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Relationships between health care professionals and users from a gender perspective

Relaciones entre profesionales de la salud y usuarios/as desde la perspectiva de género

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ABSTRACT The objective of this article is to analyze relationships between health professionals and users from a gender perspective. Using Pierre Bourdieu as a theoretical reference, we critically analyze data from two studies carried out in Brazil in which we took part as authors. The first of these studies was based in Rio de Janeiro and the second was a multicenter and ethnographical study carried out in eight health care facilities distributed throughout four Brazilian states, two in the Southeast region and two in the Northeast region. Among the principal results of the present study, we found that although the relationships between health professionals and users demonstrate varied opinions, all are marked by a gendered *habitus*. We conclude that, among other aspects, the construction of diverse femininities and masculinities and the way in which these are exercised in health care contexts are the product of process that is both socio-historical and personal.

KEY WORDS Gender; Health Services; Health Personnel; Consumer; Brazil.

RESUMEN El objetivo de este artículo es analizar las relaciones entre profesionales de la salud y usuarios/as desde la perspectiva de género. A partir del referencial teórico de Pierre Bourdieu, se retoman y analizan críticamente datos de dos investigaciones realizadas en Brasil de la cuales participamos como autores: la primera, realizada en la ciudad de Río de Janeiro y, la segunda, un estudio multicéntrico y de naturaleza etnográfica desarrollado en ocho servicios distribuidos en cuatro estados brasileños, dos de la región Sudeste y dos de la Nordeste. Entre los principales resultados se destaca que las relaciones entre profesionales de la salud y usuarios/as, aunque estén marcadas por opiniones divergentes, están atravesadas por un habitus "generificado". Se concluye, entre otros aspectos, que la construcción de las diversas feminidades y masculinidades y la forma en que se da el ejercicio de estas en los contextos asistenciales de la salud son producto de un proceso que es, al mismo tiempo, socio-histórico y personal.

PALABRAS CLAVES Género; Servicios de Salud; Personal de Salud; Usuarios; Brasil.

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INTRODUCTION

Since the mid-80s, Brazilian female/male researchers from different areas in the health field are trying to understand the diverse risks of becoming ill and dying in the population, the way in which both men and women have access to and use health services, how they understand their own health-illness processes, and the way in which they deal with their own health care and others'.[1-4] From a historical point of view regarding the structure of gender and health studies in Brazil, the contributions of social science and feminist scholars in the academic sphere stand out. This is due to the efforts they undertook as from the 80s, when they started to problematize the health differences between men and women by placing them in a broader social context that involves gender as one of the most important social markers. Thus, the perspective that denaturalizes the relationship between men and women with health, suffering and care has been created as a result of the gradual theoretical advance of the gender category and its use in empirical research in the wide field of health.

The incorporation of the gender perspective in the health field in Brazil is similar to the international production since it was originally focused on women. This is understandable in a broader social and political context where it was important to recognize, report and act in women's health and life conditions, especially regarding their reproductive life[5,6] and issues that demand greater social attention such as the violence women suffer in their private environments[7] and the fact that the AIDS epidemic now affect both genders.[8] The conceptual analyses of the initial field studies that focus on the relationship between women and health and between biologic and social aspects are similar in the sense that they care both about making progress in a definition of women's condition that entails the relationship between production and reproduction spheres, and the way this relationship is shaped in women's lives.

Contrary to what was originally defined as "women's health," the definition of "men's health" from a gender perspective has been recently developed as areas of academic and political interest. It was not until the mid-90s that men's health began to be considered as a study field that contributes to the understanding of health through public health and social science. Laurenti *et al*.[9] created a pioneering study in Brazilian public health field that acknowledges an epidemiological discussion about the main death causes and the male mortality rate for all causes of death among the population, varying by age in American countries. With the incorporation of men as individuals with different identities in gender and health studies, the relational character of the gender perspective has increased over time. It is acknowledged that studying the gender-health relationship means assessing the male-female pair, in their distinctive features as well as in the uniqueness of their relationships.[10]

After the incorporation of the gender relational perspective in health field studies, some reviews about the national production in gender and health[3,11] and also in men and health[4,12] show an increasing production, especially since the 90s, with a wide variety of theoretical-conceptual references, a variety of methodologies and empirical data production techniques, although there is a predominance of studies on women in comparison with studies on men. In addition, review studies show political, epistemological and methodological challenges to the field. For example: a wider integration of biomedical and social science knowledge; the need to empirically and conceptually broaden the relational dimension in the studies; the importance of acknowledging the political origin of the gender concept and introducing it to the particular analysis of the subject-matter being studied and, finally, the consideration of the relationship between the gender perspective and the need to relate it to other social markers of difference, such as race/ethnic group, generation, social classes, etc.

After the incorporation of the gender perspective in the health field, especially in the prevention and promotion spheres, the effects of including men in health field research can be perceived. It was originally focused on the pair women/mothers-offspring, which created tension and broadening the debate about the formation and consolidation of a gender agenda in the health policies in Brazil is evident. Historically, this agenda took place in a historical, political and cultural context of redemocratization in the cou-

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ntry and an overall restructuration of the health system. In this context, the first health public policies focused on gender perspective, which were outlined and carried out with the support and involvement of women movement. It focused on social inequality for women in comparison with men and was aimed at reducing and/or overcoming this inequality. Therefore, women became their target public.[13,14] The "Women's Comprehensive Healthcare Program" (PAISM) [*Programa de Atenção Integral à Saúde da Mulher*], created in 1983 and modified in 2004 as "Women's Comprehensive Healthcare National Policy" (PNAISM) [*Política Nacional de Aten*ção Integral Integral a *Saúde da Mulher*) provides examples of the incorporation of the gender perspective in health public policies because of its political principle: reproductive issues are no longer considered from a moral sphere and from strict actions of the State. They are now considered from an individual ethical decision and social rights and from the protection of the integrity principle, from which women's health became more meaningful on a global basis and in every phase of their lifetime.[15]

Regarding the incorporation of men in health policies, it was not until 2009 than men were first considered relevant agents of policies and programs.[16] This statement seems to be valid for assistance programs aimed at health recovery (ailments) as well as health prevention and promotion practices within such models as the Women's Comprehensive Healthcare Program and Women's Comprehensive Healthcare National Policy, mentioned above. In this regard, men have been considered agents of gender inequality and primarily responsible for reducing inequality between men and women.[14,17] However, even though the recent implementation of the Men's Health Policy is a legal document that represents an international breakthrough (because it is the first public policy on a national scale in Latin America and the second one in the American Continent, after Canada), an analysis on the document[18] and, more specifically, on its initial implementation[19-21] shows a focus on ailments, on erectile dysfunction as a public health issue. Consequently, the risks of medicalization applied to men are showed.

The context that justifies the delay in the incorporation of men in the health policies' agenda focused on gender and the setbacks faced in the initial phase of implementation is connected with the little importance that was given to the social movements organized by men and with the difficulty of the academy and the people who formulate the policies to promote and revise the "men-gender" notion.[22] In other words, as the gender incorporation to public policies originally took place because of feminism, which fights against the differences and inequality between men and women, a man tends to be considered a practically homogeneous "someone else" that aims at keeping the power and the privilege that his gender enables him to have.

Finally, another important aspect to take into account in the field of gender and health studies in Brazil is that, contrary to the studies that are focused on health care professionals, the emphasis is on the research conducted on the users, regardless of whether they are women, men or both. In most studies with health services users, in different levels of assistance, the concepts of masculinity and femininity are problematized along with the way in which they contrast in terms of specific experiences of ailment acknowledgement and health care/handling. Thus, male and female, as users, are different on the basis of their self-perspective regarding care needs, health assistance search, the relationship they establish with the assistance professionals and their compliance with treatment.[23-26] The very studies that are focused on male and female health professionals criticize the traditional organizational structure, especially in the basic assistance services, which originally get the offering of educational actions and mother-son health practices into focus. Not only do those studies take men, women or both as empirical subjects, but they also study the way in which the organizational structures and practices of these male/female professionals influence the reproduction of "gendered" health practices. That is to say, how gender, as the principle that regulates thoughts and actions, comes to devise assistance logics and health practices that (re)produce male and female stereotypes, which make women responsible for their care and for others' care[27,28] and reinforce the fact that men are not responsible for that, as they are described as absent or not very helpful in their own or in others' health care and as being ignorant of the social codes that regulate health assistance services.[21,26,29]

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In view of the foregoing, our objective is to analyze the relationships between health care professionals and male/female users from a gender perspective. We intend our study to be a contribution towards a relational gender perspective that takes both related subjects as "gendered", that is to say, (re)producing gender patterns that were historically rooted.

The analysis presented is oriented by a gender focus, which is conceived in terms of those cultural characteristics that are associated with each gender. These characteristics create models that express a relational perspective (what is culturally seen as masculine does only make sense from a feminine perspective and vice versa) by referring to conceptions and, therefore, to the specific relationships in which negotiations and flexibility about what is considered masculine and feminine may occur. Consequently, gender was considered as an analytic category that creates problems of man-woman, man-man, and woman-woman relationships, especially in connection with other identity referents such as social class and race/ethnic group. The intertwined interaction between them plays a structuring role in the reproduction and production of identities, relationships and social institutions.[30]

THEORETICAL BACKGROUND

Bourdieu's perspective is our choice of theoretical background[31,32] to think of the actions of men and women as users in relation with health care professionals. At the same time, we consider the special emphasis on the incorporation of patterns that rule the individuals' social structure and their actions, as rational agents aiming at certain goals.

Bourdieu's "practice theory" has been called in different manners: "social reproduction,"[33] "genetic structuralism"[34] and he himself has named it "reflexive sociology"[36] "constructivist structuralism" or "structuralist constructivism."[36]

Apart from the gender category,[32,37] Bourdieu also mentions the term "relationship between both sexes." The use of this term reflects the connection with the French research field that, according to Heilborn and Sorj,[38] without having included the gender category, established the use of the term "social relationships of sex."

Bourdieu sees the body[32] as a social construction. Through this construction, the division between things and activities (whether sexual or not) tends to be arbitrated from homologous oppositions, such as up/down and public/private, between male and female aspects. With those thought schemes it is possible to examine them and their naturalization. In this regard, the body is built as reality with a vision and division based on the sexes. Thus, the biological difference between male and female bodies may help to justify the socially built difference between both sexes.

According to Bourdieu,[39,40] the society conceptually prior to the individual, might have had an organized structure of symbols and meanings as well as pre-established interactive models. Within that society, the subject is formed by constant interactive games. The individual acquires, through a socialization process, the social roles and values that the other members of the society share, thus becoming a person. As a subconscious learning process – through the imitation of gestures, postures and reactions that have a meaning in social life – behavior is burdened with hierarchical values. Culture, therefore, offers patterns that are taken as *habitus*. These patterns become schemes of perception, appreciation and action – incorporated to the body through past experiences – that enable the development of practical knowledge and strategies that are constantly being adapted and renewed. In this regard, the *habitus*, understood as a grammar that generates practices and determined by the social position of the individual, enables the agents to reproduce consistencies of behavior and improvise. Thus, actions are not only reproduced, but they are also produced. Therefore, the *habitus* tends to form and direct the action but, when it is the product of social relationships, it tends to ensure the reproduction of the same objective relationships that have brought it into existence.

Pinto[42] presents dimensions of the *habitus* that can help us to understand this concept and its use in the analysis of the relationships between people and social structure. These dimensions, which are interrelated, are classified as follows: dispositional, distributive, economic and categorical dimensions.

The dispositional dimension expresses the idea that the *habitus* shows the problematic relationship of adjustment between interior and exte-

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rior features, subjective and objective aspects. In other words, we may say that as a result of the values, regulations and principles internalized by subjects, an adjustment would occur between their actions and the objective reality of the society as a whole.

The distributive dimension of the *habitus* refers to the differences between social groups, broken down into social class. This organization would somehow reflect the material and symbolic distribution of some individuals compared to others. In this regard, individuals are unequally distant because of the distribution of property legitimized by culture and educational institutions. This dimension tries to explain the mechanisms used in the appropriation process of legitimate property and its corollary, which is the reproduction of the existing cultural inequalities among the groups.

The economic dimension of the *habitus* is based on aspects that go beyond the economic rules and is related to the economy of symbolic property. Within this economy there are values, such as honor. In this economy, something is assumed as a valuable asset, but a valuable asset that, on certain terms, does not allow the explicit form of calculation. Thus, production and acknowledgement of symbolic property are not only limited to the pecuniary field, but they also reveal aesthetic, ethical and political positioning.

The categorical dimension states that, through the *habitus*, the agents of the actions may make a logical ordering of the world from a small number of schemes that can be generalized and transposed.[42] Thus, underlying the practice, there are contending categories that make up schemes of production, interpretation and view of the world that work from opposing pairs, such as the notions of tall and short, male and female. Those pairs are cognitive, ethical and aesthetic classifications.

According to Bourdieu´s theory, the *field* – seen as a universe regulated by social rules in which agents and institutions are inserted – is made up of forces and struggles to maintain and transform.[43] Although they are regulated by general rules, each field has its own history and a relative autonomy related to other fields. In this regard, fields – without strictly delimited boundaries – have both specific characteristics and general rules.[41] The valuable asset distribution among the different agents that are inserted into a field is one of the elements that structure the fields, and it involves order maintenance as well as order subversion. *Habitus* and field are connected; since when a dispute arises it is necessary for people to have a *habitus* that involves the knowledge of field rules.[32]

METHODOLOGY

Regarding study methods, we used an essay design, which is understood here as an exploratory, critical exercise about an issue or object of reflection, looking for a new approach.[44]

For this purpose, we revisited the data obtained in two investigations in which we took part as principal investigators. The first one, which took place in the city of Rio de Janeiro, Brazil[45] and which was approved by the Ethics Committee for Research on Human Beings of the Fernandes Figueira Institute [*Comité de* Ética *em Investigacão com Seres Humanos do Instituto Fernandes Figueira*], Fiocruz, intended to problematize aspects related to the hegemonic model of masculinity that may impede men from taking care of their own health. The second investigation, approved by the Ethics Committee of the Federal University of São Paulo [*Comité de* Ética *da Universidade Federal de São Paulo*], studied elements of the structure of health care services and the dynamics of health practices from a gender perspective focusing on men in this assistance context. The multi-centric and ethnographical study was carried out in eight health care facilities distributed throughout four Brazilian states, two in the Southeast region and two in the Northeast region.[24]

We selected information from these investigations to make new interpretations from Pierre Bourdieu´s perspective regarding body, *habitus* and field notions in their analytical dimensions.

Even regarding methodology, also understood as "thought path"[46] – after the reinterpretation of the information and with support in our experience – we tried to problematize the gendered relationships that were established between health care professionals and male/female users of health services and to outline principles to deal with those relationships.

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RELATIONAL SITUATIONS

In order to problematize the relationships between health care professionals and male/female users, we presented four situations that were taken from the mentioned investigations, which are referenced in each of them.

Situation I[45]

The following accounts show the difficulties to carry out the rectal exam on men as a secondary prevention from prostate cancer:

> [For a man] *it is just uncomfortable that another man puts his finger into his anus* (Physician, RJ).
> *I don't feel comfortable if someone comes and touches me there* [referring to his anus] (Man, RJ, 40 years old).

Both accounts are representative of the 28 men over 40 years old that lived in the city of Rio de Janeiro, 10 of them had received higher education, 8 of them had only undertaken the first grades of primary education and the remaining 10 were urologists. Regardless of the education they had and no matter their professions, these men shared some of the same ideas, although they expressed themselves differently. One of the shared ideas – shown on the accounts – is that, whether consciously or not, men aimed at the male body prohibition.

Situation II[24]

Two female physicians explain why men do not frequently attend health care facilities:

> *Men do not suffer; men do not get ill* [...] *men never seek health care facilities* [...] *cultural issue* (Female physician, RN).
> *Due to a cultural issue* [...] *he comes more objectively because of something specific, not because he is looking for a subterfuge as women do...*
> *In general, men do not have time to waste... women come every day, even if they have nothing* (Female physician, SP).

This situation gives professional explanations to reinforce the idea that men frequently attend health care facilities less than women do.

We see that, even though the male and female professionals that were interviewed were from four states of two Brazilian regions (Southeast and Northeast), they all shared opinions that reflect their practices´ interpretations, which were made not only in the field of their medical education but also based on common sense.

Situation III[24]

When structuring activities and within the routine of health services, it has been possible to verify similar attitudes and actions in male and female professionals, as clearly illustrated in the following situation:

> *At the specified time, the nurse, responsible for the group, appears with 28 medical records. The researcher mentions that there is only one file that belongs to a man. The nurse, puzzled, goes to check this information. Later, she comments that it was a mistake, that she had wrongfully brought a pediatric medical record and explains the following: "the contraception group is made up of women, it is a group aimed at female users; sometimes some of their husbands come to accompany them, but men are not registered to take part in this group"* [...] *However, during the conduction of the group, the following debate was held*:
> Nurse: *And I wanted to tell you something: Who is responsible for avoiding having a child*?
> Female user A: *We are*.
> Nurse: *Is it women´s responsibility*?
> Female user A: *It is men's responsibility as well*.
> Nurse: *It is men's responsibility as well. Does everybody agree*? [...] *Or do you think it is only women´s responsibility*? *Or men's*? *What do you think*?
> Female user B: *We are both responsible*.

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> Nurse: *Both*? *Then, why is it that men do not join this group*? *Is it because we do not invite them*? [Laughs]
> *At the end of the meeting, the nurse asks which contraceptive method female users chose among the ones that were offered, thus restricting the decision only to women*. (Fragment taken from a field diary, SP1).

The situation described above at the primary care center in the city of San Pablo can be taken as a common example that specifies the focus of assistance logics and the daily work of the professionals that take care of women's health all along the country. The crystallization of reproduction as an "exclusively" feminine area reinforces the idea that women are responsible for taking reproductive decisions within their marriage/family. Even when the gender relational dimension, which is essential to family planning issues, is considered important by the professional, putting actions into practice appears to be contradictory to the perspective they defend.

Situation IV[24]

In the organizational context of services incorporated to male and female assistance professionals' practices, the gender stereotypes internalization makes up *habitus* and practices. The following example, which belongs to the nursing care routine during the medical post-consultation in a primary care center that follows the model of the Family Health Strategy, reveals a common situation in primary care centers in Brazil.

> *...the nurse asked the patient's wife if she was giving the medicine to her husband at the right time and the wife answered that she did not know, because her son was responsible for giving the medicine to him and he was not at home. This answer visibly annoyed the nurse, who started explaining, not very patiently, the importance of giving the medication at the right time* [...] *she said that his blood pressure was normal, but she warned the wife to be attentive to the medication* [...] *The nurse complained* [to the researcher] *that the wife did not seem to understand the seriousness of the problem her husband had, because she did not respect the time of the medication and her son was to take care of that*. (Fragment taken from an ethnographic report, RN, service 1).

The situation described above shows some aspects that prove that the male and female assistance professionals, in a strongly imposing sense, make women responsible for taking care of their health and the other members of the family's health; there is a men's lack of involvement regarding the possibilities they have to take care of their own health because they delegate this task to women. The persistence of these patterns, which reinforces gender stereotypes, in the way in which male and female professionals carry out assistance activities can become a "technological rejection" to the incorporation of a new subject (the men). Thus it is impeding, on the part of the services, a renewal in the sense of a comprehensive health care that encourages people to take care of their own health, which, after all, would involve the clash of broader gender issues.

SITUATION DISCUSSION

Health care services can be seen as a specific field within the social sphere. However, this field is not completely autonomous; it is influenced by general rules that regulate the relationships between agents and institutions within society. These rules, in turn, are made of structuring and structured *habitus*. For example, we can define the relationship between both sexes as a changing *habitus* in the different fields. Considering Bourdieu's approach, we can state that the relationships between agents (professionals and users), whatever the field in which they occur, are influenced by a *habitus*, that we categorize as "gendered."

In that sense, even though they include opinions of people classified by sex, occupation or region, the situations presented above are influenced by a *habitus* ruled by the structuring gender values in the society and culture. Thus, people – before being professionals or users – are men or women who act categorically as from opposing pairs (masculine/feminine), who have a

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different material and symbolic distribution and who (re)produce cultural inequalities. Their way of thinking, perceiving and behaving reflect the internalization of values, rules and principles that express the division between both sexes.

In Situation I, we observe that both the physician and the user of the health care service reveal a male body prohibition, which is different from the female body. The sexual difference is shown in the front of the body, whereas the back of the body shows the sexual similarity.[32] Men – in anatomical terms – are only different from women in the front of their bodies. In addition, there are prohibited areas marked by symbolic lines.[30] Associating buttocks with being passive and the rectal exam with penetration establishes dissonance for certain male identities. In that sense, in the situation described above, whether a physician or a user was involved, the relationships between them, apart from medical semiology, can be influenced by a model of masculine sexuality constructed in opposition to being passive and penetrated.

The accounts in Situation II illustrate the tensions between nature and culture while trying to explain the absence of men in health services. The first account, even though it recalls culture and does not mention nature, deals with a masculine essence, which leads to men not attending health care services, thus naturalizing the problem. The second account starts by recalling culture and ends with the differences between male and female users. In that comparison, it seems that men, with their absence or infrequency in those services, are better than women. In the first account, it seems that men are considered strong, while in the second one they are considered from a more objective perspective. In the latter case, it seems that women – by attending the services for no reason – request to be assisted without needing it, while men attend the services because they do need it. As men do not attend these services frequently, it can be understood that they are stronger than women. In both accounts, it seems that, in order not to talk about essence naturalization, they deal with culture.

In Situation III, we see that the *habitus* influences the low incorporation of men within the organizational structure and the activities provided by the services, even towards such a relational topic like conception/contraception. As a result of this, male and female professionals (nurses, in this case) are not capable of dealing with the importance and the contribution for men and women's health that the incorporation of men in sexual/reproductive issues would provide. Moreover, the use of technical terms causes blindness, which makes people think that what is right/wrong is always the logic of male and female professionals and, therefore, women are not encouraged to talk in groups such as the family planning group. Hence, there is no dialogue or knowledge exchange between professionals and users.

In Situation IV, the "gendered" *habitus* influences professionals to make women responsible for health care and do not see men as people who can take care of themselves and do not encourage them to be responsible for their own health care.

In all the situations, we can perceive the categorical and dispositional dimension of the male *habitus*. In this regard, that *habitus* – considering the categorical dimension – is used to distinguish men from women in the relationships that are established between professionals and users. In addition, regarding the dispositional dimension, both professionals and male/female users of health care services acquire structural aspects in a practical sense to be able to orient themselves in their social lives.

FINAL CONSIDERATIONS

Even though Bourdieu's practice theory states that individuals specifically perform social actions, the opportunities to carry them out are objectively structured within a global society. In this regard, we acknowledge the contribution of the incorporation of the author's notion, such as the *habitus* and the field, for the analysis of the empirical data presented. However, it tries not to reproduce an understanding of a social reality in which stability and the reproduction of oppressive systems (especially the gender system) never surrender in favor of rupture and change.

When it comes to stating the action possibilities of the agents involved in the health assistance context in Brazil and emphasizing the gender category as a historical process of social and individual positioning, we defend a position contrary

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to the still conventional narrative in the bibliography about the relationship between gender and health, either with professionals or with male/female users, which sees gender as a social pattern equally in place for both men and women. The empirical examples under review demonstrate processes that occur in the micro-relationships between professionals and male/female users, these processes contain change and permanency, on (re)combinations of conceptions and on a variety of practices combined in a mosaic. This includes the perception that making different femininities and masculinities and the way they are carried out in health assistance contexts are the result of a process that is, at the same time, socio-historical and personal.

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