeking treatment for acute cardiac symptoms cannot be easily parsed or categorized into distinct, gendered patterns. In terms of the cardiac literature and our understanding of help-seeking behavior, our findings suggest that attempts to tailor 'gender sensitive' health promotion messages based on culturally-dominant gender ideals to men or women might be misguided. Instead, a range of messages may be required that are sensitive to the complex nature of our gendered lives.

Acknowledgments

This research was supported by a Canadian Institutes of Health Research (CIHR) operating grant (MOP 145706). Dr. Ratner is supported by the Michael Smith Foundation for Health Research.

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Table 1

Demographic information.

Participant number	Age/sex	Marital status	Admission diagnosis	Discharge diagnosis	Relevant past medical history
1	80/male	Married	Chest pain	AMI	Chest pain
2	89/female	Widowed	ACS	Pulmonary edema	Hypertension, atrial fibrillation/pacemaker insertion
3	58/female	Divorced	Chest pain	AMI	Hypertension
4	59/male	Married	ACS	AMI	None relevant
5	54/male	Married	Chest pain	AMI	Hypertension, chest pain
6	48/female	Married	Chest pain	AMI	Diabetes
7	69/female	Married	Chest pain	AMI	None relevant
8	80/male	Married	ACS	AMI	Coronary artery bypass grafts, angina
9	61/male	Married	AMI	AMI	Hypertension
10	52/male	Single	Chest pain	AMI	None relevant
11	68/male	Married	ACS	AMI	ACS
12	58/female	Married	AMI	AMI	None relevant
13	69/female	Married	Chest pain	AMI	AMI
14	60/female	Married	Chest pain	AMI	AMI, diabetes
15	54/male	Married	Chest pain	AMI	Hypertension
16	66/female	Married	AMI	Unstable angina	None relevant
17	73/male	Single	ACS	Unstable angina	ACS
18	67/female	Widowed	AMI	AMI	None relevant
19	54/male	Married	Chest pain	AMI	Hypertension
20	78/male	Married	AMI	AMI	AMI