Friends with your testicles?

Men's health problems are not to do with being powerless or being discriminated against. Murray Couch uses the Proudfoot case to show that the real problem in men's health is men's power and masculinity.

Men are not well equipped to understand or articulate their own health needs.

"HOW YA GOIN'?" If you're male, how much is the sense of "how you're going" determined by the fact that you are a man or boy?

Does your sense of how well you feel or function—as a whole or as a collection of particular bits and pieces—have anything to do with the fact that you have male parts, and have found yourself belonging to that group (men) which benefits most from the way the world we live in is structured and run?

Men do not commonly rap about that sense of well-being or loss of it which they may have in common as men. Men's bonding is more likely to have to do with talk of size and performance than with the sharing of the experience of common fragility or malfunction.

Interaction between men is more likely to have to do with the shape of pectorals, and performance in the gym, than with the subjective experience of testicular cancer self-examination.

So, how to talk of "men's health"?

Some public discussion of "men's health" as a concept and an issue has been generated as a spin-off of what has come to be called the "Proudfoot Case".

Proudfoot: men as victims

IN JULY 1990 Dr Alex Proudfoot, of the Therapeutic Goods Division of the Commonwealth Department of Health, Housing and Community Services, brought a complaint to the Human Rights Commission. Two other men brought similar complaints. In effect the complaints provided a challenge to the Commonwealth funding of women-specific health services, such as women's health centres. The complaint was that the funding of women-specific health services, services which also offer general health services, discriminated against men. The complainants argued that men's health, as indicated by statistics about death and illness, is worse than women's health and therefore is in more need of resources. Commissioner Sir Ronald Wilson found in March 1992 that such funding was discriminatory under the Sex Discrimination Act, but that such discrimination was exempted as legitimate under the provisions of the Act.

The case provides a rich source of social information for anyone with an interest in such issues as the dominance of science and the practices of mainstream medicine in determining what is considered legitimate in discussions of health, and the extent of professional dominance in the discussion of health. The case provides a rich source, too, for an understanding of how women's bodies (and men's bodies) are seen, and fragmented, by the gaze of science, mainstream medical practice, and dominant professionals. In particular, the case raises the issue of what are conceived of as "women-specific" and what are conceived of as "men-specific" health issues.

The arguments presented by the complainants around health funding are of a zero-sum type, and their logic could be caricatured as: "Traditional medicine may not serve women well, but it serves men even worse (they are sicker and die earlier). Any money spent on women's health (except for gynaecological and reproductive health services) must be at the expense of men's health, so resources need to be taken back from women's health and applied to men's health."

"Women-specific" health, in this view, is confined largely to the reproductive system (ignoring the implications for well-being of women's status and their social location as a group, with less equal access to the labour market, with the feminisation of poverty, etc).

One view of men-specific health presented by one of the complainants is similarly located in the reproductive system, but extends to the construction of men as social victims. "[Men] have sex specific disease—impotence, prostatism, often have to suffer the loss of children in divorce. Have to internalise emotions because of macho society."

Clearly, there are sex-specific problems with the health of Australian men. However, the construction of men, as a group, as victims and in competition with women

for health funding is unhelpful, and unlikely to open a constructive way ahead.

In my view, a constructive approach to men's health concerns will come from seeing such concerns as a product of the power of men as a group, and not from their status as powerless or victims. My argument is that men are more likely to become attentive to the maintenance of their own health to the extent that they confront the power and homophobia that lies at the base of the practices that preserve male privilege in societies like ours.

Dominant masculinity

THE Australian sociologist Bob Connell has, among others, described how men's power is maintained through "hegemonic, heterosexual masculinity". By this he means that there is a dominant set of ideas about what it means to be a man and masculine, and although any individual may not embody all of these notions, all men are measured against the set of ideas. This dominant masculinity presupposes an heterosexual man.

The health problems of men may be constructively conceived of, then, as a consequence of maintaining power, rather than of being powerless. Victor Seidler argues that men maintaining power become invisible to themselves and to their own needs. In *Rediscovering masculinity: reason, language and sexuality* (1989) Seidler says that "men become strangely invisible to themselves. They become estranged from the personal aspects of their experience, as they learn to think of themselves in terms of the neutral standards of reason." Consequently, they are not well equipped to understand or articulate their own needs. Men, socialised to believe they speak about reality as it is, on behalf of all, are not well equipped to understand or articulate their own needs or to speak on behalf of themselves out of their own subjectivity.

If maintaining the dominant masculinity is a health hazard, so too is homophobia. I hazard a guess here that fear of same-sex sex, and the panic that this possibility commonly invokes in men, restricts many men from feeling comfortable about acquiring an intimate understanding of all their parts.

Three conditions mentioned by the complainants as of concern to men are impotence, testicular cancer and prostatism. Men do not treat the three body parts involved here as having equal honour. In a masculine symbolic system, and particularly in a homophobic masculine system, the penis is honoured above all, especially when it stands up as powerful. The testicles are not the site of power, but merely "hang about", and are ascribed less honour. The prostate is in the least honourable space of the three, and can only be reached through the dishonoured and taboo act of anal penetration.

Impotence, testicular cancer, and prostatism: in a homophobic masculine system, the penis is honoured above all.

"Hegemonic" (or dominant) masculinity, which is constructed as heterosexual, then, provides profound difficulties for men in dealing with their health issues, for to do so is to acknowledge the stress and strain of social power and privilege and, maybe, to confront homophobia.

Meeting men's needs

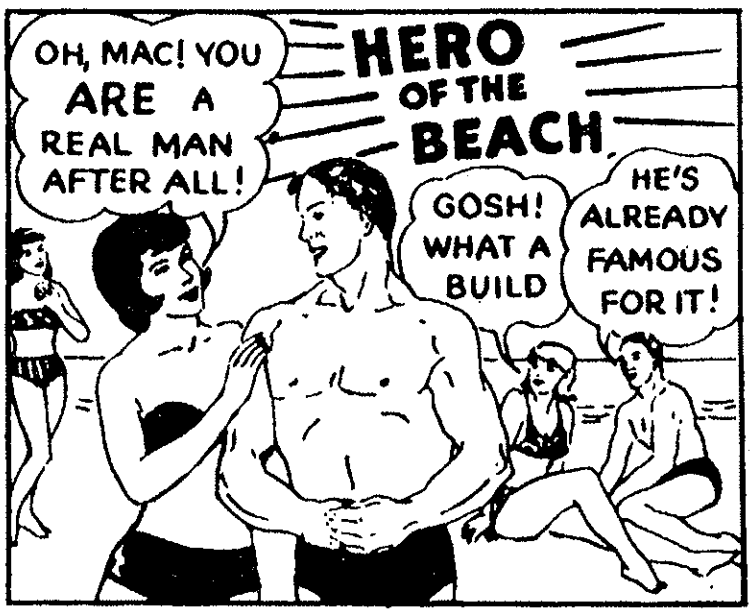
WOMEN who committed themselves to the women's health movement and established women's health centres did so because they believed that traditional medical practice did not meet their needs, treated their bodies as parts and not as a whole, discounted their subjective accounts of their well-being or illness, and did not account for the social position they occupied.

There may be decreasing space between the experience of some men and their health and the experience of these women. Increasingly, mens bodies are being treated as commodities, and use to market products. Increasingly, too, mens bodies are being dissembled, broken into parts, as the piece on gay porn in *XY* (Spring 1992) testifies.

So, as men are being broken down into parts, they are also, in increasing numbers, being placed in less powerful positions in society, as the labour market restructures.

It could be, too, that men are experiencing the practices of traditional medical as not meeting their needs. The moment may have come for men to talk about their health. This will be most constructively done, in my view, if the issue is not construed as one of wresting resources away from women so that they can be spent on men. Improvement in mens health will not necessarily follow increases in or reallocation of health care resources. Rather, improvement is likely to follow changes in the way men experience and express the social power they have.

If the status of their health is to improve, men will need to become sensitive in articulating their own felt health needs and mapping and becoming intimate with their own bodies. Confronting their social power, and the possible fear of the homosexual, may be an emancipating and healthy consequence of this. ●



There is a dominant set of ideas about what it means to "be a man" and to "be masculine", and all men are measured against this set of ideas.