Men's Health Promotion in General Practice.

A project of the North East Valley, Northern & Melbourne Divisions of General Practice.

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Men's Health Promotion In General Practice: A review of the literature

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1 Introduction

This literature is designed to serve two purposes 1/ to place this project in a literature and knowledge base; and, 2/ highlight important aspects of men's health in context to health promotion in the general practice setting.

There are two reference documents for this project. The RACGP general practice health promotion guidelines,[1] and the Men's Health Strategic Framework[2]. Rather than summarising these documents this literature review attempts to lead the reader through the complexities of men's health and health promotion in the general practice setting.

1.1 Executive Summary

The important findings of this literature review are as follows.

- The relationship between general practitioner needs to change to a collaborative partnership approach.
- All staff within the general practice setting need capacity building training to change the way they relate and work with men.
- Focussing on men as a target group further complicates introducing complex health promotion systems into the general practice setting, as historically men are the least likely group to respond to health promotion activities.
- For health promotion in the general practice setting to be successful it must include, staff training, environment changes, opportunistic preventative activities, and a reduction in economic barriers.
- Rather than just focussing on disease specific risk reduction, men need to address lifestyle changes, which must include, stress management processes, improvement in physical activity, and positive dietary changes.
- An improvement in the relationship between men and their general practitioner will have a positive effect on the satisfaction of the general practitioner.
- An improvement in men's health will have an overall benefit for society.

2 Men's Health

Men's health is defined as the biological and psychosocial aspects of the health and wellbeing of men.

2.1 Introduction

It has been suggested that taking care of men's health is seen by some – including men and health practitioners – as women's work[3] (ie: food buying and preparation, encouraging men to go to the doctor to the point of making appointments). This suggestion highlights an important construct that is explored further in the next section – the relationship between men's health and gender roles. What is about men that they tend to smoke, drink and eat fattening foods more than women do; combined with insufficient exercise?[4]

Other ways of explaining why men live shorter lives than women do include:

- The biological (testosterone and genetic factors).
- Socio-biological (risk taking behaviour).
- Intrapersonal (poor communication skills about health issues).
- Environmental (society fails to assist good health seeking behaviour).
- Time (never the right time).

Further, there is a very large volume of evidence that men's health varies considerably in relation to socio-economic status, race, culture, criminality and disability.[5] Also there is a tendency by most health professionals to view a persons health as within the individuals control. However such views fail to recognise the material and social constraints on people's lives that reduce an individuals ability to access health care.[6]

2.2 Gender and Men's Health

The relationships between the roles of gender (particularly masculinity) and men's health is a rapidly emerging body of knowledge. Fundamental to this knowledge base is that health is social. With the advent of women's health services and women's health professionals it is important to reflect on the different influences mediated by gender in health service delivery and how these influences might further reduce access to primary care for men.[7] One of the important facets of this project is to raise awareness in general practice setting, of "what gender differences have come to matter socially while other remain invisible or are ignored".[8] Another aspect of gender that is important to this project is articulated well by the same author "gender can shape both *exposures* to health problems and the *experience* of illness in various ways"[9].

To further discuss the male role one enters the world of gender studies incorporating philosophy, psychology and sociology, therefore a difficult and detailed growing body of literature. In Australia one of the principle sources of 'male' gender studies was the HIV/AIDS epidemic and the need for further understanding of how to promote health and HIV/AIDS prevention campaigns to the predominantly non-heterosexual infected/affected male communities. Currently there is a view that sex role-gender analysis discourses (ie: masculinity discourses)

stresses the importance of the range of male roles, males experiences and variety of choices open to *some men* – particularly those with social and economic power.

Therefore viewing men as of a single group embracing a universal masculinity is clearly wrong. Instead it seems logical that there are many different types of masculinities. Some researchers suggest that developmentally boys –men experience and experiment with a range of masculinities and sex roles. From this pool an individual adopts a masculinity that suits their peer group, environment, work role and family life.

Therefore there is a need to separate what is an individuals experience (ie: amount of physical activity) and what someone thinks all men experience (ie: poor health care). Another piece to this 'men's health - masculinities' puzzle is that there is a peer pressure to prove "manhood"[10] which may prevent men from accessing health services generally.

The important aspects of the gender research that are relevant to this project are:

- there is a predominant masculinity that supports the belief that being ill equates to "being weak";[11]
- waiting for an appointment is considered a waste of time taking the man away from work, family commitments;[12]
- day time appointments are considered too difficult to attend for working men;[13]
- men find it difficult to articulate what is wrong with them;[14] and,
- men find it difficult to isolate what is most important to there overall health (ie: stress).[15]

Finally a study in the USA found that men don't go to the doctor because of fear, denial, embarrassment, and a threatened masculinity.[16] However, it is difficult to identify how masculinity might be mobilised to diminish the impact of risk taking .[17]

2.3 Epidemiology - Status of Men's Health

It is well documented that there is what seem at first striking gender differences for disease, incidence, prevalence, mortality and morbidity data, (with the exclusion of sexual and reproductive health). That is, men fair worse than women do. Yet what use is there in highlighting gender differences when there is greater discrepancy within gender than across gender.

For example for cardiovascular disease (CVD) the overall mortality for men has dropped slowly over time which is in parallel to an overall reduction in smoking.[18] However the uptake of smoking in women is now higher than men therefore it is expected there will be an increase in mortality data of CVD for women. Which over time will in effect equalise any current or future gender difference of CVD data - this will also impact on lung cancer rates.

Yet the relationship between socioeconomic status and poor health behaviour is known. Research has identified that low socioeconomic status is an indicator of smoking and substance misuse[19]; and low physical activity[20] in men.

However the benefits of physical activity as both a preventative measure and a post-vention rehabilitation measure cannot be underestimated.[21] It has been suggested that 30 minutes of moderate physical activity 3 times per week reduce mortality of CVD by up to 50%.[22] Importantly it has been shown there has been little improvement with rates of physical activity combined with an increase in 'fatness'.[23] Therefore diet and physical activity need to be managed together for the best results.

Table 1: Cancer incidence and mortality data of four most important cancers for men in Australia[24]

Rank order	Incidence	Mortality
1	Prostate	Lung
2	Colorectal	Prostate
3	Lung	Colorectal
4	Melanoma	Unknown primary cancer

NB: gender differences for non sex based cancers suggest that men over the age of 50 years are more likely to present with primary cancers than women of the same age.[25]

Diabetes mellitus

Incidence of diabetes mellitus increases with age (especially 45+) with men having a high mortality than women.

Even though it is well documented that men, present later with more advanced disease and generally die younger than women the question still remains – what groups of men skew the gender imbalances?

2.4 Psychosocial influences & Mental Health

Overall the attitudes and behaviours of men in regards to their health mean that, on average, men born in the mid-twentieth century can expect to die six years earlier than women born in the same year.[26] Of particular importance is the way men respond to significant life stressors. For example, it has been suggested that there is a strong correlation between the quality of relationships and overall health and wellbeing. With family breakdown correlated to important factors that relate to early death[2728] ; adult suicide [29]; and depression.[30]

As the proportion of the population that either has been or currently are divorced has risen from 0.15% (1991) – 6.4% (1996). This figure combined with the number of single parent families in Australia equates to a startling figure that approx 1/3 of adult Australians live on there own or with children only. [31] Further the overall mental health status of the family is also an important factor - this equates to 'family system' stress.[32] Specifically in regards to gender differences it is well documented that after relationship breakdown males are more likely than women to engage in para-suicidal behaviours, physical and psychological self-harm[33]. Further, the National Advisory Council for Youth Suicide Prevention state that significant stress and crisis precede parasuicidal and suicidal behaviour[34]. Effective strategies for the early detection and management of depression is an essential target for reducing the incidence of suicide in Australia.[35]

What is also known is that boys suffer from higher incidences of illness, injury and death after infancy. Young adult males are seriously injured in accidents and die more frequently than young women.[36] Additionally, men are more likely to than women display self-harming behaviours, substance abuse, suicide and trauma.[37]

This picture is worse for:

- younger and working-class men[38];
- under-unemployed men.[39] ;
- under-educated men.[40] ;
- men from a non-English speaking background[41] ; and,
- indigenous Australian men.[42] .

There is emerging evidence that supports the suggestion that men do not have the resources (communication skills) to and /or a value attributed to seeking help from health professionals when in crisis[43]. Factors that enhance this isolation when men are most at need, include:

- poor modelling of health seeking behaviour;
- a strong sense of overwhelmed by emotions;
- a low level of ability to process emotional experience;
- a low threshold of emotional tolerance perceived "weakness" or as 'weak' if seeking help; and,
- a low awareness of 'how to' access health services men and mental health[44].

Also, changes in roles of men have been linked with increase in depression as alienation and despair increase, this is in parallel to any change in family structure –ie: separation. Other factors (stressors) that effect a man's mental health status includes: [45]:

- parenting and antisocial behaviour (ie: violence)
- post-traumatic stress disorder (both war and critical incidence)
- underemployment
- low literacy
- dangerous occupations –vicarious traumatisation
- sexuality issues – identity issues and sexual dysfunction
- immigration issues – loss and identity issues

Finally stress is the main factor that causes early death in men and it is the male role itself that is 'life depleting'.[46]

2.5 Men's Health Policy

The need for governments to develop Men's health Policy emerged in the early 90's in response to the recognition of a gap in health policy. Unfortunately as a result of change in Federal government the National Men's Health policy remains in draft form.[47]At the time of writing NSW has a Men's Health Paper and SA is currently developing a Men's Health Policy. These developments are in response to an emerging theme, that men's health is important to address and that government can facilitate that process through policy development and therefore allocation of resources. Thereby addressing the biological, psycho

The draft National Men's Health Policy[48] identifies the need for broadening the context of masculinity to accommodate a variety of masculinities (ie: increase the range of feelings and experiences). This document goes further as to suggest that Australian socialisation of boys and men results in men being out of touch with their bodies, emotions and health. This socialisation process plays a key role in men not recognising symptoms of ill health and avoiding medical advice. Initially the authors stress the need for men's health programs to target existing services to improve health outcomes for men.

The way to help men is to not view men as problems but to relate to men in a partnership approach. To positively change men's health requires an ongoing collaborative working partnership between the health professional and the man[49].

Therefore this project has been designed to target men in context to their Australian socialisation and resulting poor health outcomes by identifying features of the general practice setting that could be barriers to attendance. This is also, in context to the RACGP general practice health promotion guidelines, which stresses the importance of appropriate environmental changes specific to health promotion target groups[50] (ie: male friendly spaces and partnership approach).

2.6 Men's Health Promotion Strategic Framework - NEHPC

In mid 1997 the participating agencies in the NEHPC identified men's health as a significant issue for the north - east region of Melbourne.[51] The strategic framework was developed through partnerships between the NEHPC and its participating agencies. It focuses on agencies and other service providers in the region to build community capacity to address men's health needs. In doing so, it draws upon the Ottawa charter.

Further, this document has been identified as a key reference document for this project and amongst its many recommendations, the following are relevant to this project. To address men's health needs agencies need to:

- initiate professional development and on the job training opportunities for staff to ensure appropriate knowledge and skills for evidence-based men's health promotion;
- disseminate information about best practice men's health promotion and relevant research; ensure that services, policies, procedures and organisational ethos are relevant to men and facilitate their access to appropriate services and programs; and,

2.7 Conclusion

To summarise men's health is shaped by, biological, psychosocial, social and structural factors. By fostering a 'partnership approach' and a 'male friendly' environment within the practice open to all men in the local area, it is envisaged that men from the most at risk groups will be attracted to the clinic. A limiting factor to the capacity of male general practitioners to engage men in the community will be the influences of the same forces that shape men's health.

3 Health Promotion In General Practice

3.1 Introduction

Health promotion activities in the primary care setting have evolved from single interventions (eg: Polio vaccination) to a range of complex activities that are implemented as part of systemic change (eg: Pap smear services). More recently with the pressure for evidence based interventions in the health care setting, health promotion activities have come under more rigorous scrutiny and evaluation.[52] The major thrust of this project is utilising the recommendations of the RACGP general practice health promotion guidelines.[53] However, the tensions with implementing complex health promotion strategies in general practice will be exacerbated by the target population of focus for this project – men.

3.2 Health Promotion Overview

The World Health Organisation (WHO) defines health promotion as the "process of enabling people to increase control over and to improve their health."[54] It is "based on an understanding of the determinants of health (including and an understanding of the causes of ill health) and acts to address these."[55] The Ottawa charter is both a statement of principles, including empowerment and advocacy, and a framework for health promotion action. Further, the Ottawa charter broadly defines health to include factors such as, biological, psychological, social and environmental aspects that interrelate as part of a whole health definition encompassing wellbeing.

Other factors that need to be considered in any health promotion strategy[56]:

- individual motivation and behaviour;
- how messages relayed through population group;
- behaviour and social interaction;
- organisational change; and,
- social change.

3.3 Principles of Health Promotion In General Practice

General practitioners are well placed to engage in health promotion and facilitate primary prevention. Recent evidence suggests prevention activities reduce morbidity and mortality, with the general practice setting identified as vital to the delivery of preventive activities.[57] There is also good evidence for the effectiveness of a range of general practitioners interventions in disease prevention and health promotion, particularly lifestyle change.[58]

Two key action areas identified within the Ottawa charter[59] that are relevant to the divisions of general practice and primary health care are:

- **Skill development**. Develop personal skills by providing information and education for health, and enhancing life skills. This increases the options available to people to exercise more control over their own health and environments, and to make choices conducive to health.
- **Reorient health services**. The role of the health sector must move increasingly in a health promotion direction beyond its responsibility for providing clinical and curative services.

The recent Review of Infrastructure Support for National Health Advancement identified the role for the Divisions of General Practice as enabling general practitioners to "engage with the wider health system, in part, so that they can more readily contribute to promoting health".[60] The General Practice Strategy Review Group also identified a role for Divisions of General Practice in achieving a heightened role for general practitioners in public health (including health promotion).[61] To date however, health promotion activities that have been conducted by Divisions of General Practice have tended to emphasise the role of general practitioners in the community rather than in the practice setting.[62]

Many efforts to improve health promotion in general practice settings have focused on attitudinal and skills change amongst general practitioners with limited success.[63] It has been suggested that general practitioners have the perception that it is poor patient motivation that is the major barrier to change of lifestyle.[64] However over the last few years, research shifted away from the target group to the importance of systems change in achieving optimal health promotion.[65] Solberg et al, found that:

> "…. preventive services rates could be improved more effectively by targeting factors related to the provision of preventive services, particularly those that shape the clinical environment in which clinicians work."[66]

A number of strategies for facilitating changes in physician behaviour have been identified,[67] which have been adopted by the RACGP.[68] Of particular importance are the quality assurance approaches - audits and reminder processes; and, the social influence approaches - the use of opinion leaders.[69] It has been identified that alterations in behaviour and the primary care setting lead to changes in attitude.[70] Therefore by altering the environmental barriers that interfere with providing preventative services (ie: office systems, structural features) there will be a change in behaviour with a resulting attitudinal change.

Therefore this project has been developed in response to a clearly identified need to make attitudinal, structural and environmental changes in general practice to health promotion. It is envisaged that these strategies will help general practitioner's to better promote health (biological, psychological, social and environmental) to men.

Finally, some evidence-based principles for implementing preventative services in primary care settings.[71][72]

- Capacity build all staff (ie: education and training).
- Practice design to facilitate flexible and sustainable preventative activities.
- Opportunistic preventative services.
- Reduce economic barriers to patients.

3.4 Screening and Risk Factors

As previously stated risk factor screening has been readily adopted by general practitioners as a health promotion activity. However, many researchers into the effectiveness of risk factor screening (both of cost and reduction in morbidity) state that screening should be targeted to people identified as high risk[73]. Screening asymptomatic 'well' people can result in negative outcomes (worried well, unworried yet at high risk of other conditions). Further, effective screening allows appropriate follow-up and long-term management of the person screened.[74]

Below is a summary of identified risk factors for a variety of conditions previously identified.

CVD risk factors[75]

- increased blood pressure
- smoking
- high cholesterol
- low physical activity
- obesity
- excessive alcohol

Colorectal cancer[76]

- family history of either polyps &/or colorectal cancer
- personal history of polyps
- high fat, low fruit & vegies diet
- low physical activity
- excessive alcohol

Prostate Cancer

The single prostate cancer risk factor is age. The older the man the more likely benign prostatic hyperplasia and the more likely prostatic carcinoma.[77] Prostate specific antigen (PSA) screening has questionable evidence for any long-term benefit for men.[78] However there has been a marked increase in the incidence of prostatic disease (which correlates with the advent of PSA testing) but an overall reduction in mortality[79].

Testicular cancer

There is insufficient evidence to recommend routine clinical examination or self-examination of the testes to screen for testicular cancer[80]

Physical activity

There is a rapid decline in vigorous physical activity levels from 18 – 34 years for men, however overall more men than women participate in vigorous exercise generally[81]. Yet there is little to no difference across genders for moderate and low levels of physical activity. The positive benefits of an increase in physical activity for depression, mental health (stress) and wellbeing are well documented.[82]

Risk factors for poor/low physical activity levels are [83]:

- 45+
- geographical isolation
- NESB
- underemployment

Other than producing physical benefits, physical activity produces quality of life and secondary prevention benefits. Further moderate physical activity (at least 3 times a week for greater than 20 minutes) improves; physical performance; psychological functioning (anxiety, depression and overall well-being); and, social functioning. Also, there is further evidence that exercise training reduces mortality, morbidity, recurrent events and hospital readmissions.[84] Importantly for men stress reduction is deemed to be of marked benefit with an increase in physical activity.

Other health issues important for men

Diet and nutrition, eye care, hearing and skin care are part of the complex issues that effect men's health. In summary the three most important conditions (which have a cross benefits) for men to address are:

- stress management (including: smoking, substance use);
- amount of physical activity; and,
- poor diet.

3.5 Settings for Health Promotion

It has been identified that there is a role for local community health centres to provide regular men's health evenings to create a 'space' for men in community health[85]. However these Men's Health Nights are of limited value particularly if they are not linked to a 'male friendly' general practice (see section 4.3.1 for further discussion).

Within the general practice setting

- a consultation space that is 'safe' in terms of the sort of conversations that can take place and the length of time for that conversation space to be held
- a male 'friendly' waiting room –
- with pamphlets and posters relevant to men's health issues
- referral information for stress management, nutrition and exercise programs

4 Men's Health Promotion In General Practice

4.1 Introduction

There are many documents linking high male suicide[86] to reactive depression[87] which is usually a psychological response to significant life stressors (ie: death of spouse, relationship breakdown, loss of job).[88] Since unemployed men and men experiencing mental illness utilise health services more frequently than other men, this means general practice settings are important settings for health promotion for these men.[89] A patient focussed research process in a general practice setting in Victoria found that stress issues where the most self-identified health factor that the patients wanted addressed by the doctor[90]

The key principle underpinning the activities of this project is that the way to help men is to not view men as problems but to relate to men in a partnership approach. To positively change men's health requires an ongoing collaborative working partnership between the health professional and the man[91]. Also, reorientating the general practice setting to a 'male friendly' environment will ensure best practice health promotion for this project.

4.2 Men's Health Needs In General Practice

The NorthEast Health Promotion Centre discovered, through an action research project[92] involving nearly 200 males aged between 15-80, that men were willing to talk about their health concerns with others in safe, facilitated environments. However, the majority reported negative experiences consulting general practitioners.[93] They were concerned about:

- perceived lack of adequate discussion regarding the reason for and circumstances surrounding the visit ;
- perceived lack of adequate exploration of alternatives to medication; and,
- problems with communicating at a level that the men could understand and respond to.

Those men who were positive about general practitioners and other health professionals commented that such professionals had developed a good rapport with them, talked in language that they understood, and provided information and strategies that they could act upon.[94] Researchers working with unemployed men and general practitioners in Sydney discovered similar outcomes.[95]

Therefore the needs of men in general practice is:

- longer consultations
- better relationship with clinic staff
- creation of a male friendly environment
- language change of health professional

Overall men want a partnership approach to their health. That is, collaborative ongoing relationships were they are equals with their general practitioner. It is envisaged that this partnership approach will enhance the quality of the relationship and broaden the role of the general practitioner in delivering ongoing health care (eg: stress management).

4.3 Overview of Health Promotion Activities for Men

Many documents recommend tailoring health promotion activities for specific target groups [96] [97] and specifically for men[98] [99] [100]. However, currently the range of health promotion activities for men is limited in variety and effectiveness.

4.3.1 Men's Health Nights

General practitioners have been participating in localised 'men's health nights'. These are usually one off events held in a local venue appropriate to men (ie: pub, sporting club, scout and community hall). The purpose of these nights is to raise the awareness of men who attend about specific health issues. These health issues are often defined by what the general practitioner is willing to talk about. There is little if any follow up, so it is questionable if any lifestyle changes are effected for the men who participate in these 'nights'.

However, they seem to be extremely popular and well attended as they provide an opportunity to publicly raise awareness about issues that the general practitioner considers important to men. This is not a 'community based' approach as the general practitioner is *second-guessing* what the men want to hear about. A limited peripheral benefit of these Nights is that they often raise the awareness of the local health agencies to the health needs of the local men. Yet again there is no evidence yet of any change in service delivery, development of specific men's health networks or sustainable men's health promotion activities in the area.

4.3.2 Work Site Visits

Divisions of General Practice have been increasingly participating in work site visits and health forums with often similar formats to Men's Health Nites[101][102]. These work site visits can also combine screening events with similar limits on effectiveness as discussed above in Sections 3.4 and 4.3.1.

4.3.3 NEHPC's Model for Effective Men's Health Promotion in the Worksite.[103]

The NEHPC Men's Health Project[104] developed a peer leader role for men in small working groups focussing on health and wellbeing issues. The project manager provided ongoing workforce support and development of the men who participate in the peer 'men's health' groups. Once the groups are established then a health care provider is invited to speak to the men on topics decided on by the men (a community based approach in line with the principles of the Ottawa Charter[105]). Referral is made from the peer groups to a specific doctor considered 'male friendly' once a 'health' issue is identified. This model, although in its infancy, is deemed to be the way to promote health among men. Unfortunately there is no scope in this project to follow suit.

As has been suggested that settings (ie: primary health care) offer practical opportunities for the implementation of comprehensive evidence –based health promotion activities,[106] this project will focus on:

- developing the partnership approach;

- capacity building staff;
- developing 'male friendly' environments; and,
- developing appropriate linkages in the community for the support of men's health.

4.4 Barriers to Men

The difficulties of introducing complex health promotion strategies into general practice settings are further complicated by targeting 'men'.[107] As it is well documented that men ignore traditional health promotion messages and strategies.[108] Except for infants and boys, they present to general practitioner's less often and later in the course of an illness than do women. Too often men fail to report crucial symptoms known to them selves until the situation is beyond the best point for intervention.[109] One area where this trend does not hold is the use of mental health services. Even though men and women utilise specialist mental health services equivalently, men with negative attitudes are the most likely to utilise mental health services. [110] Also the Commonwealth recently reported that depression is the most under-diagnosed, under-treated and most common mental condition in men.[111]

Therefore it is important not only that general practitioners are able to identify men 'at risk' but also that general practitioners allow enough time for exploration of other seemingly unrelated issues (ie: social functioning, well-being, family and work relationships). General practitioners also need to be encouraged to allow both time and space for men to discuss these broader issues. Further, there is a need for referral processes to allied health services (particularly mental health) to be tailored to meet the needs of the general practitioners, the allied health professional and the man.

Evidence –based barriers for men to primary health care are:

- Low socio-economic men have diminished access due to costs of health care.[112]
- For rural men, geographical isolation combined with an amplification of the negative aspects of masculinity .[113]
- For employed men and shift workers time available for consultations is often restricted to 'within work times'.[114]
- Settings of health activities may not be suitable to men.[115]
- Low literacy issues for minority groups.[116]
- Poor communication abilities for NESB men[117].

Other factors I can identify are that contribute to poor early diagnosis is that men often find:

- Find it difficult to articulate there emotional world;
- present in a state of crisis with a myriad of issues experienced as emotionally overwhelming;
- present with biological symptoms little connection to their emotional experience; and,
- have limited communication skills when it comes to their own experience.

4.5 Barriers for General Practitioners in Delivering Men's Health Promotion in the General Practice Setting

General practitioner's health promotion role has been predominantly defined as 1/ screening for early disease; 2/ education of patients; and, 3/ lifestyle assessments and interventions[118].

The barriers to implementation of health promotion by the general practitioner have been identified as[119][120]:

- time restriction during consultation;
- lack of knowledge and confidence in applying health promotion strategies; and,
- fear of over servicing.

In summary the major barriers to men's health promotion in general practices are:

- the length of time of the consultation
- limited after hours service;
- the assumption that men attend a doctor *knowing* what the problem is; and,
- that generally both participants in the consultation are men who both are influenced by the same gender based, social and structural influences.

4.6 Roles of Other Practice Staff

The roles of other practice staff are to implement and monitor the health promotion strategies adopted by the practice. Therefore, recall & reminder systems, changes within the waiting area, update of waiting areas material and time management issues are the responsibility of the clinic manger in consultation with the general practitioners. As there is a wide range of skill bases of the practice mangers and a diverse range of uptake of IT systems, there will be limitations as to the depth and systematic application of health promotion strategies. However, all clinic staff contributes to creating a 'male friendly' environments so as to reduce the barriers for men in attending a general practice.

5 Recommended Activities of this Project

The three main activities for this project are evidence based screening, healthy lifestyle change, and a range of specific health promotion activities (ie: developing healthy partnerships, enhancing communication and capacity building community supports for men).

5.1 Recommended Screening of this Project [121122]

For asymptomatic people (ie: well men) recommended screening activities are:

- family history (CVD, DM, Cancer)
- CVD history
- exercise history
- alcohol & drug history
- cholesterol, HDL & LDL, BMI, BGL & BP
- diabetes mellitus history
- psychosocial functioning

It is suggested that low dose aspirin therapy may be considered for men over 50 years of age whom have no contraindications to aspirin. However the potential benefit of a reduction in cardiac mortality should be weighed up against the potential increased risk of stroke.[123]

5.2 Individual Healthy Lifestyle Plan

The overall lifestyle change would be an increase in physical activity levels in combination with dietary change to a low fat (particularly saturated fat), higher fruit & vegetable intake, and a reduction in alcohol intake to less than 3 standard drinks per day. Further any ongoing stress management process would be best. Participation in exercise groups has shown to have marked benefit on the psychosocial functioning particularly when combined with stress management programs and relaxation therapy post open heart surgery[124]. Clearly men will need ongoing support when undertaking any lifestyle change. This support would be provided within the improved relationship (ie: partnership) between the general practitioner and the man. The role of this partnership would be to collaboratively negotiate and identify achievable goals, barriers, self-monitoring processes and any supports within the community.

5.3 Recommended Health Promotion Activities of this Project

Education and up skilling of all clinic staff regarding the issues men face when entering a general practice. This includes:

1/ Skills for general practitioner's:

- The ability to engage men in setting priorities and identifying health needs in the form of a partnership approach[125].
- Develop communication skills and strategies about "how to talk to the male patient" and "how to identify what is important to that man", "how to ask the difficult questions".
- Increase awareness of male general practitioner's that they to play a role in supporting the predominant masculinity (work long hours, successful).
- Increased understanding that preventative medicine is a sequence of events that is funded under Medicare in context to the examination and/or tests being necessary to maintain the person's state of health.[126]

2/ Skills for men:

- Participate in peer support that is both age and culturally sensitive.[127]
- Participate in community 'safe places' for men to talk[128]
- Develop communication skills and strategies about "how to talk to the doctor" and "how to identify what is important to their health".

6 Conclusion

There are four intersecting forces that shape men's health - the biological, the psychosocial, the social and the structural (environmental). This project is attempting to address these forces at the: biological at a preventative health level (ie: disease risk factor screening and lifestyle assessment); psychosocial relational level (the relationship between the man and his general practitioner); and, social and structural micro level (the general practice setting).

7 Endnotes

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