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All Change? Gender, Health and the Internet

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Statistical analyses increasingly suggest that women use the Internet at similar rates to men and may be even more prolific users in the area of health information (Fallows, 2005). Such analyses might suggest that there is, therefore, no significant gender divide when it comes to Internet use in a health information context. However, more sophisticated understandings of digital divides would be alert to the dangers of such an interpretation. For example, Kvasny (2006), following Hargiatti et al. (2004), has distinguished usefully between 'the digital divide' and 'digital inequality', arguing that whereas the former refers to disparities in the structure of access to and use of information and communication technologies (ICTs), the latter is a broader concept, reflecting the ways in which long-standing social inequalities shape beliefs and expectations regarding ICTs and their impact on life chances (Kvasny, 2006: 160). This hints at the need for much more 'situated' understandings of Internet use than statistical analyses can offer. With respect to gender, it suggests that long-standing divisions and inequalities—in health, in the home, in employment and in relation to technologies—may shape how people approach use of the Internet and integrate it into their daily lives to engage in specific tasks and achieve specific ends. This chapter seeks to explain how gender and the Internet are 'co-produced' in specific use contexts and how Internet use for health information and decision making might be understood in the context of the discourse of the 'informed patient'.

By 'informed patient discourse', we are referring to a set of assumptions about responsibility for health and health information seeking that have emerged in late modern societies. These assumptions can be found in government policy documents setting out agendas for public health and self-care and, as we have argued elsewhere (Henwood

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et al., 2003), versions of the discourse can be found in some academic literature, too. This 'informed patient' can be understood as a sort of 'ideal model' of how health care consumers should engage with health services. 'Informed patients' (IPs) are understood as taking increasing responsibility for their own health and those of their families and communities by actively seeking health information and making informed choices through engagement in shared decision making with health professionals. The Internet is seen as playing a significant role in supporting the emergence of informed patients, offering access to information that can assist the processes of increased self-reliance and self-care. Our own previous work and that of others (Henwood et al., 2003; Kivits, 2004; Nettleton et al., 2004) has identified factors facilitating and inhibiting the emergence of the informed patient and these have offered important insights for the debate about the Internet and so-called 'patient empowerment'. In particular, important conceptual distinctions have been made between the Internet and information (Henwood et al., 2003) and the need for people's engagement with information (more or less 'reflexive') and the Internet (more or less 'domesticated') to be analysed separately (Nettleton et al., 2004). However, there has, as yet, been no systematic analysis of how gender shapes engagement with health information and the Internet in these detailed empirical studies. This chapter seeks to offer such an analysis, arguing that such engagement is mediated by the informed patient discourse.

Although the IP discourse seems to hail men and women equally, we argue that there are good reasons to suppose that gender is implicated in the different (and varied) subject positions individuals take up in relation to it and that gender may continue to be constituted through such subject positions and related information and Internet practices. As we argue in the next section, both health and the Internet can be shown to be sites of gender construction and so, when health and the Internet are brought together in the way in which they are in the informed patient discourse, we might expect to observe some disturbances to existing gendered subject positions and practices. This theoretically informed section is followed by a narrative analysis of the relationship between gender, health and the Internet, drawing on data from an empirical study of Internet use in the context of health information seeking and decision making.

Health and the Internet as sites of gender construction

Health and gender can be understood as inextricably linked or even 'co-constructed'. As argued in the Introduction (Balka, Green and Henwood,

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this book), women's health is negatively affected by gendered divisions in work (both paid and unpaid), women have lower levels of income and wealth and report higher levels of anxiety and depression than men, women take the major responsibility for the health of others (including men and children) whilst ignoring their own well-being (Doyal, 2001; Daykin and Naidoo, 1995) in line with traditional notions of femininity. Men, too, experience negative consequences of socially constructed gender differences. Once again, some seem to result from what might be thought of 'gender structures'—for example, working-class men experiencing the health risks associated with working-class male occupations—whereas other differences may be thought of in relation to the formation of masculine identities. Doyal, for example, has argued that 'the development and maintenance of heterosexual male identity usually requires the taking of risks that are seriously hazardous to health' (Doyal, 2001: 1062). Other commentators explain the fact that men are more likely than women to engage in 'risky behaviours', including, the practice of unsafe sex, as being associated with the development of a hegemonic masculine identity (Canaan, 1996; Schofield et al., 2000).

It has also been suggested that the need to demonstrate a 'hard' masculinity may explain men's unwillingness both to consult a doctor when problems arise and to take health education messages seriously (Doyal, 2001: 1062; Griffiths, 1996; NHS Executive, 1998). Men are less likely than women to seek advice from peers, magazines, books and the television. Middle-class men are more likely than their working-class peers to access and respond to health promotion information from leaflets and advertising, but in general men are less likely than women to rely on the experience of their peers, preferring to live life as 'normal' (Banks, 2001; Lloyd, 2001). A study of young men's use of sexual health services found that the average young man is unlikely to access any help or support at all if he has a problem (Biddulph and Blake, 2001).

These gendered structures and practices raise interesting questions in light of the promotion of more non-face-to-face means of accessing health information and communicating with health care professionals. In the United Kingdom, NHS Direct, NHS Direct Online and information kiosks in places such as railway stations and shopping centres have all become more prevalent in recent years and some commentators on men's health have argued that the provision of more anonymous sources of health information will actually improve men's access to health care. Banks, for example, has argued that the success of the Impotence Association helpline—which receives tens of thousands of calls from men about erectile dysfunction—suggests the importance of more anonymous, confidential services for men (Banks, 2001).

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When it comes to the medical encounter, gender again emerges as a significant factor, both shaping and shaped by the exchanges that take place between patient and practitioner. For example, men receive less of a doctor's time in medical encounters than women, and are provided with fewer and briefer explanations—both simple and technical (Courtenay, 2000, cited in Banks, 2001). Furthermore, although men are more likely to engage in high-risk behaviour, they receive less advice about changing risk factors than women do during check-ups. As Courtenay has found, only 29 per cent of doctors routinely provided age appropriate instruction on testicular self-examination, compared with 86 per cent who provided instruction to women on breast self-examination (2000). Furthermore, Well-Man clinics were first introduced in the United Kingdom in the early 1990s but did not take off in the same way that the earlier established Well-Woman clinics did (Kirby, 1999, cited in Banks, 2001).

Thus, there are a number of ways in which gender can be seen to shape health care practices and structures and in which, conversely, health structures and practices might be understood as contributing to the formation of gendered identities and gendered practices in health care. A parallel co-construction, we argue, is taking place in relation to the Internet.

Discussions of gender and the Internet should properly be located within the wider literature on the gender–technology relation but such studies have a long history that cannot be revisited in any depth here (for useful overviews, see Wajcman, 2004; Lie, 2003). Suffice to say that, over time, there has been a shift in focus from women to gender and from exclusion and inclusion to a more nuanced understanding of the ways in which gender and technology are mutually constitutive. The focus on gender enables analysis of how men as well as women are gendered and at the durability of the assumed link between masculinity and technology, often in stark contrast to observable variation in practice. A central concern in gender and technology studies then is the tension that often exists between, in Harding's terms, symbolic gender, gender structures and gender identities (Harding, 1986). As has been pointed out elsewhere (Henwood, 1996; Henwood and Hart, 2003), these three aspects of gender may be understood as interrelated but that does not mean that they always pull in the same direction. Thus, whilst 'gender' and 'technology' can be understood as cultural categories, used in popular discourse as a way of making things familiar and easier to deal with (Lie, 2003), we need to remain alert to the practices and processes of change that cause such symbols to be mobilized. Such mobilization

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may be more pronounced when traditional gender structures or identities are perceived as under threat. For example, in Henwood's study of reactions to the UK-based 'WISE' (Women into Science and Engineering) initiatives in the mid-1980s, she argued that gender binaries and essentialisms were re-asserted as a direct response to the perceived threat to traditional gender boundaries posed by equal opportunities initiatives (Henwood, 1996). In this chapter, we contend that a similar process is occurring in response to the threat posed to traditional gender binaries by the informed patient discourse.

The Internet has no fixed meaning and, in gender terms, cannot be understood in binary terms—as either pink or blue. It is constantly evolving and its meanings are constructed in use, as well as in production. As Miller and Slater have argued, 'the Internet is not a monolithic or placeless "cyberspace"; rather it is numerous new technologies, used by diverse people, in diverse real-world situations' (Miller and Slater, 2000: 1, cited in Consalvo and Paasonen, 2002: 8). Nevertheless, gender binaries continue to circulate, not only in popular discourse but in media representations of the Internet and (less explicitly perhaps) in academic discourse, too. Dorer has shown how, in the Internet's 'third phase', characterized by commercialization, the media ceased to address themselves specifically to technically sophisticated male users and hailed women as 'mothers, cooks and consumers' (Dorer, 2002: 67). In academic discourse, Sadie Plant relies heavily on this gender binary when she argues that information networks, such as those represented by the Internet and the World Wide Web in particular, are signs of feminization, offering an 'alliance of women and machines' (Plant, 1997) as do those who argue that the Internet is in danger of becoming a masculine space where women are successfully 'flamed out' as men dominate online interaction and masculine priorities continue to shape the Net (Herman, 1999; Spender, 1995; Scott, Semmens and Willoughby, 2001). Others appear to think beyond the gender binary, arguing that the Internet is better understood as a transformative space where gender categories become reconfigured (see, e.g., Turkle, 1995; Stone, 1995) but even here, there appears to be more emphasis on gender 'swapping' (implying two opposite genders) than on reconfiguration as such.

Other work has attempted to account for historicity and differences between women and to relate online and offline worlds by developing what Consalvo and Paasonen (2002) have called 'situated formulations of cyberfeminism' (see, e.g., Braidotti, 1996; Wakeford, 1997). Meeting this body of work from a different starting point are those studies of gender and the Internet in everyday life that build on earlier work on the

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'domestication' of technologies in media studies work by, for example, Silverstone and Hirsch (1992) and in technology studies work by, for example, Lie and Sørensen (1996). These works have been influential in our thinking and approach, as has the work of Bakardjieva (2005) and Bakardjieva and Smith (2001) on the use of the Internet in everyday life. In particular, Bakardjieva (2005) examines not just how people use the Internet but how they 'relate' to it. Following Turkle (1984) and Aune (1996) on computers and Moyal (1992) on telephones, Bakardjieva distinguishes between those people whose main concern is with what the Internet can 'do' and those who are more concerned with how it makes them 'feel' (Bakardjieva, 2005: 19). Some people have more 'instrumental' relationships to computers and the Internet and others have more 'expressive' or 'intimate' ones. The more 'intimate' the relationship, the less technology is experienced as a tool and the more as an aspect of self—something that enhances one's status perhaps or threatens one's sense of identity. This is an important contribution to the debate about Internet use and one that we explore in our narrative analysis, later in this chapter.

One further area of Internet research that is important for our analysis here is that which focuses specifically on non-users. Wyatt et al. (2002) have offered an important insight here by arguing that not all non-use is involuntary (as is implied in the much-used term 'digitally excluded'). By so doing they have re-introduced the notion of agency into digital divide debates. Selwyn's analysis of those who stand 'apart from technology' has also emphasized the importance of human agency in non-use of technologies (Selwyn, 2003). In his article addressing non-use of ICTs in everyday life, he offers an account of non-use (and indeed all variations of use) that emphasizes the importance of the 'reading' of (or meanings attributed to) technologies. Acknowledgement of this symbolic aspect of technologies was also used in one of the (still) few studies of gender and ICTs in health care to explain midwives' resistance to electronic patient records (EPRs). Here, it is argued, computerized record-keeping was read by midwives as 'masculine', in contrast to the more 'feminine' work of midwifery and it was in these terms that midwives sought to rationalize their resistance to EPRs (Henwood and Hart, 2003). In this chapter, we continue to explore the symbolic aspects of technology by analysing how the Internet is 'read' by our participants in the context of a study about Internet use and the informed patient.

Re-introducing agency into the debate about non-use of technologies should not, in our view, be done at the expense of an account that

recognizes structural factors shaping use and non-use. Indeed, just as with our understanding of gender where we seek to explore the relationship between structure and agency, technology's 'duality' has also been recognized (Orlikowski, 1992). The choice to use or not use technologies is clearly not a free one and structural constraints and enablers can be seen to exist in, for example, institutional hierarchies and domestic divisions of labour. Indeed, structural factors will make some symbolic 'readings' of technologies more likely than others and it is our contention, that, in order to better understand how gender shapes Internet use, we need always to keep in mind the relationship between structures, symbols and identities.

Counting men and women, constituting gender

The data on which this chapter draws was collected during a study that examined the health information practices of a group of midlife and 'older' men and women who were recruited on the basis of two gender-specific health problems—erectile dysfunction (ED) for men and menopause for women.[1] We recruited those who were considering using, were using or had used the two most conventional treatments for these conditions at the time—Viagra for men and hormone replacement therapy (HRT) for women. We examined how these men and women came to a decision about whether or not to try these treatments. We sought to identify their main information sources and the media used to access these sources and their deliberations regarding the associated risks and benefits of taking or not taking Viagra and HRT. The aim was to examine the significance of the Internet to these people in the context of their wider health information landscapes, their decision making regarding health care and treatments and in their relationships with health care practitioners.[2]

It is important to remember that our study was of older women and men and there is some suggestion that age may now be the strongest 'digital divide' but this, in and of itself, does not render gender insignificant. Liff and Shepherd (2003) have analysed data from the Oxford Internet Survey (a representative sample of 2030 respondents in May and June 2003 in England, Scotland and Wales) and have come up with a number of interesting gender-related findings. For example, they found that, of the retired population, 25 per cent of men but just 18 per cent of women used the Internet; that broadband access is higher amongst men; that men have more access to the Internet at home (92 per cent men and 86 per cent women said home was their current access

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place) and that, even after controlling for length of experience, women were still less confident than men in using the Internet. Studies of the 'lived experience' of Internet use can offer insights into the complex workings of gender that lie behind such figures.

A simple count of men and women's use of the Internet for a range of activities can tell us very little about gender when the numbers are so small and when a study has been designed as a qualitative one. However, we present the numbers here because they suggest a number of lines of enquiry that we were able to follow up through detailed qualitative analysis of the interview data. Our number counts showed no major differences between men and women in relation to digital connection (about two-thirds in each case had access to the Internet somewhere convenient, namely home or work) but use figures were slightly lower for women than for men (20 of 24 connected women used the Internet compared with 9 of 10 connected men). More interesting perhaps are the figures for use of the Internet specifically for health-related activities. Here, women's use was higher than men's—18 of the 20 women users used the Internet for health-related activities, compared with only 3 of the 9 male users. These use patterns make sense in terms of what is already known about gender and health where women take the major responsibility for health in mixed gender/heterosexual households and where health is still generally framed as a feminine area of interest and responsibility.

An interesting set of questions arises when looking at the figures for use of the Internet in relation to ED/Viagra and menopause/HRT, specifically. Here, men who used the Internet for health-related activities also all used it for ED/Viagra-related material whereas just 10 of the 18 women who used the Internet for health-related activities had used it for HRT/menopause-related material. It is difficult to know how much to make of these differences but several explanations for women's non-use in this context are suggested by further analysis of the interview data. First, it did seem that when it came to menopause and HRT-related information and advice, women seemed to find what they needed through traditional sources—GPs, but also family, friends and work colleagues and traditional media, such as women's magazines and the health pages of daily newspapers. Second, a significant minority of women not using the Internet for this purpose were those who had originally taken their doctors' advice to start taking HRT and who had experienced no problems with it—they therefore could be construed as simply having no 'need' for further information and hence no need for Internet use in this context. Finally, as we discuss below, for others, the Internet came to

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symbolize an undermining of the doctor's authority, restricting use lest this undermine the trust relationship, inhibiting access to appropriate health care at some later time.

The numbers above tell us little on their own but do suggest some interesting gender-related questions that can be better understood through detailed qualitative analysis of the situated use of the Internet in the context of health-related activities. In the next section, we illustrate how gender shapes Internet use in a health context and is, at the same time, constituted in relation to both health and the Internet. We do this through a narrative analysis, which can be understood as being co-produced by our study participants and ourselves as researchers/analysts. It is important to emphasize this co-production process. By situating our questions about Internet use firmly within the context of a set of questions about health information practices, health decision making and practitioner–patient relationships, we were clearly drawing on ideas and assumptions from the informed patient discourse, where the Internet is positioned as central and potentially transformative of these practices and relationships. Thus, whilst our aim was to analyse how people positioned themselves in relation to this discourse, we can now see quite clearly how our questions were, at times, understood as promoting the IP discourse and its associated practices, resulting in sometimes forceful statements of rejection and resistance to the Internet and, at other times, attempts at compliance with the connection imperative embedded within the IP discourse.

Narratives of everyday practice: gender, health and the Internet

We begin our narratives of everyday practice with stories from Victor and Peter. Both men experienced the 'connection imperative' implied by the particular configuration of the Internet in the informed patient discourse but responded to it in very different ways which we explore in relation to their different relationships to masculinity which are, in turn, shaped by their specific health contexts.

Victor is 59 years old and married. He and his wife have three children, all grown up, with the youngest living partly at home still. Victor works as a personnel consultant and his wife works part-time as a school secretary. He has had a low sex drive for a year and the possibility of a low testosterone count was being explored at the time of the interview. He had tried testosterone patches and Viagra that worked (technically) but he did not 'feel like sex'. The sexual counsellor thinks his problem

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with ED may be psychological but Victor is not keen to think about that possibility.

With regard to health information and the management of health, Victor is quite traditional. He trusts doctors and nurses to provide him with the information he needs and tends not to look things up himself though he did once visit a 'Well-Man' clinic, which he read about on the notice board in his doctor's waiting room.

Victor is very defensive about his non-use of the Internet:

> I'm not interested in computers. I just want to get on with my life in the easiest way. I can't see what benefits it would give me. I'd rather hear it from the horse's mouth and talk to someone. Not get lost in cyberspace. Seems bloody obvious, and a waste of time doing this research, I reckon.

Victor's reaction to questions about possible use of the Internet in the future is very strong and we want to suggest that this may be linked to his fragile sense of masculinity (see Wyatt et al., 2005 for a first attempt at this analysis, with longer interview extract). If, as some feminist scholars have suggested, men's close relationships with technologies are forged on the basis of a sense of impotency in other areas of life—for example, personal relationships (the so-called 'hacker thesis'—see Faulkner, 2000 for discussion) or class power (McNeil, 1987)—then this defensiveness (rather than the non-use itself) would make sense. It is as if our questions are drawing attention to his lack of potency not only in the sexual arena but in the potential, compensatory arena of technology as well. We suggest that Victor's particular fragility in relation to his sexual impotency can be explained by the lack of a clear physiological explanation and his very apparent unease with a psychological one.

This interpretation can be supported in part by examining a contrasting case: that of Peter. Peter is 66 and has recently retired; he is separated from his wife. He has four sons, of whom the first and the third live with him. There is a connected computer in the house, but only his sons use it. While he feels some pressure to become a user, he says,

> I don't use it. I can't be bothered. … I should use the computer more, I just, I don't know, I just can't be bothered. I'm lazy about that. It's not my sort of thing. I'd rather pick up a phone and talk to somebody rather than send them an email which I find takes too long.

Compared with Victor, Peter is not at all defensive about his non-use of the Internet. He talks easily about his preference for the immediacy and

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presence offered by the telephone, and his self-confessed incompetence in dealing with email. This more relaxed response to questions about Internet use parallels his ease in talking about his ED. Peter's erection problems are linked to his diabetes. Having a clear physiological explanation for his ED, we would argue, made him less susceptible to a sense of personal inadequacy than Victor and left his sense of masculinity rather more intact, making his minimal interest in technology and the Internet easier to voice.

We now turn to examine two women participants' relationships to health and the Internet. We start with Barbara whose account demonstrates extremely well the interconnection between gender structures, gender symbols and gender identities, and then we meet Kathy, whose story offers important insights into how gender intersects with the symbolic aspects of the Internet to shape use practices and, ultimately, access to appropriate health care.

Barbara is 50, a single mother with two sons, the youngest of whom lives with her. She works in hospital administration and owns her house. Barbara was having a bad time on HRT, which she was prescribed after a total hysterectomy a few years prior to our first interview with her. She had an implant at first but later tried both patches and pills. She had gained weight and was experiencing severe migraines since starting on HRT. By the time we talked to Barbara a second time 6 months later, she had come off the HRT, citing the headaches and weight gain as the main reasons. She was trying reflexology for the headaches and had joined Weight Watchers. She was also trying black cohosh, a herbal remedy that some believe can help alleviate menopausal symptoms. She is generally mistrustful of doctors whom she feels do not listen to women. She is quite critical of what she sees as the 'over-prescribing' of HRT.

Barbara has Internet access at home and at work but is a very reluctant user. In her first interview, Barbara describes her feelings about the Internet:

> I hate using the Internet. I hate computers. I really hate them. I guess if I was put in a corner, I had something that was really worrying me, then I would, but that hasn't happened, thank god. And so, I hate even switching a computer on. I can't stand the things. . . . I'm useless with a computer . . . I think it's just my age group. I just hate them. They don't interest me whatsoever, frustrate me like mad. It's like having a car that doesn't work to me. I get raging with them and I don't want to be there. I'd rather pick up the phone. . . . can't bear the damn things. I know I've got to eventually give into it.

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Here, she describes her relationship to the Internet in a way that suggests a mixture of dislike and under-confidence, which she ascribes to age. However, the rage that she clearly feels may be explained, in part, by the sense of pressure she feels to give in and use the Internet, as suggested by the sense of inevitability about use, expressed in her final comment.

Barbara also explained how her son is the main user of the home machine, a situation that one might think was not a problem for her given her dislike of computers. However, by the second interview, we learn more about what we now prefer to see as Barbara's ambivalence towards, rather than hatred of, computers and the Internet—an ambivalence that appears deeply rooted in gender structures, is clearly expressed through gender symbols and lived through a gendered identity forged in relation to her son.

By the second interview, Barbara's son has left home:

> I've had a teenage son around for years who has been hogging the Internet and he won't show me how to use it because I'm too slow. He's actually just gone to University so I have actually this week been trying to get it up and running and sort it out but it's in such a mess and I have got various neighbours who keep promising to come round and help me, so I'm getting close to it. I've actually been on a basic course now. I don't like it. I hate it. … well, I know I've got to do it. I'll learn as little as possible but as you get older it really is quite hard to take on board especially if you're not interested in it. I have no interest in it at all. I just think it's absolutely boring. The thought of switching it on is like doing the ironing to me.

Barbara's account of her relationship with computers appears to be slightly different this time. She describes her son as 'hogging' the Internet, suggesting that it was something she would have liked more access to but was somehow prevented from having whilst her son was around. Indeed his construction of her (the projected identity) as 'too slow' to teach may well be a reference to her age, something Barbara continues to draw upon in her own subjective identity construction. Between them, it seems that they constructed both gendered and aged identities for themselves and each other in relation to Internet competence. However, with her son out of the way, Barbara does, in fact, get on line. She has identified the problem with the machine's slowness—the 'junk' left on by her son—and has been on a course to learn more so she can sort the problem out. In the final part of the account, Barbara reverts to her initial positioning again—her 'hate' for computers but

this time we gain a deeper insight into her strong feelings. Here, she compares computer work to domestic work—cleaning up the computer is 'boring', and 'like doing the ironing'. Her feelings about computers now seem linked to a more general resentment about cleaning up after her son.

Later in the interview, Barbara talks more positively about what the Internet could offer her—specifically in relation to health and health care experiences:

> I think it would be useful to get information from other women, their experiences of using HRT or having hysterectomies or whatever.... I think that's where it's going, probably already is. It's just that I'm so slow with the Internet, it probably is already on there but I think that would probably be the way forward, networking through the Internet... That's the best place to get it [information] from—other women—not from doctors who are influenced by drug companies.

Here, Barbara can envisage overcoming her ambivalence about computers in order to take control over her health by sharing experiences with other women. She still refers to her 'slowness' but is willing to keep on trying in order to network with other women who she sees as good sources of information on HRT, hysterectomies and so on. When she makes a direct comparison between information from other women and from doctors, who she sees as influenced by drug companies, Barbara can be understood as drawing on understandings of the Internet as somehow 'transformative', enabling a challenge to medical expertise, going beyond the more neo-liberal notion of 'empowerment' found in the IP discourse.

Barbara's story illustrates quite neatly the way in which different understandings or 'readings' of technologies can influence use. When she reads the technology as a machine, full of junk left there by her son for her to clear up, it seems to signify work, domestic work even, and Barbara presents herself as a reluctant user. However, when she reads it as a communication medium, a means to network with other women with shared health problems, she becomes more enthusiastic about Internet use.

We now turn to Kathy's story which illustrates clearly, as did Barbara's, not only how gender intersects with the symbolic aspects of the Internet to shape use practices, but also how this process may be linked to adverse material consequences by limiting Kathy's access to appropriate health care.

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Kathy is 57 and has been married 35 years. She and her husband have two grown-up children. She left school at 15 and has been working as an auxiliary nurse for 30 years. Her husband is a steel fixer. They own their house. Kathy was first prescribed HRT for a hormone imbalance. She took it for a few years then stopped because she was due for an operation on what was thought to be an ovarian cyst. It turned out to be a twisted fallopian tube. She went back on HRT after the operation. She was a very reluctant user of HRT and would have preferred to go through the menopause 'naturally'. She was concerned about side effects and worried about whether she was doing the right thing. However, Kathy's relationship with her GP was fraught as he thought her to be 'neurotic', a label that, although rejected by Kathy, nevertheless seems to have affected her future information seeking practices.

When we first met Kathy, she had Internet access in her home but did not know how to use it. Her husband was the main user. However, when we spoke to her again nearly a year later, she had been on a computer training course that included Internet training and had really enjoyed it. She was planning more training. By this time, Kathy was using the Internet for email and shopping and had looked for health information on behalf of her sister but not for herself. This seemed strange given her interest in health and her ongoing concerns about HRT use. Exploring this further with Kathy, we concluded that her relationship to the health care professionals and their tendency to label her as neurotic was actually working against her attempts to use the Internet to become more informed.

Kathy had a very real fear about how her questioning of the doctor would be interpreted and the effect this would have on her access to appropriate care. In particular, she feared that if she refused the doctor's advice to go on HRT, she might be refused treatment if she developed osteoporosis:

> I was still very anxious about being on HRT and all I wanted to do was to come off it but when you read the literature you're given in the packet it said you must consult your doctor … and whenever I tried to consult my GP, they didn't want me to come off. I think he [GP] had been to a seminar and he'd been brainwashed into thinking it was the best thing since sliced bread … I didn't want to be on HRT, I didn't want to upset him because he told me that the reason he wanted people to go on HRT was for preventative medicine to prevent against osteoporosis and heart problems and the way the NHS was going, if

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people didn't look after their own health, they would become too expensive to treat.

Kathy's interest in health and in the active seeking of health information to support health choices would seem to fit the ideal model of the informed patient and, in so far as it involved taking responsibility for health matters, was clearly in line with traditional notions of femininity, too. However, her attempts to engage critically with her GP about the risks of HRT were dismissed as neurosis, effectively limiting the effectiveness of such attempts. Here, we can see how gender was mobilized (the labelling of Kathy's practice as neurotic) by the GP in the face of the perceived threat to his authority posed by Kathy's critical questions. This, in turn, can be seen to have restricted her Internet use, for fear that such use would be read by her doctor as part of that same critical practice he resisted.

Conclusion: all change, or does it?

In this chapter, we have shown how the Internet's symbolic significance cannot be underestimated. All participants can be understood as taking up positions in relation to the 'informed patient' discourse, within which the Internet figures as a key actor and is understood as empowering, if not transformative. This is not entirely surprising and we have already acknowledged the very significant role played by our research, its framing and its questions, in this regard.

There is evidence that both women and men feel the pressure to become more informed in relation to health but this posed more problems for men than women, especially in traditionally gendered households where women take responsibility for health. In relation to the Internet specifically, we have shown that the masculinity-technology equation was evident, even though it was not always expressed explicitly. Thus, we have argued that Victor and Peter's responses to questions about Internet use can be understood as indications of their awareness of this equation and that the different positions they take up in relation to it can be explained in part by their particular experiences of ED and the differential impacts these had on their masculine identities.

Barbara's story illustrates how the use of and relationships to the Internet are forged in relation to significant others, in this case her teenage son. Here, gendered and aged identities were constructed by each of them in relation to the other and it was not until Barbara's son

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had left the household that she was free to explore a less limited and limiting gender subject position in relation to the Internet. However, even then, so long as her son's 'junk' remained on the computer, her work in cleaning it up is resented by her and she still presents herself as a reluctant user, justifying that reluctance through reference to housework and ironing, clearly mobilizing gendered symbols and meanings (Harding,1986; Lie, 2003).

Kathy's story, as with Barbara's, shows how women can, and do, move from being non-users to users of the Internet and how, as in Kathy's case, they can become quite comfortable in its use in certain contexts. However, it also illustrates the way in which, in the context of her own health care experiences and practices, specifically, the mobilization of gender symbols by her GP inhibited her active information seeking and her use of the Internet. Kathy believed that Internet use was being read by her GP as a type of critical practice that could threaten his authority. This belief, whether justified or not, can be seen as limiting Kathy's Internet use and her active approach to information seeking more generally.

The analysis offered here demonstrates, once again, the value of studies which explore the lived experience of Internet use, rather than simply employ counts and measures of Internet usage patterns. The specific context of Internet use is always important for understanding such usage patterns and we have shown how understandings of gendered use of the Internet in the context of health information and decision making need to take into account not just structural and material factors such as divisions of household tasks (including responsibility for health of family members) and the skills and competence of the potential user, but also the more symbolic aspects of use and the way this links to identity or a sense of self. We have taken this analysis further and suggested that these different engagements with the Internet need to be understood within the wider discourses within which such use practices occur. We have argued that, in the context of this study, the discourse of the informed patient, with its imperatives about becoming informed and using the Internet to do so, is key to understanding the gendered patterns of use we observed.

While the accounts given in interviews suggested a range of different levels of engagement with the Internet by both men and women, they also re-asserted the gender binary in ways that suggest that the informed patient discourse constituted a threat to traditional gender boundaries in the areas of health and technology. Some circumstances, practices and discourses change, such as the introduction of the Internet into many people's daily lives and an emphasis by health policy

makers and practitioners on the need for patients and their carers to be informed. At the same time, some practices and discourses, in this case those around gender, remain obdurate and resistant to change, and may actually become stronger if seemingly under threat. It therefore remains to be seen how the informed patient discourse will be worked through in both a gendered and a digitized context.

Notes

1. The study, entitled 'Presenting and interpreting health risks and benefits: The role of the internet', was undertaken between 2001 and 2003 and was funded under the joint UK ESRC/MRC research programme on Innovative Health Technologies (www.york.ac.uk/research/iht).
2. Thirty-two women were recruited via a family doctor or gynaecological clinic and 15 men were recruited via a urology clinic, a psychosexual counselling service for men suffering from erectile dysfunction or via a diabetes clinic. All were interviewed once and about half were interviewed a second or even third time in the period between November 2001 and January 2003. All first round interviews were audio-recorded and fully transcribed. Some follow-up interviews were conducted via telephone and email. The follow-up interviews provided a longitudinal dimension to the study, providing us with an opportunity to focus on changes over time, in Internet use as well as in health conditions and treatments. Of the 32 women interviewed, the average age was 55, with the youngest being 39 and the oldest 73. Eighteen were in a relationship. The men were older, ranging from 54 to 81, with an average age of 66. Eight were in a relationship. As far as we are aware, our sample included only heterosexual women but included a mix of heterosexual and gay men. The sample as a whole included a range of socio-economic groups, with varied educational experience and qualifications. Most were white and British.

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