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# Development of a men's health program: Do we need a new approach in BC?

After-work group sessions could provide more men with information about screening options and ways to identify their personal risk factors and make lifestyle changes.

**ABSTRACT: Men in British Columbia have a distinct life expectancy gap of 4 to 6 years compared with women. The cause is multifactorial, but one certainty is that men are less likely to have contact with the health care system and are not receiving timely advice on health measures that could improve both longevity and quality of life. The current model of episodic care is not working for the majority of younger men. One possible approach to improve the situation would be to offer a dedicated after-work evening "school" of five 90-minute modules presented weekly over 5 weeks. These would include cardiovascular health, diet and exercise, "plumbing," stress in the workplace and at home, and high-risk behavior. A personalized health care plan could be developed for men with clear outcome measures and suitable follow-up.**

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In general, men in BC have poorer health outcomes than women. Traditionally, boys and men are taught that they should be self-reliant, control their emotions, and maintain a strong image by denying pain or weakness. This way of expressing masculinity and demonstrating social power and status means men often adopt beliefs and health behaviors that increase their risks, and they are less likely to engage in actions that are linked with health and longevity. Social determinants of health, such as education level, economic status, employment, housing, working conditions and job security, ethnicity, sexual orientation, geography, social exclusion (homelessness), and food security,[1] also play a role in men's health. Socially defined aspects of masculinity include *acceptance of physical risks* (leading to reckless driving and motor vehicle accident fatalities), *reluctance to seek support from others for emotional suffering* (leading to alcohol dependence, depression, and increased suicide rates), and *resistance to preventive health care behaviors such as improved nutrition* (leading to cardiovascular disease and its associated mortality). Although traditional or hegemonious masculinity may indeed be hazardous to one's health, we must not portray masculinity as a "problem" to be overcome in the name of good health. As Rutz has said, "Having a Y chromosome should not be seen as possessing a self-destruct mechanism."[2] Instead, we must recognize that a masculine quality like risk-taking is a double-edged sword: positive for the individual and society when it involves accepting risks of necessary but dangerous jobs like military service, but negative for the individual and society when it involves taking pointless risks like fast and reckless driving.

One consequence of traditional masculinity is that men are less likely to seek support or information from the health care system. Men visit health care providers less often than women, are less receptive to preventive health advice, and return less frequently for follow-up.[3] Indeed, it is estimated that 80% of men refuse to seek medical care until a woman (a spouse, girlfriend, mother) pleads with them to see a doctor. When a self-proclaimed "invincible" teenage male leaves home to attend college, begin steady employment, and start a family, he is highly unlikely to establish a connection to a particular family physician or

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will avoid visiting a physician unless symptoms occur that indicate urgent need for medical assistance. The fact that young men are less likely than young women to visit health care practitioners means there is no opportunity for general risk assessment, early detection of health problems, and recommendation of preventive health practices. It also sets the stage for a lifetime of health care avoidance.

## Current care approach

The model of health care in Canada, as in all developed nations, is known as episodic care. This traditional approach is complaint-driven: the "customer" (patient) feels unwell, and either visits a primary care physician at an office or walk-in clinic, or decides to go to a hospital emergency room if the condition is severe enough. The patient is often asked by one of the health care team (receptionist, nurse, or physician) to limit the number of concerns to only one. Lists of problems cannot be considered because of time constraints, particularly in rural areas with a shortage of physicians. Clearly, in this situation a thorough discussion of poor dietary habits or smoking as the cause of future cardiovascular disease is not going to happen.

One way around this difficulty for family physicians has been the hallowed practice of the annual physical, which offers an opportunity to provide some health education. Unfortunately, many professional organizations no longer support an annual screening exam for asymptomatic adults, and although most physicians agree with this decision, they still miss the opportunity provided by the check-up to counsel patients and order tests for blood glucose and a lipid profile.[4] Another concern is that the patients who present dutifully for an annual physical tend to be older, better educated, and have higher health literacy. The larger target audience, the men who really need to be seen, are the out-of-shape young men with poor lifestyle habits and low-paying stressful jobs. Studies have shown that this group is less likely to get proper advice on diet and exercise than their more affluent peers,[4,5] thereby missing an opportunity for primary prevention. Finally, there is the issue of a lack of standardization in the approach to men's health issues so that even if a man makes contact with a health care provider, there is no consistent template, checklist, educational material, efficient website, or guideline available to aid in identifying risks and recommending appropriate follow-up or lifestyle modifications.

## Current screening patterns

At present, widespread health care screening is inadequate because of the unwillingness of men generally to pay attention to preventive care, the lack of balanced and well-written informational materials, and the failure of the system to capture a man's attention for general screening when he enters the health care system through a specific portal for a particular problem (e.g., erectile dysfunction, Colles fracture, appendectomy, vasectomy). Other factors affect our ability to promote healthy lifestyles and screening as well. For example, of 11 developed nations, Canada is last in "timely access for urgent care," last in "after-hours care wait times," and has the longest wait to see a specialist. Fortunately, this same survey reveals that only 15% of Canadians are deterred from seeking care because of cost factors, compared with 33% of Americans.[6] At present, male screening strategies apply to four age groups:

- Men age 15 to 24 should be advised to perform testicular self-examination on a monthly basis in a warm shower after soaping up. This is particularly important if there is a history of undescended testicle.
- Men age 25 to 40 should be screened for work-related stress, occult depression, and risk factors for suicide, erectile dysfunction (ED), and other sexual dysfunctions (e.g., premature ejaculation), alcoholism, liver disease, HIV, and metabolic syndrome in the overweight.
- Men age 40 to 65 years are at risk for premature death from coronary artery disease. Screening is most important in this group. The physician should obtain a blood pressure reading, a baseline lipid profile, and a blood glucose level, assess waist circumference, and chart the BMI. A routine or stress ECG and echocardiogram may be indicated. Questions regarding erectile dysfunction are important, as ED is a sensitive marker of significant vascular disease, especially in younger men. Smoking cessation should be a major focus, as should diet and exercise. A prostate evaluation with digital rectal exam and PSA screening should be done, as early detection does save lives for those with a life expectancy of more than 15 years, and a single baseline PSA reading can help with determining cancer risk in later years. A screening colonoscopy should be arranged, resources permitting, to rule out occult polyps or cancer. Alcohol consumption should be noted, and counseling undertaken if excessive. Screening for low testosterone conditions such as late-onset hypogonadism and associated metabolic syndrome are not routine in BC.
- Men age 65 to 84 consume the lion's share of the primary care physician's time and energy. Most of the care relates to management of chronic disease, but finding an occult abdominal aortic aneurysm could be

life saving. Identifying patients with early Alzheimer disease or other causes of dementia is important. Osteoporosis is not often considered as a condition affecting older men, but should be.

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## New approach possible

An approach that might improve on the episodic health care model in BC is the longitudinal and continuous care model that has already been implemented successfully in the Veterans Affairs hospital system in the US. This massive organization, with 68 hospitals, 200 000 employees, 20 000 doctors, and a $50 billion annual budget, sees 6 million patients per year. The Veterans Affairs system has used electronic medical records since 1985, and more recently the sytem has added standardized care plans, metrics for risk assessment, electronic communication, and home health Internet tools for monitoring patients after discharge from hospital. Telehealth is used by the family physicians to obtain same-day consultations with specialists and is found to be especially valuable in the areas of mental health and in rural medicine.The response of US primary care physicians has been very favorable, largely because of convenience and accessibility. Every electronic chart is highlighted with clinical reminders (e.g., revaccination schedules, smoking cessation, and lifestyle advice) that pop up at each visit to the health care team. Every medical condition is on a care pathway to allow for standardization of care across a huge geographic area. Patient satisfaction rates are very high (greater than 85%) and the Veterans Affairs has moved from being regarded as a poor-quality provider in the 1970s and 1980s to being an industry leader.[7]

BC would have an advantage over most Canadian provinces when implementing such a system as the EMR network is already well developed. However, the shortage of physicians would make it difficult, if not impossible, to enroll every citizen in a care network, so we need to consider alternative means of reaching out to large numbers of "healthy" men. Both Australia and the UK have trialed programs that may work in BC as near-term options. For example, Australian "Well Man" clinics were set up and invitations were mailed out to men to attend during male-friendly time slots. Clinic visits increased threefold, with many visits made by uninvited participants, and a range of health risks were found that required intervention and follow-up.[8] Several UK sites implemented opportunistic outreach, which involved recruiting men through sporting events, at race tracks, barber shops, and workplaces, and using a telephone-based system to provide health information.[9]

The Men's Health Initiative of BC (MHIBC) is currently developing outreach programs to talk directly to men using male-friendly communication methods. Information about screening, risk assessment, health promotion, and prevention will be provided at hockey and football games, car shows, gyms, and community events. At a recent Canucks hockey game, for example, a men's health promotion night introduced many men of all ages to the concepts of risk assessment and prevention, and recommended follow-up to 20 of 50 men who were found to be hypertensive after a random blood pressure assessment.

MHIBC is also planning to generate widespread awareness and education about men's health through social media programs, web-based interactive games, videos, fun school events, and public forums (www.manupcanada.ca). As well, continuing medical education events and conferences will be developed to address men's health needs, while online risk assessments and health survey tools (www.aboutmen.ca; www.howsyourhealth.org) will enable men to better understand and manage their own health conditions in collaboration with their physicians.

In BC the number of men we need to reach is huge, and there isn't enough time in overloaded medical offices and clinics. Many men won't sit in a busy waiting room for a 10-minute appointment. A solution worth con-

sidering is an after-work group men's health session in a fitness club or yoga centre. Such sessions of 8 to 12 men, ideally all younger than 50 years, would last for about 90 minutes and would include the use of computer-based questionnaires and a targeted physical exam. Five modules could be developed, each done weekly on the same night:

1. Cardiovascular health. Hypertension, diabetes, and metabolic syndrome would be the focus. Waist measurements would be taken. Lab referral would be made if necessary for lipid profile and blood glucose, PSA, and testosterone levels.
2. Diet and exercise. Canada's Food Guide and osteoporosis prevention would be discussed. (Input from sports medicine, nutritional science, kinesiology, and chiropractic experts would be helpful when developing this module.)
3. "Plumbing." Prostate and sexual health questionnaires would be completed. HIV and safe-sex information would be provided. Blood work results for PSA and testosterone would be reviewed. A DRE, preferably performed by a urologist, could be completed.
4. Workplace and home. Issues relating to stress, anxiety, and risk of depression/suicide would be explored. Sleeping disorders would be identified. (Help from psychology/psychiatry experts would be essential when developing this module.)
5. High-risk behavior. Nicotine, alcohol, and other drugs would be discussed, along with reckless driving and other destructive behaviors. Guides for anger management could be included.

Once a participant completed all the modules, an individual care plan would be developed with outcomes measured at 3- and 6-month follow-up. Reports to the primary care physician would be sent at the participant's request.

Logistics regarding meeting places, recruitment of health care professionals (nurse practitioner involvement could be important), and any cost to the patient ($150 seems like a good ballpark figure to start) would be best left up to the interested communities. A very detailed syllabus and any necessary training could be offered through MHIBC. Once a number of patients were actively enrolled, opportunities for outcomes research would definitely present themselves.

## Summary

Our current health care system rewards diagnosis and treatment but not prevention. This has more of an impact on men as they are generally less likely than women to embrace preventive measures because of denial, feelings of invulnerability, lack of time, and even fear of appearing less masculine. We must adopt innovative approaches to better serve men in a dedicated environment where they can be counseled about personal risk factors, educated about screening and prevention, and given the opportunity to process the information to make the required lifestyle changes. Through aggressive and comprehensive prevention and health promotion campaigns that engage males of diverse age groups and socioeconomic situations, we can decrease the impact of preventable diseases and thus ease the downstream financial strain on our health systems.

**Competing interests**

None declared.

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