About John B McKinlay PhD

As Senior Vice President and Chief Scientist at the New England Research Institutes (NERI), John B McKinlay is an internationally prominent epidemiologist with experience in public health, epidemiologic field studies, clinical decision-making and health policy. Before founding NERI, he was a distinguished academic at Boston University, holding simultaneous Professorships in Medicine, Biostatistics and Epidemiology, and Sociology and directing the Center for Health and Advanced Policy Studies and the Gerontology Institute. For 25 years, he has been a Member of the Division of Medicine at the Massachusetts General Hospital (Harvard Medical School). He is the author, co-author, or editor of over 500 professional papers and 17 books. Several of his papers have been designated “citation classics”. John is the recipient of many awards and honors including:

- National Institute of Health MERIT Award
- American Psychological Association Award for Distinguished and Pioneering Contributions to Research on Women’s Health
- American Sociological Association Leo G. Reeder Award for Distinguished Contributions to Medical Sociology

John’s commitment to social epidemiology began in his native New Zealand with studies of heart disease among Maori and the health consequences of migration by Polynesian Tokelau Islanders. Since 1973, John has collaborated on studies of menopause -- culminating in the highly regarded Massachusetts Women’s Health Study. His own Massachusetts Male Aging Study (a longitudinal study of over 1700 men) continues to make pioneering contributions in endocrinology, urology, cardiovascular disease, geriatrics and behavioral medicine. John is presently leading NIH funded research on the epidemiology of erectile dysfunction (impotence) and establishing a population epidemiologic laboratory in the Boston inner-city area involving over 5000 individuals. He is involved in the first large epidemiological study (n=1100) of osteoporosis in a racial and ethnically diverse population of aging men and is conducting a study on nonmedical influences and how they influence clinical decision making in both the US and the UK.

RSVP indicating clearly which event(s) you will attend to:
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Is There a Male Andropause?
+ Speaking Up About Men’s Health!

### Event 1

**Is There A Male Andropause?**  
**The Medicalisation Of Normal Ageing**  

**By John B McKinlay PhD**

Some pseudoscientists recently claim to have discovered a new syndrome – “male andropause.” But the notion of a “male menopause”; “mid-life crisis” or “male climacteric” has actually been discussed for several decades. Worldwide, male aging is generating pubic interest and also, incidentally, a lucrative market. Pharmaceutical involvement is producing new treatments (eg testosterone replacement) in search of a disease. Several authors have written nonscientific books on “male menopause”: They self-select and misrepresent scientific data in support of preconceived notions. This lecture will explode the myth of andropause using data from the milestone Massachusetts Male Aging study (MMAS).

Medicalisation of normal aging and perpetuation of the fiction of andropause presents serious ethical quandaries.

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**Speaking Up About Men’s Health: Discussion About A National Men’s Health Policy**

In response to the federal government’s call for input into the development of its National Men’s Health Policy, you are invited to participate in a discussion focused on the following key questions:

- What are the gaps in knowledge and information on men’s health in the community?
- What can be done to raise awareness of men’s health issues in the community?
- What are the innovative and effective projects/approaches addressing men’s health in the community?
- What are the specific barriers to men accessing health services?
- How can health services be more responsive to men?

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### Event 2

**Race / Ethnic Disparities in Disease Rates – the Fallacy of Misplaced Concreteness**

**By John B McKinlay PhD**

Researchers continue to document worrisome disparities in disease rates by race/ethnicity, age, gender, socio-economic status (SES) and geographic location. Men reportedly have more coronary heart disease, women more depression, blacks and Hispanics more diabetes, and so forth. To illustrate: diabetes in the United States is reportedly twice as prevalent among blacks and Hispanics as it is among whites, with genetic influences and family history now the explanation du jour. Our analyses show that after controlling for SES, almost all of the race/ethnic difference in diabetes prevalence disappears. The many risk factors associated with diabetes together contribute only 11.8% to the explained variance; and of this small proportion, race/ethnicity and family history combined contribute only 20%.

We may be looking for causes in all the wrong places, which could explain why attempts to reduce health disparities to date have produced disappointing results. Instead health disparities may result from variable provider behavior when encountering different patients with similar risk factors or symptoms.

It is argued that social disparities in the prevalence of diabetes (among other diseases) may be socially constructed by providers, legitimated by current epidemiologic thinking and reinforced by our healthcare systems.