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"Just Treat Me Delicately": A Qualitative Exploration of What Works to Engage Australian Men in Health Care Encounters

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Abstract

There is growing consensus for upskilling the health care workforce on gender-responsive strategies to more effectively connect and respond to men during health care encounters. To inform health practitioner education, the primary aim of this study was to gain insights from a diverse sample of men in Australia on their experiences and expectations when engaging with health care practitioners. Thirty-two men (18–70 years, median 33) participated in eight online focus group discussions. A combined deductive and inductive thematic analysis was undertaken to reconcile their expectations with prior published approaches for practitioners to engage men in care and identify new themes. Participants desired a genuine relationship, signaled by upfront and informal communication, active listening, and enquiry. In structuring treatment, participants sought transparency and respect for autonomy. Regarding the therapeutic alliance, avoiding gender stereotyping and empathetic, sensitive, and holistic care were valued by men. These expectations for how practitioners engage with men in care were reflected in their advice for health practitioner student training and aligned with approaches published previously. Participant insights were synthesized into four outcomes, for men, of successful engagement: legitimize the relationship to build trust, create a safe space to facilitate disclosure, empower men, and assess and treat the whole man through a biopsychosocial lens. In conclusion, men seek authentic connection and a caring style that allows them to legitimize and forge an ongoing relationship with their practitioner. These outcomes of successful engagement are key to developing consumer-informed health practitioner education and competencies on gender-responsive health care for men.

Keywords

men's health, engagement, primary health care, practitioner, gender-responsive health care, masculinities

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Introduction

Thirty-seven percent of Australian men die prematurely, often from preventable or treatable conditions (Australian Institute of Health and Welfare, 2023). As such, the health challenges experienced by men cannot be underestimated. Instead, they must be contextualized amid suboptimal experiences of health care. Gender is recognized as a key social determinant of health, and gender-specific socialized health behaviors and attitudes shaped by various masculine norms (i.e., emotional restriction, delayed help-seeking, stoicism, and dismissal/denial of health symptoms) may

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moderate the effectiveness of health care interactions between men and their health care practitioner (HCP; Leone et al., 2021; Macdonald et al., 2022). Gender stereotypes and biases, which when protected and/or enacted by health care providers, may also amplify barriers that men can experience when engaging with health care (Govender & Penn-Kekana, 2008; Hay et al., 2019). Furthermore, within-men differences in experiences of gender socialization can have markedly unique impacts on health outcomes for certain groups of men, often interacting with key social determinants such as race, sexuality, and class (Baker, 2018; Griffith, 2012; Kavanagh & Graham, 2019).

Conversely, the unique interaction between an individual's adherence to certain masculine norms and their health may also facilitate positive health care experiences and outcomes for men. Health systems must therefore respond and adapt to gendered experiences to ensure the delivery of equitable, effective, and efficient care (Baker et al., 2014; Hawkes et al., 2020; Manandhar et al., 2018). Without HCPs being sensitized to the influences and potential to leverage masculinities and having the tools to respond, men may be more reticent to articulate and discuss their health and well-being. When HCPs inadvertently dismiss or do not recognize health concerns or their severity, the risk is increased for missed or delayed diagnoses and delays in the initiation of preventive health measures and treatment pathways (Kavanagh & Graham, 2019). Unsatisfactory health care experiences, including a lack of connection with their practitioner, may lead to an overarching mistrust, discomfort, or prognostic pessimism, increasing the likelihood for men to be reticent to engage in care or drop out of care altogether. For example, Seidler et al. (2021) reported from a survey of 1907 Australian men who had accessed mental health care, a therapy dropout rate of 44.8%, with 26.6% of the men who dropped out not returning at all. For the men who were more likely to identify with traditional masculinity, a lack of connection with the therapist was the primary reason for drop out. Similarly, in a recent survey of a representative sample of 1,658 Australian men, 67% reported having felt like wanting to leave their practitioner or having left their practitioner, due to a lack of personal connection, and of the 43% who left their practitioner, more than a third of men stop going back entirely (Movember, 2024). This may have long-term implications for delayed or abandoned help-seeking in the wake of future health issues.

Long-standing calls to integrate and mainstream gender responsivity into health care systems to advance men's health (e.g., Banks, 2009; Giorgianni et al., 2013) are now being reciprocated in men's health policy recommendations (e.g., Health and Social Care Committee, 2024) and strategy documents (e.g., Australian Government, Department of Health, 2019; World Health Organization, 2018). Aligning with these calls is the recognition that gender-responsive practices and competencies to optimally engage men need to be built into formative undergraduate and postgraduate education curricula for students entering the health and social care disciplines. This should be accompanied by professional development training to support the upskilling of the current health care workforce. This momentum is accompanied by a shift, over time, from a focus on more traditional expressions of masculinities as a primary analytical lens to understand and optimize men's health service engagement, toward a strength-based focus applying a more flexible, healthy masculinities lens (Ragonese & Barker, 2019; Robertson et al., 2016).

To inform the content for these curricula, gender-responsive approaches for effectively engaging with men in a range of health care settings have been collated through a scoping review by Seidler, Benakovic, and colleagues (2024). Offered approaches were reported under three themes. First, under the theme of tailoring communication to better reach and connect with men, the use of informal language, enabling men to tell their story and raising issues by asking direct questions, was the common approach offered to HCPs. Under the theme of structuring treatment to better respond to men, approaches included collaboratively setting goals and action-oriented, solution-focused treatment, all aiming to alleviate potential power imbalances. Third, under centering the "therapeutic alliance" to retain men in care, approaches included exploring strength-based masculinities, promoting men's autonomy and empowerment, and validating men's personal experience. The approaches offered for HCPs from this review came largely from the experience of HCPs, but rarely from the perspectives of men, or outside of mental health care settings.

Notwithstanding the important value of insights from practitioners themselves, these approaches that can be applied by HCPs need to be reconciled with, and sit alongside, men's lived experiences of what works and does not work for them during health care encounters. The latter adds depth and highlights the value of adopting these approaches with men's needs and desired outcomes in mind. Furthermore, such insights are essential if we are to offer consumer-informed and codesigned men's health education curricula content to improve the systems reach, response,

and retention of men in care (Australian Safety and Quality Goals for Health Care, 2017). Indeed, Australian tertiary educators in health-related disciplines, when asked about gaps in education, pointed to the need to include the voices of a diversity of men regarding their health care experiences to sensitize students to gender and men's health (Seidler, Sheldrake, et al., 2024). A wealth of studies have explored men's gendered experiences of engaging with practitioners in specific clinical settings, such as for mental health care (Seidler, Rice, Ogrodniczuk, et al., 2018), prostate cancer (e.g., Chen et al., 2021), or HIV (e.g., Sileo et al., 2019). There are limited dedicated, qualitative studies (e, g. Ab Aziz et al., 2022; de Oliveira et al., 2015; Mitchell et al., 2019) including in the Australian context (e.g., Canuto et al., 2018; Smith et al., 2008) that dive deeper into men's feelings toward their interpersonal, face-to-face interactions with HCPs in primary health care settings more broadly.

Given the increasing interest in progressing toward more gender-responsive health care, the overall objective of this study was therefore to strengthen the contemporary evidence describing gender-responsive engagement practices in primary care that work for men. The specific aim of the study was to gain insights from a diverse sample of men in Australia on their experiences, needs, and expectations when engaging with HCPs. Additional sub-aims of the study were to, first, reconcile men's expectations for HCP engagement with the engagement approaches offered for HCPs in the abovementioned scoping review (Seidler, Benakovic, et al., 2024), and, second, to identify key outcomes for effective engagement, as described by men, that can be used in consumer-informed HCP and student training curricula.

Method

Adults, 18 years and older, identifying as men and living in Australia were recruited to participate in focus group discussions (FGDs). Men who had participated in previous research conducted at the researchers' institution (Orygen) and who had agreed to be contacted about future research were invited to participate, and researchers also shared the study information with relevant contacts for snowball sampling. The study was approved by the Bellberry Human Research Ethics Committee (Protocol No. 2020-04-318).

A qualitative approach ensured that men's experiences of health care encounters could be explored in-depth, providing rich insights into the very specific interpersonal interaction between an HCP and patient (Moser & Korstjens, 2017). FGDs by their interactive nature can reduce inhibition and therefore enhance the sharing of experiences, emotions, and ideas among participants with a common experience (Tracy, 2024). Health care encounters were defined in this study as face-to-face interactions with HCPs delivering allopathic health care in primary care settings. HCPs were defined in this study to refer to any professional delivering health care directly to men as patients (e.g., general practitioners [GPs], nurses, physiotherapists).

Consenting men completed a brief online demographics survey covering gender, age, country of birth, cultural/ethnic background, estimated number of visits to a medical doctor per year (e.g., general practice and, or, specialists), and estimated number of visits to allied health professionals in the past year. From more than 180 interested men, these data were used to purposely select a diverse group of men with varying sociodemographic and health service utilization profiles, who were then invited to participate in the study.

For descriptive purposes only, selected participants were invited to complete a further optional survey with questions on sexual orientation, geographic location, education, employment status, and relationship status. Participants were also asked to rate their overall health status and mental health status in response to the questions "In general would you say that your [health] / [mental health] is excellent, very good, good, fair, or poor" using the question derived from Australian Bureau of Statistics (ABS, n.d.) National Health Survey (ABS, 2020–2021).

FGDs (three to five men per group) were conducted online in 2023, each approximately 90 min in duration and co-facilitated by the same two researchers (M.S., M.A.M.) using principles described by Braun and Clarke (2021). Groups were added until theoretical saturation was reached. A semi-structured interview guide with open-ended questions was developed to explore participants' interactions with HCPs, their gendered health experiences, their positive and negative experiences, and what aspects of the engagement met their expectations and led them to want to or not want to return to a practitioner (Supplementary File 1). Finally, by drawing on their experiences and expectations, men were asked what they would like health care students, including medical students, and practitioners to be taught in regard to effectively engaging with men in care. Each FGD was recorded and transcribed verbatim.

A combined deductive and inductive thematic analysis was undertaken following the principles of Braun and Clarke (2021). The initial thematic codes included a category on participant's general health and health care values, and three themes generated

previously by Seidler, Benakovic, et al. (2024) to categorize their experiences and expectations for engagement during health care encounters, being (a) tailoring of communication, (b) purposefully structuring treatment, and (3) centering the therapeutic alliance. For the purpose of this study, acknowledging that not all engagement in primary care relates to delivery of therapy, the definition of therapeutic alliance included "patient-practitioner alliance" more broadly. One researcher open coded transcripts using NVivo (Version 12; 2018). Data were coded to these initial themes, with new categories and codes added as they were identified. The coding was reviewed by a second independent team member, followed by other research team members to ensure consensus was reached on data allocated to initial and new codes. A final synthesis involved reporting the codes that did and did not reconcile with the initial three themes, and drawing these together into key outcomes, for men, of successful engagement, to reflect what gender-responsive health care looks like and achieves for men. The research team represented a diverse range of experiences and qualifications in men's health, clinical practice, and research methodologies, which resulted in robust discussion of any assumptions or presuppositions about the themes during the analysis and synthesis.

Results

Participant Profile

Thirty-two men aged between 18 and 70 years (median 33, $M = 39.4$; $SD = 15.7$) took part in one of eight FGDs (Table 1). The majority were Australian-born, metropolitan-based, partnered men with tertiary education qualifications. In terms of health, most participants (78.2%) reported their general health to be good, very good, or excellent. Just more than one third (34.4%) reported their mental health as poor or fair. In the past 12 months, participants reported a median of five medical care encounters (ranging from 1–26) and a median of five non-medical health care encounters (range 0–30 +).

Table 1. Focus Group Participant Profile

Characteristic	*n* (%)[a]
Number of participants	32
Age group	
18–24 years	6 (18.8)
25–44 years	14 (43.7)
45–64 years	9 (28.1)
65+ years	3 (9.4)
Sexual orientation	
Straight	26 (81.2)
Bisexual	3 (9.4)
Gay	1 (3.1)
Not reported	2 (6.3)
Residence	
Metropolitan	19 (59.4)
Regional	11 (34.4)
Remote	1 (3.1)
Not reported	1 (3.1)
Australian-born	26 (81)
Aboriginal and/or Torres Strait Islander	2 (6.3)
Highest level of education	
High/secondary school	2 (6.3)
Trade certificate or Certificate II or Diploma	7 (21.8)
Undergraduate degree	13 (40.6)
Postgraduate degree	8 (25)
Not reported	2 (6.3)
Relationship status	
Single	10 (31.2)
Partnered	20 (62.5)
Not reported	2 (6.3)
General health status	
Poor	0
Fair	5 (15.6)
Good	11 (34.3)
Very good	10 (31.3)
Excellent	4 (12.5)
Not reported	2 (6.3)
Mental health status	
Poor	3 (9.3)
Fair	8 (25)
Good	8 (25)
Very good	9 (28.1)
Excellent	2 (6.3)
Not reported	2 (6.3)

[a]Some percentages rounded down to give sum of 100 for selected categories.

Participant Experiences and Expectations

General Health and Health Care Values. Positively, most men conveyed the importance of health to them, referencing longevity, quality of life, and the capacity to be active as main reasons. Most participants reported having positive relationships with HCPs and had a regular GP. Some men who were seeing a regular psychologist or psychiatrist again reported positive relationships. Men described the value of finding and maintaining a regular practitioner whether it be a GP, mental health practitioner, or physiotherapist with most clarifying that some trial and error was involved in finding a practitioner that worked for, and with, them. This led to a sense of confidence that when they went to their HCP, the treatment they received would be relevant and geared toward them.

Participants did not consider services specifically for men as necessary, although men recounted examples where tailored services for men can be beneficial

and/or potentially valued by men, such as cancer care services for male-specific cancers, or a counseling program run by men for men without a father figure in their life. The sex of the practitioner was also not a consideration for men, apart from some scenarios quoted by mostly older men and culturally and linguistically diverse men relating to sexual and reproductive health. Rather, it was acknowledged that it was more important to have HCPs that are comfortable and competent in providing care for men.

Engaging With HCPs

Tailoring of Communication. Participant's preferences and expectations were focused on the interpersonal skills of HCPs and communication approaches that were conducive to engaging encounters with men. Participants generally expressed a preference for a free-flowing conversation like a more informal friendly chat, describing initial health care interactions that were inherently awkward or uncomfortable. The use of informal language to humanize the encounter and streamline the initial interactions was described as useful to get to a point of feeling comfortable. Some men reflected on the value of their HCPs incorporating informal language such as colloquial terms and humor.

Most men described the importance of making allowance for a diversity of different types of men regarding their preferences for communication style and not to pigeonhole men into one approach, through stereotyping, that may alienate some.

> *. . . I like it when people make a joke here and there just to release the tension, but I understand that maybe that doesn't work with everyone, so I guess read the room as well. But don't be afraid to talk to people, get to know them, relieve that tension, be relatable, that kind of stuff.* (Kevin, 27 years)

Participants also discussed active listening as key to a sense of genuineness in their HCP. Listening, or lack thereof, was one of the most raised aspects of what constitutes a positive or poor relationship when engaging with HCPs. They regarded it as an underestimated but fundamental communication strategy that ensures HCPs connect with and get the most out of male clients. Although very aware of the time pressure, particularly in general practice consults, participants reflected that it does not take much time to connect, and by taking time to listen, HCPs can earn the trust of men during health care encounters, leading to greater sharing of information by men.

Furthermore, the inference from men was that listening breaks down the barriers to successful engagement arising from masculine socialization processes. One participant described that for some men, their mode of engagement hinges on the openness and communication skills demonstrated by the practitioner, especially for men whose default mode is one of traditionally masculine reticence to disclose.

> *some blokes might have grown up in households where it wasn't really a thing [to seek help] or where they just didn't feel supported . . . a medical professional who actually displays that they're listening to me and is open . . . I'll just keep talking. Compared to someone typing away on a laptop . . . I'll say the bare minimum, that's it.* (Risa, 26 years)

Equally important to participants as active listening was having an HCP who is not afraid to ask questions about what is going on both in their life and with their health, noting that some probing and investigating can reduce their anxiety and increase their willingness to disclose information. This was also seen as a sign of professional competency.

> *If I know that the health practitioner is probing a little bit into other things, into my personal life, into my social life, it's very, very quick. But it makes me feel that they're making the proper investigation, so my anxiety goes down and my level of trust goes up.* (Adam, 42 years)
>
> *as I said, ask those questions of "How is your family life? What's going on in your personal life? Are you looking after yourself? If not, why not?" And I find quite often in those circumstances, the reason I look out for those people is then I actually am more forthcoming with information that helps them help me.* (Seth, 29 years)

Some participants indicated a preference for very direct questioning, whereas others recognized this would not suit all men.

> *Matt was speaking—real men don't cry. That old saying. There's still a lot of us blokes out there like that. We don't want people digging into our emotions, our feelings, and how you're doing, all that stuff. It's like, "Well it's none of your business."* (Simon, 52 years)

Participants also referred to the value of the "doorknob question" toward the end of health care encounters. By a practitioner genuinely and purposefully asking "is there anything else?" rather than as a formality, men described this as helpful in overcoming hesitancy and internalized stigma to disclose further health related matters that they may not otherwise do.

> *I think you might need prompting because you're like, "They don't need to hear my crap." Well, but they are*

doctors. But you're just like, "I want to get out of here." Or they've got other people with bigger problems and some of us have a background of being told there's nothing wrong with you and things being minimised. I think that little prompt was a really useful thing for me. (Matt, 47 years)

Purposefully Structuring Treatment. When talking about the structure of the clinical care process and treatment, participants referred to both the time and resources pressures on HCPs and their desire to be involved in treatment decisions. There was evidence that the systemic time pressure, particularly in a GP setting, can impact the extent to which HCPs can prioritize relationship building and connection and increases the risk of deferral of discussions around their health.

. . . maybe you're going to the GP for your once-in-a-year check-up. There might be two or three things you think about and you think, well actually the third one's not important enough because I won't fit it in the 15 minutes. I'll talk about that maybe next year if I've got nothing else. (Ray, 57 years)

Participant's desire to be involved in treatment decisions was evidenced by their call for HCPs to provide transparency and clarity around the "what" and "why" of proposed treatments. They stated that this put them at ease and gave them a sense of control over decisions being made throughout their health care experience.

Thinking about my GP, she will go through drawing pictures, she'll pull out the model, go through a decent explanation if that's warranted of course . . . And that I really appreciate, to understand what the cause and effect of the recommendation is that is priceless and puts you at some ease, I think. So the detail, somebody actually coming out and just explaining to you that we're now going to do this and this is the reason that we're going to do it is enormously helpful to my mindset. (Greg, 66 years)

Related to men's need for autonomy and being empowered in health care was HCPs allowing space for men to ask questions about their treatment. A few participants shared negative experiences, mostly in specialist settings, of HCPs becoming defensive, for example, when they asked questions in attempting to clarify their treatment options, leaving them feeling shut down. These negative experiences highlighted the importance of a man feeling he can ask questions about his condition and treatments. Some men raised this as being important to establish an alliance typified by an "even playing field" between them and their HCP. It was these moments that led some men to feel comfortable in the health service interaction, as they could identify practitioners' efforts to leverage and incorporate their strengths into the structuring of treatment that could ultimately feel more personalized toward them.

You realise he's a human and he connected with me in the way of being like, I'm not just a customer almost. He specialises his health treatments towards you a bit more I think is what I got the feeling of I reckon. (Tom, 28 years)

Centering the Therapeutic (Patient–Practitioner) Alliance. In regard to the patient–HCP therapeutic relationship, participants desired personable, warm, and welcoming practitioners who were genuine and compassionate. The desire for HCPs to engage with them with care and empathy was one of the most memorable, quality-related characteristics of their interaction with HCPs, noting also that being empathetic does not take time out of time-restricted consultations. Participants also suggested they can readily identify genuine empathy in HCPs, and the absence of this can be a key determinant of disengagement.

I can tell pretty quickly whether or not someone's got a genuine care for the situation you're in, and whether or not they're prepared to do that little bit of work to get an understanding so that they can broaden their level of empathy, what you might be going through over and above just being objective. (Nathan, 29 years)

Participants extended the emphasis on genuine connection, by sharing that a sound alliance is built on HCPs genuine willingness to engage with them through a humanistic approach.

. . . just taking that time to explain to us what's going on and to have a brief moment of just talking to us like we're humans and not just another, I was going to say cog in the machine, but more be more like a person on the assembly line that needs to be fixed. (Joel, 24 years)

Participants shared expectations of being seen as "whole person" throughout their care and treatment. Within this, men valued broader holistic conversations around general life stressors they might be experiencing that can compound or complicate presenting health concerns, even if not directly related.

He assessed my life and where I'd come from and why I was who I was. It was very helpful because I could go to him with anything that was more sort of abstract or something bodily located. And he would be helpful because he just

understood me on a much, much deeper level than just seeing the problem, I suppose. He saw me as a person and considered my worldview and we shared a similar worldview and that helped a lot. (Owen, 22 years)

Most participants did not feel they had been treated differently by HCPs because they were a man. It was evident that some men had had a negative health care experience where they may have felt a rigid expression of masculinity and manhood was expected (e.g., stoic, tough, self-reliant) which was at odds with presenting with a particular health issue. They recounted indirect experience of gender bias through the reinforcement of outdated gender stereotypes and sentiments, typically in the context of sexual health checks or in hospitals, and when managing pain, and as a result they were not treated as sensitively (or as delicately) as they desire.

You're not treated as delicately, I guess. You're a tough guy. You can deal with it. You can handle it. (Evan, 52 years)

Participants experiences suggested that this gender bias and complicity in perpetuating stereotypes by HCPs could at times combine with the gender socialization of the male clients, resulting in both a struggle to articulate the severity of issues from the men's perspective and an inability among practitioners to recognize the severity of men's concerns.

When a bloke comes in with tattoos and a shaved head, he still might have issues and might need someone to reach out and say, "Hey, you want to talk about it?" Because he is not going to do it unless somebody does it. Someone like myself, unless you asked me, I'd even be reluctant to then, unless I had a really good relationship with somebody to open up. Other people, not so much. But there are still a lot of guys like me that are out there, especially in the construction. I'm in construction. I reckon 90% of those blokes, won't tell you nothing. (Evan, 52 years)

Another key aspect of the therapeutic alliance was participants expressing the need to feel safe in health care interactions where they typically are feeling vulnerable. This orientation, or lack thereof, was often referenced in relation to general practice.

That's been very mixed. I've had really good therapists and doctors and whatnot, but I've also had some pretty bad experiences with GPs before where I just haven't felt safe or haven't understood anything of. I just didn't feel good in their care. (Dante, 18 years)

These types of experiences culminated in participants feeling that their specific needs were not being met, that they were misunderstood, giving rise to an overriding sense of discontent with the interaction, not getting the help they needed, and increasing the likelihood of not seeking help in the future.

Participants highlighted the positive benefits for themselves or other men, particularly those who are feeling vulnerable, of being treated as a man with care and tenderness. For many, the authentic relationship and a strong alliance often went together with professionalism. Participants valued professionalism but sought the right balance between their HCPs expertise and professionalism, and their own autonomy, empowerment, and strengths.

Both older and younger participants spoke to generational shifts with younger men, compared with older men, feeling less stigma and being more comfortable and proactive in speaking about and seeking help for health concerns. It was suggested that in one-on-one settings with genuinely interested and caring practitioners, any socialized barriers to effective engagement that men may otherwise experience should fall away.

Yeah, I think the blokey industry and the whole blokey stoicism goes away when you're one on one. So I think then you can have very honest conversations. (Ray, 57 years)

Reconciling Participants' Accounts With Prior Scoping Review. Participants' expectations for engagement with HCPs were deductively assigned to existing codes within the three themes of tailoring communication, purposely structuring of treatment and centering the therapeutic alliance, and thus largely reconciled to common approaches to engagement offered for HCPs as described by Seidler, Benakovic, et al. (2024) (Figure 1). Engagement approaches that were described more uniquely by participants in this study and which were inductively coded to the theme of centering the therapeutic alliance were, for HCPs to be authentic in their delivery of care and for HCPs to be sensitive and tender toward men, as distinct from empathy, and to treat a male patient as an individual and holistically. Participants considered that an HCP's ability to meet all these expectations was a demonstration of their competency and professionalism as a practitioner (Figure 1).

Health Care Student Competencies. Participants' advice on the competencies that health care students should be taught on effectively working with men in care reflected the experiential insights offered throughout the FGDs (quotation examples; Table 2).

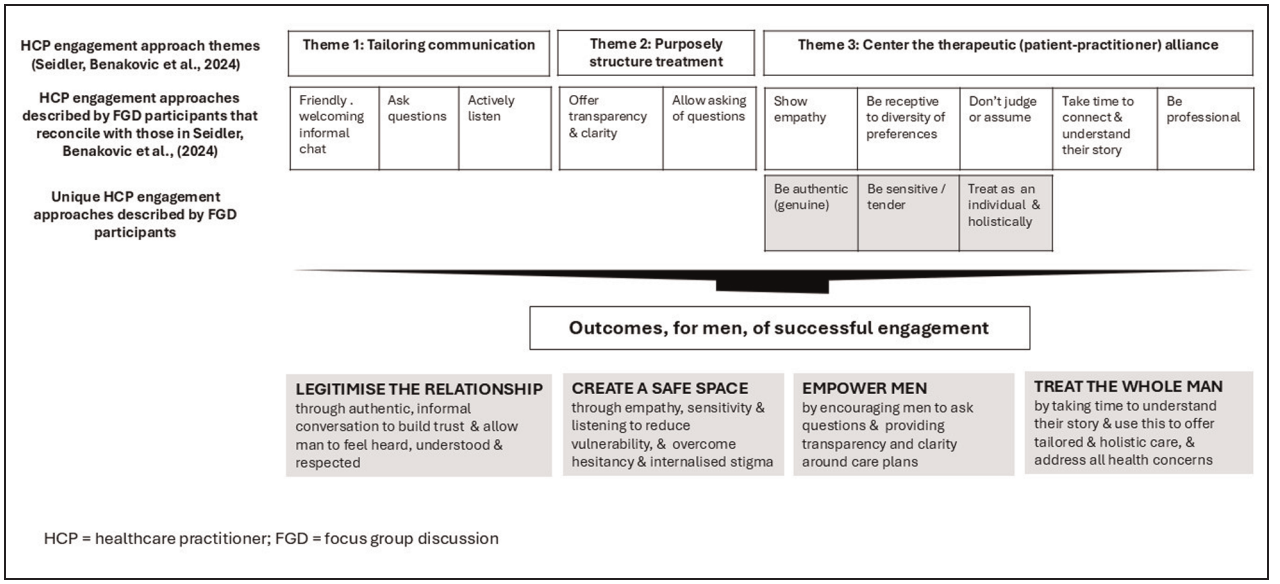

Figure 1. Outcomes, for Men, of Successful Engagement With HCPs Synthesized After Reconciling Published Approaches for HCPs for Engaging Men in Care With Approaches Described by FGD Participants That Work for Them

Participants particularly emphasized that optimizing the outcomes of care for help-seeking men hinges ultimately on their interpersonal skills that allow them to connect with men as individuals, authentically and with empathy.

Outcomes, for Men, of Successful Engagement. Participant data were subsequently synthesized to describe four desired outcomes, for men, of successful engagement with HCPs reflecting the principles of gender-responsive health care (Figure 1; Table 2). These outcomes are legitimizing the relationship, through authentic, informal conversation to build trust and allow the man to feel heard, understood, and respected; creating a safe space through empathy, sensitivity, and active listening to reduce vulnerability and overcome hesitancy and internalized stigma; empowering men by encouraging men to ask questions and providing transparency and clarity around care plans and treating the whole man by taking time to understand their individual story and social circumstances and use this to offer tailored and holistic care; and address all health concerns, including those beyond the presenting complaint.

Discussion

In this study, a diverse group of men provided insights on what works and does not work for them during health care encounters and these were synthesized into four outcomes, for men, of successful engagement with HCPs that can be used to build consumer-informed education curricula. The participants shared expectations for authentic and sensitive interactions that allow them to legitimize their relationship with the HCP and feel comfortable in their vulnerability within a safe space to disclose and discuss their health. Men described wanting to be empowered in the care process, seeking transparency and agency by feeling comfortable in asking questions to clarify medical and treatment information. Finally, participants described their desire for holistic and individualized care that is underpinned by their HCP asking questions and practicing active listening to better understand their story through a biopsychosocial lens. Participants strongly emphasized their desire for empathy-based care. Men's expectations for care were largely reconciled with previously published approaches HCPs can use to effectively engage with men. The insights shared by men were reflected in their advice for the competencies that should be developed during health care student training.

The results highlight that perhaps the greatest barrier to delivering gender-responsive health care to men is the failure to respond to men's fundamental desire and need to be genuinely cared for with, as one man related, "*warmth*" and "*delicately*." Men inferred the need for gender responsiveness of existing services such as "*there aren't many male spaces where you can be looked after as a man*," and that HCPs "*have to*

Table 2. Example Quotes Regarding Participants' Advice for Training of Health Care Students and HCPs on Engaging With Men According to Synthesized Outcomes, for Men, of Successful Engagement With HCPs

Outcomes, for men, of successful engagement	Example quotes	Participant pseudonym, age
Legitimize the relationship	*. . . just empathy. Just be very aware of the patient, how they feel. And if you don't think that you can get that kind of information from the patient, well I don't know. I don't know what you would do. But yeah, I think if there was something I could say to the people who were teaching the university students, I would say really focus on helping them become aware and connect well with the patient. And obviously if you're struggling you might have to go and recommend somebody else see them because you just can't make that connection/ because I just think that's paramount. If you can connect with a patient, you can help them with whatever they need.*	Joe, 35 years
	. . . it's really good to be professional and have really good listening skills. And also try to be patient because sometimes, men do not always say things direct, especially when it comes to time that they need to be direct. So, you just have to be more patient, then try to create a kind of relationship that enables them to be able to be . . . a professional relationship that would enable them to be more open to you . . ., so they can give them the kind of treatment they would need.	Henry, 23 years
Create a safe space	*I think you have to have a real respect for the process that someone's undergone to go and see a health practitioner. Especially a man because I think we know that men struggle to access health services for whatever, for societal, familial, whatever, stigma. So I think I'd probably tell . . . [students] just hold that space and respect the fact that they've taken this step to see you, whatever type of health professional you are. And kind of understand the gravity that the process of them actually coming to see you might hold for them*	Sean, 30 years
	But getting that little prompt, being asked that question, feeling like you're in a safe space where you can actually talk to someone you can connect with, might be just what that person needs. I think that's important. They need to know that.	Evan, 52 years
	You've just got to approach it with a sense of care, which I think most people would do because that's why they work in a medical profession is because they care about people. For some blokes you've got to really show it and actually show that you're interested in what they're dealing with, whether it be physical, mental and just not show that judgment. As a bloke, when you feel someone's judging you, you instantly go on the defensive. . . It's just about demonstrating that there is no reason to feel embarrassed. You can go in for something that for you is really embarrassing then you find out 5 out of 10 blokes go through it too. It's not a big deal at the end of the day and just being able to convey that and reinforce that things can be a lot more common than you think they are is really beneficial and will help men to open up.	Risa, 26 years
Empower men	*One which I think is probably typical of the better experiences I've had is that you are an active participant in the healthcare, you are not a recipient of. They explain what they're doing and I'd like to know not just what they're doing but why they're doing it, so they include you in that.*	Malik, 49 years
Treat the whole man	*I think just showing that sort of warm, care, by reflecting back personal information, understanding your context and your reasons for seeking care. And I suppose from the male perspective, I think going into those sessions, understanding that there might need to be a bit more work done to understand the patient.*	Luke, 32 years
	. . . give you the time to hear your perhaps family history and personal history so that they really get a picture of your holistic, your overall health and I guess showing some empathy and some interest.	Allen, 65 years

work a little harder to show [they] care." In their study of Malaysian men's experiences of primary care, Ab Aziz et al. (2022) describe men's desire for health promotion information to be delivered using a "soft style." As has been described for Australian men experiencing anxiety, approaches that are used to reach and connect with men in care once they overcome help-seeking barriers must be purposefully applied with gender responsiveness as its core (Ford & Keane, 2024). The narrative of genuine care aligns with that within the theoretical framework of "caring masculinities' constructed by Elliott (2016). Caring masculinities describes men's rejection of domination and their integration of values of care (positive emotion, interdependence, and relationality) into their masculine identities. This framework pertains to the concept of men being providers of care to others in their lives. We propose here that this framework should be extended for its relevance to men being recipients of care and their expectations for how this is

received. If men have positive health care experiences, they are more empowered to care for themselves, which then enables them to care for others (Gupta & Hook, 2021). Indeed, Elliott (2016), in developing the framework, reinforced the importance of there being a focus on men's "lived, emotional lives" and the costs of masculinity.

Legitimize the Relationship

Men quickly appraised for interpersonal and situational experiences that legitimized their patient–HCP relationship and spoke positively to being able to find a practitioner who gives them this type of authentic connection, rather than one that is transactional. Seidler, Rice, River, et al. (2018) and others (e.g., Calabrese et al., 2022; Madsen, 2015; Rabinowitz & Cochran, 2007) referred to a less clinical and more conversational style of communication early in encounters to connect with the reticent male patient. Conversely, participants described how they were able to recognize disingenuous HCP interactions and the consequences of them not receiving this type of care, being withdrawal. That is, men may choose not to raise health concerns, feel that they cannot ask questions, or resort to saying what they think needs to be said when their expectations of health care engagement are not met. This dynamic plays into perceived gender roles and situational expectations (Ab Aziz et al., 2022; Booth, 2020; Ford & Keane, 2024; Gerdes & Levant, 2018). The detrimental impact of this lack of connection on social and psychological health in men is well documented and increases the likelihood of future disengagement with health care (Ford & Keane, 2024; Seidler et al., 2020). In their qualitative study of Brazilian men's use of primary care, de Oliveira et al. (2015) referred to the need to engage with men respectfully and effectively to have problem-solving in readiness during men's attendance to avoid men disengaging from care.

Create a Safe Space

This study highlights the importance of shifting away from a narrative about men's reticence in health help-seeking that originates from a deficit-based position of men which may have a negative impact on some men in itself, to one that is compassionate to men needing to overcome a sense of vulnerability in seeking and asking for help (Farrimond, 2012; Fogarty et al., 2018; Seidler, Rice, River, et al., 2018). Men spoke to the power of HCPs empathic, broad-ranging, and probing questions to reduce anxiety and increase their willingness to disclose within a safe space. Men were willing to be asked questions genuinely and curiously, and pointed to this helping to overcome internalized stigma and increase engagement. Indeed, Kwon et al. (2023) spoke to HCPs breaking down power imbalance between the man and the HCP by actively addressing safety and power dynamics earlier on in encounters as a strategy to garner a healthy and trusting relationship. This concept of health consumer subjective experiences of vulnerability, particularly in the face of prior negative experiences and unresolved health concerns, has been described previously as a barrier to optimal health care experiences and outcomes (McGraw et al., 2024).

McGraw et al. (2024) recently drew on this research to model data from Australia's Ten to Men study to describe men as a segment of health consumers who are particularly vulnerable in health care interactions for preventive health. Importantly, their modeling suggested that men, as a segment, experience vulnerability; however, those men who conformed to traditional masculine norms (further segmented as either traditional self-reliant or traditional bravado) were more likely to have prolonged experience of vulnerability over time when compared with those who were less likely to conform to traditional norms (modern status segment). This modeling, confirmed by men's insights from this study, highlights the transformative impact that gender-responsive health care could have for those men more likely to experience gendered barriers to effective health care. Cultural competencies of HCPs are intimately tied to gender responsivity. Men from culturally and linguistically diverse backgrounds, including Aboriginal and Torres Strait Islander men, may, in particular, experience heightened barriers to effective engagement arising from distrust and fear of health services (Canuto et al., 2019; Harrison et al., 2020) along with a greater sense of shame and stigma around sensitive health, social, and cultural issues. Practitioners creating safe and supportive spaces for men are critical here, which includes consideration to the provision of male practitioners in certain clinical scenarios.

Empowering Men

On the contrary, while men sought a sensitive, caring model and were willing to tell their stories if they are asked, this did not necessarily mean that all men are looking to discuss their emotions and feelings at length. Rather, they seek an environment and empathetic engagement experience that reduces paternalistic hierarchy and gives them agency to ask questions and gather information that empowers them with the

readiness to take action (Lefkowich et al., 2017). This also requires providing clarity of process and including men in decisions and, wrapping around this, a demonstration of professional competency, assessed by men as the thoroughness of the HCP in establishing the rapport and asking questions. Facilitating such active involvement in the care process and decision-making has been shown to lead to improved self-care, compliance, outcomes, and satisfaction of care (Marzban et al., 2022). Conversely, Kwon et al. (2023), in the context of Australian men's experiences of mental health care, reported a sense of loss of autonomy, and a lack of perceived professionalism and authenticity of the HCP are key factors for their disengagement from care. Cameron & Bernardes (1998) referred to men wanting to be linked into the health care system because once they are, they are actively engaged and enter "Bernardes monitoring business "mode. This taps into masculinity not only impeding health care but also being a resource for men to leverage in dealing with health challenges. That is, men's desire for control and personal agency for decision-making and drawing on resilience and coping resources (Gough & Novikova, 2020; Seidler et al., 2021; Staiger et al., 2020; Swetlitz et al., 2024). By applying a masculinities framework and strength-based approaches, HCPs can leverage these preferences to their advantage in collaborative care with men (Madsen, 2015; Raciti et al., 2022; Seidler, Rice, River, et al., 2018). Cameron & Bernardes (1998) described the scenario with men engaged in prostate cancer care through written accounts, monitoring, and record-keeping as a gendered alternative to conveying health through extended dialogue. One goal of gender-responsive health care competency, therefore, is to tune HCPs more sensitively to the multiplicity of ways gender and health link together for men and intuitively adapt practices accordingly.

Treating the Whole Man

Participants shared a common sentiment of a desire to be cared for, which starts with HCPs enquiring about their lives, in a holistic, person-centered manner, understanding them as individuals with unique life circumstances and preferences. As suggested by Malcher (2009), HCPs incorporating a focus on men's societal engagement (e.g., work, recreation, education) are important, given that much of men's health-related activity occurs in those spaces and are thus relatable and may further facilitate men's willingness to disclose. This "whole man approach" interconnects with the empowering men element of care, in that treatment decisions may be tailored to social context and therefore what is best for them and their livelihood. While person-centered care, alluded to by participants, is foundational in education and training of health care professionals and reflected in competency standards for such (Dielissen et al., 2012; Gerteis et al., 1993; Gillon, 2008), rarely is this taught through a gendered lens. Without such, person-centered care risks being too generic and dismissive of the nuances of care for those men who experience greater gendered barriers to engagement. Participants empathized with HCPs in regard to how time pressures and protocol-driven health care practices may conflict with, and put constraints on, their desire to deliver holistic care, a scenario that has been described previously by HCPs themselves (e.g., Sturmberg, 2007; Derksen et al., 2018). Yet, men in this study were substantially referencing many of the fundamental qualities that medical doctors themselves recognize as those defining good practitioners (Schnelle & Jones, 2022).

Limitations and Further Research

The study population may have been biased toward men who hold aligning views by virtue of the fact that they sought to participate in the study. Likewise, drawing upon a sample of participants who have previously participated in similar research conducted by the authors may be inadvertently biasing the field toward men who actively reflect on their health and service use, and missing the input of men who are more prone to disengagement from both health services and research. While this is an unavoidable feature of research to an extent, the investigators did subjectively note a diversity of health experiences and expectations within the sample that captured a broad array of men.

While some men did talk to acute care, inpatient services, and allied health, much of the data captured were steered toward primary health care encounters, and particularly those with GPs. As general practice is typically the initial point of contact for men seeking help, meeting men's expectations for general practice should be prioritized but many of the skills are transdisciplinary in application and need to be transferred to other health care scenarios for when and where men seek care. This highlights the importance of innovation in HCP education that is concurrent across health and social care disciplines. For this, additional research is needed on men's expectations and experiences of engaging with HCPs in allied health and subspecialty health and social care settings. Related to the latter, the scope of the discussions with men excluded engagement with health care providers using telehealth or phone help line services, and in community and workplace health

promotion settings. Future research can build on our findings to inform specific nuances in these settings (Galdas et al., 2023).

While a diversity of men participated in the study, further dedicated insights from priority groups of men who are underrepresented in health encounters in Australian primary care or may be more likely to experience barriers to effective engagement are still needed. This will aid in the development of appropriately tailored gender-responsive engagement strategies that are readily transferable to curricula. For example, while men in this study stated that the sex of an HCP did not matter as much as the characteristics, care, and authenticity they displayed, this may be different for other ethnic and culturally diverse groups of men. Such sensitivity of the data will ensure that education content on engaging with men in care adequately considers the interplay between men's negotiation of gender norms and sociocultural and ecological factors that may lead to inequitable health care experiences (Griffith, 2015; Palmer et al., 2024). Canuto et al. (2018, 2019) have led important scholarship in this area for Aboriginal and Torres Strait Islander men, and further community co-led research with other culturally and linguistically diverse men, sexually diverse men, transgender men, and men from lower socioeconomic backgrounds is also needed. Whether eHealth technology, such as the integration of pre-consultation data provided by patients (Holt et al., 2021), has a role to play in facilitating an authentic connection with men overall, and for different groups of men, in time-restricted settings is also an area for further research.

Conclusion

Translating these consumer insights into health workforce education on gender-responsive approaches to engaging with men in care is a critical step toward achieving equity, efficiency, and effectiveness of health care for men. Indeed, the insights within study contribute to an already existing call to action to enhance and expand higher education curricula and professional development opportunities for HCPs in men's health (Australian Government, Department of Health, 2019). Equity among different groups of men will be achieved by amplifying approaches that resonate with men who, for gendered and other sociocultural reasons, are more likely to keep an emotional distance and need more time to connect with HCPs and feel safe. It is these same men who may be more likely to carry a higher burden of ill health over time and experience crises. These education priorities aim for systems-level change and therefore need to be driven through advocacy and policy. If done well and early, these approaches to engaging men will drive health care efficiencies and effectiveness through early diagnosis and intervention, empowering men in self-care and shift men's expectations for future help-seeking. These approaches can be applied within a 10- to 15-min consultation window with well-designed gender-responsive health care education that builds on, what should be intrinsic interpersonal competencies of emerging HCPs.

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Author Contributions

All authors contributed to the conceptualization and study design, with Z.E.S. responsible for funding acquisition, and ZS providing supervision. Focus groups were conducted by M.S. and M.A.M., Z.E.S., R.B., M.J.W., K.F., M.S., and M.A.M. were all involved in the thematic analysis and interpretation of the data. The original draft manuscript was prepared by M.A.M., M.S., R.B., with Z.E.S., S.R., K.F., and M.J.W. involved in the reviewing and editing process. All authors read and approved the final manuscript and met ICJME criteria for authorship.

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Ethical Approval and Informed Consent

Participants provided informed consent in order to be eligible for the study which was approved by the Bellberry Human Research Ethics Committee (Protocol No. 2020-04-318).

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Data Availability

Human research ethics approval was not sought to use these data for future research, and therefore, the use of these data is limited to this study. Researchers interesting in accessing the data would need to seek a waiver of consent.

Supplemental Material

Supplemental material for this article is available online.

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