

Are Family Physicians educated about Men's Health?

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ABSTRACT— Objective *The goal of this study was to explore what quantity and quality of training family doctors currently receive in the field of men's health.*

Methods: *A mixed-methodology was used. A quantitative survey was sent to program directors of Canadian family medicine training programs. This was followed by qualitative interviews of selected program directors and two focus groups with practicing family physicians.*

Program directors from all 17 family medicine training programs in Canada were surveyed. One focus group consisted of family physicians in urban practice and the other group had family physicians in a rural setting.

A case study method with a sequential transformative strategy was utilized. Quantitative data were analysed for frequencies and relationships between variables were determined using chi-squares. The qualitative data were thematically analysed through a deductive process.

Results: *Very few of the 17 training programs had any structured curriculum in men's health. The focus group participants also reported a lack of any formal men's health training. Exposure to men's health topics were sporadic and preceptor dependent. Six different themes were identified: current men's health teaching in programs, previous men's health training, need for a curriculum, different mental and physical disease topics, gender differences and procedures related to men's health.*

Conclusion: *Very little formal training in men's health takes place in family medicine training programs in Canada.*

Keywords— Male, Health education, Curriculum, Family physician

1. INTRODUCTION

During the course of a medical doctor's training, more time is spent on the teaching of medical issues related to women's health, compared to men's health. The specialty field of Obstetrics and Gynecology is primarily responsible for teaching many of these issues.

The training of family medicine residents in Canada takes place in residency programs in the 17 schools of medicine across the country. These programs include a minimum of two years, and the curricula of these programs are mostly based on the Standards for Accreditation, set by the College of Family Physicians of Canada.[1] This publication is traditionally referred to as the document with the "should" and "must" statements. A relevant quote from these standards reads: "To provide effective care, residents must become knowledgeable about the special health care requirements specific to men and women." [1](p16). Another relevant quote states that "Residents must be well acquainted with important physical and psychosocial aspects of men's and women's health care, including occupational health, family planning, spousal abuse, sexual assault, and sexual abuse. Residents must become familiar with gender-based differences in the management of common health problems in men and women." [1](p17)

With these clear expectations, it would be anticipated that all family medicine training programs would have a clearly defined set of goals and objectives for gender specific care. This is however not the existing reality and therefore led to the need for this research endeavor.

The content of a men’s health curriculum is of much debate. There is quite a big disconnect between what services health care providers think should be offered at a “men’s health clinic” and what the patients expect. Patients of different ages also have different needs when it comes to their own health. [2, 3, 4,5] This dilemma of differential expectations might be resolved by conducting a needs assessment and/or survey of Family Medicine Training Programs in Canada.

2. METHODS

A mixed-methodology approach was selected for this research project. Even though the philosophy of pragmatism (non-committal, freedom of choice) is often associated with a mixed-methodology approach, social constructivism would be a better worldview for this research. Social constructivists believe that individuals seek to understand the world in which they live and work. [6] Learning is therefore achieved more effectively through interaction with others. This worldview is usually associated with qualitative research predominantly and thus the greater emphasis on the qualitative portion of the study.

The ethics board of the University of Saskatchewan reviewed this project and permission was obtained to continue.

A sequential transformative strategy, a form of a mixed-methodology approach, was used for this study. The first section was quantitative and the second section, which builds on the data that were obtained in the first section, was qualitative. (Figure 1)

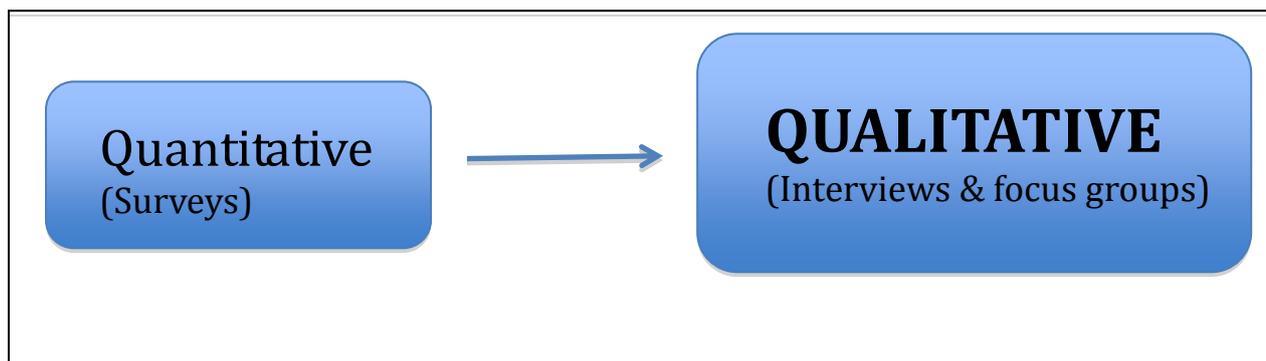


Figure 1. Sequential Transformative Design

For the quantitative section, a questionnaire was sent to all the Program Directors or Site Directors of Family Medicine Residency Training Programs in Canada. The names of these individuals were obtained from the College of Family Physicians of Canada’s website: www.cfpc.ca. At the time of the study, there were seventeen programs in total in Canada. The questionnaire was distributed as a fillable pdf document that could be completed and returned to the researcher. The survey collected information about the program (size and location of different sites as well as number of residents), as well as, on the presence or absence of a women’s and men’s health rotation and their respective goals and objectives. Participants were also asked if there was a curriculum for women’s and men’s health that was followed during their formal academic teaching rounds or lectures.

Many elements of the questionnaire focussed on different topics that might be considered relevant to men’s health and whether the participants felt that it was important to include in a men’s health curriculum. Participants were asked in the end to add any topics that they felt should be included in such a curriculum. Data were analysed using SPSS version 19 software. Frequencies were calculated and relationships between variables were determined using chi-square tables.

A case-based approach was used for the qualitative portion of the research. Case studies lend themselves well to the identifying themes. [6] Semi-structured interviews were arranged with selected participants of the survey. In a true sequential fashion, the questions used in the interviews were based on some of the information obtained from the questionnaires. The initial plan was to invite participants that have a men’s health curriculum as well as some that did not. However none of the participants stated that they had a men’s health rotation or curriculum. Participants were

therefore selected based on availability as well as the quality of information received from the surveys. Saturation of information was felt to have occurred after only three interviews as no new information was obtained.

Two focus groups were convened and the topic of men’s health issues in family medicine practice was discussed. The first focus group consisted of four family physicians that are practicing in a single urban clinic. This group had a mix of Canadian trained as well as internationally trained family physicians. Most members of the group had graduated within the last 20 years. The second focus group consisted of family physicians in a single rural clinic. These physicians were all Canadian trained, but the time since they graduated ranged from one medical student, one resident, two recently graduated physicians and two physicians who were at the end of their career. It was felt important to have both rural and urban family physicians in the focus groups as often the scope of practice differs in these two settings.

The emphasis of the discussion in the focus groups was on the following: previous training in men’s health, the need for training in men’s health during family medicine residency, as well as, different topics that should be included in such a training curriculum. The discussions within the focus groups were recorded with both audio and video recording equipment and later transcribed. (Videotaping was used only to identify different speakers during transcription.)

These interviews were transcribed and imported into the Nvivo (version 9) software. Each interview and focus group was treated as an individual case.

Analytical analysis of the data obtained from the quantitative survey was performed. Through a deductive process, certain themes were identified. These predetermined themes were registered as “nodes” in the Nvivo software and was used while analysing the qualitative data. Further themes (or nodes) evolved through an inductive process as the transcriptions were analysed. Phrases in the text of the interviews were then linked to the different nodes and were used as examples to illustrate the different themes that evolved.

The author was involved in all aspects of this project, including conducting the interviews and focus groups as well as transcribing the interviews and analyzing the data.

3. FINDINGS

For the purpose of this paper, the focus will be on the data that were obtained in relationship to what is currently being taught related to men’s health.

A total of eleven questionnaires, that represented 10 (59%) of the 17 Family Medicine Residency Training Programs in Canada, were completed and returned. In one case, two different sites in the same program returned a survey. Three of the Program Directors forwarded the survey to other people in their program, such as Curriculum Coordinators or Deputy Program Directors. All the questionnaires were included in the analysis of the data except in the one instance where the two questionnaires from the same program were treated as one. The data are summarized in Table 1. In the role description, “other” was identified as mostly curriculum planners or leaders. Of the ten programs, six stated that they have a dedicated women’s health rotation with goals and objectives, whereas all of the programs stated that they have no men’s health rotation or any goals and objectives for such a rotation. One of the programs did mention that it follows a horizontal curriculum. (A horizontal program traditionally has no rotations.)

Table 1. Survey data from Program Directors in Canada

	(n)	(%)
Role		
Program Director	5	45.5
Site Director	3	27.3
Other	3	27.3
Women’s Health Rotation		
Yes	5	45.5
No	6	54.5
Women’s Health Rotation Objectives		
Yes	6	54.5

Does not apply	5	45.5
Women's Health Curriculum Objectives		
Yes	7	63.6
No	3	27.3
Men's Health Rotation		
Yes	0	0
No	10	100
Men's Health Rotation Objectives		
Yes	0	0
No	1	9.1
Does not apply	4	36.4
Men's Health Curriculum Objectives		
Yes	5	45.5
No	5	45.5
Where do residents get most of their men's health training?		
Urology	0	0
Women's Health Rotation	0	0
Other	10	90.9

Seven of the programs have objectives for women's health in their academic teaching sessions and five of them mention that they have objectives for men's health problems for these same sessions.

Six different themes were identified in the end: current men's health teaching in programs, previous men's health training, need for a curriculum, different mental and physical disease topics, gender differences and procedures related to men's health.

It was evident from the interviews and the focus groups, that if it happened at all, a lot of men's health teaching was sporadic and unorganized throughout a physician's training. One respondent commented that

".....what I recall besides some very cursory lectures on prostate and BPH and prostate cancer screening and not even so much on the treatment of prostate cancer, was about all we received about men's health." – recent graduate.

Another recent graduate commented that

"I was lucky enough to be with a preceptor – he had an interest in men's health – so that's how I got some exposure to things like that."

Participants felt that most of the time they were responsible to initiate discussions and teaching around men's health:

"We had pretty much just a men's health academic half day and that was initiated by us residents."

Participants felt that they were not prepared for what was expected of them in practice:

"We receive, I mean, extremely poor training in our undergraduate and received excellent training after graduation when you were just dumped in the swimming pool." – International Medical Graduate (IMG).

These participants were not exaggerating or misled because the Program Directors admitted that they do not have dedicated men's health rotations or a set of goals and objectives for men's health in their programs:

"I'm not aware of specific curriculum goals that are unique to men's health." – Program Director

And yet another:

"As far as the specific time in the program, no I think that the residents are getting exposure to some experiences that might include men's health but they're certainly not dedicated towards men's health".

4. DISCUSSION

It is clear from all aspects of the study that there is very little emphasis on men's health in the curriculum of family medicine residency programs in Canada. This is alarming when it has been established that men die younger than women [7,8] and that most family physicians in Canada do not feel competent to deal with most problems that are unique to men. The expectations from the College of Family Physicians of Canada's Standards for Accreditation requires residents to become knowledgeable about the special health care requirements specific to men and women [1]. This study has shown that programs have ensured that residents become skilled in women's health but not men's health. This study also showed that practicing physicians acknowledged their lack of training in men's health. Most physicians have to rely on their own thirst for knowledge and hope that they will have the appropriate guidance to meet their needs. The real danger often is the fact that you don't know what you don't know until you are faced with a situation that requires you to have knowledge and skills in a certain area. People might argue that the issues of men's health are often not life threatening and that the physician can read up around the topic as the need arise. This does not however instill a lot of confidence in a male patient who is already hesitant to make contact with a health professional [9,10].

5. CONCLUSION

Based on the information gathered through this study, there is clearly a need for a formalized curriculum in men's health to be included in the Family Medicine Residency Training Program in Canada. This curriculum would have to be competency based to fit well with the new Triple-C curriculum of the College of Family Physicians of Canada (CFPC). [11] Even though some participants mentioned a "men's health rotation" as a venue to obtain the necessary skills, the CFPC has elected to move away from rotation-based training. The competencies that will be expected from residents in the area of men's health will have to be achieved in a longitudinal family medicine experience and will most likely rely on directed self-learning from the resident's perspective. [12 p. 146]

6. REFERENCES

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