Male gender role and its implications for family medicine

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Men experience more life-threatening and serious illness and die younger than women. Across cultures and countries there is an average 7-year difference in longevity between men and women. Social and cultural barriers to seeking health care have been used to explain this difference; however, a large part of this mortality can be explained by male gender* behaviour.

Male gender behaviour can be defined as behaviour regarded by a particular culture to be acceptable for men. Male gender behaviour in Western societies has been thought to consist of four roles that lead to risky health behaviours, such as drinking and not wearing seat belts or protective equipment while playing sports. The following paragraphs describe these four roles and some of the evidence for their existence.

No sissy stuff
In this role men deny their emotions and hide their tears and vulnerability. It has been shown that men are less emotionally expressive than women. This behaviour has been implicated as the reason men do not ask for emotional support or express distress so that others can respond to their needs. The more traditional men’s views of masculinity are, the less likely they are to seek psychological help. This image is sometimes nurtured by the popular media, which often portrays and maintains the stereotype of men as cold and emotionless. Admittedly this stereotype is not as widespread as before in North America.

The “big wheel”
The big wheel role encourages success, status, and power. Evidence suggests that there is a benefit to being in control; however, type A behaviour, often a feature of the big wheel, has been found to be associated with increased morbidity. Several investigators have found a positive correlation between type A behaviour and the male sex role.

Extreme aggressiveness, easily aroused hostility, a sense of time urgency, and striving for achievement (the features of type A behaviour), have been associated with an increased risk of mortality from coronary heart disease. The construct of social dominance, which can be measured by verbal behaviours such as quick responses or interrupting another’s speech, have been found to be positively correlated to mortality.

The sturdy oak
In this role men maintain an air of toughness, confidence, and self-reliance and might deny pain, eg, angina. Denial of pain can translate into delayed intervention for myocardial infarctions and increased risk of death. The sturdy oak also denies the psychological pain, loneliness, and despair of depression, which might ultimately lead to suicide. In 1991, 80% of all suicides in Canada involved men.

Give them hell
This role asks men to take risks and be aggressive and might manifest by the use of guns or by working in physically hazardous environments. These factors are thought to account for 5% to 10% of gender difference in mortality.

Pleck and Sonnenstein interviewed 15- to 19-year-old male subjects on two occasions in 1980 and 1988. Results of their analyses showed that traditional male role attitudes had a significant, independent association with problems, such as being suspended from school, drinking and using street drugs, and frequently being picked up by police. The traditional male role extended into sexual behaviour; these men were sexually active, had a large number of heterosexual partners in the last year, and had tricked or forced someone to have sex.

Role of family physicians
Men are often victims of their own constricting role expectations. How can family physicians use this knowledge to assist men to overcome these...
stereotypes? The four principles of family medicine help explore this issue.19

Evidence shows that organizational and environmental support can assist in changing health behaviour (personal communication from Skinner H, Botelho R. 1999). Because men do not readily present to doctors’ offices, much of what doctors can do for men is often at a social and organizational level.

**Physician-patient relationship is crucial**
The quality of the physician-patient relationship will often determine the success of attempted health intervention.20 As male physicians we need to recognize our blind spots when dealing with male patients. We are vulnerable to the same roles. Do we feel uncomfortable talking about sexual preferences and practices with our male patients because of our own homophobia or prudishness? Do we assume that our male patients are healthy and reinforce the male sex role of invincibility? Men often attend our clinics at the bidding of their wives,21 families, or employers; we need to acknowledge this before we can foster the relationship.

Finally, family physicians need to remember that the gender role often teaches men that revealing their feelings or emotions is “sissyish.” For the relationship to flourish, men must feel that their physicians are accepting and nonjudgmental.

**Family medicine is community-based**
As first contact, family physicians must recognize that, with male patients, their presentation could be ambiguous. It is important to look beyond their work stress and family issues. Further, as community-based physicians we must be aware of the appropriate male-friendly organizations available, whether men’s groups, physical education, or andrology clinics, and be prepared to refer when necessary.

**Family physicians as resources**
First, as a resource we need to be aware of the special risk factors facing our male population. These risk factors are likely to be different in industrial settings, gay communities, and retirement communities.

Next, physicians should be involved in data collection and analysis of their practice patterns and be prepared to evaluate new information pertaining to their male patients, as it becomes available. Our waiting room reading material should reflect our interest in the health of men.

Also, by understanding how social and financial inequality, sex roles, power, and race affect the determinants of health, family physicians will help patients gain insight into the struggles of modern living. Family physicians should always remember that those at the bottom of the class hierarchy have greater risk of morbidity and mortality.16

We need to structure our clinic hours so working men have access to us, and we need to promote an environment in our clinic where men receive information on their health and feel that male issues will be addressed.

**Family physicians are skilled clinicians**
As skilled clinicians, we must use our knowledge of male gender roles to understand the illness experience of men. For men, the illness might diminish their feelings of manliness. Skilled clinicians should expect this and are prepared to explore and validate men’s illness experience. We must be prepared to use open-ended questions, counseling skills, and a patient-centred approach to allow men space to bring up troublesome issues. We should always remember to search for the hidden agenda.

Skilled clinicians use evidence-based information in counseling male patients. For example, there is fair evidence for routine detection and counseling of men about alcohol and wearing seat belts in automobiles. Evidence also shows the benefits of physician education programs on suicide prevention in high-risk groups and support to stop smoking.17

**Conclusion**
When we address societal expectations and gender and power influences, we help both our male and female patients understand how these forces shape our lives and how they can, in turn, cause substantial morbidity and mortality.

Family physicians need to understand how the male role contributes to risky behaviour. Evidence is accumulating that our subconscious concepts of masculinity are dangerous to men’s health. We need to use this knowledge first in our medical practices and second in designing programs, organizations, and environments that reflect these understandings and bring awareness to our male patients.

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