

Men's Health:
The Healing of Prometheus

Jeffrey Elliot Manberg

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ABSTRACT

Men's Health: The Healing of Prometheus

Jeffrey Elliot Manberg

This thesis investigates the state of men's health, which is in silent crisis. The male mortality rate is 60% higher than the female mortality rate in Canada. Furthermore it is higher for all 10 leading causes of death. The difference in life expectancy is over 5 years between men and women. Contributing to their early demise are so-called preventable deaths, homicide, suicide, vehicle accidents and work accidents which are much more prevalent among males than females. In the U.S. from infancy, males die and suffer serious illnesses at greater rates than females. In fact between the age of 15 and 24, male die at a rate more than three times that of females.

This constitutes a silent health crisis - silent because it is not acknowledged, it is in fact, ignored. In Canada there are five Centres of Excellence devoted to women's health-yet there are none for men's health, which is far worse. In the U.S., the morbidity and mortality rates are proportionally similar. There are eleven Specialized Centers of Research for Women's Health, and none for men.

We will explore in this thesis both the reasons for men's ill health relative to women's, and the paradox of the silence.

Three major theoretical perspectives: the bio-medical, the environmental, and lifestyle, are examined extensively as are gender specific theories concerning the role that masculinity plays in contributing to male health.

Lastly, I present recommendations for improving men's health. Not only is there an appalling loss of men's lives and to a lesser extent women's for many reasons, but also it is extremely expensive. The economic costs of male potential years of life lost in 2001 (U.S. data), amounted to \$329,836, million dollars per annum. This money would be better invested in preventive care and Centers of Excellence devoted to men's health.

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It is in her memory that I dedicate this dissertation.

TABLE OF CONTENTS

Abstract	iii
Acknowledgements	iv
Introduction	1
Chapter 1. Mortality	5
(a) Death Rates	7
(b) Life Expectancy	13
(c) Potential Years of Life Lost	28
(d) Potential Revenue Lost	29
Chapter 2. Preventable Deaths	32
(a) Accidents	32
(b) Suicide	38
(c) Homicide	48
(d) War	53
Chapter 3. Morbidity	64
(a) Illness Rates	65
(b) Acute	65
(c) Chronic	68
Chapter 4. Conceptualizing Health	76
(a) The Bio-medical Model	76
(b) The Lifestyle Model	87
(c) The Environmental Model	115
Chapter 5. Perspectives on Health	126
(a) Feminist Theories	126
(b) Masculine Theories	138
Chapter 6. Conclusions and Recommendations	146
Appendices	
(a) Interviews	157
(b) Methodology	164
(c) An Explanation of the Title	167
Bibliography	169

MEN'S HEALTH: THE HEALING OF PROMETHEUS

Introduction

*"If I had known I was going to live this long, I would have taken better care of myself."
Mickey Mantle*

Men in every country live shorter lives than do the women of our species, and in North America males have higher death rates in all 10 leading causes of death (Burgess et al, 2003:76). My research is an analysis of the circumstances surrounding men's health and their comparative short life spans. This includes the etiologies of specific diseases, the lifestyle theory, data on men's health practices, the environmental theory, and especially preventable deaths.

One of the features that distinguish humans as a species is the ability to acknowledge and to share the realization of the inevitability of impending death. We have the capability to ponder the constraints of our existence and the certainty of its cessation. That is the impetus of my research and the subject of this dissertation. It also includes some of the roles played by the media, agencies of the Canadian and American governments, and medical fund-raising organizations.

Presently the health and longevity of males is in a silent crisis. Good health, illness and early death are areas of vital concern to men and women and for societies in general. The health of a population plays a key role in determining how a society functions. Societies in Canada, the United States, and in industrialized Europe, pay high social and economic costs for their male populations' disproportionate morbidity and mortality.

My research encompasses interviews with physicians and other health professionals, and analysis of pertinent sociological, psychological, medical and statistical literature. Hopefully, this dissertation contains a message of enlightenment to the unenlightened, of the importance of male health care. The importance of recognizing and striving for good health for men and boys, will benefit not only men and boys, but women and girls also, by extending the lives of their fathers, brothers, husbands, uncles, friends, etc.

There are multiple determinants of health, almost all of which have a differential influence on, or which are internalized differently, by males and females. The reasons for the excess male morbidity and mortality (compared statistically, to that of females), from illness, accidents, suicide, homicide victimization, participation in dangerous occupations such as lumberjacks, fishers, seamen, aircraft pilots, bridge and building steelworkers, miners, cab drivers, farm workers, police, firefighters, and military personnel, and also male lifestyles, will be discussed.

Why do men have such high mortality rates? Are they predisposed to an early demise through weak genetic engineering? Is it social mores which instill life-force-draining responsibilities, including the inclination to put one's self in harms way? Or is it psychological dogmatism with manifestations of invincibility, therefore shunning signs of weakness in the form of caring for themselves. Is it fear of the unknown, the so-called 'no news is good news' syndrome, in relation to self-care and optimum survivability? My research, attempts to discuss and answer these questions.

Chapter one, Mortality, looks at historical and recent overall death rates in the context of differences between males and females, from birth to the old-old age category. Males have higher death rates from all 10 leading causes of death.

Chapter two addresses preventable deaths: accidents, suicide, homicide, and war. These all disproportionately affect males.

Chapter three, Morbidity, examines illness rates in relation to gender and age. A distinction is made between acute illness which is usually short term, and chronic which is long term and may even extend until death. However it is not always the principle cause of death, although it might be considered a contributing factor.

Chapter four, conceptualizing Health, discusses three principle paradigms on health. The general premise of the Bio-Medical Model on which the foundation of modern Western medicine is based, assumes that disease is a deviation from normal biological functioning, and that diseases have specific causes that can be located in the ill person's body. Furthermore, it distinguishes between the body and the mind, and asserts that disease can be treated separately from the mind. Ivan Illich denigrates the importance of the Medical Model and David Horrobin refutes his assumptions in his literary defense. The lifestyle theory takes a more behavioral approach. Marc Lalonde explains patterns of personal behavior and their consequences or rewards in relation to health. With the environmental theory, John McKinlay describes the impact of American cultural norms and industrial production on health in general.

It is only since the 1970's and 1980's that research really started to develop comprehensive theoretical approaches to understanding the linkages between gender and health issues. Previously, socioeconomic status, socio-culture and biological determinism

prevailed as the leading hypothetical determinants of illness and premature death. The primary gender specific focus was on the health of women in the context of motherhood, and related reproductive exigencies, primarily from the feminist perspective. (Lorber, 1997:2. Bolaria and Dickinson, 2002:57. Edginton,1989:22).

Chapter five examines masculine and feminist theories in relation to health and health care, from their inception to the present including their influence on the populous and the government.

Chapter six consists of a compilation of conclusions concerning the present state of men's health, which are based on my analysis of the relevant statistical data and understanding of my secondary analysis of published material, and the findings of interviews with medical professionals. The chapter concludes with recommendations for improving men's health and extending their lives. These are condensed into three areas of influence: lifestyle, bio-medical and environmental/social.

The thesis concludes with the appendices, which include interviews conducted with four prominent doctors, Barry Fine, Claude Maranda, Michael Malus, and Gerald Kudo, and an example of the participation consent form. An explanation of the methodology is next and finally an explanation of 'The Healing of Prometheus'.

Chapter 1

MORTALITY

Introduction

Men die about six years earlier than women, on average, in both Canada and the United States; and their mortality rates are higher for all 10 leading causes of death. In this chapter we will explore the mortality differentials between men and women, paying particular attention to the so-called preventable deaths: homicide, suicide and accidents, and the wide gap between the high male mortality figures and the relative low figures (compared to the males), of the females. The mortality gap seems to be narrowing in heart disease, lung cancer and stress-induced ailments as these conditions are becoming more prevalent in women, while maintaining the high rates for men.

Death Rates

Table 1 shows that Canadian males die in greater numbers, at the age standardized rate, than their female counterparts of the 10 leading causes of death, (cancer, heart disease, strokes, accidents, pneumonia, diabetes, suicide, liver disease, etc. They die in greater numbers in every age category, and under every detrimental social circumstance. Unlike assessing total gendered populations by causes of death (for instance), age standardization allows comparing men, at a particular age with women in that same age group. This is calculated by a specific set of formulae, based on the standard population. To derive age standardized rates one must formulate a common denominator to eliminate the effects of the age variable, when calculating causes of death over the entire life span. For instance, many men die in there 50's from heart attacks, and many women die in there 80's and 90's from heart failure. The age-adjusted rate would take into

consideration the age difference. This is very important when considering that passing away from heart disease beyond the late 70's might be considered death from old age, while death in the 50's is unnatural. Age standardized rates are used mainly for comparison purposes as their numbers do not reflect any actual population figures.

Table 1

LEADING CAUSES OF DEATH
By Gender, Per 100,000 Population*
Canada, 1997

Illness	Male	%	Female	%	Total	Ratio* M:F
Heart Disease	36,747	64%	20,670	36%	57,417	1.16:1
Cancers	31,555	54%	27,148	46%	58,703	1.56:1
Cerebral (Stroke)	8,828	55%	7,223	45%	16,051	1.22:1
Pulmonary Disease	6,636	69%	2,982	31%	9,618	2.22:1
Suicide	6,035	64%	3,454	36%	9,489	1.74:1
Accidents	5,866	68%	2,760	32%	8,626	2.13:1
Pneumonia & Flu	4,980	62%	3,052	38%	8,032	1.63:1
Diabetes	3,305	58%	2,394	42%	5,699	1.38:1
Degenerative Disease	2,777	55%	2,272	45%	5,049	1.22:1
Kidney Disease	1,699	64%	955	36%	2,654	1.78:1
Liver Disease	1,380	68%	650	32%	2,030	2.12:1
HIV Infection	551	88%	75	12%	626	7.34:1
All Other Causes	<u>15,607</u>	58%	<u>11,301</u>	42%	<u>26,908</u>	1.38:1
Total	125,966		84,936		210,902	

Statistics Canada, 1997. Cat. No. 84F0209XIB Mortality-Summary List of Causes

In this section we will consider the number of deaths per annum, the differential mortality rates by gender, age-standardized, and the decline in infant mortality rates, which has had such impact on longevity.

Three significant sets of statistics of mention are in Table 1. The first are the rates of cancer and heart disease affecting the population compared to the other causes of death. Almost four times as many males and three times as many females die from cancer or heart disease than from the next leading cause of death.

Cancer was responsible for 29% of Canadian deaths in 2001. This amounted to 63,774 deaths, of which lung, colorectal, breast and prostate accounted for about half. Lung cancer killed 9,925 men and prostate cancer (more easily diagnosed), killed 3,825. Percentage wise, 9% of all male deaths and 29% of male cancer deaths were caused by lung cancer. Prostate cancer was responsible for 3% of all male deaths and 11% of male cancer deaths. For women, the incidence and death rates of lung cancer in the last 30 years have risen almost fivefold. Since 1993, more women have died each year from lung cancer than from breast cancer. In 1998, 6,500 women died from lung cancer and in 2004, 8,200 women succumbed from it. Breast cancer death rates have been declining since 1986. In 1998, 5,300 women died from breast cancer and in 2004, 5,200 died (Statistics Canada, Canada e-Book 11-404-XIE 'Major Causes of Death' 2003-05-26:1. National Cancer Institute of Canada, Canadian Cancer Statistics, 1998:32. Canadian Cancer Statistics, 2004:18).

Heart disease claimed the lives of 58,155 Canadians in 1997. This total includes mortality due to ischemic heart disease (insufficient oxygen supply to the heart muscle), heart failure/dysrhythmias (inadequate pumping/irregular beating) and other related heart conditions causing death. In 1999 the Canadian death total due to heart disease was 50,970. Both male and female mortality numbers from heart disease declined between 1997 and 1999, however the decline was more substantial for males as 738 fewer of them

succumbed. The actual numbers were: 27,396 male and 27,219 female deaths in 1997, and 23,751 male and 24,312 female deaths in 1999 (Statistics Canada 1997, Cat. No.84F0209XIB, Statistics Canada 1999, Cat. No. 84F0209XPB).

The second major significant sets of data are the rates in relation to gender. The greatest gender difference occurs in HIV/AIDS where 88% of those who died were male. Evidence shows that lifestyle and personal behavior are major contributors. Pulmonary (lung disease) is next at 69% males. Aside from lung cancer, smoking is known to be a major contributor toward the contraction of emphysema, COPD, asthma, and bronchitis. Following closely are the gender differential percentages of liver disease and accidental death at 68% male. (see Table 1). The most common cause of Cirrhosis of the liver is alcohol abuse and accidents/injuries are a major cause of death among young males. For males, aged 1 to 44 years, accidents were the number one cause of death.

In years past, communicative diseases were the major killers, and now, except for HIV/Aids, they do not even make the top lists (Statistics Canada 1997, Cat. 84F0209XIB. Courtenay, 2002c).

Table 2

MORTALITY RATES
By Gender, per 1,000 Population,
Canada, 1921 - 2001

	<u>Infant Mortality Rate</u>			<u>Overall Mortality Rate</u>			
	<u>Male</u>	<u>Female</u>	<u>M:F Ratio</u>	<u>Male</u>	<u>Female</u>	<u>Gap</u>	<u>M:F Ratio</u>
1921	98.2	77.4	1:27	10.9	10.2	0.7	1:06
1931	94.4	74.4	1:27	10.5	9.6	0.9	1:09
1941	67.0	51.9	1:29	10.8	9.1	1.7	1:18
1951	42.7	34.0	1:26	10.1	7.8	2.3	1:29
1961	30.5	23.7	1:29	9.0	6.5	2.5	1:38
1971	19.9	15.1	1:32	8.5	6.1	2.4	1:39
1981	11.0	8.5	1:29	8.0	6.0	2.0	1:33
1991	7.5	6.1	1:22	7.9	6.5	1.4	1:22
2001	5.7	4.8	1:19	---	---	---	---

Statistics Canada 1999, Cat. No. 84F0209XBP. Statistics Canada 2002. Cat. No. 82-003

Mortality rates in Canada, for both males and females have shown a general and substantial decline over the last 80 years, as Table 2 indicates. Much of the decline in overall mortality has been due to the remarkable decline in the infant mortality rates, improved sanitation, and the decrease of epidemic proportions of deadly infectious diseases*, and as a result, life expectancies have increased. However even from conception, male mortality rates are higher than female rates. In 1991, the overall

mortality was 22% higher for men than for women (*See appendix for list of infectious diseases)

The most significant drop in death rates occurs with infants. In 1921 there were 98.2 infant male and 77.4 infant female deaths, per 1,000 infants. With each decade, there has been a continuous decline in infant deaths for both genders. In 2001, the number of deaths was 5.7 and 4.8 per population of 1,000, for male and female infants respectively. The rates of the most current data available, works out to .006% to .005% for male and female infants respectively. The difference between male and female infant deaths totals 0.1% for 2001, down from 2.1% in 1921.

The higher rate of male mortality starts even before birth:

The sex ratio of male to female conceptions is approximately 140 to 100. In other words, in the absence of technological interventions, 140 male embryos are created at the moment of conception, to every 100 female embryos. From conception onwards...the male fetus is at greater risk of miscarriage and stillbirth. The gender gap at birth is approximately 105 males to 100 females (Nelson and Robinson, 2002:380).

From the earliest months of life, male deaths outnumber female deaths. “Immediately following birth, 25% more newborn males die than females. Sixty seven percent of Sudden Infant Death Syndrome (SIDS) victims are male” (Men’s Health Network, 2003). By about the age of fifty-five men are about twice as likely to die as women from both external interventions and internal breakdowns. (Moore,1989:110).

In Canada and the United States, proportionally more men are likely to die at all ages than are women. (Nelson and Robinson, 2002: 380, 387). One of the reasons for this difference appears to be genetic, as the male fetuses in early stages of development do not seem to be as hardy as the female fetuses at the same stage, and consequently succumb in

greater numbers. However, for both genders infant mortality are higher in neighborhoods of low socio-economic situations. (Clarke, 2000:112).

Decreases in overall mortality have not been as dramatic as the decreases in infant mortality. Newborn infants are very fragile but with the advent of better hygienic conditions and birthing facilities, the high death rate decreased rapidly. In 1921, there were 10.9 male deaths per 1,000 people. For females, for the same year there were 10.2 deaths per 1,000 people. In 1921, seven more males died, per 10,000 people than did females. By 1961 the mortality rate gap had more than tripled from 0.7 per 100,000 people in 1921 to 2.5 per 100,000, due mostly to the rapid decline in female mortality, this translates to twenty-five more males dying per 10,000 population than females. In 1991, the mortality rate gap declined to 1.4, slightly more than half of the 1961 gap, but double the 1921 gap of 0.7.

Some of the reasons for a decline in overall mortality are similar to those contributing to a decrease in infant mortality. Men, women and children are living longer due to advances in medical and scientific research. Lives are being extended daily, monthly, and yearly with the use of modern antibiotics, chemotherapy, radiation, and other modern medications which prevent, control, suppress, or reverse the effects of some debilitating illnesses.

Among the reasons for the decline in the mortality rate of women, are improvements in sanitary child birthing facilities and greater access to medical personal such as obstetricians, gynecologists, pediatricians, medically trained midwives and nurses. Another childbirth variable, which has impacted the North American female

mortality rate, is and availability of the birth-control pill and the fact that the overall childbirth rate per female is down appreciably.

Mortality rates in Canada for both males and females have shown a general and substantial decline. The age-standardized death rate per 1,000 population, per year has declined from 10.2 in 1921 to 6.5 in 1999 for females and from 10.9 to 7.9 for males. In 1921 the gap between male and female mortality was 0.7 years. In 1991 we see the gap narrowing slightly. (Table 2). From 1951 to 1991 the decline in mortality rates have benefited females to a greater extent than males. In that time period the age-standardized all-cause mortality rates for Canadian women fell by 49.5% from 1,025 to 518 deaths per 100,000; while for Canadian men the drop was 32.8% from 1,322 to 888 deaths per 100,000 population.

Life Expectancy

Life expectancy is a good indicator of the overall health of a population, and is also a good indicator of general trends in gender inequalities in health.

Table 3

**LIFE EXPECTANCY
From Birth, By Gender**

	Canada 1831-2001			U.S. 1921-2001		
	Years		Gap	Years		Gap
	Female	Male		Female	Male	
1831	39.8	38.3	1.5	-----	-----	
1921	58.4	55.0	3.4	54.6	53.6	1.0
1926	58.9	56.9	2.0	58.0	55.5	2.5
1950	70.8	66.3	4.5	71.1	65.6	5.5
1970	76.4	69.3	7.1	74.7	67.1	7.6
1980	79.0	71.9	7.1	77.4	70.0	7.4
1991	81.0	74.6	6.4	78.9	72.0	6.9
1996	81.5	75.7	5.8	79.1	73.1	6.0
2001	82.3	77.2	5.1	79.8	74.4	5.4

Data prior to 1950: Clarke (2000:50). 1926 Data: adapted from Nelsen and Robinson (2002:386). 1950-70: Statistics Canada, Vital Statistics 1977, vol.III Cat. no.84-206; 1980:Statistics Canada, Life Tables, Canada and Provinces; 1980-82, Cat. no. 84-532; 1991: Canada Yearbook 1994:1991; Report on the Demographic Situation in Canada 1994 Cat. no. 91-209E; 1996: Report on the Demographic Situation in Canada 1997 Cat. no. 91-209-XPE, 77. 1920-50-70: (U.S.) National Vital Statistics Report. Vol. 48, No.18 Feb.7, 2001, pp. 33-34. National Vital Statistics Report. Vol. 51, No. 5, March 14, 2003. pp. 25. The World Health Organization Report 2003. National Vital Statistics Report. Vol. 53 No. 6 Nov.10, 2004

In Canada, from 1831 through 2001, there has been a steady increase in overall life expectancy, culminating in its more than doubling for males, (from 38.3 years to an expectancy of 77.2 years) and more than doubling for females (from 39.8 years to 82.3 years). This is an increase of 38.9 additional years of life for males and 42.5 additional years of life for females from the 1831 birth life expectancy figures. The extended longevity has benefited females more than it has males, and the life expectancy gap between males and females, at 5.1 years for Canadians, and 5.4 years for Americans, is among the highest in the world.

The gap between the (average) life expectancies of Canadian and American men and women (with women living longer than men), progressively widened and has been greater in the past 50 years than at any point in history. While both men and women gained extensions to their life expectancy, in the 1920's, there was a two-year gap in favor of Canadian women and a one-year gap for American women. During the 1970's and 1980's, the life expectancy gap in Canada reached a high in favor of females of 7.1 and 7.6 years in the U.S. By the early 2000's, the gap for both countries was marginally over five years.

During the period from 1970 through 2001 (see Table 3), women gained 5.9 years of life expectancy and in the same time period men gained 7.9 years. This is a substantial gain for both males and females, however the higher gain rate in life expectancy for males can be explained by considering the slower life expectancy growth for females.

The 1960's social (and economic) evolution saw the substantial emergence of women into the previously male dominated workforce, (a notable exception being in the U.S. during World War Two, the 'Rosie the Riveters', replacement workers), with the

requisite pressures and stresses, and their adoption of previously male practices such as smoking, drinking, driving, and eating fast food/junk food. Even the act of commuting to and from work for those who had not previously worked outside the home, contributed additional stress when driving on crowded roads and exposure to germs and air-borne pollutants, when using crowded public transportation. Economics had begun dictating that two salaries were required to support the family nest and the frequency of chronic afflictions began to slowly rise for females.

During the same time period, males began giving up smoking cigarettes, cigars, pipes, and chewing tobacco. This was due at least in part to continued warnings from the U.S. Office of the Surgeon General.

A popular conception is that, in Canada and the United States, the consistently lower life expectancy rates for men appear to be the result of “a more hazardous lifestyle associated with masculinity in our society” (Nelson and Robinson, 2002:387). Conversely, improvements in technology and hygienic birthing facilities, and lower birth rates have contributed to increasing the life expectancy of women.

A major reason for the increase in expected female longevity may be attributed to women experiencing fewer childbirth complications leading to their death. Modern birthing procedures and the increased availability of modern hospitals with proper labor and delivery facilities are among the most likely contributing factors to this increase. In this time period, the wide spread use of birth control devices resulted in smaller families, and less stress on females. The beginning of the 1990’s saw many women promoted in the workforce to high stress jobs. Women began to experience the effects of workplace stress on their physiology. (Bourbeau et al. 1997:77-86. Statistics Canada, Vital Statistics

1997 Vol.3. Cat. no.84-206. Clarke, 2000:49. Ory and Warner, 1990:viii. United Nations, 1999. World Statistics Pocketbook).

Table 4

LIFE EXPECTANCY
By Health Status and Gender
Canada, 1911-1993

<u>Year</u>	<u>Years of Healthy Life Expected</u>		<u>Years of Ill-Health</u>		<u>Life Expectancy</u>	
	<u>Females</u>	<u>Males</u>	<u>Females</u>	<u>Males</u>	<u>Females</u>	<u>Males</u>
1911 (at age 15)	58	53	9	7	67	60
1993 (at birth) (estimate)	74	70	8	7	82	77

(Canadian Social Trends (Summer 1995). The World Health Organization Report 2003.

One important measurement of life expectancy is disability-free life expectancy, or the number of years of life that can be expected to be free of activity limitations. While the life expectancy of both males and females increased significantly since 1911, the number of years of ill health one could expect, has remained constant, between 7 and 9 years. Even though we are in Canada and the U.S., healthier overall than in 1911, due to advances in medical research and social policies, as life expectancy increases, infirmities commensurate with old age become increasingly evident for the portion of the population, which previously would have already died. Even though the gender gap in life expectancy is five years, the gap in ill health before death, is only one year. Even

though males live shorter lives, they sustain almost as much ill health before death as do females.

Table 5
LIFE EXPECTANCY – INTERNATIONAL COMPARISON
By Gender

Lowest Life Expectancy		Highest Life Expectancy Gap			
Country	Life expectancy (Years) (Both Males and Females)	Country	Life Expectancy (Years) (Males)	Life Expectancy (Years) (Females)	Gap
Zambia	32	Russia	59	72	13
Zimbabwe	33	Ukraine	60	72	12
Swaziland	34	Kazakhstan	58	69	11
Lesotho	35	Brazil	59	70	11
Mozambique	38	Seychelles	66	76	10

The Economist, 2004:77. Carnell and McDevitt, 1999:A50-A52

There are countries in the world, especially on the continent of Africa, where men and women presently live to approximately the same age, which is relatively young. Residents of Malawi, Zambia, and Zimbabwe, both males and females have life expectancies of 37 to 39 years, which are less than half the life expectancy rates for Canadians or Americans. Poor medical and social services combined with very high levels of HIV/AIDS infection; 900,000, 920,000, and 1,600,000, (estimated) infected

residents of these countries respectively, or 7.5%, 9.3% and 14.1% men, women, and children of their total populations are infected, which contribute to the low life expectancy rates. Males and females of Bangladesh and Nepal also live approximately the same length of time, but which is about 20 years longer than residents of Malawi. The agricultural potential of these countries is very low due to the lack of geological or mechanical soil irrigation, especially during periods of severe drought. Tribal warfare and internal strife limit foreign investment and food relief assistance from other countries and agencies is piecemeal and does not address the problem of self-sufficiency. “Give the man a fish and you feed him for a day, teach him to fish and you feed him for life” (anonymous). In countries where daily existence itself is a struggle, life expectancy is dependent on basic necessities: clean water to drink, sustainable food rations, shelter from the elements, safety from aggression, a gainful means to provide for one’s family, medical care and instruction on proper sanitation and hygiene and the prevention of disease and the spread of infection, which are more or less taken for granted in the West (National State Office, Govt. of Malawi Population Statistics. Central Statistical Office of Zambia. Zimbabwe Government Online. Population Statistics. UN-AIDS Org. Global Report 2004:1).

Among the countries with the largest life expectancy gap are three in the former Soviet Union, Russia, Ukraine, and Kazakhstan, with gender gaps of 13, 12, and 11 years respectively. Illness and death rates are not linear or uniformly progressive due to societal and environmental variables “life expectancy rates for Russian men, have declined from 65.5 years in 1991 to 57.3 years in 1995” (Lorber,1997:15). Lorber implies that the decreased longevity of men in the capital state of the former Soviet Union, after the

introduction and implementation of capitalism and rudimentary democracy in the previous communist country, is due in part to social, environmental, and economic factors associated with the collapse of the Soviet industrial and manufacturing economy and lends credence to Clarke's argument that "This disparity seems to be related to industrialism and capitalism" (Lorber,1997:15. Clarke, 2000:121). Russia has been industrialized for a long time. Lorber and Clarke might be referring to industrialization in a capitalistic venue where production is for profit and there is stringent cost accountability, which results in fewer workers doing more varied jobs while under more stress. Unemployment, AIDS, and vodka, both the homemade sometimes poisonous variety and the commercial brands which have a large following among Russian males, are all known contributing factors in the diminishing male life expectancy rates.

Alcoholism, excessive smoking, and depression are all indicators and consequences of abrupt societal changes. President Gorbachev of the former Soviet Union tried to implement democratic capitalistic policies at a slow yet progressive pace to reduce the social, psychological, and economic impact on the citizenry but was defeated by Boris Yeltsin and his all-at-once social change plan. (Mikhail Gorbachev after leaving office taught at Harvard University in the United States).

Heart Disease

The leading cause of death in Canada and the U.S. is heart disease. The term heart disease encompasses many conditions from congestive heart failure (the heart does not pump as strongly as it should), to coronary heart disease (cardio-vascular) where one or more blood vessels leading to the heart have narrowed or blocked and can no longer give enough blood to meet the hearts demand. "During the average life span men and women

have the same proportional mortality from cardio-vascular disease however, men develop CVD's approximately 10 to 15 years earlier than women and these result in a shorter life expectancy for men" (Fodor and Tzerovska, 2004:2). In other words, men actually die in great numbers and at an early age from heart disease. "Middle-aged men (35-65 years old) have a progressively increasing risk of coronary heart disease as they age. Up to one-third of all new CHD events and about one-fourth of all CHD-related deaths occur to middle-aged men" (Fodor and Tzerovska, 2004:2).

Table 6

DEATH RATES FROM HEART DISEASE*
By Gender, 1990 to 2000 - U.S. and Canada

	U.S.			Canada		
	Male	Female	Ratio M:F	Male	Female	Ratio M:F
1990	412.4	257.0	1.60:1	259.0	142.0	1.82:1
1995	372.2	239.7	1.55:1	246.1	138.3	1.78:1
1997	349.6	228.1	1.53:1	230.8	129.7	1.78:1
1998	336.6	228.1	1.48:1	-----	-----	
1999	328.1	220.9	1.49:1	198.0	105.6	1.88:1
2000	315.0	213.0	1.48:1	-----	-----	

* Per 100,000 population

U.S Census Bureau, Vital Statistics #112, 2004-5.

Statistics Canada, Cat. No. 84F02D9XPB, Cat. No.82-003-X20020036557

The death rates from heart disease for both men and women are falling, however the male death rate is still 48% higher than that of females (See **Table 8**) however the age standardized death rate is 62% higher.. In 1996, heart disease accounted for 20.6 % of mortality in Canada. Heart attacks accounted for half of that. In women, the proportion of

all deaths due to heart disease increases after menopause. In men the percentage of heart disease deaths increases steadily from age 35. More men than women are at risk for heart disease. Past age 40, 49% of men and 32% of women are likely to have some form of heart disease. (Statistics Canada Cat. No.82F0076IE).

Individual behavior, social conditions, and advances in medical care and pharmaceuticals, are said to be largely responsible for the overall lowering of the death rate from heart disease. The ratio of men to women in reference to dying from heart disease is narrowing (see Table 8). This change in the gap may be explained by the changes in lifestyle, which women have been undergoing. The additional stress in the workplace with the cracking of the glass ceiling has exposed women to both the benefits of middle and senior management, and its inherent health detriments. Smoking has also shown to be a contributor to cardiovascular disease and less women are quitting smoking and more girls are starting smoking than men and boys (Statistics Canada Cat. No. 82-003-XPB. Health Reports 1997 Vol.9 No.1).

The propensity towards developing heart disease can run in families. Multiple sources recommend vigorous exercise, a healthy, low-fat diet, and abstention from tobacco, and stress-control as actions that individuals can adopt for keeping heart disease at bay and controlling its ravages after it appears.

Cancer

The number two leading cause of death in both Canada and the United States is cancer, in one form or another.

Table 7

LIFETIME PROBABILITY OF DEVELOPING AND DYING FROM CANCER*
2003

Male	Developing %	Dying %	Female	Developing %	Dying %
Prostate	12.0	3.6	Breast	1.4	3.7
Lung	8.8	8.3	Lung	6.1	5.0
Colorectal	6.7	3.5	Colorectal	5.5	3.3
Lymphoma	2.9	1.6	Uterus	2.3	6.0
Bladder	2.7	1.0	Ovary	1.6	1.1
Oral	1.4	0.5	Pancreas	1.3	1.3
Kidney	1.6	0.7	Leukemia	1.1	0.7
Stomach	1.4	1.0	Kidney	1.0	0.4
Leukemia	1.4	1.0	Bladder	1.0	0.4
Pancreas	1.2	1.3	Stomach	0.8	0.7
Melanoma	1.1	0.3	Melanoma	1.0	0.2
			Cervix	0.7	0.3
			Oral	0.6	0.3

(All cancers)					
Male	41.2	27.4	Female	37.6	23.1

* Age-standardized rate.

National Cancer Institute of Canada: 2004

Men have a higher probability of developing and/or dying from cancer in their lifetime than do women. During their lives, Canadian males have a 41.2% chance of developing cancer, a slightly higher probability than for females, and also a higher probability of dying than do females (see Table 7).

Since the mid-1990's the most common sites in which new cancer cases are detected are the male prostate and the female breast. In 2000, there were 18,487 new

prostate cancer cases reported and 18,530 new breast cancer cases. Lung cancer is responsible for the largest number of cancer deaths for both males and females. The rate of new cases of lung cancer reported from 1996 to 2000, had increased 1100 % more for females than the male rate (1095 new female cases per 100,000 people compared to 92 new male cases). Cigarette smoking has been scientifically linked to lung cancer. Since the 1970's, women began smoking in large numbers. The only smoking group now increasing is that of young girls. The age-standardized five-year relative survival rate for lung cancer is a low 15 % for men and 18 % for women. The prognosis for colorectal cancer survival based on the age-standardized five-year relative survival rate is a little better at 56 % for men and 58 % for women. Using the same standards, both prostate and breast cancer patients, have an 80 % chance of living another five years (Statistics Canada, Catalogue 82-003. Health Reports, Vol.12 No.3. Statistics Canada, Canadian Cancer Registry Database, Nov. 2003. CANSIM table 103-0513, Cat. No. 84-601-XIE).

Sixteen percent more men than women die from cancer each year. But the age standardized mortality rate for men is 56% higher because they die younger. According to Statistics Canada, the probability of a male developing a malignant neoplasm in his lifetime is 40%, and of dying from it, 26%. Women fare better at a 35.5% chance of development and 22.2% chance of dying. All cancers are potentially deadly however, prostate cancer holds the highest probability of development for men at 11.2%. The risk of it causing death is 3.6% or less than half the mortality rate compared with the probability of developing lung cancer (at 8.8%) and dying from it at 8.1%. Lung cancer is the leading cause of cancer death for males. It kills 2.3 times more men than women in Canada and 2.5 times more in the U.S.

A likely contributor to respiratory and lung cancer problems is linked to some men's industrial work venues where carcinogenic substances might be found and inhaled. Cigarette smoking is considered to be a major contributor in the development of lung cancer and other respiratory diseases. According to a survey conducted in 2001, 23.5% of Canadian males, over 12 years old reported that they smoked. (Note: The social aspects of smoking will be examined in the behavioral section). (Clarke, 2000:107-8,110. Statistics Canada, National Population Health Survey 1997 Cat. No.82-567-XPB).

Prostate cancer, because of its frequency, and effects, has been covered earlier under major causes of death. Testicular cancer accounts for only 1 percent of cancers in men, but is the most common form of cancer in young men between the ages of 15 & 35.

Table 8

**CANCER CAUSING AGENTS
By percentage**

<u>Causes Of cancer</u>	<u>Percentage</u>
Smoking	30 %
Poor diet	30 %
Food additives	1 %
Radiation exposure	2 %
Occupational exposure	5 %
Infectious agents	5 %
Environmental pollutants	2 %
Medical products/treatments	1 %
Alcohol	3 %
Sedentary lifestyle	3 %
Heredity/mutation	5 %
Gynecologic factors	4 %
Others	<u>9 %</u>
Total	100 %

=====

Trichopoulos, Li and Hunter, 1996:85

Skin cancer (malignant melanoma), is the most common cancer. The increase in melanoma among men is higher than that of any other cancer. A major contributor to the development of malignant melanoma (skin cancer) is the absorption of ultra-violet solar rays by sun tanning without proper sunscreen or engaging in other activities which leaves unprotected skin exposed to the harmful solar rays, (see Table 7). While tanning has traditionally been more important for women, it has become increasingly popular with men, (the smooth-chest, oiled, and tanned look). Recent evidence shows that now women

tend to be more careful (i.e. use of suntan lotion, protective clothing, hats, etc). A 1996 survey of Canadians over 15 years old, reports that in each of the four categories: use sunscreen, wear protective clothing, cover head, and seek shade, during leisure hours, women (more often or always) took precautions at greater percentages than men (Sun Exposure Survey 1996: Health Reports, Autumn, 1998). “In the U.S. women are 1.5 to four times more likely than males to protect themselves from the sun with sunscreen and other forms of protection” (Courtenay, 2000f:88).

Men traditionally used to taking risks, and possibly ignorant of the consequences (men’s magazines do not usually include health care articles unless they concern potency/impotency or hair restoration), are less likely to use protective devices, resulting in increased instances of skin cancer. “The gap between men’s and women’s rates of melanoma is now the narrowest it has been for the last 25 years” (Williams, 2003:93). “During the 1970’s and early 1980’s, age-standardized incidence rates of melanoma rose steeply for both sexes, but were slightly higher for women than men. In the mid-1980’s women’s incidence rates leveled off, and the rate among men surpassed that for women” (Gaudette and Gao, 1998:31).

Since the late 1980’s, not only were overall melanoma mortality rates lower among women than men, but the death rates to incidence ratio was also lower compared to that of males. Statistics show that the Canadian (age-standardized) melanoma incidence rate per 100,000 men was 9.8 compared to 8.7 for women. The death rate for men was 2.5 compared to 1.4 for women (Canadian Cancer Registry: Statistics Canada. Health Report, Autumn1998). This reflects a death rate to incidence ratio of 25% for men compared to

16% for women. Males in the U.S. make up two out of every three deaths from melanoma (Courtenay, 2000f:88).

Potential Years of Life Lost

This segment includes the number of years of life lost due to premature death from disease and injuries. While mortality rates are useful in evaluating the relative impact of causes of death, the potential years of life lost rate, is a good indicator of premature mortality. The PYLL is calculated by subtracting the age at which death actually occurred to age 75. This calculation puts more weight on early deaths, and on causes of death occurring to the relatively young. For instance, the PYLL figures on suicide reflect the relative importance of this cause of death during the teenage and young adult stages. The age-standardized mortality rates for suicide, calculated without reference to age, rank lower (Statistics Canada, Vol.12, No.3. Cat.82-003). For most major causes of potential years of life lost, the rate for males exceeds that for females, indicating a higher risk of earlier death. Males are over seven times as likely to die prematurely from HIV than females, over twice as likely to die prematurely from liver disease, pulmonary disease, and accidents and almost twice as likely as females to die prematurely from causes such as heart disease, accidents and suicide (see Table1).

In 1999, lung cancer alone was responsible for over 120,000 potential years of Canadian lives lost among Canadians from birth to age 74. Colorectal cancer was responsible for nearly 39,000 potential years of life lost (The Canada e-Book, 2001:2).

Table 9

POTENTIAL YEARS OF LIFE LOST¹ & ECONOMIC COST
By Gender and Selected Cause
U.S. - 2001

Cause	Total Cost in Millions ²		Cost per Death ³		Years of Life Lost Per Death	
	Male	Female	Male	Female	Male	Female
Heart Disease	\$ 59,848	\$ 18,373	\$ 176,518	\$ 50,891	13.8	11.8
Cancer	80,701	36,920	281,120	138,437	18.8	17.9
Accidents/ Injuries	58,991	15,341	894,405	432,607	35.3	30.5
Other	130,296	58,390	304,543	124,401	17.8	16.3
Totals	329,836	129,024			21.4 mean	19.1

¹Based on remainder years (before age 75), of life expectancy (from birth), after death.

² & ³ Cost estimates based on the following variables: person's age, sex, life expectancy at the time of death, labour force participation rates, annual earnings, and value of homemaking (Resource; Institute for Health and Aging, Univ. of Calif.).

U.S. Census Bureau, Vital Statistics. No. 87-112, 2004-2005.

The average years of life lost for men was 21.4 years, compared to 19.1 for women, but these years of life lost cost the U.S. in 2001 an estimated \$459 billion, mostly due to heart disease, cancer and accidents. (see Table 9). Accidents, and violence are especially a problem for young males. They contribute a large share to potential years of life lost and also to work days lost (Hamburg, Elliot, Parron, et al. 1984:37).

Potential Revenue Lost and Medical Costs

Lost tax revenue can be realized from multiple sources. Serious illness (or death) usually brings a cessation of work income, and the paying of income tax. Serious illness also usually means low or no purchases, as few of the very sick go to restaurants or purchase new cars etc. Low (or no, in the case of death), sales tax revenue is generated.

In some cases serious illness means low revenue, requiring low cost housing and/or government financial assistance. Hospitalization, private or State run assisted-care living facility, or living with relatives is sometimes an unavoidable reality. None or minimal service taxes are realized by the municipality when serious illness depletes ones reserves or reduces their autonomy to the point where institutional tax rates apply.

The consequences of certain behaviors have a detrimental monetary effect on the health care system and are disproportionately present among the 20 percent of patients with highest hospitalization costs. According to a survey conducted at six (U.S.) hospitals, "...from 31 to 69 percent of the high hospitalization cost patients, (those requiring intensive, expensive, and/or extended hospital stay and medication costs), but only 20 to 45 percent of the lower-cost patients, (those requiring relatively less expensive treatment, day surgery, etc.), had at least one unhealthy habit, alcohol or drug abuse, cigarette smoking, obesity, noncompliance with medical advise" (Hamburg, Elliot and Parron, 1982:38). What the authors are trying to say is that there seems to be a direct correlation between unhealthy habits and extensive hospitalization (unstated, but most likely). In other words, the unhealthy habit of cigarette smoking causes lung cancer, which requires extensive, expensive treatment. An accidentally caused broken leg or malfunctioning gall bladder, require routine treatment and relatively rapid convalescence.

Conclusion

In the last 160 years both men and women have undergone great increases in life expectancy, however the gap in years of males dying sooner than females has been greater in the past 35 years than in years past. At every stage in the life cycle, men are more likely to die sooner than women, and they have higher death rates for all 10 leading

causes of death. Heart disease and cancer are the leading causes of death for both males and females. The uncontrollable risk factors of heredity, age, and gender are offset by the multiplicity of controllable risk factors high cholesterol levels, high blood pressure, smoking, obesity, poor eating habits, unblocked sun exposure, etc. Also regular medical check-ups contribute to lower early mortality rates.

Chapter 2

PREVENTABLE DEATHS

Introduction

Preventable deaths include accidents, homicides and suicides and war. Other “preventable”, directly attributable, risk factors or major contributors to causes of death, are smoking, drinking, and obesity. These will be considered as lifestyle factors in Chapter 3.

Seventy-five American males between of 15 and 24 years of age die every day. Eight out of 10 of these deaths are violent, and preventable - the results of accidents, homicides, and suicides (See Tables 10 & 11). Male deaths are higher than those of females in more than 30 causes of preventable deaths. (Courtenay, 2002:1).

Accidents

Table 10

ACCIDENTS
By Gender, 1998 and 2000
U.S.

<u>Year</u>	<u>Male</u>	<u>%</u>	<u>Female</u>	<u>%</u>	<u>Ratio M:F</u>
1998	63042	64%	34793	36%	1.81:1
2000	63817	65%	34083	35%	1.87:1

National Vital Statistics Report, Vol. 48, No. 11, July 2000

National Vital Statistics Report, Vol. 50, No. 16, September 2002

Once past infancy, in the U.S., at every age and at every stage, males are much more likely to die, as a result of a preventable death than females. In fact, males are 87%

more likely to die accidental deaths than females (See Table 10). The likelihood of males dying from preventable deaths compared to females has increased from 1998 to 2000 by 3% and while the total amount of female preventable deaths has declined during that time period by over 700 deaths, the male total has increased by about the same amount. (See Table 10). It would seem that women are becoming more careful and men more careless, or perhaps parents are being more careful of girls than boys.

Between the ages of 15 to 19, young men are four times as likely as young women are to die as the result of an accident. From ages 20 to 24 that rate increases to five times as many males likely to die accidentally. The types of accidents in the statistics include; motor vehicle accidents, falls, poisoning, drowning, choking, electrocution, and shot by a firearm. Almost half of all the deaths in the combined two age groups, are due to motor vehicle accidents, in which nearly 3 times more young men, than young women die. The second leading cause of accidental death in this age group, is drowning, in which 12 times more young men than young women succumb. A suggestion that young males are accident-prone would have to be predicated on the elimination of all other variables, which could contribute to the accident scenario (Clarke, 2000:114, Courtenay,2002a).

In Canada, the accident rate is slightly more than twice as many males dying than females (see Table 1). U.S. accident death rates per 100,000, by race and sex, excluding car accidents, for white males is overall 5 times greater than for women, 25.3 versus 4.5 and it is double for black men compared to black women, 29.1 versus 13.0. Males both black and white, die at higher rates, of females in motor vehicle accidents.

Workplace Fatalities

Table 11

DAYS LOST PER WORKER DUE TO ILLNESS OR DISABILITY
Canada, 1995–2003

Gender	Year / Number of Days				
	1995	1997	1999	2001	2003
Male	5.4	5.3	5.9	6.3	6.6
Female	6.6	7.6	7.9	8.0	8.7

Statistics Canada CANSIM 279-0029, 2004

Even though there are more men working at accident-prone, full-time paid jobs, women workers in 2003 lost 2.1 more days of work than did men. An important reason for this is that many workplaces operate with a minimum workforce requiring replacement staff when someone is absent. In the past, men, as primary breadwinners in many households, were loath to jeopardize their jobs or loose pay by taking off time from work. Another important reason is that women habitually visit their doctor's more often than men do for regular check-ups and as caretakers for children and senior relatives, and so are apt to do so when they themselves are ill or disabled. Medical recommendations may entail bed rest or cessation of work duties for a period of time to ease the symptoms or help heal the complainant. The number of days lost is steadily increasing over time, for both sexes, suggesting either a lower tolerance for illness or disability or deteriorating health or perhaps reduced company loyalty. Furthermore the gender gap has widened from 1.2 days in 1995, to 2.1 days in 2003 (see Table11).

High-risk, work related accidents and exposure to pollutants take their toll on the exposed population. Certain industries have been traditionally considered male-

dominated, partly because of the danger involved in the workers' performance of their duty. Among these are mining, construction, transportation, fire fighting, police work, and combat military service. Although over 95% of workers in the 10 most hazardous jobs are men, recently women have begun to make inroads into these and other high-risk, high-paying jobs and the statistics will eventually present proportional, female casualty rates, along with the male casualty rates. But for now, 95% of work-related fatalities are still the men and boys dying in the mines, in the fires and in the wars (Clarke, 2000:105, Bonhomme, 2002:2).

In recreation, as at work, injuries and deaths are mostly male; indeed 33% of the male population of twelve years of age and older, were injured, compared to female injuries at 22%. Statistics show that boys and men participate more in rough sports and dangerous activities than girls and women. Work related injuries are almost double for men at 29% versus 15% for women. The one category shown to have a higher percentage of female injuries is that of, in the home/ surrounding area at 39% versus 26% for men. Women usually spend more time in the home than men do which would account for the difference. This is an age-related phenomenon. Older women fall with serious physical consequences. The intervening variable is age (Statistics Canada, 2001. Cat. No. 82-003-XPE).

Deaths resulting from occupational injuries are much higher for males. Although women make up 46% of the total labor force, they account for only 8% (6% according to Courtenay), of occupational fatalities (U.S. Department of Labor, 2001. Wong, 1999:47. Courtenay, Code/Facts, 2002:1). Men constitute 54% of the total labour force (TLF) but suffer 92-94% of the occupational fatalities. Over 12 times the amount of males died as a

result occupational injuries even though they represent less than 10% more of the workforce.

Working conditions have improved to the point where workplace mortality and morbidity statistics have greatly dropped. Asbestos, a mineral ore prevalent in northern Quebec and possessing both fire-retardant and lung damaging (psittacosis) properties, has been banned from North American schools and industrial installations. The miners involved in its extraction wear protective clothing and breathing filters. Also affecting the health and increasing the longevity of mine workers are modern bracing materials, methane gas detectors, first aid stations and trained personnel, and emergency evacuation equipment and procedures. Less and less underground blasting is being done, being replaced by hydraulic very-high-pressure, vibration free, water boring devices. Even the old, gas helmet lamps have been replaced by battery static-free lights.

In the North American factories (those left, that is), safe working conditions, fire prevention materials and evacuation procedures have become the norm thanks to the efforts of the unions and the publicity of previous tragedies such as the New York City Triangle Shirtwaist factory fire of 1911, in which 146 young women lost their lives because all except one of the exits were locked. Construction workers now wear safety equipment ranging from safety hats, and steel-toe boots for ground workers to waist harness hookups for elevated building and bridge workers.

Office workers once subject to freezing conditions in winter and sweltering conditions in summer, then to closed-system circulated, sometimes bacteria, virus and/or spore laden stale air, progressed to a micron filtered, interior/exterior air exchanged working atmosphere. The unhealthy, unsafe, and dehumanizing sweatshops of yore are

almost all gone in North America. Workers are able to live longer and healthier lives. Farm workers also benefit health-wise with safety devices on machinery and roll bars on tractors. Machines are replacing backbreaking hand picking and planting. Even fruit tree picking where many pickers have fallen off ladders or have been stung by bees has been modernized somewhat with the development of very low, fruit-laden, hybrid, cross-pollinated, variegated, varieties of trees. Every industry, craft or profession has benefited from safety-driven modernization methods.

One industry, accepted by some, reviled by others, has seen relatively recent benefits to both sellers and purchasers. Prostitution has benefited by the somewhat recent manufacture, availability, and acceptance, of the condom. In the state of Nevada, prostitution is legal and highly regulated, the females (and males) purveying their wares and services, especially in one of the famous or infamous establishments, are routinely medically checked, provided and instructed to use condoms, dental dams and antiseptic soap, the linen is changed after each client, and their working hours are regulated.

Men and women toiling in the workplace to provide for their families can also live longer, healthier lives because legislation changes now permit them to go to the doctor if ill, instead of to work, for fear of losing their jobs. However many workers would not take the chance of pitting government work rules against their employer's deadlines.

For all types of accidents, from those involving cars and motorcycles, to work related, to being shot by mistake, men greatly outnumber women. This is not because men are accident prone, but because men and boys are encouraged by society to be the risk-taking, action-oriented adventurers. Females on the other hand, are neither encouraged nor discouraged from demonstrating such behavior consequently there are

less women who engage in risk-taking activities and therefore, less women and girls die as a result of accidents attributable to risk-taking.

Certain high-risk occupations, such as deep mining and commercial fishermen, retain their traditionally male workforces by financial necessity rather than the love of coal dust or salt water. Safety, health and other conditions, have been, and are being improved in all workplaces including those deemed hazardous or high-risk, due to the actions of high-profile social groups, unions, and the introduction of more women into all workplaces. The net result in many instances, of improved health and worker safety, general working conditions and decent compensation, is for the workplace to migrate to climes which do not have, or do not enforce Canadian or American minimum standards of working conditions, or financial compensation. Where the workplace cannot be moved, such as deep mines, robotics (without families to feed), are replacing miners. This is considered by some progress, and does alleviate instances of local workplace injuries and work-related illnesses.

Suicide

Table 12

SUICIDE
By Gender, Canada and U.S, 1997 – 2000

Country	Year	Male	Female	M:F Ratio	Totals	Male %	Female %
Canada	1997	2,724	957	2.8:1	3,681	74%	26%
U.S.	1997	22,483	6,716	3.3:1	29,199	77%	23%
Canada	2000	3,421	1,202	2.8:1	4,623	74%	26%
U.S.	2000	22,600	6,750	3.3:1	29,350	77%	23%

Statistics Canada. 1997 Cat. No. 82-003:1997. American Association of Suicidology Oct. 4, 2002.

The Canadian ratio of suicides by gender, at 2.8 male suicides for every 1 female suicide, is relatively close to the U.S ratio of 3.3 male suicides for every 1 female. The percentages reflect a 3% difference from 74% male suicides in Canada, to 77% in the U.S. Out of 4,623 total suicides for 2000, in Canada, 3,421 were males (See Table 11). There are three female attempts at suicide for every male attempt, for all age groups, however males in greater numbers than females commit suicide. In 2000, a total of 29,350 Americans committed suicide. Seventy-seven percent or 22,600 of these were men. Males succeed in committing suicide four times more often than females, and in the 20-24 age group that figure climbs to six times. Suicide is the 11th leading cause of death for all Americans and in 2000, there were 1.7 times as many suicides as homicides. (Statistics Canada 2002, Cat. No. 82-003. U.S. Government Infoplease July 2004:1, U.S.CDC Suicide Prevention Update, April 2004:1).

While both males and females use various methods to commit suicide, these methods vary according to gender. In using firearms as a means of committing suicide, in Canada, in 1998, there were 15 times more males who committed suicide than females (Statistics Canada 2002, Cat. 82-003 Vol.13 No.2, Table 1 'Suicide Methods by Sex'). In the United States "Firearms are currently the most often utilized method of suicide by essentially all groups (males, females, young, old, white and non-white" (American Association of Suicidology). In 1996, 15,808 U.S. males committed suicide by using firearms compared to 2,358 females. Almost 7 times more males than females used guns to commit suicide in 1996. (Men's Health Network Research Department).

The most common method of suicide for women in Canada in 2000, was poisoning at 41% of all female suicides as opposed to 22% of all male suicides. The rate for men was about half that of the women's rate. (Statistics Canada, Cat. No. 82-003). The probable reason for the difference in all categories of using a firearm to commit suicide is that guns are much more easily obtainable in the U.S. than they are in Canada (U.S. CDC. updated April 1, 2004).

Does love affect the rate of suicide among young men? A 30 year old man after divorce or whose wife dies, is eleven times more likely to commit suicide than a 30 year old man whose wife is living. This is a reflection of Durkheim's findings in his 1897 work *Suicide*, that more single men than married ones commit suicide. Daniel Dagenais argues that Durkheim's observation that marriage protects men from suicide, is a sound supposition, based on age (between 20-26 years old), and family demographics. However, 50% of marriages end in divorce and divorce has a much more negative impact on men than it does on women. Dagenais argues that at the age which single men would normally do like their fathers, find a job, get married, and start a family, they take their lives (Dagenais, 2004:5). This is unfortunately true, but only of a small percentage of men. According to Warren Farrell, "...it is the loss of love that devastates men" (Farrell, 1993:164; cf 169, 20-21).

Just twenty years ago, young men (between 25 and 34) committed suicide at twice the rate of young women; today, it is four times the rate. The number and rates of suicide keeps going up for males, but not for females. Men's rate increased 26 percent; women's rate decreased 33 percent over those 20 years. These rates are reflective of current economic as well as social conditions and behavioral practices. The employment picture

is tightening; plants and factories are closing due to blue collar and technical jobs being out-sourced. The requirements for retaining existing jobs and the prerequisites for new employment opportunities demand more and more skills, experience, education, and time involvement. These put pressure especially on young males who are competing for a very limited number of jobs in an ever-shrinking market. Many young men contemplating marriage and raising a family are either unemployed or are working at what might be called a tenuous position with no future, no benefits, and no guarantee of employment beyond the end of next week. The days of 20 or 30 year jobs, of sons following in their fathers footsteps in a particular industry, or even of the tenured or security-through-seniority positions and jobs are no longer available, except for some small vestiges remaining in government bureaucracy.

Socially and psychologically, the pressure to succeed as a provider, along with the stigma associated with thoughts of inadequacy caused by personal failure to provide for oneself and present or future family, is in itself a tremendous burden. Add to this the social conditioning in young men, that real men don't cry or go whining to others about their health, emotional, self-esteem, or financial problems and a pattern begins to develop showing the normally microscopic cracks in the armor, expanding to chasm size, and rationality escaping, being replaced by despair. When we add easy access to guns (from pre-teens to death or dementia), we have a formula for a painless and quick escape scenario.

Not only young men are affected by the loss of the love of a mate. The suicide rate of elderly men is 14.5 times that of elderly women, and in the 85 and over age group, it rises to 15 times, according to the U.S. Bureau of Census, 2000:99. These suicide figures

are most likely to be underreported, but over-reported as accidents, and natural causes. For instance, nurses note that elderly men are more likely to just fail to take their medicine. Forgetfulness or suicide? The resultant demise would most likely be reported as either an accident or death from natural causes. Farrell states that "...Men stop taking medicine when no women is around. Because men can't live without being served? No. Because men can't live without being loved." Farrell, 1993:175). Or having someone to love.

Another opinion as to the cause of excessive suicide in elderly males comes from Silvia Canetto, who interviewed male survivors of suicide attempts. She argues that their higher suicide mortality has to do with men's limited coping abilities. "Older women may have more flexible and diverse ways of coping than older men" (Canetto and Lister, 1995:224).

"...older men who killed themselves were so fiercely proud and independent that they appeared unable to bend in the way of most older adults when life confronted them with the ordinary stressors of aging, such as increasing limitations on physical and mental functioning or the increasing need to rely on others for help..." (Canetto,1995:303).

This may have less to do with 'limited coping ability' and more to do with some older men (or women) just wanting to go because they were becoming dependent and not productive, which is the male *raison d'être*.

In the cases of divorce, the wife usually gets the children the husband gets every second weekend with his children. If a husband loses his wife to divorce or death, he becomes single again, often without any support to help him. Women on the other hand tend to generally have a better support system, such as close friends that they can talk things over with. For males, unless they go to see professional therapists, have no one to

talk things over with. Women start setting up “support groups” from a very young age, men tend to never set them up because of societal influences, which forces them to be independent, autonomous, and quietly strong. Men who lose a spouse may become depressed and socially isolated.

We live in transient times, often children who may be able to help their fathers are not around, they have moved halfway across the country. In the past, people lived in tighter knit communities, where perhaps more community support was available, but with urban sprawl, people may only have a superficial relationship. “With changing work and social structures – divorces, job demands and losses, spread out families, the rise of the suburbs - so did the possibility of feeling completely alone and overwhelmed, depressed and socially isolated” (Social Trends & Indicators, 2003:260).

The suicide rate often follows the economy. In good times the rates go down, in bad times the rate goes up. During the Great Depression, in 1932, there were more suicides than ever before, 17.4 per 100,000. In the late forties and early fifties, after the Second World War, the economy was booming, and the rate of male suicides fell to 10 per 100,000. In the decades that followed the rate of male suicide “fluctuated between 11.1 and 13.3”. (Schmittroth,2003:260). Instability within the employment market, i.e., previous long term employment no longer exists, and has been replaced by uncertainty of the next paycheck, may possibly be a reason for the high rate of male suicides, since males identify so strongly with the role of provider.

An important possible link to consider in any discussion of suicide rates of young men, is drunk driving. As is well known, many accidental driving fatalities may often be suicides so the current suicide rates would underestimate the numbers of male suicides.

Farrel “cites the case of a teacher asking her class ‘if you were going to commit suicide, how would you do it?’ Most of the girls said ‘by overdosing on pills or drugs.’ But half the boys said they would get drunk and either drive off a cliff or into a telephone pole”. Because of clauses on insurance policies, suicides can be covered up or classified as accidents (Farrell, 1993:164, 174-5, 169).

The suicide rate of boy and girl pre-adolescents is very low and almost equal, with slightly higher rates for boys. At this stage boys and girls express and deal with their emotions in the form of ending their lives, almost equally.

It is during adolescence that teenage boys begin to change, they withdraw emotionally, and it is also the time when boys’ suicide rate increases to four times as great as girls’ suicide rate, even though girls attempt suicide twice as often (see table 11).

Table 13

SUICIDE AND ATTEMPTED SUICIDE
By Gender, aged ten years and older, per 100,000 population,
Canada. 1998

	<u>Males</u>	<u>Females</u>
Suicide	142.9	36.7
Attempted Suicide	57.9	98.5

Statistics Canada 2002 Cat. 82-003, Vol.13, No.2

Adolescence is a particularly difficult time for both males and females. They both want to be attractive to the members of the opposite sex. For girls, this means that the prettier she is, the more attention she gets. The not-so-pretty girls garner less attention and become extremely vulnerable for attention, even at a price. Girls begin to realize the value of their looks. The pretty girls are the ones who get taken out and have their date

expenses paid for by the “popular, successful” boys. For boys, Farrell believes that the anxiety is greater. Fear of rejection by the opposite sex, is experienced by both adolescent boys and girls. The boys must be able to perform what Farrell calls the three P’s; performing, pursuing, and paying. Performing for the young man, means taking on a role such as school council president, star athlete for the high school sports team, or owning (or borrowing from an older brother), a really cool car. Pursuing entails the ability to interpret incomprehensible cues from girls. He is supposed to take the initiative when it comes to sex, to know when to proceed, when to stop, and what exactly to do, without lessons or instruction. Paying is what boys do, the more desirable the girl is, the more he is willing to pay. Ironically, the girls he desires most are the ones most likely to reject him. He is never prepared for rejection.

Girls may be able to cope with these turbulent years better than boys, because they haven’t withdrawn and become silent, as boys do. Girls seem to have peer group support systems and are able to express their emotions, thoughts and feelings, while boys suppress these feelings due to strict social protocols emphasizing self-analyzing and self-healing among males. They may feel that the only answer is suicide (Farrell, 1993:164-6)

Unemployed men commit suicide at twice the rate of employed men. (Among women, there is no difference in the rate of suicide based on whether or not the woman is employed). During the Great Depression, men were 650 percent more likely to commit suicide than women were. During that period, there was a greater likelihood of a man loosing his family’s savings, their possessions, and his job. Men who have been fired, or are underemployed, unemployed, or suffer from the fear of unemployment, often feel humiliated, violated, helpless, angry, guilty, self-blaming, depressive and suicidal. Their

vulnerability leaves some feeling powerless, and valueless. “When men feel they are valued according to net worth, they begin to confuse net worth with self-worth. No hope for work, means no hope for love, means no hope for life...means suicide.” (Farrell, 1993:164,173-4)

A widely accepted theory of suicide is that it arises from chronic depression associated with problematic interactions with one's' total environment. Even though age, love/marriage, and socio-economic conditions, have shown to be factors, which influence the rates of male suicide, the problem has long been shrouded in silence and neglect.

Suicide is a personal and social tragedy that can be prevented. But to be effective, prevention programs must target those persons at highest risk. A man who contemplates suicide is saying to himself, ‘I don’t see any way out of this mess. There is no hope.’ One reason why men lose hope is because society itself downplays, distorts or even ignores the problem. Since suicide predominantly affects boys and men, suicide prevention programs need to be male-specific, and address the underlying social and psychological causes that affect men. This common sense principle is used in designing female-specific programs on osteoporosis, eating disorders, and breast cancer.

According to the National Institute of Mental Health, “More than four times as many men as women die by suicide; but women attempt suicide more often during their lives than do men (See Table 13), and women report higher rates of depression” (Shackleton, 2003:52). David Shackleton, a men’s activist in Canada critiques the NIMH’s statement in reference to male suicide, he states that:

Many believe that the medical criteria used to diagnose depression are slanted, to pick up the type of symptoms that women often experience. Also, some have criticized mental health programs as not being adequately tuned to men’s psychological needs. As a result, men are less likely to

seek help when they do experience psychological distress, and male depression is widely under-diagnosed (Shackleton, 2003:52).

In the U.S., between 1970 and 1989, the suicide rates for males of all ages had increased while the rates for females had declined. They state that the rate of death by suicide for that time period, for white males has increased from 18% to 21.4%. The black male suicide rate, less than half that of white males in 1970, increased significantly from 8.0% to 12.2%. The white female suicide rate decreased from 7.1% to 5.2%, however the black female rate declined much less dramatically from 2.6% in 1970, to 2.2% in 1980, then to 2.4% in 1989 (Stillion, 1999:53).

From middle childhood until old age, males, particularly white males, are at significantly higher risk of suicide, then are females. The most dramatic increases are from age 15 to 19: 9.4% to 19.4%, and from 20 to 24: 19.3% to 26.8% and also over 85 years old, from 45.8% to 71.9%. Even though much has been written about sex differences in suicide, Sabo and Gordon carry masculinity in reference to suicide from the family- provider-failure stage, to the accomplished suicider stage. Accordingly, males who kill themselves may be responding to some gender role signals rather than to some internal illness such as depression (Stillion 1999:52-3). “Suicidal females may make attempts, cry for help, expect to be rescued, and receive social and emotional support” (Stillion 1999:53). On the other hand “suicidal males, may see attempting suicide as evidence of weakness and, moreover, surviving a suicide attempt may be regarded as yet another failure (Stillion 1999:53).

Other researchers have maintained that more men than women intend to commit suicide. They point to males' greater frequency of substance abuse, subjection to more psychosocial stressors than women, and their use of more violent, immediately lethal means of taking their lives when compared to females. ...the major reason more men than women in the

United States commit suicide is that more men intend to do it (Stillion, 1999:54).

In sum, males outnumber females in rates of suicide for all age groups. Although women attempt suicide more often, men are more successful at it. The suicide rates of adolescent and early teenage boys, is four times that of girls. Boys often become silent and withdrawn when in the depths of despair whereas girls usually have a peer support group or person to whom she can confide her emotions, feelings and/or intentions. The loss of a spouse through divorce often leaves the male feeling like he was a meal ticket and sperm provider. The loss of a loving spouse has devastating emotional and psychological effects on some males. Men do not have a strong support system available to them as women do, nor are they inclined to seek out peers or support organization personnel to confide in. Socio-economic status also has an effect on suicide rates. During economic boom times, or among the affluent, the rate decreases, conversely, during economic downturns, among impoverished divorced males with heavy financial responsibilities, and unemployed married and single males, the suicide rates increase. Male values are tied into how well he can support his family and himself.

Homicide

The Canadian Criminal Code classifies homicide as first-degree murder, second-degree murder, manslaughter or infanticide. Deaths caused by criminal negligence, and accidental or justifiable homicides are not included.

Table 14

**VICTIMS OF HOMICIDE
By Age and Gender, Canada, 2002**

<u>Age</u>	<u>Male</u>	<u>%</u>	<u>Female</u>	<u>%</u>	<u>Ratio M:F</u>
0-11 years	22	51%	21	49%	1.05:1
12-17	13	54%	11	46%	1.18:1
18-24	79	71%	33	29%	2.39:1
25-29	43	61%	28	39%	1.54:1
30-39	78	66%	41	34%	1.90:1
40-49	66	69%	30	31%	2.20:1
50-59	37	71%	15	29%	2.47:1
60 & over	38	59%	26	41%	1.46:1
Totals	376	63%	205	37%	1.83:1 (Average)

Statistics Canada, CANSIM, 253-0003. 2003

Homicide victimization is a major cause of male mortality and homicide commission is a major cause of male incarceration in Canada and the U.S. In 2002, there were 582 Canadians, killed by homicide of these 63% were male (See Table 14). U.S. demographic statistics reflect a higher percentage of male homicide victims at 76% verses 24% female victims for the time period 1976-2002 (Bureau of Justice Statistics). Canadian males are the predominant victims of homicide, in every single cohort as Table 13 indicates, and also the predominant perpetrators (or accused) of homicide (See Table 13). During the period from 1998 to 2002, approximately 2.2 times more males were killed by homicide than females (Statistics Canada, CANSIM, 253-0003. 2003). The rate is much higher for the category of 'accused of committing homicide'. That rate over the same time period is 7 times more males than females accused (See Table 14). In the U.S., homicide is the 15th leading cause of death; but it was the second leading cause of death

in 1999 in the age group of 15-24, and the third for the age groups 10-14 and 25-34. Overall five times more young men, than young women, die by homicide.

Most murder victims in the U.S. were familiar with their assailants. In fact spouses and family members made up about 15% of all victims and about one third of the 512,599 victims, between 1976 and 2000, were acquaintances of their assailant. By gender, female murder victims are substantially more likely than male murder victims to have been killed by an 'intimate', which is a judicial term for a spouse, an ex-spouse, boyfriend or girlfriend. In 2000, of the 1694 murder victims killed by an intimate, 442 were male and 1,252 were female. Almost four percent (3.7%) or 442 out of 11,818 of male murder victims, were killed by an intimate. Out of 3,733 female victims one-third or 1,252 were killed by an intimate, and 26% of these 'intimate homicides' were committed by women. (U.S. Bureau of Justice Statistics, Homicide Trends, 2002:1-4).

The breakdown of U.S. mortality data by gender and race shows that among black males in the 20-24, age category, the rate is 155.5 per 100,000 and constitutes their leading cause of death. White men are three times more likely to be murdered than females and 21 times more likely to be murdered than white females. For black American young men between the ages of 15 and 24 years, homicide is the number one killer. Overall, black men are victims 7 times more often than white men are. In 1996, just 4 years previous to the year 2000, 4,689 females per 100,000 U.S. population, representing an age adjusted rate of 3.56 were homicide victims compared to 15,945 males, or 13.11% per 100,000 males. Even though the overall U.S. male death rate due to homicide dropped in 2000 from the 1996 rate, the male-female ratio stayed about the same at 3 to 1.

In the 20 years from 1976 to 1996 almost half a million U.S. males have been murdered (Courtenay, 2002c).

Table 15

ACCUSED OF HOMICIDE
by Gender, 1998 to 2002

<u>Year</u>	<u>Male</u>	<u>Female</u>	<u>M:F Ratio</u>	<u>Totals</u>
1998	464	65	7.3:1	529
1999	438	48	9.0:1	486
2000	418	56	7.3:1	474
2001	430	63	6.7:1	493
2002	466	57	8.1:1	523

Statistics Canada, CANSIM, 253-0003. 2003

The ratio of males to females accused of homicide has fluctuated between 6.7 to 1 in 2001 to nine males accused, for each one female in 1999. The actual numbers of those accused has been fairly stable for males and only slightly descending for females (See Table 15).

There are striking variations in the homicide rates of different societies. In a comparison of two South American countries, Columbia and Costa Rica, Columbia's homicide rate is 15 times that of Costa Rica, and the U.S. rate is 10 times higher than that of Norway. Regional rate differences also exist adding the variable of social and cultural differences to be considered along with the argument for men's '*natural predisposition*' towards aggressivity. In cities in the U.S. South and Southwest, the homicide rate for white males is about double that in the rest of the country (Nisbett and Cohen, 1999:18).

Men are not only more likely to be victims of homicide as well as the villains, and killers, they are also more likely to be penalized more severely. A man convicted of murder is twenty times more likely than is a woman convicted of murder to receive the death penalty. Farrell states that “For nearly four decades now, we have become increasingly protective of women and decreasingly protective of men” (Courtenay, 2002a. Farrell,1993:244). Farrell argues that women can use different methods of defense, such as when a man and women jointly commit a crime; women usually have first option to plea bargain, claim the man was ‘in charge’ or the ‘kingpin’, convince the man to take the rap called ‘learned subservience’, claim that she, the woman, is the real ‘victim’, and the women can make herself appear to the judge or jury as being incapable of committing a crime or so weak and defenseless and needing the protection of the male jurors called the ‘chivalry factor’, that she should be let off (Farrell, 1993: 242-248).

Another variable, or in this case a particular set of conditions, affecting the male homicide rate carries with it its own type of social system. Nisbett and Cohen describe this culture of honour. “It occurs when men face danger from the actions of other males, and the state does not provide protection. Men respond by resorting to self-protection and demonstrating that they are strong enough to deter aggression. Such a code of behavior deters theft and wanton aggression, but it also requires that violence sometimes be employed: disputants cannot be too willing to back down, or honor will be compromised” (Nisbett and Cohen, 1999:21).

In some parts of the world including parts of the U.S. South, insults are considered verbal abuse, which is very serious, as is theft of property. In this context their

womenfolk are considered their property and not to be toyed with or especially not to be slept with, without risking severe repercussions by the husband, brother, or father.

“Laws and social policies in the South reflect the culture of honor. Southern laws are more likely to exonerate people who shoot someone escaping with their property. And many statutes in the South endorse a ‘true man’ rule, which allows someone to stand his ground and kill rather than forcing him to beat a cowardly retreat from an attacker” (Nesbett and Cohen, 1999:19).

In recent years, men accused of homicide outnumber women approximately 8 to 1. Males in some U.S. states, convicted of homicide are much more likely to receive the death penalty or much longer sentences (U.S. and Canada), than women perpetrators. A Florida state law just enacted by Governor Jeb Bush, provides for the exoneration of citizens who commit justifiable homicide if the person feels threatened in his home or on the street and does not retreat. Montreal has a new resident, Karla Homolka. She completed a 12 year sentence. Her boyfriend will spend the rest of his life behind bars. The culture of chivalry (and/or incompetent investigation/prosecution) lives on.

War

The American battle deaths listed in Table 16, along with the combat mortality figures from the 1775-1783 American Revolution (4,435), the War of 1812 (2,260), the Indian Wars (1,000), the Mexican War (1,733), and the U.S. Civil War (214,938), demonstrate the total to be over 724,705 U.S. military personnel killed on the battlefield in combat, during the 18th, 19th, and 20th centuries. (U.S. Department of Veterans Affairs)

TABLE 16

**WAR FATALITIES IN THE TWENTIETH CENTURY
Canada and the U.S.**

<u>Conflict</u>	<u>Canada</u>	<u>United States</u>
1899-1902 Boer War	267	----
1914-1918 World War I	59,544	116,516
1939-1945 World War II	42,666	291,557
1950-1953 Korean War	516	33,686
1953----- UN Peacekeeping*	106	54
1965-1975 Vietnam War	309	58,198
1983 Grenada Conflict	----	19
1989 Panama Conflict	----	23
1990-1991 Gulf War	----	268
1992 Somalia conflict	----	18
2001----- Afghanistan Conflict		Ongoing
2003----- Iraq War		Ongoing

Totals	103,408	500,339

Veterans Affairs Canada. General Statistics, March,2000:1. Clodfelter, 2002:481,735. U.S. Department of Veterans. Affairs, 'America's Wars Fact Sheet', May,2001:1,2. United Nations Peacekeeping Fatality Statistics. June,2004:1-4. Lee, 2001:3. FreeDictionary.Com 'Invasion of Panama' 2004:2. Military.Com Resources 'Somalia'. 2004:1.

*Canadian peacekeepers have been killed in Croatia, Morocco, Congo, Rwanda, Syria, Egypt, Cyprus, Kosovo, India/Pakistan, Somalia, Cambodia, and the Middle East

Wars are fought between countries, societies, and cultures, religions and ethnicity's, and primarily by young men. Men are usually the first victims of war: they are the fighters, the volunteers or conscripts, so often killed, maimed or wounded fighting for their countries. The degree of male self-sacrifice is enormous (See Table 16). About 500,000 Americans sacrificed their lives in combat in the twentieth century. The war

deaths include 116,516 in World War I, 291,557 in World War II, about 33,686 in Korea, 58,198 in Vietnam (including 8 women), 19 in Granada, 23 in Panama, and 268 in the Gulf conflict. Canada lost over 100,000 men: 267 in the Boer War, 59554 in World War I, 42,666 in World War II, 516 in Korea, 309 in Vietnam and 106 in United Nations operations since Korea (see Table 16).

In Canada over the years spanning World War I and World War II, and to a lesser degree during the Korean and Vietnam wars, the vision of the warrior was associated, albeit temporarily, with images of masculinity. Some said that the national defense was a male duty and responsibility. Even though that outlook is metamorphosing and more and more women are included in ancillary services related to peacekeeping and policing roles, the actual Canadian combatants involved in search and destroy missions, such as in Afghanistan and Iraq, (presently) are overwhelmingly male.

The world's standing uniformed armies contains about 23 million soldiers, 97 percent of whom are male. Most of the women in military forces worldwide occupy roles such as nurses, prison guards, cooks, transport and communications officers and computer operators. Of the world's designated combat forces, 99.9 percent are male. In 1993, only 168 women belonged to the ground combat units of Canada, Netherlands, Denmark, and Norway combined. The U.S. has been undergoing a (non-ground combat) military gender integration program for over 10 years. In the first Gulf War nearly 40,000 U.S. women participated and 12 women soldiers died, (268 male soldiers also died) 5 from hostile fire, and the rest from training exercises and other accidents. (Goldstein, 2001:94). In Iraq over 1,700 men have been killed and 38 women.

Through either conscription or voluntary enlistment, substantial numbers of Canadian and American young men find themselves in a foreign land as defenders of their country or as part of a coalition to neutralize a particular threat to world peace. These altruistic motives, emphasized and romanticized in Western motion pictures, continue to draw (mostly) American young men to the military. The degree of male self-sacrifice in the name of duty to one's country is enormous. Some say that the roots of the association of heroism with manliness was the (successful) attempt by ancient rulers to convince young men of the 'cause celebre', or of something that real men, not boys, not children, not women, but something that real men do, in defense of their country, their women, their families, and their military buddies.

Another action (or re-action as the case may be), cowardice, is supposedly the antithesis of masculine bravery, has been written about just as long. This example is recorded in the annals of American history.

Private Buck, mortally wounded at Gettysburg, Virginia in 1864 during the U.S. Civil War, with his dying breath, implored his commanding general, "Tell my mother I did not die a coward." (Anonymous).

According to Joshua Goldstein, "Cultures mold males into warriors by attaching to "manhood" or "masculinity" those qualities that make good warriors. War does not come naturally to men, so warriors require intensive socialization and training in order to fight effectively" (Goldstein, 2001:252-3). This being the case, then gender identity becomes a tool with which societies induce men to fight.

In one battle alone, the Battle of the Somme, in 1916, during World War 1, British Casualties were 420,000; French were 195,000; and German were 650,000. The total for

that battle exceeded one million men and boys who died or were badly injured. One year later at the battle of Passchendale the British lost 300,000 men (Nelson and Robinson, 2002:79. Farrell, 1994:29. Encyclopedia Americana, 1990:974. Wells, 1996:50).

Many men and boys pay the ultimate price for doing what many men and boys believe is the manly thing to do. And many men and boys having that decision made for them by others using conscription laws, who believe that it is the manly thing to do... to send other men and boys to fight and if necessary, to die .

By associating military service with masculinity, Farrell compares two popular slogans with devastating results. His popular slogan for women "A Woman's Body, A Woman's Choice" leaves options open to individual women while, his men's popular slogan "A Man's Gotta Do What A Man's Gotta Do", puts males at the mercy of rigid masculine behavior expectations which sometimes puts them smack in harms way (Farrell, 1993:30). According to Farrell, "Understanding men requires understanding men's relationship to the three W's: Women, work, and war. Should a major war break out (i.e. requiring conscription), it is only our sons who will be notified within forty-eight hours to report to boot camp. Before men can vote, they have the obligation to protect that right. (Farrell, 1993:123).

Millions of men, women and children have been killed in wartime due to what is considered 'collateral damage', men are not the only victims of war. Women also suffered. In World War One 111 nursing 'sisters' lost their lives tending the wounded within range of enemy guns. World War II saw atrocities committed against nurses, nuns, and native women in the Pacific. Many endured untold atrocities and many perished. The same enemy used U.S. Marine prisoners of war for bayonet practice and killed tired and

starving soldiers with impunity during and after the Bataan Death March. The Pacific was not the only theatre where women suffered and died, as evidenced in the 'Rape of Nanking' where all of the women and young girls were given to invading soldiers to rape with the full authority of the military hierarchy. The Japanese enslavement of foreign women, for use by its soldiers as 'comfort women', the Nazi concentration camps where women (and men and children) were experimented on and butchered before being turned into soap and in some cases, lampshades. Many British women, children, and men were killed by bombs and rockets during the blitz, women, along with men and children, also died in the fire-bombings of Dresden and Tokyo.

Many women children and men died during the killing sweep through Eastern Europe by the Nazis, not only in warfare, but by starvation and in their gas chambers and slave labor camps as well, and the subsequent sweep through eastern Germany by enraged Soviet Forces which had experienced the brunt of losses to the Nazi regime.

The atomic bombs, which were dropped on Hiroshima, and Nagasaki, killed many women, children, and men (yet presumably shortened the war and saved countless Allied invasion force lives). Women and men and children have died in the ethnic cleansing in Bosnia and Iraq, genocide in Rwanda, and even now, are dying in tribal warfare in the Sudan and terrorist led and instigated warfare in Afghanistan and Iraq.

To many young men, especially before and during the First World War, participating in war was considered a rite of passage to wit they endeavored to pass the test. "The ultimate test of manliness", claimed that "men envisioned the battlefield as a proving ground where they could enact and repossess the manliness that modern society had lost." From a very young age, boys were raised to be soldiers. They were prepared,

from early on to view war as both a thrilling adventure and an honorable endeavor. Military heroes abounded. The romanticization of war in toys and books, the emphasis on winning and self-sacrifice in sports, and the instilled ideals of honor and duty, combined to train young men for eventual sacrifice in war. This effective social conditioning provided an ample supply of young warriors. (Moss, 2001:59).

The last sentence of the United States Declaration of Independence penned on July 4, 1776 and signed by the 56 male representatives of the original 13 states, placed their confidence in being on the side of (or at least under the guidance of,) God, along with patriotism, brotherhood, and honor, as ideals, to be upheld and emulated:

“And for the support of this declaration, with a firm reliance on the protection of Divine Providence, we mutually pledge to each other our lives, our fortunes, and our sacred honor”.

Leaders and ‘wannabe’ leaders of some countries, tribes, organizations and gangs, have seen the merit in the concluding statement of this judicious document in appealing to the propensity of some young men to put order in their lives and purpose to their existence through bravery and self sacrifice.

In many cultures to this day, the coming of age and the socialization of young men is spelled out clearly in times of war. No matter how vague the concept of manhood may be, military service, especially combat service, has been touted to be an acceptable passage through which, to be initiated into manhood. It is said to provide structured initiation rites, which strip away a young man’s boyish past. “In most cultures, boys must repudiate their prior vulnerability and aspire to a matrix of personality traits more appropriate to manhood: strength, endurance, courage, confidence, and self-reliance”

(Moss, 2001:27,28). “Cultures produce male warriors by toughening up boys from an early age... They produce, through the socialization of children, adult gender roles suited to the nearly universal need of societies to be prepared for the possibility of war” (Goldstein, 2001:287,8). Mark Moss argued that culture blended the desire for maleness and the attraction of militarism during World War I:

“When the war did end, in 1918, it was victory, not peace, that was celebrated. The archetypes of manliness and the examples of militarism that had been used to attract young men to the army were inscribed on the memorials erected in every community... The concepts and ideals of masculinity are not simply a reflection of individual psychology but a part of public culture, a collective representation. In the period from Confederation to World War I, war was consistently presented as the definitive test of manhood. War, in all its manifestations, served as an antidote to the crises of masculinity...” (Moss, 2001:142,3)

Some of the militaristic/manliness cachet was lost after the Second World War. The close association of nationalism and the symbols of war were regarded with some distaste. In Germany, the ‘cult of the fallen’ had in pre-World War II times provided martyrs and a shrine of national worship. Post-World War II, monuments commemorating the fallen and symbolizing the strength and manliness of the nation’s youth were no longer of great importance. Ancillary benefits account now for many enlistees in the U.S. military. Decent housing, family medical and dental benefits, a steady paycheck, education (very expensive, especially in the U.S.), pensions, and travel, now attract young men. (Along with a sense of duty, still, for some) (Mosse, 1990:35,222,224).

The male propensity for putting themselves and their young men in harms way was stated in this succinct epitaph to war from the early 1800’s Prussian General Karl von

Clausewitz, “Wild as is the nature of war it still wears the claims of human weakness, and the contradiction we see here, that man seeks and creates dangers which he fears at the same time, will astonish no one” (Murray, 1914:107). Clausewitz would have us believe that it is in our nature, entrenched in male genetic structure, the penchant for placing ourselves and others, in dangerous life threatening situations.

Betty Reardon takes a realistic approach in reference to war, “Once the actuality or possibility of war becomes the context within which we live, men and women are forced into set roles.” (Goldstein, 2001:410). In modern times, the very same words have been used, often against those seeking to destroy freedom and democracy or against those seeking to embrace it. “Western societies treat battlefields as predominantly male preserves in which women are occasionally welcome only in so far as they contribute to a man’s warrior ethos.” (Goldstein, 2001:307).

Economic Cost of War

The economic cost of mortality and morbidity is difficult to measure under the best of circumstances. It is impossible to calculate in reference to casualties of war, either combatants or non-combatants. What can be estimated however, is the approximate cost of the conflict. Of course these estimates are without consideration of the sentimental value to the loved ones of the dead, the wounded and the permanently incapacitated. Also missing is the replacement value for the lost potential revenue, which the casualties might have accrued.

The following are the estimated costs to the U.S Government of the subsequent wars:*

Table 17

**ESTIMATED COSTS OF WARS
United States**

<u>Time Period</u>	<u>War</u>	<u>Cost (in millions \$ U.S.)</u>
1914-1918	World War I	\$ 18,676
1939-1945	World War II	\$ 262,259
1950-1953	Korean Conflict	\$ 67,386
1957-1975	Vietnam Conflict	\$ 150,000
1990-1991	Gulf War (first)	<u>\$ 61,100</u>
Total		559,421

U.S. Department of Veteran's Affairs, May:2001

*Lack of financial cost data for the Grenada and Panama conflicts necessitated their omission.

The war in Iraq is ongoing. Its cost so far exceeds 225 billion U.S. dollars (Weisman & Ricks, 2004:1).

Men are usually the first victims of war. During the 20th Century, 103,408 Canadians and 500,339 Americans made the ultimate sacrifice. Many more were wounded and will permanently bear the physiological and emotional scars and debilitations. It is estimated that combat units worldwide are composed of 99.9% males. Until recently, except in Israel, women (in regular military forces) were relegated to administrative, troop support, and medical positions. Presently the U.S. military has a number of women fighter pilots, naval warship personnel, and even in ground combat proximity roles. Seventeen sailors were killed on the USS Cole in 2000 - none were women. During conscription, except in the former Soviet Union during the Second World War when women were mobilized in combat units, it has been only males that were sent to war, although pressure has certainly been put upon females at times of war,

to join the military or work in arms and munitions factories or other support roles. With all-volunteer armies, incentives and benefits are usually enough of an inducement to fill the military recruitment and officer ranks. Many young men join the army to get a steady paycheck, family benefits, and decent housing, others, for an education and future civilian job opportunities. Still others, more realistic perhaps to the possible consequences, enlist for altruistic, patriotic reasons (Goldstein, 2001:64,390-3).

Conclusion

The mortality costs of being male are very high. Some of these costs are selected by men, others are imposed by other men, or women, jobs, or governments. Some are “accidents”. It is a complex matter. Preventable deaths accidents, suicide, homicide, and war, account for a large part of male early death and injury. Even though these circumstances are considered preventable, not all men have a choice to avoid them, for instance many war deaths and injuries occurred during conscription, when the young man had little if any choice. Also many occupations are dangerous however, if the employee wants to feed his family...

Chapter 3

ILLNESS

Introduction

This chapter will discuss both acute and chronic illnesses. A review of the types and changes of disease in North America precedes discussion on gender differentials in major illnesses. Male specific illnesses and maladies, and illnesses inaccurately thought to be female specific are also examined. The HIV/AIDS phenomenon, from its inception to the present rate of affliction of males and females in Canada and the U.S. will be reviewed. Cancer is discussed in a morbidity context with the focus on cancer causing agents. This chapter concludes with a review of nonfatal chronic illnesses, and preventive and maintenance visits to medical personnel and facilities.

Not so long ago most illnesses were either minor and self-healing, or acute and fatal. Today, maladies such as colds and influenza's are still controlled in a large part by our auto-immune systems. White blood cells and platelets attack the invaders, coughing and sneezing reflexes eject germs, and good bacteria which inhabit our stomach and intestinal tract in a symbiotic relationship, break down many forms of harmful as well as harmless organic and inorganic matter into digestible or eliminatable substances. Many of our previously effective antibiotics are proving ineffective against resistant bacteria. Target-specific, anti-virus vaccines are difficult to develop and produce in great quantity, and in time, to be effective against rapidly mutating strains of viruses, some of which are showing the ability to cross species lines and infect man and beast alike. So far, we are able to control the most virulent and deadly bacterial and viral outbreaks with prevention, isolation and the destruction of possibly infected, non-human carriers. The avian flu virus

is an example of cross species infection, where in Asia millions of chickens and other fowl have been slaughtered to try to prevent its spread and in Great Britain mad cow disease has caused the destruction of numerous herds of cattle. West Nile virus, bubonic plague and mad cow disease, are examples of diseases, which are able to cross species lines, in their case, from crows and rats via fleas and mosquitoes, and through eating beef, to humans. The latest virulent new strain of virus is reported to infect hogs and also humans. In cases, where the virus or bacteria is evasive, elusive and/or firmly entrenched in human cells and organs, causing damage, destruction and ultimately, cessation of function, alternative therapy is being used. This consists of removal and/or replacement of damaged tissue.

Illness Rates: (Acute)

Acute illnesses usually occur quite suddenly, persist over an extended period of time and tend to decline in later years (Bolaria & Dickinson, 2002:293).

Acute illnesses have undergone a metamorphosis of sorts. The prevalence of contagious diseases in Canada and the U.S. (with the exception of HIV/AIDS), has given way to cancers and heart diseases as major causes of death. Many diseases such as typhoid fever, measles, scarlet fever, whooping cough, chicken pox, and polio, which used to take a heavy morbidity and mortality toll, have been practically eliminated in North America, although most continue to take a toll in other parts of the world. The overuse of antibiotics is now responsible for new strains of drug-resistant tuberculosis bacilli to emerge in the U.S. (Sargent and Brettell, 1996:22-4).

The incidence of reported illnesses, among females both acute and chronic, is higher than among males. One reason is that birth control, pregnancy and childbirth are

classified as illnesses in some statistics. Some medical specialists consider childbirth and related conditions as a natural process. Others do not. This accounts for part of the difference. Expectant mothers usually see their doctors on a routine basis, for monitoring, rather than for treatment on an illness, leading up to childbirth. Most mothers tend to deliver their babies in hospitals. After the baby is born there are routine follow-up visits at the doctor's office for both mother and infant.

Many women tend to visit their gynecologist for precautionary purposes. Some women visit their doctors seeking medication to alleviate the symptoms associated with the natural onset of menopause. When female reproductive conditions, (pregnancy, childbirth, menstruation, birth control, and menopause) are factored out of medical illness statistics, then the gender gap is slightly smaller. Female illness rates (including the above mentioned conditions), as measured by the number of visits to doctors, clinics, and hospitals, are statistically "between 20% and 30% higher than illness rates for men." (Clarke,2000:114-5).

There are illnesses and health conditions, which, while not totally gender specific, target one sex more than the other. Osteoporosis is one such case. While it is usually considered a woman's disease, 5 million men in the U.S. are afflicted with it. Approximately 20 million American women have osteoporosis. One possible reason that four times as many women are afflicted is that generally males have greater bone mass than females, and that bone mass loss in men occurs later in life and advances more slowly than in women. Men's testosterone levels do decline similar to women's reduction in estrogen after menopause. In some males, the early loss of testosterone results in

accelerated bone loss. Successful treatment comes most often from seeing young men in the early stages of bone loss (Henkel, 1995:1,2).

Primarily associated with women, breast cancer also occurs in men, although rarely. In 1995, men made up 1,400 of the 183,400 cases of breast cancer. Men typically do not perform breast self-examinations to detect tumors, and doctors do not ordinarily examine men for breast cancer during physicals. Because of their low numbers, men do not get routine mammograms, consequently, a tumor may be present and go undiscovered. In men, the disease is often discovered at an advanced stage when the tumor has spread. (Henkel, 1995:1).

Many people associate eating disorders with women, these conditions also occur in males. Men make up about 1 million of the 8 million Americans with anorexia nervosa, bulimia, or both, according to the National Association of Anorexia Nervosa and Associated Disorders (ANAD). The conditions most often surface during the teen years, and in both sexes, can lead to lifelong medical and psychological complications. An estimated 6 percent of cases result in death. Diagnosis is complicated by a reluctance some men have to seek medical help for disorders that are 'still primarily women's'. According to Chris Athas, ANAD vice president, "We live in a 'macho society, many men simply are ashamed to have an illness of this type. Thus, they suffer in silence." (Henkel, 1995:1).

Just as there are female-only diseases and illnesses, there are also exclusively male afflictions. Among these are Peyronie's disease, prostatitis, benign prostatic hyperplasia, impotence, epididymitis, Klinefelter's disease, ALD, and cancer of the prostate, penis or testicles. Peyronie's disease is characterized by hard lumps on the penis

and occurs in about 1 percent of mostly middle-aged men. About 30 percent of those afflicted, develop fibrosis or hardened cells in other elastic tissues such as their hand or foot. Prostatitis and benign prostatic hyperplasia are non-cancerous disorders of the prostate gland. Prostatitis is said to account for up to 25 percent of all the doctor's office visits by young and middle-aged men for complaints of frequent or painful urination. More than half of men in their sixties and as many as 90 percent in their seventies, have some symptoms of benign prostatic hyperplasia. In the U.S., 350,000 operations are performed each year as corrective measures (National Institute of Health, 2000:A,B,C,D,E.).

Impotence affects between 10 and 15 million American men. During the 1960's and 1970's, erectile dysfunction was largely thought to originate from psychological problems such as depression, financial worries, work-related stress, or masculine pressure to perform. In the 1980's, emphasis had shifted to physiological explanations including medical treatments for diseases such as diabetes, alcoholism, and atherosclerosis. Diagnosis and treatment of erectile dysfunction, since the 1990's entails a combination of psychological and medical management with current generation pharmaceuticals such as Viagra and Cialis. Diseases account for about 70 percent of impotence. It is believed that psychological factors cause 10 to 20 percent of male impotence. (National Institute of Health, 2000:A,B,C,D,E. Kimmel and Messner, 2001:294).

Illness Rates, Chronic

Chronic conditions affect all aspects of the lives of its sufferers. They not only affect how a person feels but also their ability to function and to carry out everyday tasks. "In chronic illness, the body is in some kind of permanently altered state, from that,

which is expected and is never completely free of the discomforts attaching to sickness” (Millard and Kelly, 2003:160). Chronic illness often makes it difficult for a person to live independently. Some chronic diseases lead to death more quickly than others do. These include cancer, bronchitis, emphysema, heart disease and diabetes.

The medical profession has demonstrated some success in the diagnosis and treatment of organ specific diseases. Many organs can even be removed and replaced by others, either artificial or from human or other living donors, (heart, liver, kidneys, and cornea etc.). However its success is limited so far, in its ability to cure the ever-expanding range of chronic and multi-system diseases. (Clarke,2000:295,302)

Much of the illness today in North America is chronic. Chronic illness is an increasingly significant component of the over all disease profile. Long term degenerative diseases afflict both men and women. Since women on average, outlive men, they are apt to be afflicted at a time when most men in their age peer group have passed away.

According to Wayne J. Millar,

“It has been argued that chronic illness can be postponed through a combination of personal lifestyle and medical care, and that the morbidity associated with aging will be compressed into a smaller proportion of the life-span. A less optimistic view is that the result of increasing life expectancy may be an increase in both the prevalence and duration of chronic diseases” (Millar, 1995).

Women who die of heart disease have usually done so after reaching their 75th birthday. Most men who die from heart disease are usually dead 3 years before they would have reached their 75th birthday.

HIV/AIDS

On June 5, 1981, in a publication of the U.S. Center for Disease Control (CDC) called *Morbidity and Mortality Weekly Report*, an article was published titled 'Pneumocystis Pneumonia-Los Angeles'. This was the first U.S. published account of something terribly wrong with the immune system of five young homosexual men, who were treated at three different hospitals in Los Angeles. A month later on July 4th 1981, *MMWR* published another article about an uncommonly reported malignancy, Kaposi's Sarcoma, diagnosed in 26 homosexual men in New York City and California. The *Morbidity and Mortality Weekly Report* was alerting its readers to the coming pandemic, which as of 2002, infected 51,180 Canadians and 384,906 Americans. Discovered in the U.S. in the late 1970's, it was not until the end of 1982, that the underlying condition on which it was reporting would be known as Acquired Immune-Deficiency Syndrome (AIDS). The first recorded case in Canada was in 1982 (*Canada Communicable Disease Report Volume 29-23 1 December 2003*. U.S. Centers for Disease Control and Prevention End Year Vol.14 December 2002).

The disease is caused by a virus called the human immunodeficiency virus (HIV), entering the white blood cells and preventing them from triggering the immune system to produce antibodies, which fight invading microbes. Without our immune defenses, or drugs to stimulate or duplicate their function, we are helpless against even minor infections (Klaidman, 1991:129-30). However according to Health Canada, "Some medications that once held great promise are now failing in the face of drug resistance and new HIV strains. Research has also shown that long-term use of antiretroviral therapies can cause organ damage, heart disease, diabetes and other health

consequences”. With medication the disease may progress more slowly or even much more slowly, however the secondary effects of consistent use of medication brings forth its own ravages and premature death. (Health Canada: Canada’s Report on HIV/AIDS 2002:2. Clarke, 2000:71-2).

Table 18

NUMBER OF HIV AND AIDS CASES IN CANADA
By Sex and Age Group, 1985 – 2003

<u>Age Group</u>	<u>Male</u>	<u>%</u>	<u>Female</u>	<u>%</u>	<u>Total</u>
To 14 years	392	59%	263	41%	655
15 to 19 years	380	58%	273	42%	653
20 to 29 years	9,604	80%	2,459	20%	12,063
30 to 39 years	16,436	86%	2,700	14%	19,136
40 to 49 years	8,554	89%	1,023	11%	9,577
50 & over	3,399	88%	474	12%	3,873
Age not reported	4,717	90%	506	10%	5,226
Totals	43,482	85%	7,698	15%	51,180

Surveillance Report June 30, 2003, HIV and AIDS in Canada. Human Resources and Communications.

In Canada since 1985 when testing for HIV/AIDS became available, 43,482 males and 7,698 females have tested positive (see Table 18). From 20 years of age and older, males have consistently accounted for 80% and over, of all reported HIV/AIDS cases.

Males are infected over 5 times more than females in Canada but the number of women infected is climbing rapidly. “In 1986 2% of the HIV-positive population was

female” (Clarke, 2000:72). By 2003 females accounted for 15% of the national total. Up to age 19, females account for over 40% of the total HIV/AIDS cases. The above table shows that Canadian females become infected with HIV/AIDS at an earlier age than do males. Possibly because one young male once infected, can infect many young females. Another possibility is that perhaps some of the young people may have been born infected. This may account for the number of cases reported in the youngest two age categories in Table 18.

AIDS, as an infectious, contagious disease, includes multiple risk categories. Of the AIDS/HIV cases reported in Canada in 1995, 76% are men who have sex with other men; 9% are the result of heterosexual contact; 4% are men who have sex with men and inject drugs; 4% are recipients of contaminated blood products; and 3% are from injection drug use (Clarke, 2000:71,2).

In the U.S. the instances of HIV/AIDS infection are staggering. The 384,906 known case numbers, according to Dr. Harold Jaffe, acting director for the National Center for HIV, Sexually Transmitted Diseases and Tuberculosis Prevention at the CDC, are much higher. On February 25, 2002 in an interview with Reuters, Jaffe stated that “the actual number is closer to double that of Americans infected. We estimate that roughly half of all people living with HIV either don’t know they are infected, or they are not in care or both”. That means men and women are going untreated, and may be spreading it unintentionally through unprotected sex or shared needles. Others are spreading it intentionally, and even acquiring it intentionally: bug-chasers, as they are called.

Fifty thousand more people (in the U.S.) are living with HIV or AIDS than two years ago, and 40,000 more people are being infected with HIV every year. In 1999, 17,200 people died from AIDS and 15,300 in 2000. Aids is the eighth leading cause of death in the U.S. Globally, 3,000,000 people die of AIDS every year and 40,000,000 are infected, most of them in Africa. More people are alive with HIV in industrialized countries than ever before because of drug treatments, which keep it at bay. (Fox, [Reuters] 2002:1).

Of the 298,248 men 13 years or older, who were living with HIV/AIDS in the U.S. 57% were men who had sex with men. That figure is substantially lower than the 76% of infected Canadian men who had male to male sex. The 10% who were exposed through heterosexual contact compares to the 9% Canadian. Twenty-three percent of Americans with HIV/AIDS were intravenous drug users compared to 3% Canadians, 8% were both having sex with men and intravenous drug users (compared to 4% Canadian) and 2% are recipients of contaminated blood products; (compared to 4% Canadian). Sixty-one percent of the 82,762 infected American women were exposed through heterosexual contact, and 36% were exposed through intravenous drug use (U.S. Centers for Disease Control.2004)

Generally non-fatal

Chronic conditions not seen as life threatening are allergies, back ailments, arthritis and rheumatism, and high blood pressure. Women are more likely to report these types of conditions or symptoms of these conditions to their doctor. Women are also more likely to report experiencing a multiplicity of conditions at one time. (Statistics Canada

National Population Health Survey 1996-97, Cat. No. 82-221-XIE. Statistics Canada, Cat. No. 82-003-XPE).

Across all age groups women were more likely than men to be taking one or two medications, but less likely to be taking three at the same time. Our knowledge of the extent of greater experienced physical-health problems among women than among men is due, at least partially to the fact that women are more likely to report having consulted a physician than are men (87% versus 73% respectively).

Many women include in their schedules a yearly doctor's visit for a mammogram for early detection of breast cancer as well as a Pap smear for cervical cancer detection. Women with families are usually the ones to accompany their children and their mates, and their parents, to doctor's offices for routine check-ups as well as emergencies. "As a consequence, [women] are more likely to include themselves in a yearly round of consultations with their own physicians." (Nelson and Robinson, 2002:393).

Arthritis and rheumatism, skin or other allergies, hay fever and migraine head aches, and emotional disorders to name a few, many are of the debilitating but non-life threatening transitory type. When men report sick, however, it is more likely with a serious or fatal condition, for example from heart disease, lung cancer, cardiovascular, or obstructive pulmonary disease (see Table 1). Many of the chronic illnesses women suffer from manifest themselves in the latter stages of their lives, a plateau which few men even reach (Clarke,2000:114-5,119).

Women, more than men are likely to include their feelings in their descriptions of their health. Women's greater attention to minor signs and symptoms and their greater willingness to take preventive and healing actions (i.e., bed rest, diet) mean that their

health problems tend not to become as severe as those of men of the same age. This greater carefulness regarding their health helps women extend their lives (Clarke, 2000:119).

Women pay more attention when they are experiencing ill health and are more likely to take the necessary actions or behavior to regain their sense of well-being and avoid the possibility of the illness becoming worse. Because of the biological monthly changes in their bodies, women are more aware of even minor symptoms and are better at describing those symptoms to their physicians. Men on the other hand, when they do visit their doctor tend to minimize or not even mention minor symptoms (because of a need on their part to maintain a macho image). For this reason, often by the time a man does visit his doctor and describes his symptoms, the illness may have reached a stage of greater severity. Apparently this only applies to non-serious episodes and illnesses. In matters of serious illnesses, such as cancer, men and women are both likely to seek medical help, but men probably later.

Conclusion

The most serious illnesses in North America today are the degenerative diseases of old age, the so-called diseases of civilization; There are most notably cancers and cardiovascular diseases (CVD), associated with strokes and heart attacks. Treatments have varying levels of success in prolonging life – but not, of course, in preventing death. Particularly worrisome are the predominantly male HIV/AIDS infection rates.

Chapter 4

CONCEPTUALIZING HEALTH

Introduction

One of the most often-cited definitions of health is that of the World Health Organization: “Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (WHO, 2003:1). An editorial in the Journal of Men’s Health & Gender had modified the WHO definition to suit male health specifically:

Good male health is a state of physical, mental and social well-being that enables individual boys and men, and the male population as a whole, to meet the demands of everyday life and to realize their aspirations and biological potential (Journal of Men’s Health & Gender, 2004:2).

This implies several paradigms on health, but here we will consider only four: the bio-medical model, the lifestyle or personal choice model and the cultural environmental model. All of which refer primarily to physical health; and we will conclude with a discussion on mental health.

The Bio-medical Model

The foundation of modern Western medicine is generally described as the bio-medical model. It assumes that diseases are the results of deviations in the normal functioning of biological variables. Further it distinguishes between the body and the mind, and asserts that disease can be treated separately from the mind. This is not to say that modern medicine does not recognize the effects of stress or depression on the body. But in general the medical profession deals with the body, psychiatry with the mind, and religion with the soul. As diseases represent some form of departure from the normal

order of biological variables, they can be cured by medicine, which restores the normal functioning of the body. The body is conceptualized as a machine which tends to breakdown, the result of disease, injury or birth defects, which can in many cases be repaired.

Most advanced industrial societies have followed a broadly similar path in the increased longevity and lowered morbidity rates of the population and in the evolution of the health systems. Infectious and parasitic diseases, which were prevalent in the Western World until the Modern Era, have now, for the most part, been conquered. In their place have come cancer, chronic diseases, AIDS and violent injuries. According to George M. Torrance, one of the major turning points in the overall health status of both males and females came in the nineteenth century as changes in agriculture production resulted in the availability of improved food supplies. This increased economic surplus made possible improved nutrition, improved housing, improved public health measures, and improved sanitation. These developments, argues Torrance, along with the declining birth rate and the relatively new practice of immunization, rather than medical curative techniques, led to improved morbidity and mortality rates. (Coburn et al, 1998:3,4)

Prior to the 1960's, most of the thinking about gender and health issues were centered within the traditional bio-medical model:

Malady > Physician > Medical Technology > Magic Bullet > Cure

However, there was opposition to the bio-medical hypothesis because of its mechanical focus. The first publications of the sociology of medicine appeared in the U.S. during the 1940's but it was not until the advent of the socio-cultural model in the 1960's, that gender and health issues were viewed increasingly in light of cultural values

and practices, social conditions, human emotions and perceptions. Along with this relatively new philosophy came the emergence of criticisms of the bio-medical model, in particular, its afore-mentioned, mechanical approach with the overemphasis on biochemical processes, and overly simplistic explanations that attribute disease to one or two specific causal factors (Sabo and Gordon, 1995:23).

The criticism of the bio-medical model does not address its successes and the fact that it did work! The bio-medical model was itself 'justified' by the success of inoculations against infections and contagious diseases, the 'magic bullet' of penicillin against venereal disease (VD), and of course, the recognized significance of good hygiene and sanitation.

With the social movements of the 1960's, came the awareness that gender had to be considered in matters of health and illness. Before this, gender was considered as simply another variable in identifying health patterns and risk factors. The more modern approach of including gender factors in health research, was found to be useful in determining the different rates of illness between males and females, or by studying groups of males across various socio-economic, geographic, social, and ethnic groups. By the late 1970's, including gender in epidemiological research became standard. However, research results indicated that differences in the health of both genders could not be explained by bio-medical reasons alone. It was becoming increasingly evident that socio-cultural differences were also part of the explanation of the gender differences in health statistics (Sabo and Gordon, 1995:2,3).

Lorber and Moore investigate the transition between the medical and the social paradigms of health. They agree that the new diseases often have a social etiology.

From a biomedical perspective, isolation of the prime cause (a bacterium, virus, gene or genetic mutation, a hormone or its lack, an element of diet, smoking etc.) is the ideal, modeled after the nineteenth-century discovery that specific 'germs' cause specific diseases. But after a century that has seen the design of antibacterials, antivirals, insulin, vitamins, and vaccines to handle diseases caused by specific deficiencies or invaders, we now face chronic disorders of the cardiovascular, respiratory, and immune systems. These diseases are particularly responsive to social factors, such as the way we live and work, and to the environment, which can trigger genetic pre-dispositions (Lorber & Moore, 2002:148).

Culture, or more specifically, cultural differences, in relation to the ratio of those afflicted with certain illnesses, demonstrate that susceptibility is at least partly due to social factors, such as lifestyles, which are gender-influenced, and environmental factors. According to Ory and Warner, we are still in the dark when it comes to gender differences in respect to illness and life expectancy;

What precedes death is a very dynamic array of risks drawn from far back in someone's lifetime and also near-at-hand experiences. ...The vulnerabilities and resistances that males and females typically receive at conception, and how aging processes and social exposures alter the size and character of one's given robustness are not known. The single greatest need in population studies of sex differences in health and mortality is operational measures of that biological substrate (Ory and Warner, 1990:185).

In the bio-medical model, disease is reduced to a single primary principle of cause and effect, leaving no room "...within its framework for the social, environmental, behavioral, and psychological dimensions of health and illness. ...It not only requires that disease be dealt with as an entity independent of social and behavioral factors, it also advocates that behavioral disorders themselves are caused by bio-chemical or neuropsychological deficiencies (Bolaria and Dickinson, 2002:57-8). A current approach, the biopsychosocial model, has physiological, psychological, and socioenvironmental factors as interdependent systems that collectively determine health and illness (Bolaria and Dickinson, 2002:77).

Much has been written about the importance of the body in order to understand the experiences of good health, illness, and premature death.

“...Yet few have successfully integrated the biology of the body into a sociological account. This is due in part to a desire to avoid biological reductionism and determinism. No doubt it also arises as a consequence of the need by some to put distance between sociology and the bio-medical model ” (Millward and Kelly, 2003:157

Ivan Illich and David Horrobin: Health, Illness and the Medical Establishment

Despite its successes, the bio-medical model has been criticized for ignoring the lifestyle/personal and cultural factors affecting health. One of the first critics was Ivan Illich who in 1975 presented the argument that “The medical establishment has become a major threat to health” (Illich, 1975:11). The first part of his contention is based on what might be called commonly accepted medical understanding. The essence of which is that in the last 100 years, diseases afflicting Western societies have undergone dramatic changes to the extent that many past afflictions of epidemic and sub-epidemic proportions of yesteryear, no longer exact a toll of human life, (or at least not in the same proportions), and that many deaths are now attributed to, or associated with, diseases of old age, and those who do die young, are most often the victims of accidents, violence, and suicide.

Illich argues four points, in which he negates the efficiency of modern medicine: “(1) The impotence of medical services to change life expectancy... (2) The insignificance of most contemporary clinical care in the curing of disease... (3) The magnitude of medically inflicted damage to health... and (4) The futility of medical (i.e. and bureaucratic) counter-measures to medical care...” (Illich, 1975:11,15,16,45).

The study of the evolution of disease patterns provides evidence that during the last century doctors have affected such patterns no more profoundly than did priests during early times. Epidemics came and went, imprecated by both, and untouched by either. They are not modified any more decisively by the rituals performed in medical clinics than by the exorcisms customary at religious shrines (Illich, 1975:16).

Illich believes there is a natural progression to disease and that it will run its course without intervention, medical or otherwise (e.g. The 1918-9 flu epidemic). He cites examples of infections, which prevailed at the onset of the industrial age, and illustrates how medicine came by its reputation.

Diseases such as cholera, dysentery and typhoid reached a peak and then declined, without medical influence, maintained Illich. By the time these diseases were understood or curative therapy had been established, they had lost much of their relevance. “The combined death rate for scarlet fever, diphtheria, whooping cough and measles from 1860 to 1965 for children up to 15 shows that nearly 90% of the total decline in the death rate over this period had occurred before the introduction of antibiotics and widespread immunization against diphtheria.” (Illich, 1975:16). Illich claims that part of the reasons for the decline of these diseases might be due to a natural weakening of the virulence of microorganisms.

According to Illich, in England, by the middle of the 19th century, infectious diseases were replaced by diseases such as rickets and pellagra that were a direct result of malnutrition or a lack of adequate nutrition. These in turn peaked and vanished to be replaced by the “diseases of early childhood and then by duodenal ulcers in young men. When these declined, the modern epidemics took over: coronary heart disease,

emphysema, bronchitis, obesity, hypertension, cancer, arthritis, diabetes and the so-called mental disorders” (Illich, 1975:17).

Natural cures and the naturally declining occurrences of particular afflictions individually or of epidemic proportions, is still one of the best and most relied upon ways of coping with some illnesses such as the common cold or influenza. However coronary heart disease, cerebral hemorrhage, and cancer, to name a few, continue to be influenced positively by medical intervention.

Illich postulates that despite intensive research, there is no satisfactory explanation for the emergence and disappearance of diseases. He claims that two things are certain: “doctors cannot be credited with the elimination of diseases leading to death, nor can they claim credit for the increased expectancy of life spent suffering from the new diseases”. (Illich, 1975:17).

He makes no mention of David Jennings’ relatively early 1798, life-saving discovery of disease prevention through inoculation, nor of the continuing medical advances towards cleanliness and sterile conditions in hospitals or other places where injured or sick people are cared for. Sometimes virulent microorganisms such as C-Difficile are present in hospitals, which can be controlled or eliminated. This is possible in state-run or state-funded institutions by allocating funds for proper cleaning staff and supervisory personnel and also for isolation units to separate the infected from others. In private institutions, for health standards such as those previously stated, to be also strictly enforced. Medical personnel are at more risk than many of the patients because they are exposed for much longer periods of time since they work in the environment, although it

is the ones with weak immune systems who are usually in the most life-threatening danger.

Illich criticizes the medical profession for taking credit for a very important breakthrough, which was really an engineering breakthrough, that of proper sanitation which has saved countless lives. This begins with the separation of human and animal waste from (potable) drinking water.

Illich sees a previous time in history, a golden age, when people were not dependent on the medical system to care for them and that modern medicine has destroyed this healthy attitude. Horrobin disagrees that there ever was such a period. People who were ill always looked outside for help, whether to a priest, shaman, or medicine man, or to medicine. Most people cannot treat themselves when they are ill (Horrobin, 1980:29).

Illich complains that doctors have increasingly intervened in people's lives at all stages. He sees this intervention as starting before one is born, with pre-natal and post-natal care and specialized consideration at each stage of life. Illich feels that people are made, "to follow special medical routines in special health producing environments. The over powering emphasis on health degrades the quality of the home, the school, the street, and the marketplace" (Illich, 1975:44). Horrobin's reply to Illich at this point is to ask if he is opposed to pre-natal and post-natal care, which has contributed greatly to reducing infant mortality rates. "He would find few mothers to agree with" (Horrobin, 1980:33).

Illich brings in Talcott Parsons' "model of sickness", which states that sickness imposed the obligation to submit to repair service from doctors in order to return to work

at the earliest date. (Illich, 1975:57). This philosophy smacks of the Weberian Protestant Work Ethic and may share in the responsibility for the lack of visits that North American males make to physicians. Their work ethic might keep them working longer as major family breadwinners when considering that a trip to the doctor will mean having to take time off for a visit, and possibly orders to refrain from work during their convalescence. “Medicine has come to influence huge areas previously dominated by religion and charity, because it has achieved unequivocal objectivity, and verifiable and consistent results in certain areas” (Horrobin, 1980:39-40).

Illich sees medicine as a giant corporation, creating a desire for something and then supplying that product, which in this case is perfect health for everyone. Horrobin sees this as a false interpretation. In the past as well as now, health has always been “a major concern of traditional societies”. Most people feel confused and fearful in times of sickness, trials and tribulations, and have always sought help and advice from healers and/or priests who have offered “remedies and religions, to help people cope (Horrobin, 1980:116,117)

Horrobin agrees with Illich’s first statement that the medical establishment has become a major threat to health through iatrogenic illness. The difference lies in the interpretation of the statement. According to Horrobin, Illich sees medical professionals as ineffectual in their efforts, making decisions and taking on responsibilities that he believes fall within the realm of the gods. Horrobin agrees that medical professionals now make decisions and assume responsibilities once left to the spirits. The logic according to Horrobin is that because the gods are not doing anything to help the situation, it is left up to medical professionals and modern medicine (Horrobin, 1980:6,7. Illich, 1975:11,28).

Illich claims that the decline in diseases and the rise in life expectancy had nothing to do with treatment received from medical professionals. Horrobin agrees in part. The part being that the major killing infectious diseases in most cases, declined in importance long before they were completely understood or specific medical treatment became available. He stated that Illich misrepresented the facts by his failure to include the contributions made by the medical community. He states that while many of the improvements in the health of the population and the decrease in infant death and overall early mortality, were due to environmental changes, the contributions by physicians towards these changes and many other health improvements cannot be discounted. Among those he cited as doctor initiated, are notably, 1) safe drinking water, and 2) the safe disposal of human and animal waste and 3) nutritional supplements such as iron and vitamins (Horrobin, 1980:12-13. Illich, 1975:18).

To say doctors have not been instrumental in controlling some of the killer diseases would be inexcusable. To deny that doctors play a part in changing or controlling disease is nonsense. The causes of the problems/illnesses are discovered because of doctors' probing and medical research (Horrobin, 1980:13-14).

Horrobin replies that Illich is being unreasonable to insinuate that it is better to die early from a cerebral hemorrhage (stroke) than to live longer even with some discomfort as a result of being treated for hypertension or diabetes or some form of cancer. Modern medicine has made great strides in the prevention of strokes in patients with hypertension. "A stroke is one of the most devastating of all disasters to health. A stroke can convert active people into helpless people. To be able to prevent that is a major achievement" (Horrobin, 1980:18). Drug treatment for serious diseases such as tuberculosis, tetanus, diphtheria, and scarlet fever, has done little toward the decline of

these illnesses, Illich states. However Horrobin disagrees and claims that “the lives of malaria and tuberculosis victims are saved by medical treatment and tetanus and diphtheria are prevented by immunization” (Illich, 1975:20. Horrobin, 1980:17).

Illich argues that surgeons perform unnecessary operations, in some cases to raise their incomes, and that patients are sometimes subjected to unnecessary diagnostic tests, which may provide a defense against accusations by other experts in a malpractice suit, but which contribute nothing to the patient’s well being. Horrobin states that, “most surgeries tend to leave the patients not feeling too well, or temporarily more ill than if they had not had the surgery. But this is hardly an argument against removing an inflamed appendix or against repairing a hole in a child’s heart” (Illich, 1975:22. Horrobin, 1980:20).

Prior to the 16th century disease was usually regarded as dis-ease, a sickness of the whole person. Those who cared for sick people (and there were very few, apart from immediate family and neighbors) responded to the sick person as a whole and not just to that portion of him that was ill. Sick people were usually cared for within their own community. Hospitals were the refuges of the destitute; pest holes where treatment of the inmates by the custodians was frequently appalling. There was remarkably little evidence of Illich’s traditional compassion. Therapy had virtually no part to play. The hospitals were simply septic tanks where the destitute sick went there to die; and where they often did so more quickly than had they remained outside (Horrobin, 1980:85).

Attitudes slowly changed and Rousseau with his concept of the noble savage and his ideal of the primitive state, believed that the natural condition of man was healthy and that in his natural condition most diseases would prove self-limiting and easily

controllable. Little care would be required that could not be provided by simple measures of love and attention by the patient's own family. Illness of the modern type was seen to be largely a consequence of a fall from a primal natural state (Horrobin, 1980:85. Illich, 1975:109,136).

Lifestyle Model

Our lifestyles affect our death-styles. Lifestyle is not necessarily synonymous with choice. Smoking, drinking, and obesity, it can be argued, are not necessarily choices but are sometimes classified as addictions, initially fueled by indulging one or more times. Tobacco smoking and excessive or habitual alcohol consumption is certainly addictive and obesity when considered as having psychological or cultural roots rather than lack of exercise and/or excessive consumption of food-to-energy expended, might arguably fall into the same category.

Reasons abound for the inclination among some to be overweight or obese. Psychologically, a person might feel healthy being overweight because of a miss-guided childhood at which time a caregiver expressed and acted on the belief that a healthy child is a fat child. Sociologically, family tradition might dictate that the communal diets consist of meals high in calories and carbohydrates, or that exercise takes a backseat to sedentary pastimes such as piano playing. Multiple physiological reasons exist for overweight or underweight conditions, such as having an under-active or over-active thyroid. Certain medications can contribute to a person's weight. Steroids, for instance, generally increase the appetite, and water retention. A major differentiation between obesity and smoking and drinking is that although smoking and/or drinking may start at a young age, obesity or the tendency to be overweight, can be initiated at infancy.

Juanne Nancarrow Clarke states unequivocally that cigarette smoking is recognized as the leading cause of preventable death in Canada (Clarke, 2000:65).

Cultural and societal influences on behavior are known to affect health. The narrowing of the male-female gap in life expectancy in recent years reflects, in part, tobacco use, a factor strongly based in the cultural context. Due to differences in the wartime experiences and advertising pressures experienced by men and women, women lagged behind men in taking up smoking, and never smoked to the same extent. However among young Canadians today, there is no difference between male and female smoking rates, and sex differences in mortality due to smoking-related respiratory diseases seem to be narrowing (Statistics Canada Cat.no.82-003-XPE 2001 Health Reports vol.12 no.3).

Some forms of risk taking behavior have been recognized as being major contributing agents in life threatening epidemiological illnesses. A very significant agent is smoking and its relation with lung cancer. Former U.S. Surgeon General Koop, reported almost fifty years ago in 1956, that one third of the U.S. population over 19 years of age were smokers - 25 million men and 23 million women, plus 3 to 4 million teenagers. In the report 'Smoking and Health', Koop "Identified cigarette smoking as the single most important environmental factor contributing to premature mortality in the United States". In a 12 year follow-up of one million men and women in the U.S., mortality rates were greater for smokers than for nonsmokers regardless of age or sex (Clarke, 2000:65. Courtenay, 2000:1386).

Male death rates from lung cancer are more than twice that of female rates, and reflect past acceptability via marketing/advertising. A leading example of this would be the 'Marlboro Man, who, incidentally, died from lung cancer. "The annual risk of death for a smoker is 1/150, which is double the annual risk of death from cancer from all other causes, (1/300), and greater than risks posed by vehicle, (1/5,000) and work, (1/10,000), accidents" (Courtenay, 2002c:1. Viscusi, 1998:32).

Canadian statistics of the expected number of deaths from lung cancer attributable to smoking, before the age of 70 from among 100,000 individuals, (15 years of age in 1996-97) is expected to be 13,513 males and 4,428 females (Statistics Canada. Health Reports, 1998:309).

For men, the U.S. death rate for lung cancer declined from 81 deaths per 100,000 people in 1988 to 64 in 2000. During the same time period, the rate climbed for women from 27 to 34 per 100,000, while for breast cancer the rate dropped to 25 per 100,000. Beginning in 1993, more women have died each year from lung cancer than from breast cancer. There was a time lag, from when women started smoking in ever increasing numbers in the 1970's until recently, when the numbers of female deaths due to lung cancer, began climbing. In Canada there has been a significant decline in men smoking. From 54 percent in 1966 to 32 percent in 1994. Women's rates however, increased from 28 to 29 percent. New smokers usually begin in their youth, very few adults begin smoking (The Canada e-Book, 2001:1,2. Clarke, 2000:65,69).

The major reasons for smoking include addiction - to nicotine and other chemicals; to enhance social acceptability - which, except for die-hard comradeship among puffers, is beginning to wane as more and more people either quit or die; to relieve stress - either through inhaling the highly-addictive compounds in cigarettes, and/or the psychologically comforting, juvenile consequence of holding something in one's hand or in one's mouth. The last major reason for smoking is to control weight. Once again the chemicals in the cigarettes are responsible, they coat the taste buds on the tongue making food less appealing and they also assuage the stomach lining and brain receptors into alleviating the hankering or actual craving for food. The cigarette itself contributes by keeping the

hand and mouth busy and (temporarily) away from the fork and spoon. Even though the overall rates of cigarette smoking are declining in Canada and the U.S., they are increasing in the developing world (Clarke,2000:69,70).

Table 19

PERCENTAGE OF SMOKERS IN THE POPULATION
2000-2001

<u>Age groups</u>	<u>Males</u>	<u>Females</u>	<u>Difference</u>
12-14	2.2%	3.8%	1.6% more females
15-19	15%	19%	4% more females
20-34	37%	31%	6% more males
35-44	37%	30%	7% more males
45-64	29%	23%	6% more males
65 & over	12%	10%	2% more males
All	24%	19%	5% more males

From: Statistics Canada. July13, 2004. CANSIM, table 105-0027 Cat. No. 82-221-XIE,

According to the latest Statistics Canada data, 24% of males from the age of 12 years and over, are smokers, and 3.8% of females. In two categories, females outnumber male smokers. In the 12 to 14 year old category, 1.6% more girls than boys smoke, and in the 15 to 19 year old category, 4% more girls than boys smoke. In all the other categories, males outnumber females (See Table 17).

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It should be understood that moderate alcohol consumption might not be detrimental to the health. Statistics Canada reports that:

It is difficult to make recommendations about safe levels of drinking alcohol because there is a curvilinear relationship between the levels of alcohol consumption and the risk of mortality from heart disease. Individuals who do not drink alcohol are at a higher risk for heart disease than those individuals who consume one drink of alcohol a day. The reasons for this are not entirely clear. (Statistics Canada, 1999:37 The Changing Face of Heart Disease... Cat. No.82F0076XIE).

There are many deaths every year, which are in some way related to excessive alcohol consumption. In 2000, there were approximately 85,000 deaths attributable to excessive drinking in the U.S., making alcohol (either directly or indirectly) the third leading cause of death (U.S. Centers for Disease Control, 2005. Alcohol Fact Sheet).

Barry Edginton has classified alcohol-related mortality into three sections to which I have added other causes from the CDC and Statistics Canada.

i) Direct causes of death related to alcohol:

- Heart Condition
- Cancer
- Respiratory Condition
- High Blood Pressure
- Cirrhosis of the Liver
- Alcoholism
- Alcoholic Psychosis and Poisoning

ii) Indirect causes of death related to alcohol:

- Motor Vehicle Accidents
- Suicide
- Fall
- Fire and Drowning
- Homicide
- Hypothermia
- Severe Malnutrition

iii) Other related causes of death:

- Stroke (hemorrhagic)
- Pancreatitis
- Meningitis

Edginton, 1989:175. U.S. Centers for Disease Control, 2005. Alcohol Fact Sheet.

To some, consuming alcohol is largely social/behavioral. “What drinking means to someone is largely a function of the social expectations that are shared with other members of the person’s current peer group” (Hamburg, Elliot and Parron, 1982:91).

Excessive alcohol consumption is often deemed to be ritualistic, socially enhancing and an inhibitor-reducer among mostly male, youth and a depression alleviator among some adults seeking solace in the bottle. Men are more likely to consume alcohol than women according to Statistics Canada, and they also drink more frequently and more heavily. Drinking alcohol affects health in beneficial and detrimental ways, depending on the quantity. Moderate drinking appears to have a beneficial impact on health, yet excess

alcohol consumption has been associated with illness and death, not only for the consumer, but for others as well. Drunk driving accidents, suicide and homicides, committed while under the influence, alcoholism, liver cirrhosis, malnutrition, and obesity all have far reaching personal, communal, societal and generational effects. (Clarke, 2000:65 Statistics Canada, 82-567-XPB:1997).

There is evidence of genetic markers of a predisposition to alcoholism:

Sons of alcoholics are twice as likely as others to become alcoholics. Because parents provide both social environmental and genetic endowment, it is necessary to distinguish between these two influences. Available studies of twins and of adopted children support the existence of risk in part based on genotype. Even when raised from very early infancy by people who do not abuse alcohol, adopted males with an alcoholic biological parent have an alcoholism rate that is about the same as that for males raised by their own alcoholic parents. Also identical twins have a greater concordance for alcoholism than do fraternal twins. (Hamburg, Elliot and Parron, 1982:89-90).

We are in the realm of nature and nurture. Both genetic and social factors are significant for alcoholism. Two classifications of alcohol consumption, binge drinking and excessive drinking, are divided along amount/occasion, and gender lines. Binge drinking, is generally defined as having 5 or more drinks on one occasion (in a row or within a short period of time). However, among women the quantity is 4 or more drinks. The reasoning given for this is that women are usually smaller than men are and they metabolize alcohol at a different rate. Heavy drinking is considered for men in excess of 2 drinks per day on average, and for women 1 drink per day on average. The reasoning for the amount differences is the same as for binge drinking (U.S. Center for Disease Control, 2005 Alcohol Fact Sheet).

The Canadian standard (according to Statistics Canada) of excessive alcohol consumption by an individual is more than 9 drinks per week for women, and more than

14 drinks per week for men. In 1996, the proportion of Canadian adults who reported that they drank those amounts or over per week was 4% for women and 8% for men. As this was a self-reported survey, one must bear in mind that people have a tendency to under-report on socially frowned upon practices, such as drinking, smoking, excessive eating and under-exercising (Statistics Canada, 1999:37 Cat. No. 82F0076XIE) The actual proportion is therefore likely to be higher than the reported proportion.

Studies have found a direct relationship between excess body weight and higher mortality. Obesity is a significant risk factor for a variety of life-threatening diseases, including cardiovascular disease, diabetes, cancer of the breast, colon, and prostate, and gall bladder disease. (Clarke, 2000:65,71).

Men's eating habits have been traditionally affected by the availability of desired foodstuffs. Their "rates of coronary heart disease rose precipitously after World War II in Western industrialized countries because they had the privilege of eating more scarce red meat" (Lorber & Moore, 2002:5). Many men and women practice unhealthy dietary habits, consume excess calories and fats and are overweight. Studies have shown a higher mortality rate for those markedly above average weight. For those...overweight, mortality is 20 to 40 percent greater than for those of average weight (Hamburg et al, 1984:9)

Body weight depends on a combination of factors, including genetics, dietary practices, and the extent of physical activity. Obesity is a significant risk factor for a variety of diseases, including cardiovascular disease, diabetes, breast, colon, and prostate cancer, musculoskeletal problems, and gall bladder disease. Studies have found a direct relationship between excess body weight and higher mortality (Clarke, 2000:71).

Table 20

BODY MASS INDEX
By Gender and % of Population

Weight	Canada		Gap	U.S.		Gap
	Male	Female		Male	Female	
% Normal (or under) weight	40	62	22	42	54	12
% Overweight	45	28	17	40	26	14
% Obese	15	10	5	18	20	2

StatsCan: Joint Canada/U.S. Survey of Health, 2003, 82M0022XIE/2003001

Using the Body Mass Index: dividing an individual's weight in kilograms by their height in meters, with less than 8.5 is considered underweight, less than 24.9, is considered normal weight, 25.0 to 29.9 is considered overweight, and 30.0 or higher is considered obese. Table 18 shows that one-third more men than women are overweight and one-third more are obese. Health Canada's figures show Canadian men as almost twice as likely to have some excess weight (24% vs. 14%) and are also more likely to be definitely overweight (35% vs. 23%) to the level of having probable health risks, which is 27.0 on the BMI. In the U.S., more women than men are obese by a small margin. (Table 19) (Health Canada Online, 'Body Weight' 2004:67)

At the ages between 55 and 64 for men, 40% are overweight and 19% are obese. Being overweight is more common among men (59%) than women (37%) (Canadian Fitness and Lifestyle Research Institute, May 2004). According to StatsCan, however, being overweight is much more prevalent, they state that the highest proportion of overweight men is in the 45 to 54 age group (68%): 42% were obese and 26% had some excess weight. The age group reflecting the most overweight women was that of the 55 to 64 years. (53%): 36% were obese and 17% had some excess weight (Canadian Fitness

and Lifestyle Research Institute, 2002:3. Statistics Canada 1999:34 Cat. No. 82F0076XIE).

Being overweight is associated with overeating, poor diet, lack of proper exercise or physical activity, genetics, and in some cases medical (glandular) problems. Women are about five times more likely to be underweight (14% vs. 3%). Being underweight also carries health risks. Four percent of Canadian women overall and ten percent aged 20 to 24, have Body Mass Index less than the recommended minimum of 18.5. Despite women's tendency to be underweight, especially when young, many Canadian women with normal weights, believe that they weigh too much (CFLRI:May2004. Clarke:2000,71.).

The lack of physical activity is directly correlated to overweight and obesity. According to 2000-2001 statistics, even though there were more female than male physically inactive people, the statistics for both were staggering. 3,007,947 males claimed to be physically active and 5,611,532 claimed to be physically inactive. Almost twice as many males over the age of 12 years were physically inactive as were physically active. For females, the ratio is almost three times as many inactive as claimed to be physically active (Statistics Canada Catalogue No. 82-221-XIE).

Physical activity for some athletes professional and amateur, includes taking performance-enhancing drugs, the most popular of which are anabolic steroids (called 'roids' by the street-wise) which are the male sex hormone testosterone, synthetically produced. These drugs although prescription-controlled, are universally available and common among young amateur sportsmen. "The unprescribed use and abuse of anabolic steroids is a relatively new phenomenon that occurs most often among men between the

ages of 18 and 25, particularly among athletes” (Courtenay,2000f:98). A 1991 U.S. Department of Health statistic showed that as many as 250,000, high school senior males were using steroids (Sabo and Gordon 1995:109).

Used by some body builders and athletes, steroids have a unique effect on muscle tissue. They aid in the synthesis of protein, which facilitates increases in muscle development and enhances certain sports performance, but at a price. This substance is in certain life-saving and quality-of-life-saving medications, such as Prednisone, which is used for relatively short periods of time, for acute asthma, reducing severe inflammation, and other serious maladies. This ‘wonder drug’ has two sides, and the flip-side holds multiple potential health risks of its own. Frequent blood monitoring is required for signs of potential harmful reactions. Short-term anabolic steroid use has been associated with liver disease, altered blood lipids, growth suppression and infertility (through the suppression of sperm production), increased risk of heart attack and cancer. Behavioral effects have also been linked to steroid use: manifestations of increased aggression (‘roid rage), causing injury, suicide, and homicide. Other drugs taken at the same time tend to accelerate the effects of steroids. (Sabo and Gordon, 1995:107,8,9. Courtenay, 2000f:98).

This quote by bodybuilder Steve Michalik presents a graphic portrait of the consequences of drug abuse:

See, we’d all of us [professional bodybuilders] been way over the line for years. ...Victor Faizowitz took so much shit that his brain exploded. The aldactazone sent his body temperature up to 112 degrees, and he literally melted to death. ...[A]n Egyptian bodybuilder...went the same way a massive hemorrhage from head to toe. ...And Tommy Sansone...blew out his immune system on Androl and D-ball, and died of tumors all over his body. As for me, I couldn’t wait to join ‘em. (Sabo and Gordon,1995:109).

Sports Injuries such as football, rugby, hockey, wrestling, weight lifting and

even fighting, carry injurious connotations of male socialization by example, down to individual boys and men at street level. Pain-killers are often administered to injured male professional athletes and then they are thrown back into the mêlée, to receive the applause and adulation of the crowds who seem to be saying, what a real man! Some non-injured players whip their tired bodies into play by taking amphetamines to get them going, and barbiturates to help bring them back down (Goldberg,1976:113).

The theory of reasoned action according to Sana Loue, proposes why individuals do or do not participate in health programs or utilize services to detect, prevent, or treat illness. Although not gender specific, the gist of this theory revolves around an individual's (in this case a male's), beliefs and attitudes towards regular medical check-ups, and the adoption of healthful life practices. Many men do not see a doctor, either for routine check-ups or if they have some health issue (apart from emergencies), other men observe this and think that not seeing a doctor constitutes normal behavior (Loue, 1999:78).

Table 21

PERCENT OF PAST YEAR POPULATION CONSULTATIONS WITH DOCTORS
1998/99

<u>Age Group</u>	At least one consultation with:					
	<u>General Practitioner</u>		<u>Specialist</u>		<u>10 or more consultations</u>	
	Males	Females	Males	Females	Males	Females
	%		%		%	
12-24	67	80	10	25	3	12
25-44	68	84	17	32	6	14
45-64	75	86	24	35	11	13
65+	88	90	32	29	22	20
Total	72	85	19	31	8	14

(Statistics Canada Cat. No. 82-003-XPE. 2001 Health Reports Vol. No. 3).

Females are more likely than males to consult physicians. Among people aged 12 or older in 1989/99, 85% of females, compared with 72% of males, reported that they had consulted a general practitioner in the previous year. (See Table 21). Contact increased with age, but rates were generally higher among females. Not only was the likelihood of a doctor's visit greater for females than males, but the frequency of medical visits, (14% vs. 8%), during the year, was also higher for women (Table 21). Women are also more likely to go for regular checkups, than men. Seventy-five percent of women are reported to have annual physical checkups compared to 58% for men. Between the ages of 20-24 years, the percentage of women's annual checkups stays constant at 75%, however the percentage of male checkups within that age group drops to 45% (Statistics Canada. National Population Health Survey, 1997).

Brink does not mention self-sacrifice but concentrates on victim-blaming.

It's a lifelong heartbreak, this dying off of men, and the human race loses a lot of its young males to accident, war, disease, and violence. But often those who survive the perils of youth still push the extremities of human nature: They drink too much, drive too fast, inhale too deeply, shun vitamin pills and sunscreen, eat too much fat and not enough fiber (Brink, 2002:62).

Brink fails to mention that they also sacrifice their lives for their families, their countries, and for total strangers. During times of conflict when threats to peace and security exist, Canadian and American men and boys have taken up arms and put themselves in harms way, often sacrificing life and limb, as first line defenses against those wishing to destroy a way of life predicated on upholding rights and freedoms for all.

Sigmund Freud stated that, 'a man's mission in life is to work and to love'. Not a very optimistic outlook considering that now-a-days unprotected love can be deadly. But

what about work? Can a man actually work himself to death? The Japanese who are known to be workaholics, have a word for it, 'karoshi', which literally means 'work to death'. A 1997 analysis of over a dozen studies confirmed that there is a consistent and significant correlation between hours of work and ill health. The analysis focused on working hours and not on working conditions (Simon, 1999).

In another study, two occupational factors emerged as risk factors for death from heart disease. Men who had low control over the demands of their jobs were 1.8 times more likely to die from heart disease than men with more control were. This relates to the basic business management philosophy that responsibility without authority often leads to personnel and corporate sickness. The second factor contributing to work-related heart disease was that men, who also experienced a low level of social support from co-workers, were 2.6 times more vulnerable to cardiovascular death (Simon, 1999:44-5).

The actual mechanics of how stress at work actually contributes to death is not known. However mental stress increases blood levels of two hormones, adrenaline and cortisone and also raises blood pressure and the heart rate. According to Harvey Simon, anger is also an important component of stress on the job, and men with the most anger and hostility have the highest risk of heart disease. Stress and hostility are not so good for the brain either. In a seven year study of more than 2,000 men, at the University of Michigan School of Public Health, those who showed high levels of anger on standard tests, were two times more likely to have strokes than their calm peers (Simon,1999: 45,46). Simon suggests a (Utopian) relatively healthy scenario for men to work under. They should "seek a work environment that provides a healthy degree of autonomy and control without sacrificing social supports. At its best, work should be challenging

without being stressful; it should also be balanced by a healthy amount of play” (Simon, 1999:46).

Marc Lalonde: The Lifestyle Paradigm

Marc Lalonde, a Canadian Federal Minister of Health and Welfare, introduced lifestyle theory to compliment the bio-medical theory back in 1975. He acknowledged that while there have been great strides made in medical science and subsequently in public health protection, as well as improvements in the general standard of living, there are obstacles, which are detrimental to health. Lalonde calls these the counter-forces, which constitute the dark side of economic progress. They include environmental pollution, city living, alcohol, tobacco and drug abuse, and eating patterns which “put the pleasing of the senses above the needs of the human body” (Lalonde, 1974:5).

The modern medical system can do little to combat these threats to health, except to treat the people who become victims of destructive habits/lifestyle. People can be convinced to see physicians, but if they are not in great pain or distress, they are unlikely to listen to the physician’s advice. People are also likely to follow medical advice when their health is bad or their life is seriously threatened, but not for their future well being. The benefits of adopting environmentally friendly practices such as car-pooling to work or shopping, or the recycling of garbage, to name a few, are obvious over a significant amount of time. Environmental changes are not easily accepted, and are often deemed inconvenient by the public. “The view that Canadians have the right to choose their own poison, is one that is strongly held” (Lalonde, 1974:6).

Urbanization has been considered to be a contributor to illness. “Crowded high rise living, and the lack of recreational spaces and parks have negative health effects on citizens” (Lalonde,1974:18).

Working conditions have in the past, and continue to contribute to ill health. Many jobs are considered high-stress, and the constant demand for more and more production from workers, brings on ailments such as heart conditions. The full effect of stress may not be totally known. As well as the obvious ones, stress can bring on, or contribute to, many less known diseases (Lalonde,1974:18).

In Canada, it is often suggested that we need more medical professionals and hospitals to adequately handle the health care needs of the population. However, some responsibilities lie with the public (i.e. taking preventive measures to avoid becoming ill). These would include healthy diets, exercise, avoiding substance abuse and learning how to handle stress. “There is little doubt that future improvements in the level of health of Canadians lie mainly in improving the environment, moderation of self-imposed risks, and adding to our knowledge of human biology” (Lalonde,1974:18)

Lalonde uses two approaches from which to assess the variables, which have an impact on health. The first is historical, that is to analyze what in the past had contributed to changes in morbidity and mortality. The second is to analyze statistical evidence on the causes of morbidity and mortality. (Lalonde,1974:13).

For the historical approach, Lalonde looks at 18th century England and Wales and examines the variables, which influenced the level of health at the time. He found that some of the health improvements were linked to “limitation of family size (a behavioral change), increase in food supplies and a healthier (i.e. work and play) physical

environment (environmental influences), and specific preventive and therapeutic measures (again behavioral)” (Lalonde,1974:13). Lalonde postulates that, “Past improvement has been due mainly to modification of behavior and changes in the environment and it is to these same influences that we must look particularly for future advance” (Lalonde,1974:13).

Lalonde explains that, until now most of the efforts and financial support to improve health has been focused on the Health Care Organization, or in other words, the public health system, which is available to all Canadians. The modern medical system covers a wide array of resources such as hospitals, nursing services, medical practices, prescription drugs, nursing homes, emergency medical services (such as Urgence Santé, the Quebec ambulance service), and community clinics, (such as the CLSC’s, the Quebec drop-in clinics). Other medical services available, for a fee, are chiropractic, podiatry, dental treatment, and optometry.

The main causes of illness and death in Canada have been classified into three elements: human biology (see Illich and Horrobin), environmental influences, (see McKinlay) and lifestyles (Lalonde). It appears that money and resources are spent to care for people with illnesses that could “have been prevented in the first place”. If we want to increase longevity, quality of life and reduce illness, we must concentrate on these three elements (Lalonde,1974:32).

Lalonde suggests that any health problem can be traced to one or a combination of the elements (lifestyle, environment, and human biology and the Health Care Organization). “All who contribute to health, individually and collectively, patient,

physician, scientist, and government are aware of their roles and their influence on the level of health” (Lalonde, 1974:32).

It is not usually the construction of the roads or the design of the cars that are the cause, although there have been cars which when tested, were found to explode on impact, and several deaths did occur because of this (e.g. the Ford Pinto) These traffic deaths are also not the cause of a lack of emergency medical services. “In order of importance therefore, lifestyle, environment and health care organization contribute to traffic deaths in the proportions of ...75%, 20% and 5% respectively”. The human biology element has “little or no significance in this area” (Lalonde, 1974:32). For example, referring to traffic deaths, lifestyle is the most significant variable (at 75%).

Individuals who take risks driving while under the influence of alcohol or drugs, or speed, or fail to wear seat belts, or who generally are reckless drivers on the road, point to the importance of contributing factors when investigating the most direct links between health problems and their underlying causes (Lalonde, 1974:32) .

At issue, according to Lalonde, is whether or not it is possible to divide external influences on health between the environment, about which the individual can do little (i.e. see McKinlay), and lifestyle, in which he can make choices. Lalonde contends that social factors can dictate personal choices. The example given for this is peer pressure to conform (i.e. teenagers smoking because it’s ‘cool’). Expanding on this point, he argued that “some bad personal habits (i.e. tobacco, drugs and/ or alcohol) were so ingrained as to constitute addictions which, by definition, no longer permitted a choice by a simple act of will”(Lalonde,1975:35,36).

Lalonde carries on this same train of thought, and argues that,

Environment affects lifestyle, which may include addictive personal habits which require a philosophical and moral response rather than a purely

intellectual one. If we simply give up on people whose lifestyles create excessive risks to their health, we will be abandoning a number who could have changed, and we will be perpetuating the very environment, which influenced them adversely in the first place. In short the deterministic view must be put aside in favor of faith in the power of free will, hobbled as this power may be at times by environment and addiction (Lalonde,1975:36).

Lalonde was concerned about the question of whether the government should become involved in trying to get people to modify their lifestyles, and if so, to what extent, for the purpose of improving health. Convincing people to change their lifestyle may also be a preventive measure (i.e. dropping bad habits before becoming ill). “The marketing of social change is a new field which applies the marketing techniques of the business world to getting people to change their behavior, i.e. eating habits, exercise habits, smoking habits, driving habits, etc” (Lalonde,1975:36).

Lalonde was also concerned that social marketing by the government, in an effort to promote healthier lifestyles, may lead into “all kinds of undesirable thought control and propaganda” (Lalonde, 1974:36). In Canada, in the 1970’s, “76% of the population, over age13, devoted less than one hour a week to sports, while 84% of the population spends four or more hours weekly watching television”. This imbalance is a reflection of the “amount of money being spent by the private sector” on promoting products and services (i.e. such as alcoholic beverages, or unhealthy fast food). Lalonde suggests that society through government should “develop protective marketing techniques to offset the abuses (Lalonde,1975:36,37).

There is some apprehension, that emphasizing lifestyle choices, human biology and environment would put the onus of health and well being on the individual and would lead to withdrawal of services from the health care organization. “On this issue it can be

said, first of all that Canadians would not tolerate a reduction in personal health care and are in fact pushing very hard to make service more accessible and more comprehensive” (Lalonde,1975:37).

Further analysis of high-risk behavior reveals that the early years of adolescence are of critical importance. Decisions made at this point may affect the teenager’s health status many years down the road. This is a time that some adolescents may decide to start drinking alcohol, smoking, or taking drugs. This is a time according to Lalonde, when adolescents and pre-adolescents chose habits that will last a lifetime. “To neglect health education for the 5 to 14 age group on the grounds that sickness and death rates for it are low, would be a serious error” (Lalonde,1975:40).

Lalonde believes that most people want to live long and healthy lives, and that they are prepared to sacrifice a certain amount of immediate pleasure in order to achieve this. However, “they are not prepared to forego all self-indulgence nor to tolerate all inconvenience in the interest of preventing illness” (Lalonde, 1975:8). The behavior of many people “reflects their belief that statistical probability, when it is bad, applies to others”. People involved in high-risk occupations, such as soldiers and racecar drivers, would not be able to do their work, if they didn’t think they could take risks and survive. People who have adopted bad habits similarly often believe that they will not fall victim to their bad habits, they think it more likely to happen to others. However “when illness strikes, the patient expects rapid, quality care; all available resources must be marshalled on his or her behalf with little regard for cost” (Lalonde, 1975:8).

Between the ages of five to thirty five, the principle cause of male death is car accidents, followed by other accidents and the third highest cause of death is suicide.

Lalonde believes that most of these are caused by carelessness or self-imposed risks, “it is evident that changes ... are needed if the rates of death are to be lowered” (Lalonde,1975:14).

In Canada, we have, according to Lalonde, one of the best health care plans, however, improvements to the health of Canadians lie to some extent, in their own hands. Individuals have to adopt healthier, less dangerous habits, moderate self-imposed risks, practice some self-restraint, and “add to our knowledge of human biology” (Lalonde,1975:18).

Studying and analyzing health data, helps us to have a better understanding of how to self-improve. However, “it is difficult to act upon the conclusions reached”. Lalonde uses the example of coronary-artery disease, stating that it is one of the leading causes of death and a main reason for hospital stays. The causes are well-known, smoking, obesity, high-fat diets, genetic inheritance, lack of exercise, stress, diabetes and high blood pressure. Yet there are very few programs whose goals are to reduce coronary disease by changing habits, and the ones that do exist are not very strong or effective (Lalonde,1975:24).

According to Lalonde, not all health problems can be blamed on the Health Care System. People have to make lifestyle changes, replace bad habits with healthier ones, and reduce risk taking. Improvements within the environment, as well as a “greater knowledge of human biology are necessary if Canadians are to live a full, happy, long and illness free life” (Lalonde,1975:6).

William Courtenay: Masculinity and Behavior

Will Courtenay, analyzes 30 behaviors that increase the risk of disease, injury and death. He concentrates largely on preventable, health-risk promoting, lifestyles, and on the male gender - the men and boys - that predominate in these dangerous behaviors. He describes the behaviors, the belief, and/or the reasoning behind the action, and the consequences, and also presents statistical data showing the proportion of males to females who engage in these practices. Courtenay does not blame males as a gender, for 'inherent' weaknesses, nor does he attempt to portray high risk behavior as 'masculine psychological pre-disposition' manifested as fatalistic displays of macho aggressivity, in answer to social pressures. What he does do is portray high-risk to health behaviors and dangerous lifestyle practices, as being adopted by both males and females, predominantly male, but not exclusively. As previously stated, in almost every category, he presents the amount or percentage of females participating in the act or action or effected, along with the male data.

Courtenay commences his concept on lifestyle/behavioral factors associated with men's health, with self-care. By means of a practice, which is not preformed often, or with any regularity by many men (much to their detriment). "Men visit physicians less often than women, and they utilize significantly fewer health care services" (Courtenay, 2000f:83). Even when there are no apparent symptoms of ill health, Courtenay states that annual medical checkups are critical to the early detection of many potentially fatal diseases and for discovering conditions that are generally detected through screening. High blood pressure, high cholesterol, and colorectal cancer are among the diseases easily detected with screening. Because men do not receive timely or regular care, their health problems are often serious when they finally do seek help.

About half of men with testicular cancer are not diagnosed until the cancer is in an advanced stage, when its fatal or disabling...The primary reason that the mortality rate from prostate cancer has remained virtually unchanged for the past 30 years is that nearly half of the men have advanced forms of the disease when they are diagnosed (Courtenay,2000f:84).

Medical avoidance behavior is not limited to check-ups or preventive health care. “Even among persons with health problems, men are significantly more likely than women to have no recent physician contacts...” (Courtenay, 2000f:83).

Another important aspect of self-care along with regular medical exams and screenings that Courtenay discusses are self-examinations for cancer. These are especially important for men who see physicians less frequently. Two types of cancer are usually detectable with self-exams. However according to one study Courtenay states that 77% of females conducted self-exams compared to only 45% of males. “Melanoma (skin cancer), is 95% curable when discovered early... In a study of melanoma patients, 66% of women discovered their own lesions compared to 42% of men” (Courtenay,2000f:85-6). Inadequate self-examinations and insufficient screening contribute to more than twice as many men dying from skin cancer than women (Courtenay,2000f:86). Added to this is their failure to use effective sun-screens, despite less time tanning.

“Skin cancer is the most common and most rapidly increasing cancer. The increase in melanoma among men is higher than that of any other cancer” (Courtenay,2000f:88). Men’s failure to use sunscreen and other forms of sun protection contributes substantially to their high death rate from skin cancer. Avoiding direct sunlight, wearing sunscreen with a sufficient solar protective factor (SPF) of 15 or higher on exposed body parts, and wearing hats, could have a dramatic effect on skin cancer diagnosis rates. “If used in

young adulthood, sunscreen can lower the risk of skin cancer by as much as 80%”. (Courtenay,2000f:88).

“The incidence of testicular cancer has increased 51% since the mid-1970’s” according to Courtenay, and even though college-age men are among those at highest risk, three of four do not know how to perform a self-examination and only 8% to 14% conduct regular exams” (Courtenay,2000f:86).

Dental care is another area of health care utilization where men and women differ. “Men have fewer dental checkups than women, which contributes to poor oral hygiene. Poor oral hygiene has been found to be associated with oral cancer and the oral cancer rate for men is nearly three times higher than the rate for women” (Courtenay,2000f:83).

Courtenay explains that men are less likely than women to engage in a variety of self-care and preventive techniques, which contributes to their increased health risks. When sick: “They are less likely than women to restrict their activities or stay in bed for both acute and chronic conditions”. (Courtenay,2000f:86). Even when diagnosed with a potentially serious ailment, “fewer men than women with hypertension attempt to control it by limiting salt intake, reducing weight, or exercising” (Courtenay,2000f:86).

Sleep is another form of self-care. According to Courtenay, men get significantly less sleep than women, one study reports men get 6 hours while women get 8, there is growing evidence that immune functioning decreases with even modest sleep deprivation. Sleepiness is believed to cause over half of all work-related injury deaths. The quality of men’s sleep is also poorer than that of women’s sleep. “Sleep apnea is nearly three times more prevalent in men than in women”. Sleep apnea increases the risk of heart attack 23 times in men. Courtenay cites the findings of a study which found that

people with mild to moderate sleep-disordered breathing, performed worse on reaction time tests than people whose blood alcohol levels were sufficiently high to be considered illegal for driving in California. The higher prevalence of excess weight among men than women contributes to men's greater risk of sleep apnea (Courtenay, 2000f:88).

Social support and marriage according to Courtenay, are strongly associated with longevity. "There is consistent evidence that the lack of social relationships constitutes a risk factor for mortality-especially for men" (Courtenay,2000f:104). Courtenay identifies the health problems associated with low levels of social relationships and also expounds on the differences in male's and female's social networks. Men with the lowest levels of social relationships he cites, are two to three times more likely to die sooner. He explains that, "Men's social isolation significantly decreases their chance of survival after heart disease, cancer and stroke" (Courtenay,2000f:106).

To arrive at the unhealthy position of men compared to women, Courtenay explains that men have much smaller social networks than women do, and their relationships within those networks are different. "Men have fewer, less intimate friendships than women" (Courtenay,2000f:105). Actually, men's relationships are closer to alliances than friendships. Courtenay affirms that most men have no close friends, and that they are less likely to have a best friend, other than perhaps a spouse. "Even among adolescents and young adults, males are less likely than females to seek social support when they need help" (Courtenay,2000f:105).

Courtenay explains the benefits of social support: "People with higher levels of social support maintain more positive health practices. They are likely to modify unhealthy behavior. Their immune systems function better, and they have lower psycho-

physiologic responses to stress” (Courtenay,2000f:106). This follows through to marriage as well,

Marriage is an important health factor. Being married predicts survival, and all the current scientific evidence indicates that this correlation - and unhealthy behaviors and other health risks associated with being unmarried - are greater for men than women, in fact...marriage is associated with better health status and healthier behaviors for men, but not women (Courtenay,2000f:106).

Unmarried men, whether single, separated, widowed or divorced, engage in poorer health behavior than married men. They drink and smoke more, eat fewer vegetables and fruits and are less likely to take vitamin supplements. They go to the doctor less often, especially for what should be routine check-ups to test for abnormalities that do not show symptoms until the problem is very serious, such as previously stated, high blood pressure, high cholesterol or colorectal cancer. Unmarried men are also more likely to commit suicide (Courtenay, 2000f:87,106).

Poor diet, overweight, and lack of physical activity are all behavioral factors associated with illness and reduced longevity. “Men consume significantly less fiber, fruit and vegetables than women and are less likely to consume carotenoid-rich foods such as carrots, spinach and broccoli”. Low consumption by males of these vegetables compared to amounts consumed by females was associated with higher instances of cancer. “People who consume the largest amounts of fruits and vegetables reduce their risk of lung cancer by as much as 50% compared to those who eat the smallest amounts (Courtenay,2000f:89).

Limiting dietary fat is a way of improving health. Males of all ages consume more saturated fat and dietary cholesterol than females do. Men are more likely to eat convenience and fast foods that are high in salt, which is a prime contributor to high

blood pressure and stroke, and animal fat, which is related to the risk of prostate cancer and hardening of the arteries. Men are also less likely to eat a healthy breakfast every day which is associated with better health (Courtenay,2000f:90).

“Maintaining desirable weight is unequivocally associated with better health and lower mortality rates”. However, rates of overweight and obesity continue to rise, and the prevalence is higher for men in all age groups. Even among adolescents, obesity is more common in boys than girls. “Excessive weight is a primary contributor to high blood pressure, heart disease, stroke and colon cancer. Many overweight people, especially men, suffer from sleep apnea” (Courtenay,2000f:91-2).

Courtenay discusses physical activity as having positive effects towards reducing the risk of sickness or premature death. Men and women are both shown to exercise, but with different goals in mind. “Women place greater value on exercising for health, and they adhere to more regular exercise patterns. In contrast, men are more likely to engage in strengthening exercises”. Weight lifting and team sports which men engage in, contribute to greater risk of injury and death, as does infrequent physical activity such as snow shoveling, lawn mowing, and occasional tennis playing and jogging (Courtenay2000f:93).

Presently, there is evidence suggesting that men’s behavior is a major determinant of their excess major illness and shortened life-span. “The leading causes of disease and death among men are clearly linked to over 30 behaviors and lifestyle habits that are controllable and can be modified” (Courtenay,2000f:108). More than one of these behaviors frequently occur at the same time, and interact upon each other multiplying their effects. For instance, alcohol consumption, high speed driving and no seatbelt use,

combine and result in tragic accidents. Scientifically, drinking alcohol combined with tobacco smoking, “activates cell division and tumor growth, increasing the already high risk of cancer up to 15 times” (Courtenay,2000f:109). In concluding, Courtenay turns his hypothesis back on itself by suggesting that men’s health predicament is purposeful and intentional:

The fact that unhealthy behaviors cluster, suggests that there may be an underlying cause of men’s unhealthy lifestyles. Masculinity may be an important mediating factor in the co-occurrence of multiple health risk behaviors. Indeed, it has been theorized from a social constructionist perspective that men’s risk-taking behavior and disregard for their health needs are among the resources that men use to define themselves as ‘masculine’ or ‘manly’ (Courtenay,2000f:110).

Environmental Model

“In any gender-dichotomized society, the fact that we are born biologically female or male means that our environments will be different: we will live different lives. Because our biology and how we live are dialectically related and built on one another, we cannot vary gender and hold the environment constant” (Lorber, 1997:14).

The health of men and women is quickly affected by even minuscule changes to any of the three major components of our environment, air, water, and the land. “Environmental hazards...have increased tremendously in the twentieth century” (Clarke,2000:73). Short term evidence abounds of the deleterious effects of some of the environmental changes introduced by our species, which we breath, drink, eat, or absorb through our skin, especially during the last 100 years. “It has been estimated, amidst great controversy, that from 60 to 90 percent of all cancers are environmentally caused” (Ibid.). According to Clarke, “There are between 50,000 and 70,000 chemical substances in commercial use in farming, manufacturing, and forestry industries. Every year about

1,000 new chemicals are introduced in North America and about 2000 worldwide” (Ibid.). Environmental workplace hazards are extremely detrimental to the health.

John McKinlay: Manufacturing Illness

John McKinlay’s model of illness begins with the story of a physician trying to explain the dilemmas of the modern practice of medicine:

You know, sometimes it feels like this. There I am standing by the shore of a swiftly flowing river and I hear the cry of a drowning man. So I jump into the river, put my arms around him, pull him to shore and apply artificial respiration. Just when he begins to breathe, there is another cry for help. So I jump into the river, reach him, pull him to shore, apply artificial respiration, and then just as he begins to breathe, another cry for help. So back in the river again, reaching, pulling applying, and then breathing and then another yell. Again and again, without end, goes the sequence. You know, I am so busy jumping in, pulling them to shore, applying artificial respiration, that I have no time to see who the hell is upstream pushing them all in (McKinlay, 1977:9).

He suggests that this story illustrates two important points. The first point “highlights the fact that a clear majority of our resources and activities in the health field are devoted to what he terms ‘downstream endeavors’- in the form of superficial categorical tinkering in response to almost perennial shifts from one health issue to the next, without really solving anything”. He states that he is not suggesting that such efforts are entirely futile, or that a considerable amount of short-term good is not being accomplished. “Clearly, people and groups have important immediate needs which must be recognized and attended to. Nevertheless, one must be wary of the short-term nature and ultimate futility of such downstream endeavors” (McKinlay, 1977:9).

McKinlay’s second point brought out in the story indicates that we should somehow cease our preoccupation with this short-term, problem-specific tinkering and begin focusing our attention upstream, where the real problems lie. These are the

“manufacturers of illness”: the tobacco, alcohol, and food industries and the advertising industry.

McKinlay credits what he calls the ‘manufacturers of illness’ as being successful at making at-risk behaviors look appealing. They accomplish this in three ways; a) The manufacturers strongly insinuate that at-risk behaviors are part of the norms and accepted values of the “dominant culture”. Smoking is an at-risk habit that for many years has been glamorized, one was considered “cool” if he/she smoked. b) Pop culture heroes (movie and music celebrities) make at-risk behavior (including drug and alcohol abuse), seem appealing or even encourage it. In the third way; c) We are constantly bombarded with media advertisement for the latest, and very desirable consumer goods, whether it be ever larger homes, luxury cars, new appliances, furniture, clothing or any number of things, which we feel we must have, to show that we are “meaningful and useful members of society” (McKinlay, 1977:13). In other words, what we have makes a statement about who we are or, as Erving Goffman would say, who we present ourselves to be.

McKinlay focuses on one area, which is linked to “largely chronic diseases – namely the 161 billion dollar” food and beverage industry.

The sad history of our food supply resembles the energy crisis, and not just because food nourishes our bodies while petroleum fuels the society. We long ago surrendered control of food, a vital resource, to private corporations, just as we surrendered control of energy. The food corporations have shaped the kinds of food we eat for their greater profits, just as the energy companies have dictated the kinds of fuel we use (McKinlay,1977:15)

The diet of Americans has declined sharply during the last three decades. “Some forty percent of Americans are overweight”. The food industry is influencing Americans

away from basic foods, and towards “synthetic and highly processed items”. This creates ever greater profits for the manufacturers of these food products. “Generally speaking, it is much cheaper to make things look and taste like the real thing, than to actually provide the real thing” (McKinlay,1977:15).

“The most widely used food additive is sugar. Food manufacturers saturate our diets with the substance from the day we are born until the day we die”. Many breakfast cereals, popular with children, consist of 50% sugar. “The average adult American eats roughly 126 pounds of sugar per year, “and children eat much more”. This addiction to sugar appears to have engineered by the food industry,

It is a major contributor to such diseases of civilization as diabetes, coronary heart disease, gall bladder illness and cancer, all the insidious, degenerative conditions which most often afflict people in advanced capitalist societies, but which ‘underdeveloped’, non-sugar eaters never get (McKinlay,1977:16,17).

“If the food industry were proposing sugar today as a new additive, its metabolic behavior would undoubtedly lead to its being banned” The American food industry spends millions on ads in the media, to promote and encourage the use of manufactured food and beverage products. The food and beverage industry uses enormous resources to keep Americans hooked on sugar, even though it is a contributing factor to all major diseases of the day, thereby making huge profits (McKinlay,1977:17).

When looking at the activities of health professionals, (downstream, where they are only able to ‘pull’ the drowning patient out of the water), their efforts have been shaped by the manufacturers of illness upstream, Mckinlay puts forth the victim-blaming argument, offered by the media, and perpetuated by the manufacturers of illness and some in society, that people, who have become ill, are responsible for their illness. This is

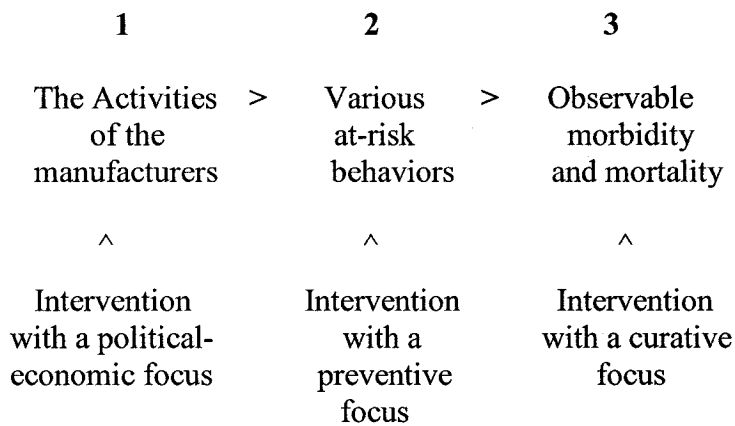
the downside of the lifestyle theory. However, he continues, in opposition to the media, that if this were the case, (i.e. that people brought on their illnesses by their at-risk behavior and bad habits), then the solution to this problem would be to advocate, “some change in behavior on the part of those involved”. By laying the blame at the victim’s door, and having the approval of health professionals and other segments of society agreeing that this is so, then it is possible to “mobilize resources” to change the behavior of the ‘guilty patient. Certain “individuals and groups are doing things they shouldn’t be, or are not doing things they should be doing”. If they would recognize that they should change their habits, they would either get well or avoid getting sick in the first place. “To use the upstream/downstream analogy” people are blamed or even punished for not knowing how to swim, when they have been thrown into a fast-moving, turbulent river (McKinlay,1977:17,18).

Recent studies have shown that Type A personalities are more susceptible than non-Type A personalities to heart disease. This personality type usually exhibits traits of excessive competitive drive, aggressiveness, impatience and constantly being in a hurried state. They are often “engaged in hostility with others, with circumstances and with life itself”. According to McKinlay, they “...almost always have a deep-seated insecurity”. (McKinlay,1977:19,20).

The attempts to reduce heart disease that is a result of Type A personality traits, is to try to get these personalities to become more laid back, relaxed, and non-competitive. However, this is rather unlikely, if for no other reason than that system rewards this type of behavior. Job ads in the newspapers, often require Type A personality traits, which are seen as an asset in the business world. “Much of our health intervention fails to take

adequate account of the social contexts which foster and reinforce the behaviors we seek to alter” (McKinlay,1977:20,21).

McKinlay argues that efforts by health professionals to treat illnesses, by “downstream endeavors” does not resolve the problem of high morbidity. He puts forth the argument that even the best endeavors to prevent illnesses, always put the blame for the illness on the afflicted individual or groups, never blaming the activities of “manufacturers of illness which foster such behavior” (McKinlay,1977:22).



Mckinlay uses this diagram to illustrate the process of (1) the activities of the (illness) manufacturers, manufacturing cigarettes, loading sugar into the foods we eat, preparing beer and liquor commercials for entry on young peoples sports and music TV shows and magazines, plying pharmacists and others hawking over-the-counter patent ‘medications’ and placebos, with free trips and gifts etc.. (2) which gets people addicted to at-risk behavior and (3) which ultimately leads to illness and death (McKinlay,1977:22).

At the beginning of the process, lower (1), are the ignored activities of manufacturers of illness, who encourage the at-risk behaviors we try to avoid. This is an

area that would greatly benefit the public, according to McKinlay, if preventative measures were taken at this point, and would have the greatest potential for change. In other words, it would be better to put up fences upstream, to protect people from being pushed in, because of corporate ‘profitability’, than to fish them out downstream and try to heal their wounds after-the-fact (McKinlay,1977:22,23).

To win the war against morbidity and mortality, McKinlay contends that greater changes in habits and behaviors will be achieved through legislation as opposed to changes in lifestyle. (McKinlay,1977:23).

In the past, we have advocated the educating of the public, to mend their ways (i.e., make lifestyle changes, adopt healthy habits, etc.). This results in blaming the victims for not making changes in their own lives, or for not taking the healthy road and disregarding the advertising and associated social pressures to the contrary. What we should be doing, is educating people, including schoolchildren about the activities of the manufacturers of illness and about how they are involved in many activities especially the ones which try to separate us from our money in return for a useless or downright harmful product. (Most children’s breakfast cereal is 50% refined sugar). (McKinlay,1977:25).

McKinlay states that he is not opposed to helping people at risk by educating them to change their habits, in the hopes of prolonging their lives, ”if this can be done successfully”. He argues that if we educate people, we should do so completely, telling them what the manufacturers are doing, upstream. This type of program, backed by the government, may arouse consumer interest, which in turn may result in curbing the “influential lobbying of the large corporations” (McKinlay,1977:25).

McKinlay's perspective concerns accountability for the 'unnatural' health hazards caused by man-made or man-introduced substances. McKinlay goes 'upstream' to the source for answers, controls, and in many cases, prevention.

Lalonde and McKinlay have offered complementary models of health: the former insisted on personal responsibility and healthy lifestyles as important for health, while the latter has argued that the lifestyle model has its limitations. Powerful lobbies have created unhealthy environments which are killing us, and require government intervention, not lifestyle change. Yet Lalonde too had recognized the limits of lifestyle:

Individuals cannot...ensure that food, drugs, cosmetics, health devices, the water supply, etc., are safe and uncontaminated; that the health hazards of air, water and noise pollution are controlled; that the spread of communicable disease is prevented; that effective garbage and sewage disposal is carried out; and that the social environment, including the rapid changes in it, do not have harmful effects on health (Lalonde,1974:32).

Mental Health

Both men and women are susceptible to the devastating effects of stress and depression, but, given our cultural norms, perhaps men more so. Masculinity carries the burden of appearing to be strong, independent and in control (in other words, not showing one's feelings). Men tend to deny that they are experiencing depression (its not manly).

Many men suffering from the symptoms associated with depression go undiagnosed and untreated. A large body of research conducted by Cochran and Rabinowitz in 2000 demonstrated this lack of recognition of symptoms by both professionals and society at large. Most, if not all, of men's mental health needs are a direct result of depression (Stephens, MHN, 2002).

The following tragedies are a direct result of this failure to recognize and treat depression/mental illness in men, Stephens asserts:

- 80% of suicide deaths are men.
- Between ages 10-18, boys are 4-5 times more likely than girls to commit suicide.
- Men are increasingly isolated from their families due to work and divorce.
- 80% of those who have serious drug addictions are men.
- 80% of the homeless on America's street are men and 35% of those are Vietnam veterans.
- Men are as likely to be the victims of domestic violence as are women. (Though less likely to be killed). (Stephens, MHN, 2002).

Although it was believed that women suffer depression nearly twice the rate of men, scientists are beginning to discount this. It is not the vulnerability to depression that distinguishes men from women, but it is the manner in which depression is managed. Women are more open to seeking professional help and also make use of support groups made up of their female friends to whom they can turn for comfort and empathy.

Depression bridges the gap between the bio-medical and the social. It can be derived from gender differences in the nature and/or consequences of social experience and it can also be biologically driven. Men's mental health problems are more often manifested in substance abuse and antisocial behavior, whereas women are more likely to be depressed, anxious, or experience somatic (i.e. physical symptoms) (Aday, 2001:55. Coburn, et al, 1998:239).

Depression is a disabling condition, which accounts for an important proportion of psychiatric hospitalizations. An irony exists within this correlation, patients suffering from depression disorder in psychiatric and general hospitals at the age of 5 years and older, per 100,000 population in 1995-96, was 32.6 for males compared to 59.7 for females. These statistics may indicate that either approximately double the number of

women, compared to men_suffered from depression, or that many more women than men sought professional help for this malady (Statistics Canada 2002 January. Health Report Vol.1. No.2).

Theories abound correlated to stress, depression and gender. One such theory as to why women show higher instances of stress/depression, the gender role perspective suggests that, "...the higher rates of distress and disorder observed among women arise directly from greater stress associated with their gender and marital roles" (Coburn et al, 1998:239). This theory makes no mention of the stress associated with male marital roles nor with the stress related to the maintenance of male gender roles. Questions as to the capacity to handle role strains and stress caused by life events are tackled in the vulnerability hypothesis, which proposes that "men and women differ in their capacity to adjust to or resolve stressful circumstances or events" (Kawachi, 1995:379).

According to Juanne Nancarrow Clarke,

Stress occurs when an organism must deal with demands much greater than or much less than the usual level of activity. As such, stress is ubiquitous. All of us are stressed to some degree or we would not be alive. The presence of at least some stress is beneficial. Stressful experiences can be healthy and can fit us for positive and flexible adaptations to stress later on. Or stress can be so overwhelming that it leads to serious illness or death (Clarke, 2000:146,147).

Almost 70 years ago, H. Selye recognized the paradox that the physiological systems activated by stress, could not only protect and restore, but also damage the body. (Kawachi, 1995:379)

Although stress has not been implicated as a *direct* risk factor for many conditions, both chronic stress and negative life events are repeatedly reported to have a strong impact on physical and mental health. Stress in its various manifestations can affect the physiology and morphology of the circulatory system. (Coburn, D'Arcy and Torrence, 1998:63).

Warren Farrell states that, "...In humans, almost all premature deaths after the first year are related to stress-induced diseases and pressures related to men's role-from suicides to heart attacks, from cancer to murder" (Farrell, 1993:184-5).

Even though this statistic is not Canadian or American, its implications are universal. "Less than 50 % of men aged 55 and over in Britain are in work and many such men die prematurely" (Beynon, 2002:77).

"Men are more likely than women to report exposure to and be distressed by work and financial events. Women, by contrast were more likely to be upset by exposure to negative events within their families. Further, men and women responded differently to negative events. Men were more likely to become hostile whereas women's somatic complaints increased". (Clarke,2000:152,3). Which may result in higher homicide rates in the former and higher hospitalization rates in the latter.

Conclusion

Discussions on health are fraught with difficulty – because health is multi-dimensional and multi-paradigmatic, as the World Health Organization definition indicates. Here we have considered the three prevalent paradigms on physical health: the bio-medical, lifestyle and environmental models, and their varying contributions to understanding health. We also discuss mental health, particularly as related to stress. That men's health is in crises can be better understood from all four perspectives.

Chapter 5

PERSPECTIVES ON HEALTH

Feminist Theory

“Feminists try to understand social structure and culture from the standpoint of women. It emphasizes the empowerment of women along with the transformation of patriarchal social structures” (Lorber and Moore,2002:xii,8). Clarke states that in general, feminist theory and methodology, in relation to health and illness, is predicated on the observation of two features of gender organization, differentiation and inequality. Feminists have asked why, how, and by whom such normal physiological events as pregnancy, childbirth, menstruation and menopause have been medicalized.

Lorber and Moore, state that “feminists have questioned the objectivity and neutrality of scientific findings that come out of a professional world dominated by men” (Lorber and Moore,2002:xi,xii,5). According to Clarke, “feminists [Marion Pirie and Dorothy Smith] argue that the institution of medicine operates under the structural functionalist paradigm to maintain the subordinate position of women in a patriarchal society” (Clarke, 2000:39-41). This is in contradiction to Barry Edginton, who sees women as having a preferred relationship with the medical profession. According to Edginton;

The ideas and practices of the medical system are neither neutral nor objective when dealing with women’s issues or problems and that women’s health patterns are influenced by their social roles. In fact, women’s problems, especially those associated with reproductive ability, tend to be put into a special category and treated as unique (Edginton, 1989:82).

Bio-medicine is a science at heart, based on research data, objectivity, experimentation, the comparison of findings – as well as an art. According to Clarke, a number of pertinent forms of feminist critique have emerged. The first reflects the work of sociologists in the symbolic interactionist tradition of Blumer, Mead, Cooley, and Goffman, and by using Garfinkel's ethnomethodology to investigate and report how people construct their world.

The second critique to positivism demonstrates that:

Science is not best represented as the continual accumulation of truths in the search for the ultimate causal explanations of the social and physical world. Thus, the development of science could be understood as consisting of revolts against findings, methods, and other aspects of scientific convention rather than simply the accumulation of truths (Clarke,2000:39-40).

The third represents the challenge to the medical profession by the new feminism of the second half of the twentieth century. Childbirth reform, including more natural childbirth, home birth, and midwifery, and safe accessible abortion have been among the issues fought for by the feminist movement as women seek to control their own bodies. Feminist theory, according to Clarke, focuses on gender as a significant social category worthy of extensive analysis, and equally important, their research usually asks women to describe their own experiences and their own viewpoints regarding health issues (Clarke, 2000:39-40).

This is an excellent concept which could be emulated by men, and those studying males in relation to their health. Perhaps both genders could benefit from an understanding of their own, and each other's lay opinions concerning health and longevity. The medical community at the family physician level, would be in a unique

position (as time permits), to treat, and render council to the whole male patient, instead of just treating their after-the-fact illnesses and residual symptoms.

Not all feminists adhere entirely to the tenets of the above philosophies. Dawn Currie takes issue with the exclusive focus on women's personal experience, which has characterized some versions of feminist research at the expense of social structural explanations of behavior. Instead of promoting a solidarity focus on women's experience, she argues that feminist research should follow the course of inductive theorizing and theory testing based on women's views of their own experiences. Bridging the gap between structural and personal issues, according to Currie, allows social scientists to see how solutions to opportunities and constraints are individually negotiated. Research done by those whose method is explicitly feminist, often prefer a combination of conflict and symbolic interactionist approaches. (Clarke, 2000:39-41, Bolaria & Dickinson, 1988:211-212).

The most well known feminist critique had its roots in gender health issues. In 1971, a group of women calling themselves The Boston Women's Health Course Collective, edited and published a book entitled 'Our Bodies Our Selves: A Course By And For Women'. These women had previously shared the commonality of attending a workshop on "women and their bodies" at a women's conference at a Boston College. The essence of their discourse concerned three main areas: sexuality, childbirth, and issues with the (U.S.) medical system. Due to space constraints and focus area, only their medical viewpoints are presented here. It is interesting to note that elements from each of the five theorist's Illich, Horrobin, Lalonde, Courtenay, and McKinley, whose

philosophy's are highlighted in this thesis, is recognizable in the Collective feminist theoretical viewpoints.

Their position concerning women's health is stated explicitly. "We want to become physically healthy, strong and enduring through exercise, proper eating and training and proud of our bodies. Pride because we feel good ourselves, not because we look good for others" (Hawley, et. al.1971:4). They attribute the quality and quantity of health care available to them (in 1971), to ignorance and male patriarchy.

We have been ignorant of how our bodies function and this enables males, particularly professionals, to play upon us for money and experiments, and to intimidate us in doctors' offices and clinics of every kind. Once we have some basic information about how our bodies work by talking and learning together and spreading the correct information, we need not be at the total mercy of men... (Hawley, et.al.1971:4).

They state that medicine, like other fields, has traditionally and historically discriminated against women. The example given is of the word 'hysteria', which comes from the Greek word for uterus and was "thought to be caused by the wanderings of the uterus to various parts of the body because of its longing for children" (Hawley, 1971:125). Hippocrates, according to the authors, recommended marriage as a remedy for this hysteria.

Authors of the collective claim that doctor's attitudes toward patients are terribly condescending, especially toward women. You aren't supposed to read or be able to understand the medical records of your own body. "In playing God, their attitude is that you must have complete confidence in them to make all of your decisions for you. Why should they make your decisions?" (Hawley, 1971:125). It is argued that doctors complain that they are tired of neurotic women with nothing wrong with them who come

in because they are lonely or dissatisfied with life. The feminist authors cite sociologically stereotypical reasoning:

...conceptions of behavior of normal men and normal adults coincided, but behavior stereotypically feminine was not thought by psychoanalysts to be normal adult behavior. No wonder more women end up on the couch, where they are supposed to learn to adjust. It is true that many women have a more difficult time adapting to 'their roles' in society (Hawley, 1971:124).

The Collective philosophy asserts that the U.S. medical system fails to provide basic preventive medicine for people while at the same time condoning unnecessary surgery (called remunectomies). It takes the U.S. Federal Drug Administration (FDA) to task for failure to properly screen drugs before their release. "It commonly approves drugs known by the drug companies, and often by the FDA itself, to be unnecessary and lethal" (Hawley, 1971:123-5).

Social conditions are also seen as contributing to ill health. "The factors in our society which produce a great amount of sickness are not dealt with by the medical establishment. In fact bad housing, poor nutrition, poor sanitation, pollution, and dangerous working conditions are not dealt with by any establishment" (Hawley, 1971:123).

The U.S. medical system is taken to task by the women's collective:

Doctors, clinics, hospitals, and medical schools do not take responsibility for the health of the people. Health care in America is not a unified system dedicated to keeping people healthy, measuring the results of treatment, or dealing with health problems in the society. It is a system designed to profit certain groups of individuals or corporations (Hawley, 1971:123).

Doctors in particular bear the brunt of responsibility for health care.

The medical system is not responsible to the community. It is controlled by the doctors...The doctors created the system. They run it. And they are the most formidable obstacle to its improvement...The fee-for-service

system sets the tone of private medical care in the country. The doctor sells a commodity to those who want to buy it and can afford it, and he sells it on his terms...It is the doctor who decides which patient will be treated, where, under what conditions, and for what fee; who will enter the hospital, for what therapy, and for how long; what drugs will be purchased and in what quantities (Hawley,1971:125-6).

The Boston Woman's Health Course Collective's philosophies concerning doctor's fees predate the avalanche of private health care management (HMO's) and insurance companies which have emerged in the U.S. to give their shareholders and senior executives large profits and exorbitant salaries under the guise of preventing catastrophic costs for medical expenses to policyholders and their families. These companies do limit costs somewhat by establishing a fee-for-procedure scale, paid to participating doctors. They also obtain quantity discounts and rebates from drug companies for approving the use of their merchandise and they also acquire hospital room rate cost reductions based on volume and ancillary service usage.

In contrast, Will Courtenay adopts an entirely different perspective on gendered health. He describes males in the U.S. as more likely than females, to adopt lifestyles, which increase their health risks and less likely than females to engage in practices that are linked with good health and longevity. The social practices demonstrating femininity and masculinity are associated with very different health advantages and risks. "Unlike the presumably innocent effects of wearing lipstick or wearing a tie, the use of health-related beliefs and behaviors to define oneself as a woman or a man has a profound impact on one's health and longevity" (Courtenay, 2000:1388). It is Courtenay's understanding that habits related to health and well-being are gender segregated. For men, proving their masculinity is much more important than taking care of their health (Courtenay,2000:1385,6). To this end, he further proposes that "the social practices that

undermine men's health are often signifiers of masculinity and instruments that men use in the negotiation of social power and status" (Courtenay,2000:1385). These social practices are often the result of social pressures, "Men and boys experience comparatively greater social pressure than women and girls to endorse gendered societal prescriptions, such as the strongly endorsed health related beliefs that men are independent, self-reliant, strong, robust and tough" (Courtenay,2000:1387).

Courtenay, acknowledges that a wide range of factors may be responsible for self-destructive male attitudes and actions. He relates them to the social construction of masculinity. "Although most young men in the U.S. may agree that a man should be tough, how each man demonstrates being tough – and how demonstrating toughness affects him physically, will be influenced by his age, ethnicity, social class and sexuality. (Courtenay,2000:1390). Whatever the influence, a growing body of research provides evidence that men who demonstrate strong masculine behavior tend to adopt poorer health habits and are at greater risk than their less traditional peers. (Courtenay,2000:1392).

Courtenay notes that, "There is agreement in our society about what are considered to be typically feminine and typically masculine characteristics" (Courtenay,2000:1387). Even though people are encouraged to conform to stereotypical beliefs and behaviors, not everything can be considered from a feminist standpoint.

From a social constructionist perspective, however, men and boys are not passive victims of a socially prescribed role. Nor are they simply conditioned or socialized by their cultures. Men and boys are active agents in constructing and reconstructing dominant norms of masculinity. This concept of agency – the part individuals play in exerting power and producing effects in their lives – is central to constructionism (Courtenay, 2000:1387-8).

Accordingly, activities such as sports, crime, language and sex are used as resources in constructing and deconstructing gender. Health related beliefs and behaviors can be used to distinguish between masculinities themselves, as well as gender differences. (Courtenay,2000:1388). Courtenay uses Connell's rhetoric to set the parameters of responsibility for men's health in relation to their lifestyles. "...Males use health beliefs and behaviors to demonstrate dominant, and hegemonic, masculine ideals that clearly establish them as men" (Courtenay, 2000:1388). Courtenay explains that it is in the pursuit of power and privilege that men are often led to harm themselves.

The social practices that undermine men's health are often the instruments men use in the structuring and acquisition of power... Health-related beliefs and behaviors that can be used in the demonstration of hegemonic masculinity include the denial of weakness or vulnerability, emotional and physical control, the appearance of being strong and robust, dismissal of any need for help, a ceaseless interest in sex, the display of aggressive behavior and physical dominance (Courtenay,2000:1388-9).

A man or boy will enact gender and health differently in different contexts. On the football field for instance, a college student may use exposure to injury and denial of pain to demonstrate masculinity, while at parties he may use excessive drinking to achieve the same end. A man may consider the expression of emotional or physical pain to be unacceptable with other men, but acceptable with a spouse or girlfriend. In some contexts, such as a prison setting, individual survival techniques may be contrary to other health care needs. An inmate is considered 'soft' if he complains too much about sickness or pain or makes frequent visits to the medical facility. If a convict is stabbed, he usually bandages himself up and considers revenge, both to get even, and to show strength, which might ward off future attacks (Courtenay,2000:1390-3).

Courtenay argues that institutional structures, the government, the military, corporations, technological industries, the judicial system, academia, the health care system, and the media, foster unhealthy beliefs and behaviors among men, and undermine men's attempt to adopt healthier habits. Mining, construction, timber cutting, fishing, truck-driving, and farm work, have the highest injury and death rates and are overwhelmingly performed by men. Required long hours of work for some, contribute to ill health by limiting access to health care for (primarily) males (Courtenay,2000:1394).

According to Courtenay, senior executives and business proprietors are also susceptible to disproportional health risks. "The businessman" who denies his need for sleep and a healthy diet, denies his stress, and works long hours, does so because of the rewards he expects to get, such as "money, power, position, and prestige". These males, even though their lifestyles mean increased health risks, feel they are compensated for with social acceptance and a decrease in anxiety about their manhood (Courtenay,2000:1394).

A sense of responsibility seems to permeate and influence male health self-perception. Will Courtenay sees a paradox. The need to appear strong and independent can be harmful to men's health. At the same time some of the behavior and habits of these men can actually contribute to their well-being. While a man may risk his life to advance his career, it is the same drive that might influence him to stop smoking (Courtenay,2002d:1). Men's psychosocial adjustments to illness itself, and the ways they perceive and use their bodies, have been shown to contribute to their health risks. Research tells us that compared to women, men know less about health, take less

responsibility for it, and are less likely to see themselves as ill or susceptible to disease or injury (Courtenay, Code/Facts 2002:1).

Women value health more than men do, and they have more responsibility to care for ill family members, which indicates more attentiveness to health matters. They believe more strongly that personal actions contribute to good health, yet they feel much more vulnerable to illness. Women are more convinced than men that medical care is efficacious (Ory and Warner, 1990:168).

Men in Canada and the U.S. do not usually seek health care either on a regular, preventive check-up basis or until a particular affliction or injury becomes debilitating, extremely painful, or is noticed by a concerned second party (confirmed by the results of medical interviews in the appendix).

Women use health care services more frequently than men do. Several possible explanations for this difference have been offered, one being that they have been socialized as mothers and caregivers to be more cognizant of health care for others and themselves. Therefore socialization roles may encourage women to be more responsive to illness and to be more active in seeking medical care.

Women, like men, have specific health needs, which revolve around their own physiology. According to Courtenay, "...adolescent girls in the U.S. are taught the importance of regular physical exams and are introduced to them as part of being a woman" Courtenay,2000:1396. Because of this, regular health care becomes habitual for themselves and their families. However "adolescent boys are not taught that physical exams are part of being a man. For many men, it is their wives, girlfriends and mothers who make the medical appointments" (Courtenay,2000:1396).

Courtenay quotes U.S. Assistant Surgeon General Susan Blumenthal, who directs the Office on Women's Health at the U.S. Public Health Service, as saying that, "Men

need to become advocates and speak passionately about their health, but they may be concerned that speaking out will reveal weakness, not strength” (Courtenay,2000:1394).

One area in which male affliction is under-reported is depression. Courtenay notes that “Early documentation on the prevalence of depression among women based on self-reporting has resulted in an emphasis on treating women for depression and suggested an immunity to depression among men” (Courtenay,2000:1396). Taking into account the correlation between depression and suicide (nearly 7 out of 8 suicides in the 15 to 24 age category are males), one could conclude that there is a reporting problem in reference to the amount of instances of depression among males. “A recent large study based exclusively on self-report data concluded that depression is a more critical health problem for college women than for college men” Courtenay,2000:1396). If treatment rates are factored into the instances-of-depression-by-gender equation, then the results are liable to be skewed as Courtenay states that,

Depressed men have been found to be more likely than depressed women to not seek help...men try to rely on themselves, withdraw socially, try to talk themselves out of depression or convince themselves, that depression is ‘stupid...Nearly half of men over age 49 who reported experiencing an extended depression did not discuss it with anyone. Instead, men tend to engage in private activities, including drinking and drug use, designed to distract themselves or alleviate their depression (Courtenay,2000:1396).

Courtenay hypothesizes that other reasons why men and boys refrain from reporting depression or seeking help for it might include that, “The linkage between depression and femininity may provide men with the strongest motivation to hide their depression from others” (Courtenay.2000:1396) and, “Because depression is frequently accompanied by feelings of powerlessness and diminished control, men may construe depression as a sign of failure” (Courtenay,2000:1396).

Courtenay concludes his theory on men's health by reiterating that research shows that women in the U.S. adopt healthier beliefs and personal health practices than men. He states that as a consequence, "women suffer less severe chronic conditions and live nearly 7 years longer than men". Those males, according to Courtenay, who adopt masculine beliefs and behaviors tend to reject what is feminine, in this case, sufficient, habitual health care including preventive measures. He argues that the North American resources available for constructing masculinities include unhealthy beliefs and behaviors, because of the desire to emulate 'idealized' manhood, which result in positions of power. Courtenay does say that some men do defy social prescriptions of masculinity and adopt healthy behavior, just as some women can and do adopt unhealthy beliefs and behaviors (Courtenay,2000:1397).

Courtenay qualifies his position on men's relative poor health and abbreviated longevity by putting the onus on male masculinity as the culprit, and by presenting women as the victims.

This relational theory of gender and men's health will undoubtedly meet with resistance from many quarters. As a society, we all work diligently at maintaining constructions of women's health as deficient, of the female body as inferior, of men's health as ideal, and of the male body as structurally efficient and superior. From a feminist perspective, these constructions can be viewed as preserving existing power structures and the many privileges enjoyed by men in the U.S. Naming and confronting men's poor health status and unhealthy beliefs and behaviors may well improve their physical well-being, but it will necessarily undermine men's privileged position and threaten their power and authority in relation to women. (Courtenay,2000:1397).

Courtenay's insistence on men's "privileged position" is ironic, given that there is nothing particularly privileged in being dead. And quite what power and authority over women, the homeless the poor, the alcoholics, the drug addicted, the drafted or volunteers, men in combat, the workers in dangerous jobs unprotected by adequate safety legislation, and the thousands in prisons.... Courtenay is classified as a feminist.

Masculine Theory

“A scout’s duty is to be useful and to help others. And he is to do his duty before anything else, Even though he gives up his own pleasure, or comfort, or safety to do it”.
Robert Baden-Powell, Scouting for Boys (1908)

A similar ethic applies to men, but this carries significant health costs. The men’s health movement, which is approximately 10 years old, may be considered to be in its infancy and still struggling. The women’s health movement, on the other hand, grew from a groundswell of concern from women themselves, mostly about the issues of breast cancer, ovarian cancer, childbirth, and menopause, ever since 1971.

Traditional masculine definitions are among the more significant risk factors associated with men’s illness. As with women, men are also fragile and vulnerable creatures, (more fragile judging by current morbidity-mortality statistics), and susceptible to a wide variety of health-related problems. Feminist women, according to Michael Kimmel, have been able to theorize vulnerability and susceptibility to disease into a social movement to promote women’s health. But masculinity is not only a risk factor in disease etiology but it is also among the most significant barriers to men developing a consciousness about health and illness. Case in point being the saying, “real men don’t get sick - and when they do, real men don’t complain about it, and they don’t seek help until the entire system begins to shut down” (Sabo & Gordon,1999:viii). Men evaluate each other and are evaluated by women largely by the degree to which they approximate the ideal masculine model. Whereas women have gained and continue to gain better health and status from feminist ideas and ideals, men pay a heavy price for masculinity.

Two points regarding masculinity should be identified. First, all males are not alike, and second, all male groups do not share the same definition of masculinity.

According to Sabo, “At any given moment, there are competitive masculinities. Some dominant, some marginalized, and some stigmatized” (Messner and Kimmel,2002:287).

According to Connell, even though there has been international discussion of men’s health issues at least since the 1970’s, it is only recently that a theory encompassing many of those issues under one umbrella has emerged. This concept brings together ideologies specific to males, such as, gender specific images of masculinity and interpretations of men’s bodies...These interpretations are invaluable when diagnosing illnesses prevalent to males and in developing forms of treatment. The concept also includes services, either specific or gender-neutral, to aid groups of men or both men and women. Included are occupational health programs, specialties such as cardiology, and sports medicine and veteran’s hospitals (Connell, 2000:177-9). In actuality, concern emerged gradually consequent to male combat casualties in World War II and the U.N. action in Korea, then to occupational deaths (asbestoses, miner’s lung, etc.), and later to suicide.

Some, including Connell, credit the feminist movement for the emergence of the masculine movement.

The new feminism of the women’s movement, is credited through the contemporary debates about women’s health, their critique of ‘patriarchal medicine’, and the questioning of masculinity and male roles, with the emergence of interest in men’s health, their illnesses, and short life spans” (Connell,2000:195).

This is absolutely not true. Feminism was not responsible – on the contrary, it totally ignores men except as problematic.

It might be argued that the reason for female longevity and comparative good health is due to male inattention to their own survival techniques rather than to female

purposefulness in relation to their wellbeing, even though historically it has been women, not men who have been encouraged to pay attention to their health. "Women should provide the standard against which men's health and men's behavior are measured. If this were the case, we would be compelled...to confront men's inadequate bed rest and men's underutilization of health care" (Courtenay,2000:139-5).

Where Courtenay cites men's carelessness, Farrell refers to the costs of their sense of duty and responsibility, enforced by society.

The wound that unifies all men is the wound of their disposability. Their disposability as soldiers, workers, dads. The wound of believing that they are lovable if they kill, and die, so others might be saved and survive. (Farrell,1993:355).

Indeed Connell argues that there is no men's health problem. On the contrary, men have set up health systems which privilege women, but ignore men's health needs.

Approximately 1990 saw the beginnings of an international men's movement, with its own organizations, Web sites, journals, and conferences. This movement had taken the feminist critique of the Western biomedical perspectives, which argue for greater attention to social and environmental causes of illness, and applies it to men's health (Lorber and Moore, 2002:1,141).

The development of a men's health movement, through the media, has been instrumental in bringing to the forefront, health issues related to the social conditions of men's lives, their behavior and attitudes directly or indirectly, affecting their health care, and the importance of developing lines of communication regarding their access to and the use of medical care.

At present, much more health and well-being information is available to the public in Canada and the U.S. pertaining to females than males. Magazines catering specifically to women's health needs abound, while other more general publications for females, usually have a plethora of articles on health-improvement, exercise, and maintaining healthy lifestyles. Pharmaceutical company's must view the publishing media's magazines, aimed at women and girls, as dollars well spent for advertising. A by-product of all the articles and the pseudo-medical advertising in women's magazines, is the constant in-your-face projection of health issues, real, or marketing-invented. Girls, women, wives, mothers, and grandmothers, who read, are constantly bombarded by slogans from healthy looking, famous peers on glossy pages reminding readers that they, being female, absolutely require (and deserve) special care. All of this attention to 'their' health must leave some beneficially affected, memory ingrams.

Males enjoy no such constant reminders of the fragility of their existence. Males do not usually discuss or read about health issues, which will affect them throughout their lives. Boys rights-of-passage do not include present or future health care tips or instructions, neither spelled out in articles in their favorite magazines, nor subliminally insinuated in advertising.

Some males relate being sick with fear of dependency, particularly on women. This makes illness for them, a kind of shameful, embarrassing experience. Their day off work in bed sick means to them:

1. His territory is threatened and someone might usurp his position.
 2. Someone might discover he isn't really needed or might try to replace him.
 3. Each day in bed is money lost.
 4. He's not a capable warrior and doesn't hold up under pressure.
- (Goldberg,1976:114).

At present Canada has five Centers of Excellence for Women's Health. These were established by the Canadian Government in 1996, and paid for by taxpayers, both male and female. According to Health Canada, "there is ample evidence that health care systems in Canada...have not given as great attention to women's health as has been given to men's" (Health Canada. News Release, 1996a:1). There are presently no Centers of Excellence for Men's Health.

Canada also has a websight on the internet devoted to women's health. The Canadian Women's Health Network was launched in 1996 by the Health Minister David Dingwall who stated, "These information capacities will assist women in becoming better informed and will enable them to be more active in decisions about their own health and health care" (Health Canada. News Release,1996b:1). There is no such Canadian Men's Health Network – despite men's higher death rates in all 10 leading causes. Also males are less informed about health matters than females. Their sports and technical magazines present a dearth of articles related to the health of their readership and the advertisements usually hawk pharmaceuticals and devices related to increasing erectile prowess, growing hair, or building muscle tone.

Men's health matters are not usually a topic of conversation among peer groups. Aside from subdued pride in recounting circumstances related to sports or heroically acquired injuries, personal discussions concerning illnesses or the professional attributes of particular doctors or other health care workers, or even the exchanging of health maintaining tips are rare among men and adolescent boys.

Males as a group would benefit immensely from a government-funded web sight where (anonymous) questions could be answered concerning where and when to go for

medical care as well as preventive care. For Americans without medical insurance, federal, state and city health welfare benefits available to low-income males, females and families, would be explained, along with directions to the nearest health benefits office for those in need of face-to-face service, otherwise locally administered participation forms could be provided on-line. Information could be disseminated on a regular basis concerning the benefits of even short-term health care and low-risk behavior, in return for the possibility of a better quality of life down the line. Even if for some, down the line is not very far down-the-line.

In the U.S. in 1991, the Office on Women's Health at the Department of Health and Human Services (HHS) was created. Besides the Washington location, ten regional HHS Regional Offices at the time were also staffed with a women's health coordinator. In 1992, the U.S. Congress approved of the establishment of an Associate Administrator for Woman's Services at the Substance Abuse and Mental Health Services Administration (SAMSA), and in 1993 Congress set up an Office of Research on Women's Health at the National Institute of Health (NIH). (Men's Health Network, September, 2002).

"In 1999, budget expenditures of the U.S. government's National Institute of Health showed that 6.5% of the budget went to male-specific research and 14% went to female-specific research" (Thompson, 2003:2). The balance of the research budget went to gender neutral research. Since then the disparity has grown and so has female-specific research. In October, 2002, eleven government-funded 'Specialized Centers of Research (SCOR) on Sex and Gender Factors Affecting Women's Health' were established by the National Institute of Health, an agency of the U.S. Department of Health and Human

Services. (U.S. National Institute of Health. News Release, October 28, 2002:1, Thompson, 2003:2).

Although men are 1.6 times as likely as women, to die from one of the top 10 causes of death, it is women's health, which continues to receive U.S. government attention and funding.

Prostate cancer makes up 37% of all cancer cases but receives only 5% of federal research funding. In addition, the breast cancer postage stamp has raised over \$25 million for breast cancer research since it began in 1998, while a 1999 bill proposing a similar stamp for prostate cancer research was unsuccessful (Thompson, 2003:1)

A bill before the House of Representatives to make the Office on Women's Health's (OWH) funding permanent – passed.

Since then men's health advocates have been trying to create an Office of Men's Health, with the goal of duplicating the OWH's success; A bill to create an Office on Men's Health, the Men's Health Act of 2001 – did not pass... (Thompson, 2003:1).

There is an Office on Women's Health and an Office on Minority Health, but no Office on Men's Health.

Herb Goldberg states that:

Precisely because the tenor and mood of the male liberation efforts so far have been one of self-accusation, self-hate, and a repetition of feminist assertions, I believe it is doomed to failure in its present form. It is buying the myth that the male is culturally favored, its a notion that is clung to despite the fact that every critical statistic in the area of longevity, disease, suicide, crime, accidents, childhood emotional disorders, alcoholism, and drug addiction shows a disproportionately higher male rate (Goldberg, 1976:17).

Masculinity, (or the process of learning to be male), is understood to be dependant upon the particular social or peer group the male belongs to, or his immediate surroundings. In other words, outside influences form, affect and pressure one's

masculinity almost continuously. In relation to health, the old interpretation of males not caring about taking care of themselves is now seen in many cases by the open-minded, as selfless concern for others at the cost of one's own health and longevity.

CHAPTER 6

Conclusions and Recommendations

To conclude: The crisis in men's health is long-standing and multi-dimensional. Men's mortality rate (age-adjusted) is 60% higher than that of women. This translates into lower life expectancies of between 5 and 6 years. Men have higher death rates for all 10 leading causes of death. Particularly problematic is the high rate, and the large number, of violent deaths by accidents, suicide and homicide: substantially higher than those for women. The etiology of these violent deaths, which account for about 8% of the total, is complex, including both altruism and self-destructive aspects of male culture. Overall however, what is particularly striking is the invisibility of this crisis and the silence surrounding it.

I will offer a series of recommendations to alleviate this crisis and to help reduce both the number of male deaths and the male death rate. Many of these recommendations will of course impact positively on women's health as well as men's. Indeed as has often been noted, what benefits men's health will benefit women's health. This is not a gender battle in a zero-sum game, in which benefits to men's health can only be achieved by cost to women. This exemplifies a humanistic perspective (or gender-neutral) from which both sexes will benefit.

I Recommend:

1. Centres of Excellence for Men's Health:

Five Centres of Excellence for research on women's health have been established by the Federal Government. In the U.S., in 2002, an Office on Women's Health was established at the Department of Health and Human Services, along with ten regional

offices, and an Office of Research on Women's Health with coordinators at the CDC (Centers for Disease Control), FDA (Food and Drug Administration), and HRSA (Health Resources and Services Administration). Either their mandate should be expanded to include men's health (which is far worse) - or if the government continues to fund gender specific centres - an equal number (at least) of such centres should be established for research on men's health. The opening of an office of men's health within Health Canada and the U.S. Health and Human Services Department, would establish the fact that a health problem does exist within society. It would disseminate information concerning positive health practices as well as those to avoid; respond to queries vis a vis general health, sex and reproduction. It can also be a center for research on diseases which males suffer disproportionately from, as well as male specific diseases. The proposed office could also act as a resource or represent male health interests in inter-governmental affairs.

2. Violence:

Legislation establishing zero tolerance for violence against women has been enacted since 1994 in the U.S. and soon afterwards in Canada. As is well known, men experience far more violence than women, not only in homicide but also by assault. I recommend that legislation be enacted to establish zero tolerance for violence against women and men.

3. Lifestyle:

Lifestyle is a major contributor to men's morbidity and mortality. From an early age, boys are often expected to be tough, not to cry if they are in pain and not to complain if they are ill. These are conditions that are often imposed at home, before the child has

ever even entered the school system, where this philosophy is re-enforced. Masculinity or the process of learning to be male is acquired at home, at school and also amongst one's peers. What are needed are positive role models demonstrating the health and societal advantages of non-risk behavior and the futility of silence when confronted with ill health. Socialization classes should start with relatively young boys and girls and teach the males especially, that it is all right to cry when hurt, and to speak up when stressed, and the value of using peers for support as well as conflict and competition. Part of the reason for the prevalence of suicide among males, is their lack of social support systems especially during times of undue stress or depression. I recommend that all levels of government, corporations, the media and the education system continue to insist on the importance of a healthy lifestyle - rather than a self-destructive lifestyle or passive attitudes to health characteristics of many men. This will help reduce the risk of the three types of violent death discussed above, but also the two main causes of death: CVD and cancer.

4. Government:

The first responsibility of government is to care for the health of the population. The federal governments of both Canada and the United States have been deficient in this regard with respect to men. My first two recommendations addressed this, but government can go far beyond this in terms of such issues as safety legislation, the enforcement of such legislation (about 95% of work fatalities are male), advertising, commissions on male suicide, as well as female, and homicides. Furthermore, following John McKinlay's indictment of the "manufacturers of illness", the food and alcoholic beverage industries, the tobacco industry, and the advertising industry, governments

should be much more proactive in reducing the manufacture of illness and increasing the manufacture of health.

5. Corporations:

Affirmative Action programs exist for the hiring and promotion of women in corporations, the education sector, the political arena, the media, and the professions. I recommend that similar programs be developed within the corporate sector to ameliorate men's and women's health. This could include requirements for annual check-ups, with confidentiality assured so the person examined would be the only person to know his or her condition, (to prevent disability bias). The costs of preventive care are lower than the costs of curative care. Initially the largest corporations could introduce such measures - the costs are minimal compared to the costs of ill-health, time lost and premature death - and the policies could percolate down to smaller companies, as well as providing behavioral models for both men and women: setting new norms and standards.

6. Media:

High-risk behavior is also reinforced in males by the media. Commercials abound depicting males enjoying the so-called good life while engaged in dangerous practices, or consuming unhealthy beverages. TV reality shows, car racing, and wrestling programs all attract viewers from the ranks of mostly young men. Presently on broadcast television we have censorship of pornographic or lascivious programming. This should extend to include the airing of undue violence before midnight at least. I recommend that the media be mandated to be more sensible in its equations of alcohol consumption, cigarette consumption, and reckless driving as badges of masculinity. Certainly there has been

improvement here, but cars are still marketed for their speed and acceleration, “The Dukes of Hazard” are back, and juvenile imitators will still kill themselves.

7. Publicity:

Two factors are particularly problematic in the domain of men’s health. The first is the invisibility of men’s high mortality rates, the widespread ignorance of the issues, and the easy acceptance of men as “disposable”, using Farrell’s term. This needs to be addressed, and I have tried to do so in this thesis. This has been exemplified in some of the above discussion, and also in the failure of the bill to establish an Office of Men’s Health in the U.S. Government in 2005.

Second, is the conspicuous failure of men to address these issues of their own health, while doing so much to address the issues of women’s health. It may be part of traditional masculine culture to be careless of their own health, while protective of women’s health. The latter is of course admirable, but the former is surely deplorable.

The success of the women’s movement in securing resources for research in women’s health and for passage of legislation protective of women from violence is also admirable. A men’s movement with similar goals should also be admirable, but men have not yet developed a national organization like NOW, and show no signs of doing so in the near future.

8. Costs:

Preventable deaths for both men and women are extremely costly both to families and nations in economic as well as human terms. A young person is unique but also an investment of thousands of dollars in housing, feeding, educating, training etc. - quite apart from the emotional investment. A preventable early death is therefore a loss there,

as well as a loss of future economic earnings. All the money saved by preventing one death, would be well invested in health care. The estimated economic costs per death in the U.S. for accidents/injuries are \$ 894,405.00 per male death and \$ 432,607.00 per female death.

This thesis has been intended to clarify some of the dimensions of men's health and ill-health, the complexity of the etiologies, and to offer some recommendations to improve men's health - improvements which, as I mentioned earlier, can only benefit women as wives, partners, mothers, daughters, co-workers, friends and lovers of men. It is only a beginning.

Surviving Middle Age

Doctors urge men to have these examinations performed:

<u>RECOMMENDED PROCEDURES</u>	<u>40-49</u>	<u>50+</u>
Physical exam	Every 2 years	Annually
Blood pressure	Annually	Annually
Blood tests & urinalysis	Every 2 years	Annually
EKG	Every 4 years	Every 3 years
Rectal exam	Annually	Annually
PSA blood test (<i>Prostate screening</i>)		Annually
Hemocult (<i>Screens the stool for blood</i>)	Annually	Annually
Sigmoidoscopy (Proctoscopy)		Every 3-4 years
Chest X-ray (for smokers)	Annually	Annually

U.S. News & World Report, March 11, 2002

These examinations are also recommended to be performed

Self-examination of the testicles ----- every month after 15 years old
(Feel for any irregularities, bumps or indentations)

Self-examination of the skin ----- every month after 15 years old
(Look for beauty marks that are getting larger, black multi-colored or odd shaped marks)

Complete examination ----- every 5 years between 18 and 30 years of age
Including; blood pressure, blood analysis for cholesterol, diabetes, liver, and thyroid problems, and eye test.

Complete examination ----- every 3 years between 30 and 40 years of age

L'actualité, October 1st, 2002

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Appendix 1

Interviews

I interviewed four professionals in the health field, three medical doctors and one chiropractor, all male and all practicing in the Montreal area. I was hesitant about attempting to interview doctors as they are very busy and usually only approachable in a doctor-patient relationship or to queries from others in the medical field. I found the contrary to be true. The ones I requested interviews from were more than willing to make themselves available, once I explained that my research was to further the cause of men's health. In fact one of them asked if I minded if he ate his lunch (at his desk) while being interviewed, and another insisted that I join him at a local noodle house for lunch during the interview. The other two had me scheduled into their busy day for the interviews. A dentist who also teaches dentistry at a Montreal university, most willingly agreed to be interviewed but due to time constraints on my part, it did not come to pass. Another doctor, was also most willing to be interviewed to "further research on health and human longevity", however his specialty, pediatrics and hospital administration, precluded his participation. He was gracious and concerned enough to recommend and provide an introduction to another physician who participated.

I remain in awe of all of these gentlemen. Their deep and unequivocal concern for the health and well being of others goes well beyond professional requirements. I am so fortunate to have been briefly privy to their innermost concerns for the well being of their patients, on a level not to be confused with courteous bedside manner. Over and over to a man, they reiterated the importance of having regular check-ups, seeking help at the first sign of an other than minor problem, and considering their health before undertaking

any dangerous activity or ingesting anything which pleases the palate but not their arteries, or inhaling anything which dulls the senses but destroys the lungs. They spoke of men having too much stress and not enough exercise, and of attitudes of invincibility. I saw the frustration in their eyes and heard it in their voices when discussing the extent of preventable illnesses and the extent of early-caught curable illnesses, which afflict men to a greater extent and to a greater degree than women. If Prometheus is not healed, it is not due to any lack of effort on the part of those I spoke with.

I commenced the first interview with a preset list of questions, which I intended to follow for all of the interviews. It was not until the second interview that I realized that not all of the questions pertained to the specialization of the individual doctors. It was not that their expertise was not broad enough, it had more to do with logistics and office procedure. For instance the question: *When men come to your office, does someone usually accompany them? If alone were they instructed to see you?*

Dr. Fine, a general practitioner answered,

“I like to greet my patients in the waiting room. That way I can see if any are in particular distress. I have the opportunity to see who is accompanied and who is not. Few males come to the office alone. The ones that do come alone, in answer to the question asked, what brings you to the office- I would suggest that about ninety-five percent of the time, the answer is usually his wife, his mother, his daughter, his grandmother. They (the males) are always feeling perfectly well and it's the females of the species that sends the male to the doctor”.

Dr. Malus, a general practitioner and head of family medicine at an area hospital had similar comments,

“The vast majority of men coming in are accompanied. The ones that aren't usually come in because of insurance or car license requirements for a physical examination. Many women come in alone or with young children in tow. Older women and young women usually visit doctors because of gynecological issues”.

Dr. Kudo, a chiropractor, mentioned that his patients are usually escorted to the examining room by his receptionist (his mother, who is in her 80's) and so he has no idea who is accompanied and who is not.

Dr. Maranda, a cardiologist, sees patients who were originally referred from other doctors. This means that the majority of his patients, have or are suspected of having, a condition warranting examination or treatment by a heart specialist. Many of his patients, both male and female, are accompanied to his office.

To the question: *What is the percentage of your male to female patient ratio*, all of the doctor's estimates were within 7 %.

Dr. Fine estimated 33 1/3 % male to 66 2/3 % female.

Dr. Malus and Dr. Maranda both estimated 40 % male to 60 % female.

Dr. Kudo estimated his M to F patient ratio at 35-40 % male to 65-60 % female.

The statistical evidence I presented in Chapters 1,2 and 3 shows that males suffer more from serious illnesses and die between five and six years sooner than females, yet their presence at doctor's offices for check-ups and treatment is clearly underrepresented. This phenomenon, confirmed with these interviews, is well documented in medical and sociological literature and presented in earlier chapters.

The next question asked was, *Do men follow doctor's advice more, less or about the same as women?*

Dr. Maranda stated that women are better at taking advice than men.

Dr. Malus pointed out that:

“Men are more likely not to follow advice. Many young and not-so-young men have an attitude of immunity to illness or believe in a fictitious self-recovery process”.

Dr. Fine said:

“Women will be more serious about their health and therefore will tend to follow a doctor’s advice more than men. Because of course with men, the doctor is always making a poor diagnosis and there is usually never anything wrong with them”.

Dr.Kudo mentioned that:

“Men don’t usually follow advice, especially if it includes a lifestyle change. They have the attitude that ‘I’ve been like this all my life’. Some interpret their particular problem in an over-simplified context of pain, acute pain, pain relief, return to previous actions. Men have to learn by trial and error. They usually come back sheepishly when the symptoms return. Many of the women I treat are willing to say, ‘I will try to follow your advice’”.

Another question asked, this one pertaining to men’s attitudes, was asked of the two general practitioners, *Are the attitudes of men regarding health care comparable to those of women?*

Dr. Fine:

“Absolutely not. Women are certainly much more involved with health care and wanting to maintain good health whereas men always see themselves as being healthy and therefore there is nothing wrong with them, so why bother seeing a doctor”.

Dr. Malus:

“Women seem more interested in health care from an earlier age. Men become interested in late middle age, when they see those around them having heart attacks and strokes”.

The next two questions were addressed to Dr. Maranda:

Judging by the condition of the patient, and their medical records, do females, males, or both about the same wait an inordinate amount of time before seeking help from you?

Dr. Maranda:

“Women complain more and sooner, but have less problems. Men complain less and later, but have more problems”.

Do the initial complaints by your male and female patients differ physiologically?

Dr. Maranda:

“Women’s symptoms often summarize stress. Males are usually truly sick, not neurotic”.

The next three questions were addressed to Dr.Kudo:

Do females, males, both or neither, wait an inordinate amount of time before seeking your help?

Dr. Kudo:

“Less seldom do women come in barely able to walk; they usually come in at the discomfort stage. Men on the other hand, usually wait until the pain is acute and then say ‘I thought it would go away’”.

Why do you think men take such poor care of themselves?

Dr. Kudo:

“The Japanese have a word ‘gaman’, which roughly means stoic indifference to pain or hardship. Grin and bear it, is always emphasized. No man says I’m a wimp- they won’t admit to weakness”.

What do you think men in particular can do to prevent back problems?

Dr. Kudo:

“Proper exercise and sensible athletic activity helps. Stress affects the central nervous system detrimentally. The suggestion to avoid excessive stress usually entails a behavioral change, which is difficult for men”.

The next two questions were asked of Dr. Fine:

Who are more knowledgeable medically speaking, men, women, or both about the same?

Dr. Fine:

“I would probably say that women spend more time thinking about health. Men, Mr. Macho, he’s always feeling perfectly well and there is absolutely no reason for him to be in my office”

Do men and women usually come for regular check-ups or do they have to be prompted?

Dr. Fine:

“Men will rarely come for regular check-ups, they’re always pushed by they’re mother, they’re wife, they’re daughters. They’re always feeling perfectly well anyway. Women come for regular check-ups. They want to make sure that there sugar is ok, that there cholesterol is ok, that in fact, they are in good health”.

The last two questions were asked to Dr. Malus:

What recommendations would you have to improve men’s health?

Dr. Malus:

Every year I spend time practicing medicine in the Northwest Territories among a tribe of natives known as the Dogredis. Not too long ago as hunters, they used to run alongside their sleds. They ate caribou, trout, and whitefish. There was no diabetes and low heart disease. With our present sedentary lifestyle and diet rich in fats, I would recommend a regular exercise program. And a diet with less fat content, and of course no smoking.

Do you think men take poor care of themselves relative to the care that women take of themselves?

Dr. Malus:

“I think women take better care of themselves than men. More women exercise and go to the gym. It could be because more women are conscience of their weight. They might also have less energy sapping mental stress and more time to go to the gym. Some men go through life as if they were riding a horse across the plains, just riding, not looking after themselves, just riding, into oblivion. Men also neglect mental health more than women. There is a condition known as disthymia, which is a form of depression that boys and men are especially susceptible to. Girls and women have a way of dealing with it, by talking. We have here at the family clinic a talk line. Fifty percent of the calls received are for psychological issues and 80% of those are from females. Boys and men don’t talk to each other. At least not about anything that is troubling them, it might seem like a sign of weakness or weirdness. This condition can exist for years without psychological help or at least a friendly sounding

board. Girls attempt suicide more often than boys as a cry for help, however boys actually commit suicide more often. No cry for help”.

Appendix 2

Methodology

This dissertation, a study on men's health and on their early demise as compared to females, contains elements of both qualitative and quantitative analysis. Chapters one, two and part of chapter three, include current statistical evidence of morbidity and mortality rates and qualify as the quantitative section although the entire thesis is in- dispersed with statistical tables pertaining to the accompanying sub-heading. I used the resources of the Canadian and United States government's health services extensively for the latest statistics and found Statistics Canada the otherwise outstanding surveyor, to be lacking in up-to-date mortality and morbidity health reference data. Their latest data (apropos to my research), was compiled from a 1997 survey, which for my purposes, was borderline current/ancient. Health Canada, CANSIM, and affliction-specific sources such as The Canadian Cancer Society or The Canadian Heart Association had more recent data available, although not always gender specific.

Current U.S. statistical data was readily available from multiple sources including The Centers for Disease Control and The National Vital Statistics Report, etc. Wherever possible, age- adjusted figures were given, and the rates were calculated at per 100,000 individuals, for consistency. The internet provided a wealth of health information and statistics with the only caveat being to separate the wheat from the chaff or the verifiable from the unverifiable.

Most of the qualitative material consisted of theoretical positions on the state of Canadian and American health and health care, past and present. One of the authors of the four major positions cited in Chapter four, was that of a former Federal Cabinet

Minister. Marc Lalonde's literary position statement on the health of the nation went to print and it is my interpretation that his agenda was to show the government position in a favorable light, big business as being both reflective and sensitive to the wants and needs of the populous, and the responsibility for most of the ill health of Canadians resting squarely on the shoulders (and the backs) of the individual citizens.

John McKinlay discounts any notion of 'victim-blaming' in relation to becoming sick, being sick, or dying (relatively) early, and credits the media, big business, and government representatives self, and regional interests over those of the individual. His analogy of 'upstream' verses 'downstream' is used to focus on the sources of the problems rather than on the solutions of the consequences.

Another of the featured theorists, Ivan Illich, tried to meld socialism with holistic medicine and show that when combined in ancient proportions, produced a recipe for health, health care, and longevity conforming to his interpretation of the natural order of our species. He implied that when these natural guidelines were imposed upon or augmented as with modern medicine, the results were indecisive at best.

David Horrobin, using hindsight and extensive research on the successes of modern medical practices, took on the relatively uncomplicated task of critiquing Illich's work. His findings are easily corroborated and are in essence, modern solutions to timeless health problems and situations. At times though, Illich deals with these problems 'upstream' and horrobin seems to concentrate on 'downstream' solutions.

Two methods of gathering research material were used for this dissertation. The first consisted of collecting data for secondary analysis, which pertained to health in general and men's health in particular. The second were interviews conducted with health

professionals, which focused on men's attendance or lack thereof, at doctor's offices for routine examinations or the assessment of perceived health problems.

The sociological, psychological, and medical sections of three libraries were perused both electronically and visually for published material. Health journals, health magazines or those containing health articles, were either begged (from doctor's offices), borrowed (from other literary types), or bought (from news-dealers). The wonderful world of the internet yielded an abundance of pertinent (and verifiable) literature.

Appendix 3

‘The Healing of Prometheus’

In reference to part of the title of this thesis, one must look to Greek mythology and also to two of the authors whose arguments in reference to health, are presented in Chapter Four. Two prominent words are illustrated in the titles of these books. Ivan Illich’s ‘Medical Nemesis’ and David Horrobin’s ‘Medical Hubris’. I have been privileged to include a third prominent word, that of Prometheus, in my title, Men’s Health: The Healing of Prometheus.

Prometheus, according to legend, stole fire from the gods and brought it back to earth to be used by earth dwelling mortals at their discretion. Chaos, torture, and near destruction – nemesis (retribution for what cannot be achieved), is what happened to Prometheus when the gods realized what he had done.

I believe Illich associates the extent of present day ill health and nemesis of the citizenry with what he considers the failings and iatrogenics of the modern medical system and its authority of life or death over the sick and injured, which he regards as since time immemorial, the domain of the heavens. Horrobin’s critique of Illich’s disregard of the modern medical system included the word hubris, in the context of keeping, and in some cases, restoring self-confidence and pride in that very same system.

By the term ‘The Healing of Prometheus’, I have endeavored to return to man and women, an understanding of the consequences we suffer from the plethora of unhealthy products and environmental conditions originating ‘upstream’ and the realization that we individually, have some control over the condition of our health.