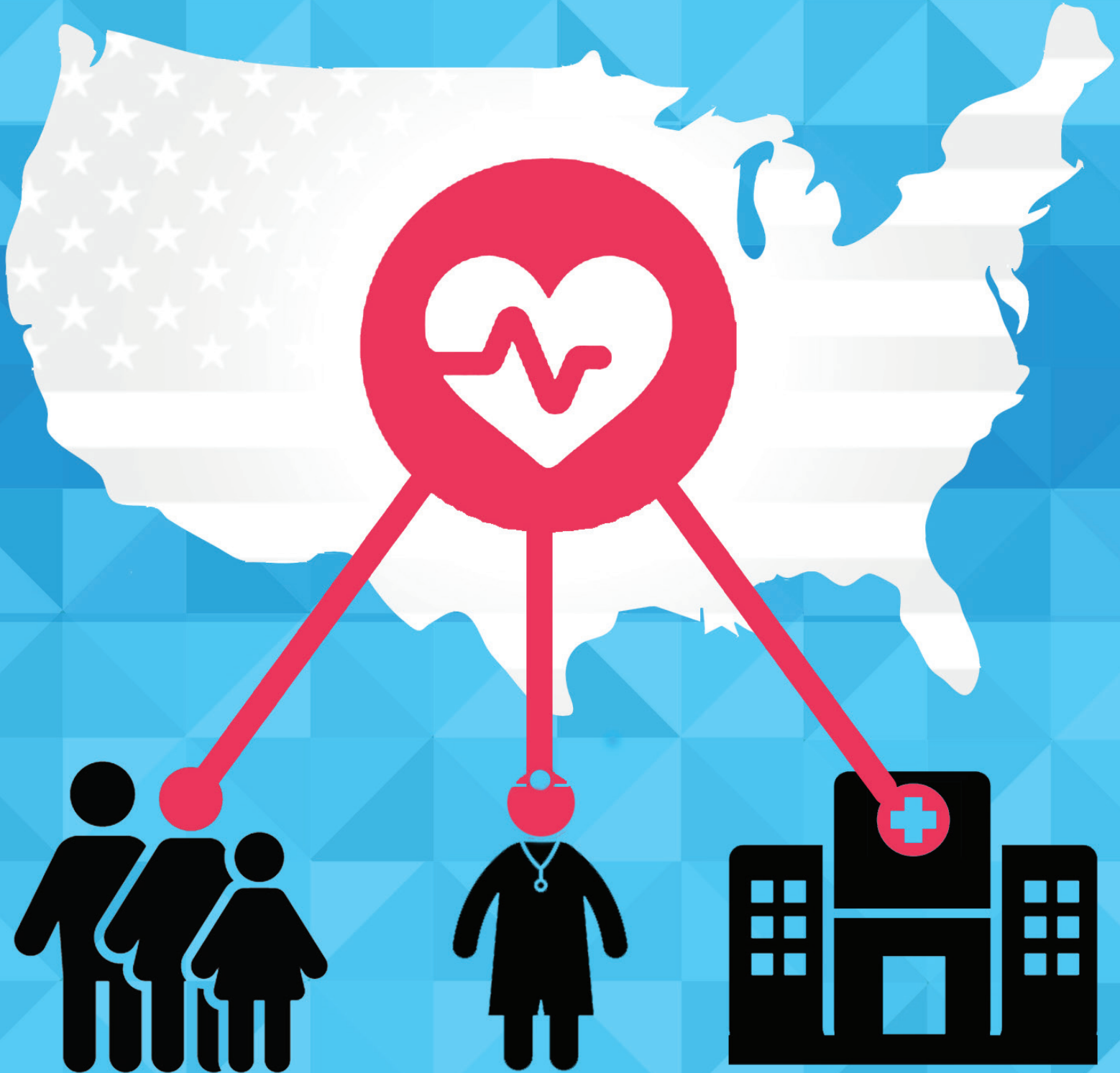


DISCUSSIONS

The Undergraduate Research Journal of CWRU

VOLUME XII, ISSUE II



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Discussions

The Undergraduate Research Journal of CWRU

Table of Contents

Faculty Spotlight: Dr. Insoo Hyun

5

Research

Analyzing Female Gender Roles in Marvel Comics from the Silver Age (1960) to the Present

8

Katherine J. Murphy

Do Healthcare Systems Discriminate? A Comparative Policy Analysis of Health Inequality in the United States and United Kingdom

18

Sarah Elizabeth Rudasill

Case Study

The Burrito Behemoth:
Chipotle Mexican Grill and Its Model for Success

30

Nealay Vasavda

Gendered Literacies: A Qualitative Study of Literacy Practices in an All Female OB / GYN Clinic

37

Ira Memaj



Letter from the Editor

Dear Readers,

Thank you for taking the time to read our latest issue of *Discussions: The Undergraduate Research Journal Case Western Reserve University*. *Discussions* is a completely peer-reviewed journal and was founded to promote undergraduate involvement in research and the publication process. As a result, by reading *Discussions*, you are supporting not only the young authors whose works are featured in this journal, but also undergraduates currently participating in research of all disciplines.

This issue is of special importance to our organization, as it marks our ten-year anniversary. In just one decade's worth of time, we have increased the number of submissions we have received almost three-fold. For this specific issue, the Editorial Board was given the privilege to read issues submitted from thirteen institutions across the country. I wholeheartedly believe that the growth of our journal and our simultaneous dedication to improving its quality is a testament to how far we have come and what is in store for us in the future.

If you are interested in contributing to *Discussions*, I ask that you visit our website at case.edu/discussions or email me at discussionsjournal@gmail.com. As *Discussions* continues to grow, our need for reviewers, copy editors, layout designers, and public relations specialists does as well. Undergraduates of all backgrounds and experience levels are always encouraged to join our organization.

Discussions accepts undergraduate research in all disciplines, from the sciences to the humanities. If you would like to submit your research to *Discussions*, the submission deadline for our next issue will be in September 2016. Submission guidelines are included on our website at case.edu/discussions, and a more precise date will be determined in the near future.

As always, I would like to thank our Editorial Board and committee members for all of their hard work. In addition, I would also like to personally thank Sheila Pedigo, Bethany Pope, and the SOURCE office for their unending support of our journal.

Sincerely,



William Qu

Editor-in-Chief

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Faculty Spotlight

AN INTERVIEW WITH

Dr. Insoo Hyun

by Saloni Lad, Xiaoyi Ren, and Daniel Mendez

Dr. Insoo Hyun is an Associate Professor in the Department of Bioethics and Director of the CWRU Stem Cell Ethics Center. In this interview, he discusses medical tourism, the fundamentals of bioethics, and how they relate to his paper: “Therapeutic Hope, Spiritual Distress, and the Problem of Stem Cell Tourism.”

Q: Before we start, what is bioethics? When we go to the hospital or seek out medical treatment, where does bioethics play into that?

A: So, bioethics is an interdisciplinary field including clinical ethics, which is the ethics of doctor-patient relations and medical care, and research ethics, which has to do with ethical issues with human research and the use of human biomaterials such as stem cell lines. Whether you're going into a research field or medical field or neither of those fields, everyone is a potential patient who will need medical care. Increasingly, patients at the end of life as well end up having care provided within a hospital setting, so there end up being some pretty tough decisions made. For those in biomedical research or healthcare fields, there's a whole other dimension of relevance for bioethics, which is what to do as a professional in these disciplines.

We normally say that an ethical issue is one in which a decision is made that could either harm somebody or impinge on their rights. So if you're a healthcare provider, you are by nature in that role of making decisions that impact people in a significant way. Same thing with research, if you have to collect biomaterials from human volunteers or use human volunteers as the subjects of a medical study, their welfare is in your hands as well. I would say that most people engage in everyday life in bioethical issues whether they realize it or not.

Q: In your paper, you talk about drivers for stem cell tourism, but what is stem cell tourism; how did it start?

A: Stem cell tourism is one aspect of a broader phenomenon called medical tourism or medical travel. You might cross borders for medical treatments because they're not available in your location. For example, you may need high-end



heart care, but you live in the Middle East, so you have to come to the Cleveland Clinic. Medical travel alone is kind of neutral; it just means people go from one place to another for treatments that they can't get at home. So, there are many instances when people think that it'd be morally permissible.

When it becomes controversial is if someone is going from point A to point B, and what they're getting at B is not thought to be medically effective. Here, travelling is not so much the issue but the provision of unproven treatments. But, even then it gets cloudy because someone could

“I would say that most people engage in everyday life in bioethical issues whether they realize it or not.”

travel for a relatively new procedure like a uterus transplant, which has just been proven feasible. With that medical trial, you know lines aren't always clear. When we're talking about stem cell tourism, we're really concerned about people who travel to places where the treatments being offered are not yet thought to be efficacious and could even be harmful.

What's troubling to me is the possibility of exploitation of people for profit by purveyors of stem cell therapies, that is, the possibility of exploitation for profit of patient hopes. Then I think you have the perfect conditions for what I talk about in my paper, which is spiritual distress and therapeutic hope being supporting factors for these clinics.

Q: Why don't you elaborate a bit on what you mean by therapeutic hope and spiritual distress?

A: Therapeutic hope is not wishful thinking; it's not the same as passively saying, "I hope that I get better." If you look at the literature in family medicine and hospice care, therapeutic hope means that people identify certain goals that they have, identify pathways for completing those goals, and believe that they're capable of completing the pathways to those goals.

So, for example, if I hope to ameliorate the symptoms of my MS: pathway—I think that going to this stem cell clinic is one way to address that goal. It's within my power to do that since I can raise money, travel, and go there; I am in control of my own disease. It's not passive involvement because it has structure. If it's the case that that is actually not a pathway to your goal—the stem cell clinic hasn't been shown to meet your physical goal—then there needs to be identified another pathway or goal for you. If we don't replace the closed-off pathway with something else, then there's a risk of slipping into what's now called spiritual distress.

"...medical schools really do emphasize, I think, a little too much, looking at the patient as a biomedical problem..."

Spiritual distress is the disengagement with your own future. It's feeling like, "If I cannot play an active role in my disease, and there's nothing I or anyone can do, then why should I care about tomorrow?" By spiritual distress, I don't mean loss of religion because spirituality as the literature has defined it is not bound to being religious. If you lose the connection with feeling like your life has meaning, then you won't be motivated to do anything to try and get better. We want to balance your retaining hope and self-investment in a productive way while holding off the slide into spiritual distress. Those are therapeutic hope and spiritual distress: two sides of the same coin that pull in opposite directions.

"If you lose the connection with feeling like your life has meaning, then you won't be motivated to do anything to try and get better."

Q: By eliminating the pathway that patients see as the only hope for reaching their goals, could governments cracking down on illicit treatment providers not cause them to fall into distress?

A: It could, so what I recommend is that there have to be identified, by the clinician or medical social worker, other ways to meet the patient's goals.

If they are saying that they want to go to a stem cell clinic, ask them what are their goals? Then, try to identify more reliable pathways to meet those goals locally.

So, if somebody says, "I'm afraid of becoming a burden on the family," then you say "what if we provide social support services so that we lessen the possibility of that happening?" This is preferred to them following an unproven route to completing that goal. I conclude the paper by advocating for a new orientation to how physicians interact with their patients; that is, doctors need to try and learn what their patients' goals are, develop a relationship of trust, and provide social support services when needed.

And, you can't get any of that done unless you have good communication between doctor and patient, so research ethics raises concerns about patients getting these unproven therapies too soon. But, that also cycles back to clinical ethics because the way you minimize these bad outcomes is to build up the ethical aspects of the doctor-patient relationship.

Q: It seems physicians need to become more psychological as well as medical. Your paper cites a figure: 77% of patients want holistic care, but few doctors (10 - 20%) are willing to give it. How can we persuade doctors that there's more to medicine than just the science?

A: It's going to be an enormous challenge because there's a lot of specialization now and doctors only spend a short time with their patients. There's no reimbursement code for talking about spiritual distress with patients, so there's no financial

motivation for people to institutionally create that space for that kind of discussion.

Furthermore, medical schools really do emphasize, I think, a little too much, looking at the patient as a biomedical problem and not so much looking at the patient as a holistic being who is going to be motivated by their own values, aspirations, and hopes.

You can diagnose a patient beautifully, run all the tests, and give them a prescription, but if they don't buy in to what you're recommending, you will not be an effective physician because you can't be at their side 24/7 to make sure that they comply if you don't take care of the holistic aspects of their care. You can't just brush off as irrelevant the psychological aspects of medicine; that's a very important part because people have to take care of themselves when they go home.

Q: So, what advice do you have to any future medical professionals?

A: I would encourage people to question the assumption of such a sharp difference between

facts and values: that facts are totally objective and value-free, and that values are somehow all subjective. What you see in real science and similar professions is a close connection between values and facts. If people didn't value the science that they're conducting or the medicine that they're recommending, then they really would be like computers sitting in a cubicle—spitting back objective sentences.

But, doctors and scientists all have their own value system; it motivates them to do what they do. Even patients have not only their own values, but they also have factual beliefs that may be wrong. So you need to start thinking about the relation between facts and values both as a practitioner and as one who may receive technological or medical goods. That'd be my advice: refrain from looking at the world in terms of separated facts and values.

This interview has been edited for length and clarity with Dr. Hyun's consent.

A Selection of Dr. Hyun's Work

Hyun, I. (2011). Moving human SCNT research forward ethically. *Cell Stem Cell*, 9(4), 295-297. doi: 10.1016/j.stem.2011.08.001

Hyun, I. (2014). Regulate embryos made for research. *Nature*, 509, 27-28. doi: 10.1038/509027a

Hyun, I. (2015). From naïve pluripotency to chimeras: A new ethical challenge? *Development*, 142(1), 6-8. doi: 10.1242/dev.119206

Analyzing Female Gender Roles in Marvel Comics from the Silver Age (1960) to the Present



POW!

Katherine J. Murphy - Hicksville High School

BIOGRAPHY

Kate Murphy is a Hicksville High School senior enrolled in the College Credit Plus Program at Northwest State Community College in Archbold, Ohio. She has presented at both the Intel International Science and Engineering Fair (ISEF) and at Ohio State Science Day. Kate hopes to attend Defiance College—majoring in Nursing and History—with the career goal of becoming a certified nurse-midwife.

ACKNOWLEDGEMENTS

I want to wholeheartedly thank the Ray & Pat Browne Library for Popular Culture Studies and its donors to the William T. Jerome Library at Bowling Green State University. In addition to the library itself, I must personally thank Alex Koch for his help in selecting the Marvel comics and randomizing the reviewed series.

Introduction

Comic books, a form of American popular culture, offer a window into the past, allowing researchers to track societal changes over several decades. The purpose of this study was to determine if, how, and how much female gender roles have changed in Marvel Comics from the Silver Age (1960) to the present (2014) to help understand how popular culture portrays and treats female characters. It was hypothesized that female gender roles in Marvel Comics in the last decade have become less stereotypical and more equitable as compared to the 1960s, as determined by the seven-point quantifiable rubric. The seven-point rubric underwent inter-rater reliability tests twice, with ten experienced raters. The researcher reviewed 68 Marvel titles for a total of 788 Marvel comic books broken down by decade from 1960 to 2014.

Quantitative content analysis determined that the average overall female gender role scores for Marvel comics consistently went up by decade from 12.20 for 1960 to 1969 to 22.50 for 2010 to 2014, which supported the hypothesis and was significant at $p = .001$. Results were also tracked for the seven rubric categories between 1960 to 1969 and 2010 to 2014, respectively (score range 0-5): average cover art (0.39 to 2.61), Bechdel Test (1.21 to 2.72), storyline (2.55 to 4.00), occupation (1.50 to 3.16), balance of power (1.45 to 3.14), female sexualization (1.88 to 3.53), and violence against women (3.22 to 3.32) with significance noted in these subsets.

According to Bradford Wright (2001), “Few enduring expressions of American popular culture are so instantly recognizable and still so poorly understood as comic books . . . Just as each generation writes its own history, each reads its own comic books” (p. 1). Comic books are a litmus test for pop culture itself. Comics do not exist in a vacuum. They are steeped in the thoughts, feelings, and values of their writers and readers. Female gender roles in comic books often reflect these values and attitudes, and they both illustrate and chronicle the year in which they were published.

Popular culture and comic books offer the reader an inside look at how society functioned when they were written. According to Dr. Christina Blanch (2013), “One benefit of analyzing gender through comics is the ability to track attitudes over time” (para. 5). Comic books often parallel American culture, values, and politics.

During the 1940s, comic book art inspired life and often imitated it. The comic books of the 1940s inspired women to be more than homemakers. The authors tried to inspire women to become part of the war effort, to leave their homes, enter the workforce, and fill the jobs previously held by men. This was the Golden Age of Comics, and the decade when female superheroes were christened symbols of American strength, freedom, patriotism, and independence (Larew, 1997, p. 592).

With the end of World War II and the return of the male work force, women were relegated back into the home. There was a backlash and return to conservative family values in which men were the breadwinners and women the homemakers. Comic books reflected the swinging of society’s conservative pendulum with regard to female gender roles. During the late 1950s, female superheroes were slowly vanishing. First, they were treated as powerless sidekicks to their male counterparts. Then, they began disappearing altogether. As women were forced out of the public sphere, they also vanished from comics (Larew, 1997, p. 596).

Women are often marginalized in the superhero universe as in American culture. Comic books frequently perpetuate social or cultural gender stereotypes or both. For many young boys, comic books act as an agent of socialization, modeling social values, and gender roles (Ito, 1994, p. 90).

Traditionally, comic books have targeted male readership. According to a 1995 survey, about 13.41% of comic book readership was female. The average age of women was 25 to 35, considerably older than the 16 to 24-year-old average for men (Emad, 2006, pp. 969-970). Today, young women make up 46.67% of comic book readership (Schenker, 2014, para. 5).

“In the last few years, the market for super heroic women in comic books appears to be moving more strongly towards primary female characters” (Palmer, 2008, p. 3). With the 2013 to 2014 introduction of four new female superheroes—Angela Assassin of Asgard, Jane Foster as Thor, Kamala Khan as Ms. Marvel, and Carol Danvers as Captain Marvel, it seems that Marvel Comics is moving in that direction. However, empirical data is still needed. There have only been tangential studies of comic books, analyzing female gender roles. Of these, most only documented Japanese comics or Planet Comics rather than Marvel Comics, and they usually only analyzed cover artwork.

The most comprehensive comic book study analyzing female gender roles was Karl Larew’s (1997) “Planet Women: The Image of Women in Planet Comics, 1940 - 1953.” It analyzed the number of female superheroes in Golden Age Planet Comics and the number of times they graced the comic books’ covers (p. 592). In addition to Larew’s, only two other quantitative comic book studies of female gender roles have been completed: Kinko Ito’s (1994) “Images of Women in Weekly Male Comic Magazines in Japan” and Erik Palmer’s (2008) dissertation “Superheroes and Gender Roles, 1961 - 2004.” Ito dealt only with contemporary Japanese publications while Palmer analyzed only Marvel Comics’ cover art.

According to Dr. Erik Palmer (2008), “A strong quantitative analysis in the style of this study that covers a greater variety of titles over a longer period of time could provide valuable support” (p. 13). “Content analysis tries to seek what is communicated in documents . . . As a sociological methodology, content analysis is easy to use (unobtrusive) and rather cheap” (Ito, 1994, p. 83). Larew analyzed Golden Age Planet Comics by decade while Palmer analyzed the Marvel cover art in eight-year segments. Comic books are divided roughly into six ages: the Golden Age (1930 to 1959), the Silver Age (1960 to 1969), the Bronze Age (1970 to 1979), the Plastic Age (1980 to 1999), the Revival Age (2000 to 2009), and the present (2010 to 2014).

From these very limited quantitative studies and other research, seven indicators of female gender roles or status were developed. The indicators or categories include: comic book cover art, the Bechdel Test, storyline, occupation, balance of power, female sexualization, and violence against women.

The analysis of comic book cover art seems to be the only consistent factor that researchers have explored. These explorations include the number of women on the cover, the number of female superheroes in relation to the number of male characters, the size and proportion of the female characters, and their activity, passivity, or both (Larew, 1997, p. 596).

The next indicator and arguably the least well-known is the Bechdel Test. The test was developed by Alison Bechdel, an American cartoonist, in her comic strip, “The Rule.” It was originally created as a test for film, has been adapted for television, and is flexible enough to be used with other media. The Bechdel Test has three criteria: The first is that the material must have at least two female characters with names; second, those two female characters must speak with each other; and third, that conversation must be about something other than men (Ulaby, 2014).

“Female gender roles in comic books often reflect values and attitudes [of their writers and readers], and they both illustrate and chronicle the year in which they were published.”

Writers often overlook the female perspective, because male storylines are considered dominant or universal (Scheiner-Fisher, 2012, p. 222). This is true in comic books and other literature. In the Golden Age of Comics, female characters were used almost entirely as companions or sidekicks to their male counterparts. They rarely had storylines of their own (Larew, 1997, p. 598). Often, female characters were treated as window dress-

ing. Traditionally, stories give meaning to life and shape gender roles. According to Marvel Senior Vice-President Tom Brevoort, “It’s not that you can’t have a successful or well-written female superhero, but in general, historically, proportionately, we just haven’t had as many” (Rogers, 2011, para. 14).

In addition to occupations being a strong indicator of female status, roles are important in comic books because superheroes have secret identities. In the Golden Age and early Silver Age of Comics, female characters often had no occupation, role, or even name (Jones, 2014). They were just window dressing. Those that had occupations were often limited to caregiving roles (Ito, 1994, p. 88). “The superheroine was placed on a pedestal of achievement, playing with the boys, and developing strength and identity in areas not traditionally available to women. But as females in a majority male universe, symbolically they had nowhere to go except into the roles of women that were recognizable and familiar” (D’Amore, 2012, p. 1229). For example, Susan Storm, aka the Invisible Woman, was a very powerful superhero in her own right, but she was relegated to the role of girlfriend, wife, and mother (Dunne, 2006, p. 6).

The fifth indicator regarding female gender roles is the balance of power between male and female characters. “Surely you’ve noticed. Female superheroes aren’t nearly as revered as male superheroes,” from “Equal Fights” (O’Reilly, 2005, p. 273). Up until 1960, most superhero-sidekick partnerships were all-male. After that, many female superheroes would not exist without their male counterparts, for example: Hulk and She-Hulk, Spider-Man and Spider-Woman, and Captain Marvel and Ms. Marvel. Female comic book characters relied on their male counterparts to rescue them, care for them, make decisions for them, and give them a purpose in life (Emad, 2006). Women were almost invisible and certainly not in any position to make decisions (Ito, 1994, p. 87).

From 1954–2005, the comic book industry was regulated and censored by the Comic Book Code Authority. From its earliest beginnings, the An-

“It was hypothesized that female gender roles in Marvel Comics in the last decade have become less stereotypical and more equitable.”

ti-Comics Crusade was concerned about gender roles, sexuality, and violence, especially in relation to women (D’Amore 1227). And yet, female sexualization is a very prominent comic book feature, especially focusing on large breasts, long legs, and tiny waists. “More precisely, the portrayal of women characters throughout comic books builds upon and continues to perpetuate the idea that women are mere objects of desire, basically submissive and ineffectual creatures whose virtue is found in the lewd display of their body” (Jones, 2014, para. 2).

Comics have traditionally exploited women for male readership, making violence against women the 7th indicator. Women often serve the role of perpetual victim in comic books. They are threatened, kidnapped, assaulted, humiliated, violated, and often killed (Larew, 1997, p. 602).

Materials & Methods

Comic Book Ratings

At least 100 Marvel comic books were collected from each era: 1960 to 1969, 1970 to 1979, 1980 to 1989, 1990 to 1999, 2000 to 2009, and 2010 to 2014. A seven-point rating rubric for all comics was designed on rcampus.com with each category being rated from zero to five such that the highest possible score a comic could cumulatively receive was 35. Each comic was rated on seven categories: the Bechdel Test, Cover Art, Storyline, Occupation, Balance of Power, Female Sexualization, and Violence Against Women.

XL Stat Software Procedure

After creating the seven-point rating rubric on rcampus.com, 10 experienced raters and the researcher scored the same comic book using the rubric to test for inter-rater reliability. Based on the raters’ feedback and comparison of their

scores, the rubric was revised and the inter-rater reliability test was repeated so that the average scores would differ by fewer than 0.5 points. Upon observing this degree of variability, 788 selected comic books for a minimum of 100 comics per decade (1960 to 2014) were reviewed by the researcher.

The total scores (35-point maximum) and scores by category (5-point maximum) for each comic from the rubric content analysis were recorded. These scores were sorted by the following year categories with at least 100 comics being subjected to rubric analysis for each: 1960 to 1969, 1970 to 1979, 1980 to 1989, 1990 to 1999, 2000 to 2009, and 2010 to 2014. The average rubric scores were analyzed for statistically significant changes over time.

Results

The purpose of this study was to determine if, how, and how much female gender roles have changed in Marvel Comics from the Silver Age (1960) to the present to help understand how popular culture portrays and treats women and female characters. It was hypothesized that female gender roles in Marvel Comics in the last decade have become less stereotypical and more equitable as determined by the seven-point quantifiable rubric as compared to the 1960s. Through the quantitative content analysis, the average female gender role scores for Marvel comics consistently went up by decade from 0.39 in the 1960s to 2.61 from 2010 to 2014. An ANOVA statistical analysis was run using XL-Stat Software. Significance was found, and the null hypothesis was rejected. T-tests were then run to determine the location of the significance. Comparing 2010 to 2014 data to each decade found very high significance at .001 for all of the time periods between 1960 and 2009.

The researcher reviewed 788 Marvel Comic Books from the Silver Age (1960) to the present (2014). The content analysis was broken down by decade: 1960 to 1969, 1970 to 1979, 1980 to 1989, 1990 to 1999, 2000 to 2009, and 2010 to 2014. A minimum of 100 Marvel Comic Books were reviewed per de-

cade. The titles of all 68 reviewed comics are listed in Appendix 1.

The 48 analyzed data sets included the rubric's seven major categories and a statistical category, Overall Total Score for Female Gender Roles. These eight categories were analyzed for statistically significant changes by decade. An ANOVA statistical analysis was run using XL-Stat Software, and t-tests were run to determine significance.

Discussion

The purpose of this study was to determine if, how, and to what extent female gender roles have changed in Marvel Comics from the Silver Age (1960) to the present to propose a hypothesis for how popular culture portrays and treats women and female characters. It was predicted that female gender roles in Marvel Comics in the last

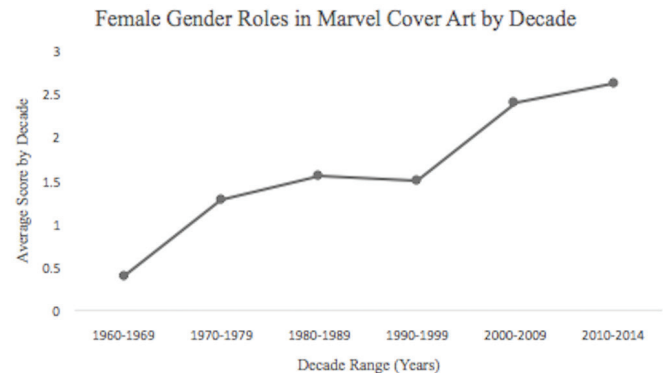


Figure 1. The average scores for this category were 0.39 for 1960 to 1969, 1.27 for 1970 to 1979, 1.54 for 1980 to 1989, 1.48 for 1990 to 1999, 2.39 for 2000 to 2009, and 2.61 for 2010 to 2014. Comparing 2010-2014 data to each decade found significance at $p = .001$ for 1960 to 1969, 1970 to 1979, 1980 to 1989, and 1990 to 1999. No significance was found for 2000 to 2009.

decade have become less stereotypical and more equitable as determined by the seven-point quantifiable rubric as compared to the 1960s. Through the quantitative content analysis, the average female gender role scores for Marvel comics consistently went up by decade from 0.39 in the 1960s to 2.61 from 2010 to 2014.

An ANOVA statistical analysis was run using XL-Stat Software that found the variations to be sig-

nificant, so t-tests were run to determine the extent of significance. Comparing 2010 to 2014 data to that of each decade determined $p = .001$ for all of the time periods between 1960 and 2009 (Figures 1 to 8).

For Female Gender Roles in Marvel Cover Art: In the 1960 to 1969, there was not a single rubric cover score over two, while there were fourteen perfect scores from 2010 to 2014 (Figure 1). This study showed a fairly steady improvement of the representation of women on Marvel comic book covers from 1960, where they were almost non-existent, to 2014, where representation was almost equal between male and female characters. There was a decrease in the range of 1990 to 1999 of 0.06, which was statistically negligible. The overall increase in score could be attributed to the increase in female title characters, writers, artists, illustrators, and readers (Chenault, 2007). This study's results were higher than those compiled by Dr. Erik Palmer in his analysis of three Marvel titles (The Avengers, Fantastic Four, and X-Men), spanning from 1960 to 2004. Palmer documented that women were represented on less than 15% of the Marvel comic book covers he reviewed in the 1960s and early 1970s. He noted

"In the last decade, Marvel Comics have created more female titles than ever before, and female readership is now over 46% of the market (Jones, 2015)."

the rise in representation of female characters on the cover to more than 24% in the late 1970s and just slightly higher than that through 2004 (Palmer, 2008). This study, with its much greater sample of 68 Marvel comic titles, documented female representation on 32% of Marvel covers from the 1960s. Female representation jumped to 70% in the 1970s with a large number of group or team titles published, after falling back to between 48% and 49% in the 1980s and 1990s, rising to 64% in 2000 and 67% in 2014.

Originally designed for film analysis and adapted for use with other media, this is the first time that the Bechdel Test has been used in comic book analysis of female dialogue. The Bechdel Test results in this context showed a slow, steady improvement in female dialogue scores from 1960 to 2014 with a slight decrease in the 1990 to 1999

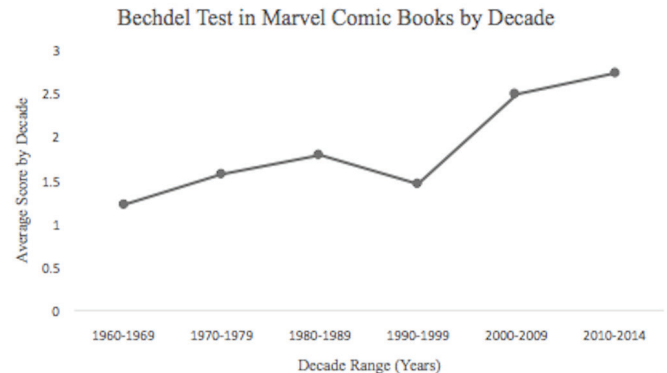


Figure 2. The average scores for this category were 1.21 for 1960 to 1969, 1.57 for 1970 to 1979, 1.79 for 1980 to 1989, 1.46 for 1990 to 1999, 2.48 for 2000 to 2009, and 2.72 for 2010 to 2014. Comparing 2010 to 2014 data to each decade found significance at $p = .001$ for 1960 to 1969, 1970 to 1979, 1980 to 1989, and 1990 to 1999. No significance was found for 2000 to 2009.

range (Figure 2). The 1990s, in many of this study's rubric categories, showed a decrease in score possibly due to a conservative backlash in American society and downsizing of the comic book industry. According to Jennie Whitwood, author of *The Changing Role of Women in Comic Books*, "Although these superheroines exist in the worlds of both DC and Marvel, they have a history of being little more than showpieces, just scantily-clad, big-breasted and generally useless ladies in lycra" (Jones, 2014). This lack-luster, unenthusiastic period in comic books is known as the Plastic Age (1980 to 1999) during which everything and everyone was disposable.

From this study's scores in female representation on Marvel comic book covers and its Bechdel Test scores, there may be a connection between female visual representation and the quality of female dialogue present in comic books. Other than the 1960s cover score and the 1980s Bechdel Test score, the scores in these categories are very similar.

For Female Gender Roles in Marvel Comic Book Storylines, there was a steady improvement in storylines related to female gender roles from 2.55 in 1960 to 4.00 in 2014, except for the 1980 to 1989 and 1990 to 1999 range (Figure 3). During the early 1960s, the lack of female characters and their interactions were often overlooked, because the male perspective was usually the dominant comic book storyline. “Women’s history is generally left out of traditionally male-dominated history curriculum; when it is included, it is usually in the margins or in sidebars” (Scheiner-Fisher & Russell, 2012). This was how the phenomenon of the two-panel woman, a term coined by this researcher, in comic books was born. The two-panel woman is a female character who appears for two panels in the comic book just to make dinner or calm a baby, for instance, and then disappears. She is a one-dimensional character who has no bearing on the storyline of the comic book. From this study, the phenomenon of the two-panel woman was a dominant force in Marvel storylines in the 1980s and 1990s. Further study could show how this phenomenon may have affected storylines, female occupations, and readership.

For Female Occupations in Marvel Comic Books, slow steady improvement in female occupations in Marvel comics was noted from 1.50 in the 1960s to 3.16 in 2014 with a dip in rubric scores from

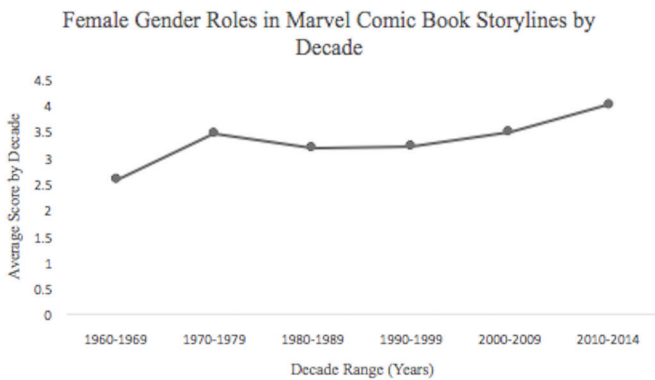


Figure 3. The average scores for this category were 2.55 for 1960 to 1969, 3.44 for 1970 to 1979, 3.18 for 1980 to 1989, 3.20 for 1990 to 1999, 3.48 for 2000 to 2009, and 4.00 for 2010 to 2014. Comparing 2010-2014 data to each decade found significance at $p = .001$ for 1960 to 1969, 1970 to 1979, 1980 to 1989, and 1990 to 1999. Significance was found for 2000 to 2009 at $p = .005$.

1990 to 2009 (Figure 4). Storylines may not have been the only thing impacted by the 1990s cultural backlash. It also may have affected the female occupations portrayed in Marvel comics and its female readership. According to Marvel comic book writer and artist Trina Robbins, “Comics changed. There were very few superheroines that had their own titles . . . There was nothing out there for girls to read anymore” (Chenault, 2007).

For Balance of Power in Marvel Comic Books, there was a consistently slow increase in rubric scores from 1.45 in 1960 to 3.14 in 2014. This category was one of the only ones not impacted by the 1990s trend (Figure 5). This could be explained by the cultural phenomenon of more women breaking through the glass ceiling of business at the end of the millennium documented in comic books.

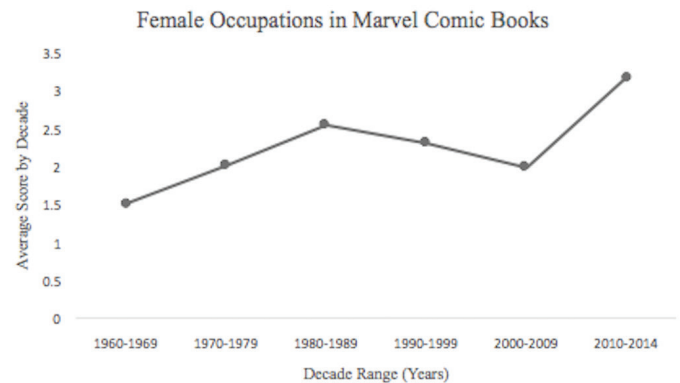


Figure 4. The average scores for this category were 1.50 for 1960 to 1969, 2.00 for 1970 to 1979, 2.53 for 1980 to 1989, 2.31 for 1990 to 1999, 1.98 for 2000 to 2009, and 3.16 for 2010 to 2014. Comparison 2010-2014 of data to each decade found significance ($p = .001$) for 1960 to 1969, 1970 to 1979, 1990 to 1999, and 2000 to 2009. Significance was found for 1980 to 1989 at $p = .05$.

For Female Sexualization in Marvel Comic Books, the average scores decreased quickly in 1970 and 1980, plateaued from 1990 to 2009, and increased steeply from 2010 to 2014. One explanation for these erratic scores was the “Comic Book Code” (Figure 6). With the backlash to conservative family values and gender roles of the 1950s, it was created to address concerns about female objectification and violence, especially the changing female gender roles and the so-called lesbian and sado-masochistic fantasies portrayed in com-

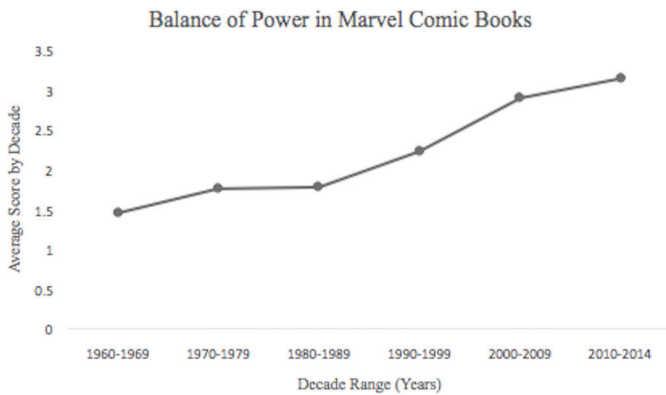


Figure 5. The average scores for this category were 1.45 for 1960 to 1969, 1.76 for 1970 to 1979, 1.77 for 1980 to 1989, 2.22 for 1990 to 1999, 2.90 for 2000 to 2009, and 3.14 for 2010 to 2014. Comparison of 2010-2014 data to each decade found significance ($p = .001$) for 1960 to 1969, 1970 to 1979, 1980 to 1989, and 1990 to 1999. No significance was found for 2000 to 2009.

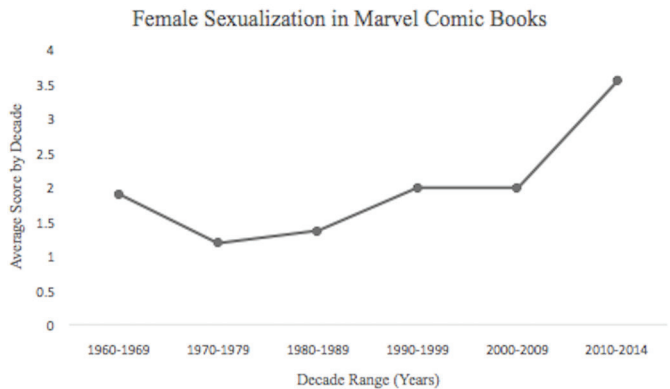


Figure 6. The average scores for this category were 1.88 for 1960 to 1969, 1.18 for 1970 to 1979, 1.35 for 1980 to 1989, 1.97 for 1990 to 1999, 1.97 for 2000 to 2009, and 3.53 for 2010 to 2014. Comparison of 2010-2014 data to each decade were significant ($p = .001$) for all of the time periods between 1960 and 2009.

ic books (D'Amore, 2012). The code was rigidly enforced during the 1960s, so comic book writers and illustrators began to take great pride in working around its restraints, especially through the 1980s. Marvel Comics began to tire of and ignore the code in the mid-1990s (Tipton, 2008). In the last decade, Marvel Comics has created more female title characters than ever before, and female readership is now over 46% of the market (Jones, 2014). These cultural changes may help to account for the rubric scores across the decades, especially the precipitous increase in 2014.

In this category, the Face-Off Test played a part in scoring. The test is used to note whether or not

a character's illustration met actual human anatomy. On the television show, the judges always critiqued creations based on their ability to exist in nature with anatomically disproportionate creations scoring considerably lower. This researcher noted numerous times that many female characters' proportions could not exist in real life. For example, they lacked full rib cages, internal organs, spines, or the ability to stand upright without being pulled over by their breasts. Notably, the better a character did on the unofficial Face-Off Test the better the rubric score for that comic book. Further research could be undertaken to note trends in anatomical illustrations in comic books.

For Violence Against Women in Marvel Comic Books, there was very little change from violence against women at 3.22 in 1960 and 3.32 in 2014, and when comparing 1960 to 1969 with 2010 to 2014, violence against women seems to remain constant (Figure 7).

For the Average Total Female Gender Role Scores in Marvel Comics, this data seemed confirm its prediction. It was predicted that female gender roles in Marvel Comics in the last decade would become less stereotypical and more equitable as determined by the seven-point quantifiable rubric. As noted previously, the total female gender role rubric score went from 12.20 in 1960, slowly and steadily increasing through 1999, and then

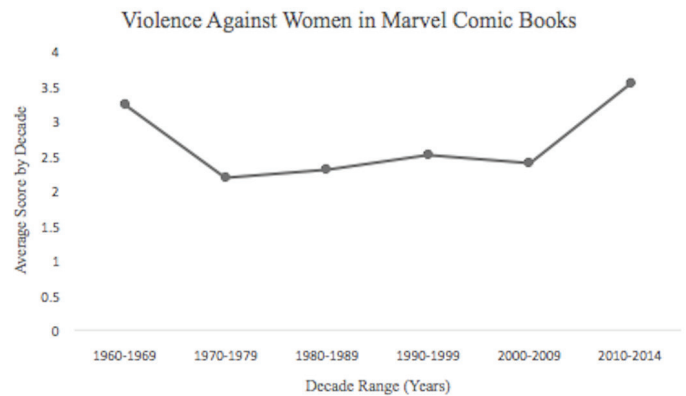


Figure 7. The average scores for this category were 3.22 for 1960 to 1969, 2.18 for 1970 to 1979, 2.31 for 1980 to 1989, 2.51 for 1990 to 1999, 2.39 for 2000 to 2009, and 3.32 for 2010 to 2014. Comparing 2010-2014 data to each decade found significance at $p = .001$ for 1970 to 1979, 1980 to 1989, 1990 to 1999, and 2000 to 2009. No significance was found for 1960 to 1969.

jumping to 17.58 in 2009, and rocketing to 22.50 in 2014. From 2010 to 2014, at no time in the history of the Marvel Universe have so many female comic book title characters been released, rebooted, and promoted (Fingeroth, 2014) including She-Hulk, Captain Marvel, Scarlet Witch, Miss America, Angela Assassin of Asgard, Thor, Storm, Kamala Khan as Ms. Marvel, and the first ever all-female X-Men team.

If additional funding and time were available in the future, this research study could be improved and/or replicated with the use of multiple comic book rubric raters rather than the single researcher used in this study. This would strengthen the credibility of the results.

One area that may have impacted and/or changed the results of this study was the unplanned randomization of comic books from 1960 to 1990 pulled for this study by a Bowling Green State Uni-

“Comic books reflected the swinging of society’s conservative pendulum with regard to female gender roles.”

versity graduate student. This graduate student randomly pulled comic books for the researcher’s review, so there was no formal randomization pattern for order of review, selection, and so forth. Likewise, there was subject bias affecting the results of this study; for instance, the researcher’s overall reading preference for female characters may have impacted the results. The researcher randomly pulled comic books from 2000 to 2014 from public library collections as well as the researcher’s personal collection. With the drastic increase in the overall rubric scores from 2000 to 2014, the hypothesis would still have been supported.

Female comic book characters and female gender roles have certainly come a long way in the last fifty-five years. Female gender roles in comic books have changed and grown to illustrate soci-

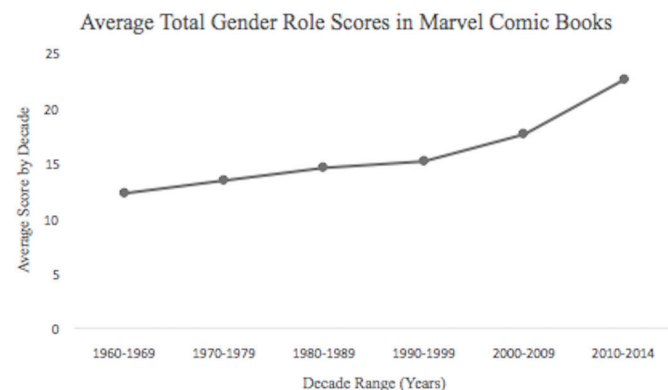


Figure 8. The average total decade scores for this category were 12.20 for 1960 to 1969, 13.41 for 1970 to 1979, 14.46 for 1980 to 1989, 15.15 for 1990 to 1999, 17.58 for 2000 to 2009, and 22.50 for 2010 to 2014. Comparing 2010 to 2014 data to each decade found significance ($p = .001$) for all of the time periods between 1960 and 2009.

ety’s ever-changing views of women and their role in American culture.

References

- Blanch, C. (2013, January 23). What do comic books teach us about gender attitudes? *Forbes*. Retrieved from <http://www.forbes.com/sites/forbeswom-anfiles/2013/01/23/what-do-comic-books-teach-us-about-gender-attitudes/#4538f76a16ac>
- Chenault, W. (2007). Working the margins: Women in the comic book industry. Georgia State University. Retrieved from http://scholarworks.gsu.edu/wsi_theses/10
- D’Amore, L. M. (2012). The accidental supermom: Superheroines and maternal performativity, 1963-1980. *Journal of Popular Culture* 45(6), 1226-1248. doi: 10.1111/jpcu.12006
- Dunne, M. (2006). The representation of women in comic books, post WWII through the radical 60s. *Portland State University (PSU) McNair Scholars Online Journal* 20(1), 81-91. doi: 10.15760/mcnair.2006.81
- Emad, M. C. (2006). Reading Wonder Woman’s body: Mythologies of gender and nation. *Journal Of Popular Culture* 39(6), 954-984. doi: 10.1111/j.15405931.2006.00329.x
- Fingeroth, D. (2014, July 17). Why Marvel needs a gimmick like Thor’s sex change. *Time Magazine*. Retrieved from <http://time.com/3001549/marvel-thor-female/>
- Goldstein, L. & Goldstein, M. P. (2014). Are you there God? It’s me, manga: Manga as an extension of young adult literature. *Young Adult Library Services* 7(4), 32-38. Retrieved from <http://connection.ebscohost.com/c/articles/43913377/are-you-there-god-me-manga-manga-as-extension-young-adult-literature>
- Haddock, C. (2014). Social injustice: Gender discrimination in comic books. Retrieved from https://cunyonline.digication.com/coy_haddock/A_Social_Injustice_Gender_Discrimination_in_Comic_
- Hammond, J. D. (2014). Gender inversion cartoons and feminism. *Journal Of Popular Culture* 24(4), 145-160. doi: 10.1111/j.0022-3840.1991.2404_145.x
- Ito, K. (1994). Images of women in weekly male comic magazines in Japan. *Journal of Popular Culture* 27(4), 81-95. doi: 0.1111/j.0022-3840.1994.2704_81.x
- Kirsh, S. J. & Olczak, P. V. (2001). Rating comic book violence: Contributions of gender and trait hostility. *Social Behavior & Personality: An International Journal* 29(8), 833-836. doi: 10.2224/sbp.2001.29.8.833
- Larew, K. G. (1997). Planet women: The image of women in Planet Comics, 1940-1953. *Historian* 59(3), 590-612. doi: 10.1111/j.1540-6563.1997.tb01007.x
- Merino, N. (2014). Gender roles, 1st edition. Farmington Hills, Michigan: Greenhaven Press, pp. 1-209.

Moeller, R. A. (2011). "Aren't these boy books?": High school students' readings of gender in graphic novels. *Journal of Adolescent & Adult Literacy* 54(7), 476-484. doi: 10.1598/JAAL.54.7.1

Nelson, T. (2004). "Even an android can cry." *Journal of Gender Studies* 13(3), 251-257. doi: 10.1080/0958923042000287867

O'Reilly, J. D. (2005). The Wonder Woman precedent: Female (super)heroism on trial. *The Journal Of American Culture* 28(3), 273-283. doi: 10.1111/j.1542-734X.2005.00211.x

Palmer, E. (2004, August 6). Superheroes and gender roles, 1961-2004. Chicago, Illinois: Association for Education in Journalism. Retrieved from http://citation.allacademic.com/meta/p271949_index.html

Rogers, V. (2011, September 2). Pro-girls part 2: History's role in comics' gender disparity. Newsarama.com. Retrieved from <http://www.newsarama.com/8408-pro-girls-pt-2-history-s-role-in-comics-gender-disparity.html>

Schenker, B. (2014, February 1). Facebook fandom spotlight: Who are the US comic fans? GraphicPolicy.com Retrieved from <http://graphicpolicy.com/2014/02/01/facebook-fandom-spotlight-who-are-the-us-comic-fans-5/>

Scheiner-Fisher, C. & Russell, W. B. (2012). Using historical films to promote gender equity in the history curriculum. *The Social Studies* 103(6), 221-225. doi: 10.1080/00377996.2011.616239

Tipton, N. G. (2008). Gender trouble: Frank Miller's revision of Robin in the Batman: Dark Knight series. *Journal of Popular Culture* 41(2), 321-336. doi: 10.1111/j.1540-5931.2008.00505.x

Ulaby, N. (2008, September 4). The "Bechdel Rule," defining pop-culture character. NPR. Retrieved from <http://www.npr.org/templates/story/story.php?storyId=94202522>

Welker, J. (2006). Beautiful, borrowed, and bent: "Boys' love" as girls' love in Shōjo Manga. *Sign: Journal of Women in Culture & Society* 31(3), 841-870. doi: 10.1086/498987

Wilson, H. W. (2014). Revisiting gender. Ipswich, Massachusetts: Grey House Publishing, pp.1-217.

Wong, W. S. and Cuklanz, L. M. (2002). Critiques of gender ideology: Women comic artists and their work in Hong Kong. *Journal of Gender Studies* 11(3), 253-266. doi: 10.1080/0958923022000021269

Wright, B. W. (2001). *Comic book nation: The transformation of youth culture in America*. Baltimore, Maryland: The Johns Hopkins University Press.

Appendix

List of all comic books reviewed:

A-Babies vs. X-Babies, The Amazing Spider-Man, The Amazing X-Men, Angela Asgard's Assassin, The Annihilators, Astonishing Ant-Man, Astonishing X-Men, The Avengers, Avengers vs. X-Men, Captain Marvel, The Champions, Classic X-Men, Cyclops and Phoenix, The Daily Bugle, Daredevil, Daredevil and Black Widow, Dark Phoenix, DC vs. Marvel, Deadpool, The Defenders, Excalibur, Fall of the Hulks, The Fantastic Four, Generation X, Ghost Rider, Hulk Smash, The Incredible Hulk, The Invincible Iron Man, Iron Man, Magneto, Marvel Super Heroes, The Mighty Thor, Ms. Marvel, Namor, The New Avengers, Nightcrawler, Power Man, Ravage 2099, Rocket Raccoon, The Runaways, Satana, The Savage She-Hulk, Secret Invasion, The Sensational She-Hulk, The Silver Surfer, Spider-Man vs. Wolverine, The Spider-Woman, Storm, Super Villain, Survive, Tales to Astonish, Tales of Suspense, Thor, Triple Action, The Ultimate Spider-Man, The Ultimates, Ultimatum 2099, Uncanny X-Men, The Uncanny X-Force, Venom 2099, World War Hulk, Wolverine, X-Factor, X-Force, X-Men, The X-Men Adventures, X-Men Fairy Tales, and The Young Avengers.

Do Healthcare Systems Discriminate? A Comparative Policy Analysis of Health Inequality in the United States and United Kingdom

EMERGENCY

Sarah Elizabeth Rudasill - Wake Forest University

BIOGRAPHY

Sarah Elizabeth Rudasill is a junior economics major with minors in Chemistry and in Health Policy & Administration at Wake Forest University. Prior to her transition into policy research, she conducted biomedical research on the bioelectric control mechanisms governing spinal cord regeneration in salamanders and interned at the Wake Forest Institute for Regenerative Medicine. Sarah developed a passion for public health by serving as director of the Roosevelt Healthcare Think Tank and volunteering at Wake Forest Baptist Medical Center. She intends to blend her love of the biomedical sciences and public policy by pursuing a career in healthcare policy following medical school.

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Abstract

This comparative analysis of U.S. and U.K. healthcare systems pinpoints inequalities in health outcomes and recommends policies to alleviate disparities. Mortality data from the CDC'S WONDER Database and Cancer Research U.K. were used to analyze two gendered conditions – female breast cancer and male prostate cancer – for mortality rates and relative mortality ratios by region, race, and socioeconomic status. The data indicate that although the United States outperforms the United Kingdom in overall mortality rates for breast and prostate cancers, outcomes for U.S. Black residents are significantly worse than those for U.K. Black residents. Potential sources of inequality are discussed with special focus on the structural differences yielding better minority outcomes in the U.K. Policy changes that reduce U.S. health disparities will save lives and ensure that each individual possesses a healthy foundation for a rewarding life.

Introduction

The U.S. has long maintained its distinction as the only advanced economy lacking a universal healthcare system that guarantees health care as a right of all citizens. As a result, inequality of access has yielded stark differences in health outcomes among socioeconomic classes, races, and genders. However, countries with universal health systems, such as the U.K., also struggle with some of the same disparities observed in the U.S. The question of achieving economic justice within healthcare systems is critical because reduction in health disparities will improve longevity and quality of life for all.

The United Kingdom's National Health Service

The National Health Service (NHS) of England is a publicly funded, universal system that aggressively manages the price and availability of health care goods and services. There are two major branches of the NHS: direct NHS commissioning and local planning committees, the latter of which were originally called primary care trusts (PCTs). Under the Health and Social Care Act of 2012, the PCTs were reformed into 211 clinical commissioning groups (CCGs), which still plan and purchase health care services for local populations but incorporate greater leadership from clinicians (Taylor, 2014, p. 7). Direct NHS commissioning provides specialized healthcare

services in technical hospital centers in addition to funding primary care for all citizens and health services for the armed forces and incarcerated population (Taylor, 2014, p. 12). The CCGs then allocate funding for urgent and emergency care, elective hospital care, maternal and newborn health, and mental health for communities of approximately 250,000 people (Taylor, 2014, p. 13).

Most distinctive is the U.K.'s strict funding and cost control measures. The treasury initially allocated approximately £107 billion (\$162.5 billion) per annum for general health care expenditure (Taylor, 2014, p. 10). NHS England received £96 billion (\$145.8 billion) of this sum from 2012 to 2013, of which the body retained £30 billion for direct commissioning services (Taylor, 2014, p. 11). The rest of the funding is allocated to CCGs on a weighted capitation basis, with budgets determined by the size of the population and adjusted for population age and health. Budgets to CCGs are provided either as lump-sum block contracts or as payment-by-results contracts, which provide funding for outcomes rather than services at an agreed-upon price. As financial pressures force the NHS to achieve better outcomes with existing resources, payment-by-results is being used more frequently, composing an unprecedented 30% of all contracts (Taylor, 2014, p. 10).

A critical U.K. cost management tool is the National Institute for Health and Care Excellence (NICE), a research arm that provides evidence-based advice and legally binding treatment recommendations. NICE uses the incremental cost-effectiveness ratio to determine if a new treatment is an improvement over existing technologies. NICE has a soft upper cost-effectiveness limit of £20,000 to £30,000 (\$30,377 to \$45,565) per quality-adjusted life year (QALY) offered by a new treatment, a standard unchanged since 2004 (Claxton, K., Martin, S., Soares, M., Rice, N., Spackman, E., et al., 2013, p. 6). The probability that any given treatment approved by the NHS is under the £20,000 threshold is 64% while 92% of approved treatments are under the £30,000 threshold (Claxton et al., 2013, p. 10). The tremendous focus on cost-effectiveness means that expensive treatments that only marginally extend or improve life are often rejected.

While there is national concern about cost control, the vast majority of medical services offered by the NHS are free for U.K. citizens at the point of delivery

(NHS Choices, 2015). Most patients only make co-payments toward the cost of prescriptions, dental care, and eye care, with funds redirected back into the NHS trust. 2015 NHS prescription costs average to £8.20 (\$12.45) per drug, but medications are free if they are administered at a hospital or personally prescribed by a general practitioner (GP) (NHS Choices, 2015). If these additional costs are too burdensome, U.K. residents may apply to the NHS Low Income Scheme to receive reduced or free co-payments in addition to reimbursed travel costs for diagnosis and treatment at public facilities.

The United States' Mixed Economic Health Conglomerate

In contrast lies the market-oriented public and private insurance conglomerate of the U.S. The public sector is one of the three financing arms of the U.S. healthcare system, providing Medicaid for low-income individuals, Medicare for the elderly and long-term disabled people, and medical services through the Veterans Administration for retired armed forces personnel. The private sector and direct-from-consumer expenditures in the form of out-of-pocket (OOP) costs compose the other two financing sources (Barton, 2010, p. 4). In 2010, these expenditures totaled \$2.59 trillion, representing 17.9% of U.S. GDP and the highest per capita health spending in the world (Barton, 2010, p. 11). Unlike the NHS, the U.S. healthcare system does not have a regulatory division that approves only cost-effective treatments. Instead, U.S. private payers individually negotiate with healthcare providers in an obscure process leading to regional discrepancies in provider reimbursement levels and care costs (Squires, 2012, p. 11).

U.S. healthcare expenditure is controversial in its lack of success in achieving the best worldwide health outcomes despite the high per capita expenditure. As a result, the Patient Protection and Affordable Care Act (PPACA) of 2010 attempted to improve health outcomes while controlling rising costs. Major provisions included mandating access to health insurance regardless of pre-existing conditions, requiring individuals to purchase a minimum level of health insurance, mandating coverage of preventative medical services, and creating either state or federal health exchanges for individuals lacking access to employer-based insurance. Furthermore, the law extended coverage for dependents, increased

emphasis on comparative effectiveness research, and highlighted the importance of primary care medicine through the designation of personal GPs as “medical homes” (Barton, 2010, p. 22).

Rather than using national taxation to fund medical care like the NHS does, the U.S. healthcare system features a dizzying array of insurance payment plans. Depending on specifics, insurance plans can hold the consumer responsible for paying a monthly premium simply to gain access. In addition to this premium, insurance companies use a number of other payment mechanisms to deter excessive medical care. Co-insurance requires consumers to pay a specific percentage of their total medical expenses, making consumers consider prices before selecting among treatment options. To further deter expensive care, insurers use co-payments, a type of point-of-service fee, as well as deductibles, which are OOP expenditure thresholds that must be paid by the consumer before the health insurance plan begins providing coverage for services. These mechanisms, in combination with the managed care systems of the U.S., were intended to control costs but failed to decelerate the growing rate of health expenditure (Barton, 2010, p. 22).

“U.S. healthcare expenditure is controversial in its lack of success in achieving the best worldwide health outcomes despite the high per capita expenditure.”

These fundamental differences in the U.S. and U.K. health systems may explain the varying outcomes observed in the relative mortality rates by race for two conditions: female breast cancer and male prostate cancer. These conditions were selected because they encompass the adult experience at both middle and later stages of life. These conditions affect a larger proportion of the population, providing an adequate sample size for data analysis while controlling for gender. As some of the most common causes of death for both the U.S. and U.K., the selected diseases represent significant challenges to life quality and longevity for the Western world. Eliminating disparities in these large disease pools will have a profound impact on eliminating disparities in all of medicine.

Methods

Research methods were dictated by the U.K.'s availability of information. While the U.S. has free public access to mortality data, the U.K.'s data on health outcomes by race were limited (Thomson & Forman, 2009). To establish a baseline for outcome differences among various ethnicities, researchers linked data from the National Cancer Intelligence Network to medical records through the Hospital Episode Statistics, allowing the calculation of mortality rates for a variety of conditions by race. Thus, where reliable data for the U.K. could be located, equivalent incidence and mortality data were generated for the U.S. from the CDC's WONDER (Wide-ranging Online Data for Epidemiologic Research) Mortality Database.

Data for breast cancer in the U.K. came from two sources. The most recent mortality rates include the female age-standardized rates (ASRs) per 100,000 for breast cancer (ICD-10 Code 50) in the U.K. in 2012 (Cancer Research UK, 2014a). The only source of data for mortality by race is a report entitled Cancer Incidence and Survival By Major Ethnic Group, England, 2002 - 2006 (Thomson & Forman, 2009). This source provides cancer incidence rates per 100,000 people for White, Asian, Black, Chinese, and mixed races, which can be used to calculate relative ratios.

Data for breast cancer in the U.S. come from the CDC's WONDER Database on U.S. Cancer Statistics, 1999 to 2012 (CDC WONDER, 2012). For cancer incidence, the database for cancer

incidence from 1999 to 2012 was used. Outputs were sorted by cancer sites, region, and race. ASRs were selected, and query factors were as follows: "all regions," "female only," "all ethnicities and races," and "all ages." Years selected were 2002 through 2006, inclusive. The cancer of interest was "female breast," and the 2000 U.S. standard was used for the ASRs. For cancer mortality, the database for cancer mortality from 1999 to 2012 was used. Outputs were sorted again by cancer sites, region, and race. ASRs were selected based upon the 2000 U.S. standard population. All regions, ages, races, and ethnicities were selected. Only females were selected, and the cancer of interest was "female breast" for the year 2012.

Data for prostate cancer in the U.K. come from two sources. The most recent mortality rates include the male ASRs per 100,000 for prostate cancer (ICD-10 Code 61) in the U.K. in 2012 (Cancer Research UK, 2014b). The only source of data about mortality by race is a report entitled Cancer Incidence and Survival By Major Ethnic Group, England, 2002 - 2006 (Thomson & Forman, 2009). This source provides cancer incidence rates per 100,000 people for White, Asian, Black, Chinese, and mixed races, which can be used to calculate ratios relative to a reference group.

Data for prostate cancer in the U.S. come from the CDC's WONDER Database on U.S. Cancer Statistics from 1999 to 2012 (CDC WONDER, 2012). For cancer incidence, the database for cancer incidence from 1999 to 2012 was used. Outputs were sorted by cancer sites, region, and race. ASRs

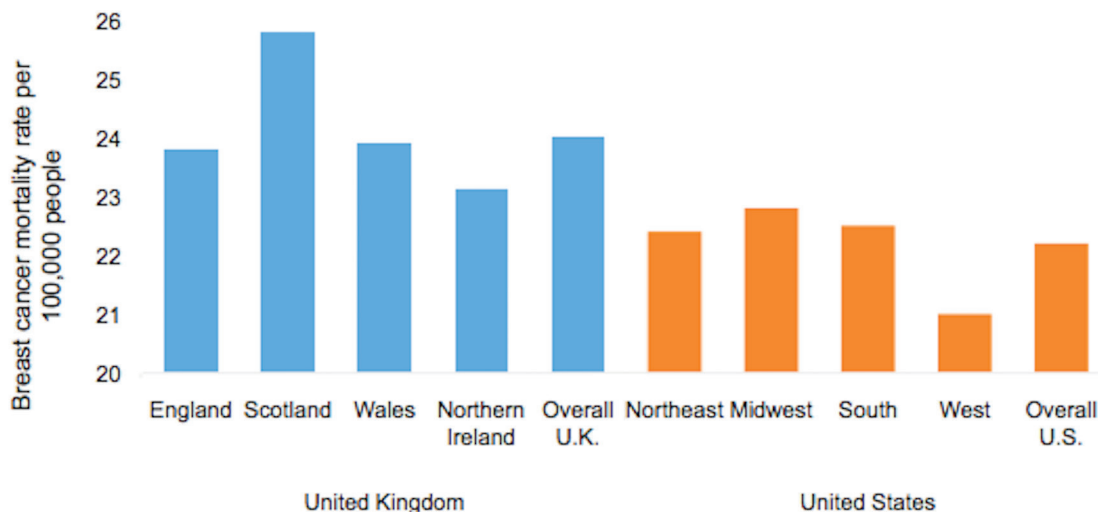


Figure 1. Female Breast Cancer Incidence and Mortality Data. Age-standardized breast cancer mortality rates per 100,000 people by country and region, 2012.

were selected, and query factors were as follows: “all regions,” “male only,” “all ethnicities and races,” and “all ages.” Years selected were 2002 through 2006, inclusive. The cancer of interest was “male genital system: prostate.” The 2000 U.S. standard was used for the ASRs. For cancer mortality, the database for cancer mortality from 1999 to 2012 was used. Outputs were sorted again by cancer sites, region, and race. ASRs were selected based on the 2000 U.S. standard population. All regions, ages, races, and ethnicities available were selected. Only males were selected, and the cancer of interest was prostate cancer of the male genital system for the year 2012.

Results

According to the 2012 mortality rates presented in Figure 1, the U.S. outperformed the U.K. in female breast cancer survival. The entire U.K. had an average mortality rate of 24.0 women per 100,000 people while the U.S. had an average mortality rate of only 22.2 women per 100,000. Even the best performing region of the U.K., Northern Ireland, has a higher mortality rate of 23.1 deaths per 100,000 than the rate of 22.8 deaths in the Midwest, which is the worst performing region of the U.S.

According to the analysis of cancer incidence rates in both the U.K. and U.S. by race in Figure 2, diagnosis levels are similar for most racial minority groups. White women in both countries are significantly more likely than other racial groups to be diagnosed with breast cancer; the U.K. had a female breast cancer incidence of 123.7 per 100,000 people for White women, which is comparable to the 124.7 incidence rate in the U.S. The only major difference in the racial breakdown is for Black women, who had an incidence rate of 93.4 in the U.K. but a much higher incidence rate of 115.4 in the U.S. Therefore, for every 100 White women diagnosed in the U.S., approximately 93 Black women are diagnosed. In contrast, for every 100 White women diagnosed in the U.K., only 76 Black women are diagnosed.

However, the actual mortality rates that are found in Table 1 for the U.S. and Table 2 for the U.K. reverse the incidence rate trend (Appendix). During the period from 2002 to 2006, one-year mortality rates in the U.K. showed a Black to White mortality ratio of 1.22, meaning that for every 100 White women who died of breast cancer in

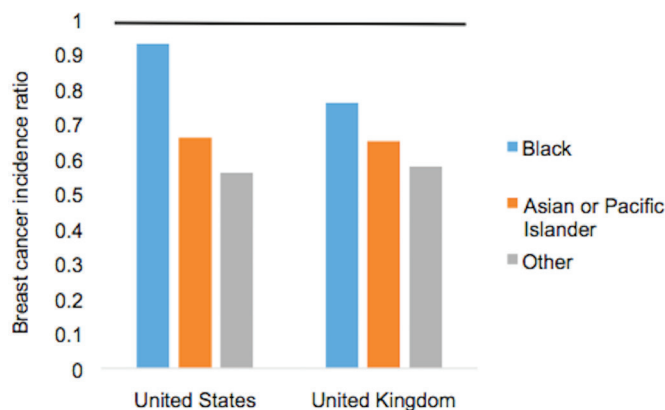


Figure 2. Age-standardized female breast cancer incidence ratios relative to White in-country reference group, which is highlighted by the black line, in the U.S. and U.K., 2002 to 2006.

the U.K., approximately 122 Black women died as well. The three-year Black-to-White mortality ratio was slightly greater at 1.27. Despite this clear inequality of outcomes, Black women fare even worse in the U.S; the mortality ratio for Black women to White women was 1.38, reflecting the fact that approximately 138 Black women die from breast cancer for every 100 White women. The data in Figure 3 indicate that even though Black women are less likely to be diagnosed with breast cancer, they are more likely to die of the disease in both countries, particularly in the U.S.

This trend is supported by the literature, which finds strong evidence that for Black women, annual incidence of breast cancer is lower but its mortality is higher (Williams & Jackson, 2005). While data from the U.K. are scarce, other research exploring the racial disparity in breast cancer mortality rates verifies this finding: Analyzing mortality rates by race between 1998 and 2003, inclusive, one study found a female breast cancer Black to White mortality ratio of 1.23 in the U.K., which is similar to the 1.27 ratio calculated from three-year survival data (Jack, Davies, & Møller, 2009). Over a similar period in the U.S., the Black to White mortality ratio was even higher at 1.35, as indicated by Table 1. The U.S. Black to White mortality ratio has risen over the past decade to 1.42 in 2012.

When focus shifts to the male experience with prostate cancer, according to the 2012 mortality rates presented in Figure 4, the U.S. significantly outperforms the U.K. in survival rates. The U.K. had a mortality rate of 23.1 men per 100,000 people whereas the U.S. had a mortality rate of

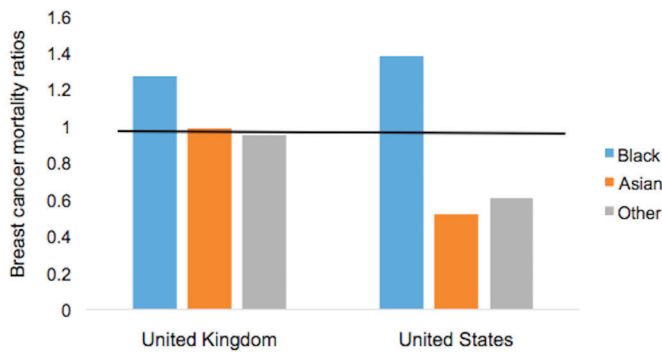


Figure 3. Age-standardized female breast cancer mortality ratios relative to White in-country reference group, which is highlighted by the black line, in the U.S. and U.K, 2002 to 2006.

only 19.6 men per 100,000. For every 100 men in the U.K. who die of prostate cancer in a given year, only 85 U.S. men are expected to die. Despite the significantly higher prostate cancer mortality rates in the U.K., men in the U.S. are more likely to be diagnosed with prostate cancer than their counterparts in the U.K. Overall, 98.0 men per 100,000 are diagnosed with prostate cancer in the U.K, whereas a rate of 157.8 men are diagnosed in the U.S for a difference of 46.8%. As with breast cancer, even the U.K.'s best-performing region, Scotland, has a higher mortality rate of 21.8 deaths per 100,000 than the rate of the worst-performing regions of the U.S., the South and the Midwest, at 19.8 deaths per 100,000.

Even though Asian and other racial groups experience lower incidence rates than their White counterparts, Black citizens of both countries

experience higher incidence rates of prostate cancer than White citizens. For instance, while diagnoses are significantly more frequent in the U.S., Black men are far more likely to be diagnosed in both countries than White men with an incidence rate of 202.5 per 100,000 in the U.K. and 238.7 in the U.S. (Figure 5). However, the relative incidence ratio of Black to White men in the U.K. is 2.08, while the relative incidence ratio is only 1.60 in the U.S. This suggests either that Black men in the U.S. are not getting prostate cancer at the same rate as their U.K. counterparts or that U.S. Black men are not getting diagnosed at a rate comparable to that of the U.K. Black men despite having the disease. In contrast, Asian men in both countries are less likely to be diagnosed than White men, with an incidence rate of 48.9 per 100,000 in the U.K. and 86.7 in the U.S. The Asian to White relative incidence ratio in the U.K, at 0.50, is close to the 0.58 relative incidence ratio observed in the U.S. (Figure 5).

“The data in Figure 3 indicate that even though Black women are less likely to be diagnosed with breast cancer, they are more likely to die of the disease in both countries, particularly in the U.S.”

The magnitude of these ratios change, however, when mortality data across the countries are compared in Figure 6. The relative mortality

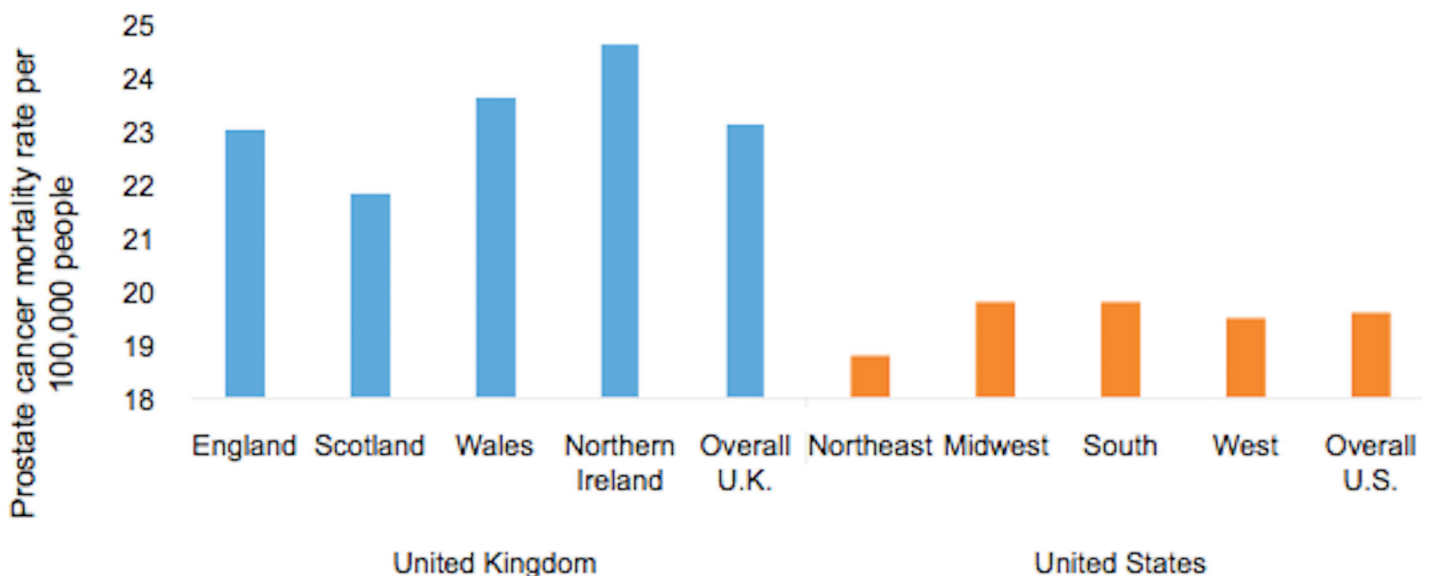


Figure 4. Age-standardized prostate cancer mortality rates per 100,000 people by country and region, 2012.

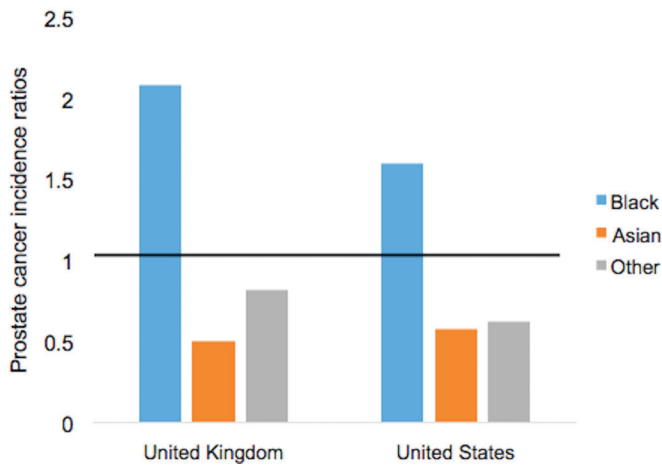


Figure 5. Age-standardized prostate cancer incidence ratios relative to White in-country reference group, which is highlighted by the black line, in the U.S. and U.K., 2002 to 2006.

ratio for Black to White men in the U.K. at one-year survival is 0.80, implying that for every 100 White men who die within the first year after diagnosis, only 80 Black men are expected to die. This occurs despite the fact that 208 U.K. Black men are expected to be diagnosed for every 100 White men as indicated in Table 3. This trend is confirmed by another study that found no significant difference in mortality rates between Black and White men for prostate cancer, with a relative Black to White mortality ratio of 0.93 despite higher incidence rates in Black men in the U.K. (Jack, Davies, & Møller, 2010). In contrast, the Black to White mortality ratio for the U.S. over the same period in Table 4 was 2.43, indicating that for every 100 White men who died of prostate cancer, approximately 243 Black men died as well. U.S. Black men are significantly more likely to die from prostate cancer than White men, which reverses the trend observed in the U.K. The trend does not extend to other racial minorities in the U.S. since both Asian and other racial groups experience mortality rates that are less than those experienced by White citizens.

“As a result, the U.S. successfully diagnoses and treats prostate cancer at an earlier stage but at the cost of extensive overdiagnosis and treatment.”

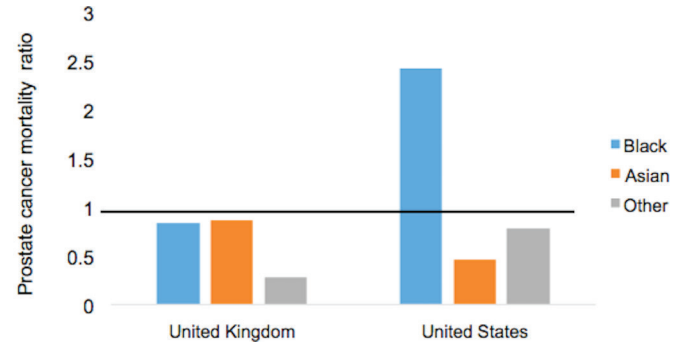


Figure 6. Age-standardized prostate cancer mortality ratios relative to the in-country White reference group, which is highlighted by the black line, in the U.S. and U.K., 2002 to 2006.

Discussion

Trend 1: The U.S. Achieves Lower Overall Mortality Rates

These results raise two prominent questions: Why is the U.S. better at overall breast and prostate cancer mortality than the U.K., and why is the U.S. worse at treating these conditions in Black individuals than the U.K.? Three key explanations for lower overall U.S. mortality rates may explain the first trend: emphasis on early diagnosis and treatment, provision of treatments regardless of their cost-effectiveness, and emphasis on intensive intervention in all age groups.

Most critical is likely the major discrepancy in screening policies. Women under 50 years of age are not offered routine breast cancer screening in the U.K., with the nation’s screening program inviting women between the ages of 50 and 70 to have a mammogram every three years (NHS Breast Screening Programme, 2015). In contrast, American women between the ages of 40 and 44 are offered the choice to begin screening, with annual mammograms strongly encouraged for women aged 45 through 54, and biennial mammograms for women over the age of 55 (Oeffinger, Fontham, Etzioni, Herzig, Michaelson, et al., 2015). Scientific evidence strongly suggests that the earlier a cancer is diagnosed and treated, the greater the rise in longevity and quality of life (Baron, 2009, p. 12). A commission tasked with explaining the relatively poor cancer outcomes in England therefore concluded that “delays in diagnosing cancer are a major reason why survival rates are worse in England” (Baron, 2009, p. 12).

This trend is not exclusive to breast cancer; the discrepancies in prostate cancer also can be partially explained by early screening and diagnosis.

Prostate-specific antigen (PSA) screening detects levels of an enzyme in the blood to predict the possibility of prostate cancer (American Cancer Society, 2015). However, this screening method is controversial because of its high miss (false negative) rate; 20% of men with prostate cancer have normal PSAs. Furthermore, there is an even higher rate of false positives; in order to avert just one death from prostate cancer, 27 men must be diagnosed, some of whom will possess innocuous forms of the cancer that would not have generated problems if left undetected (van Rij & Murphy, 2014). If PSA screening were introduced in the U.K., prostate cancer deaths could be reduced by 21%, yet it would lead to significant overdiagnosis and overtreatment, as 40% of cases are unlikely to progress to a fatal stage (van Rij & Murphy, 2014).

The NHS has therefore decided that PSA screening is not a cost-effective tool, opting not to promote the mechanism unless an individual requests it. In contrast, the American Cancer Society recommends PSA screening at age 50 for men of average risk, age 45 for men at high risk with one diagnosed relative, and age 40 for men at very high risk with more than one diagnosed relative (American Cancer Society, 2015). If the blood test returns a normal value, PSA screening is subsequently encouraged every two years; if the blood test returns a higher than normal level, patients are encouraged to pursue screening annually. As a result, the U.S. successfully diagnoses and treats prostate cancer at an earlier stage but at the cost of extensive overdiagnosis and overtreatment. These policy decisions lead to lower mortality rates but also contribute to the \$280 billion in healthcare spending that is wasted annually on unnecessary care like false positives with PSA screening (Barton, 2009, p. 15).

The second critical discrepancy yielding better outcomes in the U.S. is a relatively weaker focus on cost-effectiveness. In the U.K., NICE regulates available treatments in order to maximize cost-effectiveness, resulting in the rejection of several drugs that only marginally extend life. One such Herceptin-style cancer drug, Kadeyla, provides six months of extra life for £90,000 (\$136,670) per treatment, resulting in an estimated value of £138,000 to £153,000 (\$209,560 to \$232,338) per QALY (Adam, 2014). NICE therefore rejected this treatment for falling above its £30,000 (\$45,556) per QALY guideline, and although patients can

petition the cancer drugs fund to purchase Kadeyla, many declined the opportunity to pursue the stressful and arduous appeal process. In fact, the cancer drugs fund will be phased out by March 2016, having already removed 43 previously funded therapies over nine months in 2015 (Elvidge, 2015). An estimated 986 breast cancer patients alone will miss out on an opportunity to improve the length and quality of their lives because of these cost-effectiveness decisions (Elvidge, 2015).

The third factor explaining U.S. superiority in mortality rates is intensive intervention at all ages. Data from the U.K. suggest that ageism may explain some of its higher mortality rates. According to a parliamentary commission, nearly 15,000 people over the age of 75 die prematurely from cancer because they are less likely to be screened, diagnosed, and intensively treated (Baron, 2009, p. 15). Cancer patients aged 55 to 64 are 20% more likely to survive for at least one year following diagnosis than their 75+ counterparts, and researchers concluded that this discrepancy is not entirely explained by elevated co-morbidity and frailty (Baron, 2009, p. 10). Instead, older individuals are less likely to be offered intensive cancer treatments, increasing their mortality risk. The fact that the country does not even measure mortality rates for patients above the age of 75 indicates that the health system is focused on diagnosing and treating cancer in younger populations. This often comes at the expense of the older population, which may have many years of quality life remaining after treatment.

There are still other factors inherent in the health care system that may explain the poor cancer outcomes for the U.K. relative to those of the U.S. The infamous “postcode lottery” of the NHS suggests that access to treatment depends partially upon the CCG in which an individual resides. Some CCGs are more effective at contracting with providers to control costs and maximize quality, which manifests in better outcomes for the population. The proportion of individuals dying from cancer is 61% higher in the worst-performing CCG than in the best-performing CCG, providing evidence of the disparities in socioeconomic status and access to quality health care across regions of the U.K. (McDonnell, 2015). Delays in diagnosis and treatment plague the NHS, which set a target of 85% of individuals treated within 62 days of a GP referral. However, the 83.1% average

for the bottom quintile of CCGs is significantly lower than the 86% average for the top quintile. In recent years, the NHS has greatly improved these rates, but these improvements are not expected to compensate for the deficits in screening programs and available treatments (McDonnell, 2015).

Trend 2: The U.S. Experiences Greater Inequality of Outcomes

In both countries, Black women have higher rates of breast cancer mortality than White women. While some researchers have proposed that Black women are predisposed to certain manifestations of breast cancer through genetics, current data are insufficient to warrant decisive conclusions (American Cancer Society, 2015). This trend may instead be explained by a number of potential factors. Since younger Black women under the age of 45 have a greater incidence of breast cancer than younger White women, late stage cancers that respond less favorably to treatment are expected to develop at higher rates in Black women in the U.K., which does not screen before the age of 50 (American Cancer Society, 2015). This explanation does not exist for the U.S., which begins screenings at age 40 for women. In both countries, however, Black women tend to occupy a lower socioeconomic position, predisposing them to greater rates of breast cancer through poorer diet and exercise habits, environmental factors, and a lack of health education. Limited financial access to diagnosis and treatment may be another barrier, exclusive to the U.S, as a result of the relatively lower socioeconomic position.

Despite the higher mortality rates for Black citizens of both countries, it is clear that Black women in the U.S. face relative mortality ratios that are greater than those faced by Black women in the U.K. Furthermore, Black men have even higher relative mortality ratios for prostate cancer in the U.S. than those of Black men in the U.K. These trends suggest that the U.S. healthcare system is worse than the NHS at successfully addressing gendered cancers in Black individuals. There are several possible explanations for the poorer U.S. outcomes, including the magnified intersectional effects of the lower socioeconomic status of Black Americans, general mistrust of the medical system, racial discrimination, and a lack of financial access to care.

Socioeconomic status certainly plays a role in determining health outcomes, as mortality rates

are two to three times higher for low-income Black Americans relative to middle-income Black Americans (Williams & Jackson, 2005). The proportion of Black and Hispanic families below the poverty level is twice that of White families in the U.S., explaining some of the U.S. discrepancy as differences in socioeconomic access rather than solely racial bias (Barton, 2009, p. 30). Those in a lower socioeconomic position tend to have lower rates of education, thus reducing their familiarity with self-care and the importance of healthy lifestyles. Residential segregation continues to play a significant role in the lives of Black Americans, limiting access to healthy food, safe housing, good education, and long-term employment opportunities that improve one's financial position (Williams & Jackson, 2005). All of these factors coalesce to produce poorer health outcomes among those occupying lower socioeconomic positions.

The differences in outcomes, however, extend beyond socioeconomic factors to include fundamental suspicion of the medical system, the roots of which are entrenched in American history. From 1932 to 1972, the U.S. Public Health Service experimented on 399 Black Alabama sharecroppers with late stage syphilis. Researchers conducted their study even after the discovery of penicillin, never informing participants of their diagnosis or treatment availability, in order to determine the adverse effects of syphilis on Black individuals (The Tuskegee Timeline, 2013). The lasting effect of the Tuskegee syphilis experiment is a general suspicion of the medical profession, with race identified in studies as a significant determinant of patient satisfaction. Even when controlling for income and type of plan in which an individual is enrolled, Black Americans were 19% less likely to trust their providers (Hunt, Gaba, & Lavizzo-Mourey, 2005). The perception of racial discrimination warrants attention because it influences patient willingness to seek and follow treatment regimens, ultimately shaping health outcomes.

However, there is evidence that actual racial discrimination is present within the U.S. healthcare system. Black patients are less likely than their clinically similar White counterparts to receive preventative and diagnostic services for cancer (Williams & Jackson, 2005). Even when researchers adjusted for socioeconomic status, breast cancer stage, and age, Black women observe

a 22% higher mortality rate (Newman, 2005). Black women undergoing adjuvant chemotherapy regimens were more likely to experience delays in their treatment schedules, resulting in a lower overall dose intensity and poorer outcomes. While 67.1% of White American women utilize mammography between the ages of 40 and 49, only 60.9% of Black American women have at least one mammogram during that time (Newman, 2005). This discrepancy is also manifested in the use of PSAs by race, with 44.4% of White American men completing a PSA while only 35.2% of Black Americans received the screening (American Cancer Society, 2015). The disparate provision of life-extending diagnoses and treatments may partially explain the differences in mortality outcomes between Black and White Americans.

One potentially significant factor contributing to this disparity is that Black Americans are more likely to lack medical insurance and rely instead on Medicaid (Newman, 2005). Health insurance is one of the most critical determinants of health outcomes, and people who possess private health insurance are more likely both to receive health care and to access diagnostic and treatment tools at an earlier disease stage (Weisfeld & Perlman, 2005). For example, of men with health insurance, 43.5% had a PSA within the past year, compared to only 13.9% of men without health insurance (American Cancer Society, 2015). This trend is true regardless of race – the relative risk of death within three years for breast cancer was 19% to 44% higher in groups of uninsured patients relative to clinically similar insured patients (Weisfeld & Perlman, 2005). Inequality of outcomes can be partially explained by the fact that Black Americans compose a greater proportion of the low-income groups that lack adequate access to health insurance and, thus, medical services.

Although Medicaid is provided to low-income populations, physicians can refuse to accept new Medicaid patients and limit access to healthcare services. Medicaid co-payments were initially introduced to deter excess use of healthcare services, but consumers tend to use fewer essential medical services when facing the financial barrier. Co-payments for prescription drugs reduce the amount of prescriptions filled, but they lead to a 78% increase in adverse events – including hospitalization, nursing home admission, and death – for the population, which becomes more expensive than simply providing

“In the U.S., fundamental change in the financial structure of the healthcare system is needed.”

the initial prescriptions (Ku, 2005). Co-payments for substance-abuse services led to an initial reduction in the amount of treatment sought but a long-term increase in the rates of relapse, again backfiring in terms of money saved (Barton, 2010, p. 11). In stark contrast, the U.K. provides services to residents that are free at the point of service, thereby eliminating this financial barrier to care. All Black residents of the U.K. have access to care, regardless of socioeconomic status, potentially explaining much of the discrepancy between U.S. and U.K. relative Black to White mortality ratios.

These data raise tough questions for each country. If the U.K. wants to achieve better mortality rates overall, it must aggressively screen, diagnose, and treat patients, even if those policies lead to reduced cost-effectiveness through overtreatment. It must also raise the financial threshold per QALY that currently governs NICE’s cost-effectiveness decisions and intervene when clinically appropriate at all patient ages. In the U.S., fundamental change in the financial structure of the healthcare system is needed. Financial access to care plays a significant role in determining utilization of screening programs and preventative regimens that maximize quality of life and longevity. The PPACA has extended health insurance to all Americans, but the fundamental financial barriers to care – including copayments, deductibles, and coinsurance – remain as deterrents to medical care that particularly limit access for Black Americans. A system that is free at the point-of-service will most likely lead to more equitable outcomes. Historical racial discrimination and suspicion of the medical profession must be tackled through increased diversity of health professionals and improved cultural competence. While these challenges are formidable, public policy can play a powerful role in reducing health inequalities.

References

Adam, J. (2014). Final appraisal determination: Trastuzumab emtansine for treating HER2- positive, unresectable locally advanced or metastatic breast cancer after treatment with trastuzumab and a taxane. National Institute for Health and Care Excellence, 1-50.

American Cancer Society. American Cancer Society recommendations for prostate cancer early detection. (2015, January 6). Retrieved from <http://www.cancer.org/cancer/prostatecancer/moreinformation/prostatecancerearlydetection/prostate-cancer-early-detection-acs-recommendations>

American Cancer Society. Cancer prevention & early detection facts & figures (Rep.). (2015). Retrieved from <http://www.cancer.org/acs/groups/content/@research/documents/webcontent/acspc-045101.pdf>

Baron, J. (2009). All party parliamentary group on cancer: Report of the all party parliamentary group on cancer's inquiry into inequalities in cancer (Rep.). Sponsored by We Are MacMillan Cancer Support. Retrieved from <http://www.macmillan.org.uk/Documents/GetInvolved/Campaigns/APPG/BritainAgainstCancer2009/CancerInequalitiesReport.pdf>

Barton, P. L. (2010). Understanding the U.S. health services system, fourth edition. Foundation of the American College of Healthcare Executives. Health Administration Press: Chicago, Illinois.

Cancer Research UK. Breast cancer mortality statistics. (2014a, September 8). Retrieved from <http://www.cancerresearchuk.org/health-professional/cancer-statistics/statistics-by-cancer-type/breast-cancer/mortality#heading-Zeroaf>

Cancer Research UK. National Health Service: NHS Breast Screening Programme. (2015). Retrieved from <http://www.cancerscreening.nhs.uk/breastscreen/index.html>

Cancer Research UK. Prostate cancer mortality statistics. (2014b, September 8). Retrieved from <http://www.cancerresearchuk.org/health-professional/cancer-statistics/statistics-by-cancer-type/prostate-cancer/mortality#heading-Zero>

Centers for Disease Control and Prevention. The Tuskegee timeline. (2016, February 19). Retrieved from <http://www.cdc.gov/tuskegee/timeline.htm>

Centers for Disease Control and Prevention WONDER. (2012). U.S. cancer statistics, 1999-2012. (2016). Retrieved from <http://wonder.cdc.gov/cancer.html>

Claxton, K., Martin, S., Soares, M., Rice, N., Spackman, E., Hinde, S., Devlin, N., Smith, P. C., et al. (2013, June 10). Methods for the estimation of the NICE cost effectiveness threshold: revised report following referees comments (Rep.). Retrieved from https://www.york.ac.uk/media/che/documents/reports/resubmitted_report.pdf

Elvidge, S. (2015). NHS England cuts treatments from Cancer Drugs Fund. The Pharmaceutical Journal, 295(7879). doi: 10.1211/PJ.2015.20069298

Hunt, K., Gaba, A., & Lavizzo-Mourey, R. (2005). Racial and ethnic disparities and perceptions of health care: Does health plan type matter? Health Services Research, 40(2), 551-576. doi: 10.1111/j.1475-6773.2005.00372.

Jack, R. H., Davies, E. A., & Møller, H. (2009). Breast cancer incidence, stage, treatment and survival in ethnic groups in South East England. British Journal of Cancer, 100(3), 545-550. doi: 10.1038/sj.bjc.6604852

Jack, R. H., Davies, E. A., & Møller, H. (2010). Prostate cancer incidence, stage at diagnosis, treatment and survival in ethnic groups in South-East England. British Journal of Urology International, 105(9), 1226-1230. doi: 10.1111/j.1464-410X.2009.08940.x

Ku, L. (2005, July 7). The Center on Budget and Policy Priorities: The Effect of Increased Cost-Sharing in Medicaid (Rep.). Retrieved from <http://www.cbpp.org/research/the-effect-of-increased-cost-sharing-in-medicaid>

McDonnell, P. (2015). NHS England: Cancer Waiting Times, August 2015 (Rep.). Retrieved from <https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2015/10/Cancer-Waiting-Times-Press-release-August-2015-Provider-based-PDF-140kB.pdf>

National Health Service. NHS Choices: Help with health costs. (2015, October 29). Retrieved from <http://www.nhs.uk/NHSEngland/Healthcosts/Pages/universal-credit.aspx>

Newman, L. A. (2005). Breast cancer in African-American women. The Oncologist: Breast Cancer, 10(1), 1-14. doi: 10.1634/theoncologist.10-1-1

Oeffinger, K. C., Fontham, E. T. H., Etzioni, R., Herzig, A., Michaelson, J. S., Shih, Y. C., Walter, L. C., Church, T. R., et al. (2015). Breast cancer screening for women at average risk. The Journal of the American Medical Association, 314(15), 1599-614. doi: 10.1001/jama.2015.12783

Squires, D. A. (2012). Explaining high health care spending in the U.S.: An international comparison of supply, utilization, prices, and quality. Issue Brief: Commonwealth Fund 10, 1-14.

Taylor, F., Gauher, S., Johnson, L., Brock, R., & Wittenberg, M. (2014). Understanding the New NHS. (Rep.) NHS England. BMJ Publishing Group. Retrieved from <https://www.england.nhs.uk/wp-content/uploads/2014/06/simple-nhs-guide.pdf>

Thomson, C. & Forman, D. (2009, June). Cancer incidence and survival by major ethnic group, England, 2002-2006 (Rep.). Retrieved from <http://www.cancerresearchuk.org/>

van Rij, S. & Murphy, D. G. (2014). Words of wisdom. Re: Screening and prostate cancer mortality: Results of the European randomised study of screening for prostate cancer (ERSPC) at 13 years of follow-up. European Urology, 66(6), 1187-1188. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/25587592>

Weisfeld, A. & Perlman, R. L. (2005). Disparities and discrimination in health care: An introduction. Perspectives in Biology and Medicine, 48(1), S1-S9. doi: 10.1353/pbm.2005.0046

Williams, D. & Jackson, P. B. (2005) Social sources of racial disparities in health. Health Affairs, 24(2), 325-334. doi: 10.1377/hlthaff.24.2.325

Appendix

Table 1

U.S. Age-Standardized Mortality Rates for Female Breast Cancer per 100,000 People by Race and Year

<u>Race</u>	<u>MR,</u> <u>1999-2003</u>	<u>RRW, 1999-</u> <u>2003</u>	<u>MR,</u> <u>2002-2006</u>	<u>RRW, 2002-</u> <u>2006</u>	<u>MR,</u> <u>2012</u>	<u>RRW,</u> <u>2012</u>
AI or AN	14.1	0.56	14.6	0.61	10.8	0.52
Asian or PI	12.7	0.50	12.5	0.52	11.3	0.55
Black	34.4	1.35	33.0	1.38	29.4	1.42
White	25.4	1	24.0	1	20.7	1

Note. American Indian was abbreviated as AI, Alaska Native into AN, Pacific Islander into PI, Mortality Rate into MR, and Relative Ratio to Whites was collapsed into RRW.

Table 2

U.K. Age-Standardized Female Breast Cancer Mortality Rates per 100,000 People and Relative Ratios, 2002 to 2006

<u>Race</u>	<u>One-year death rate per 100 diagnoses</u>	<u>One-year death rate per 100 diagnoses</u>	<u>Three-year death rate per 100 diagnoses</u>	<u>Relative three-year death ratio to Whites</u>
White	5.8	1	13.9	1
Asian	5.8	1.00	13.7	0.99
Black	7.1	1.22	17.7	1.27
Unknown	8.2	1.41	13.2	0.95

Table 3

U.K. Age-Standardized Male Prostate Cancer Mortality Rates per 100,000 People and Relative Ratios to Whites for 2002-2006

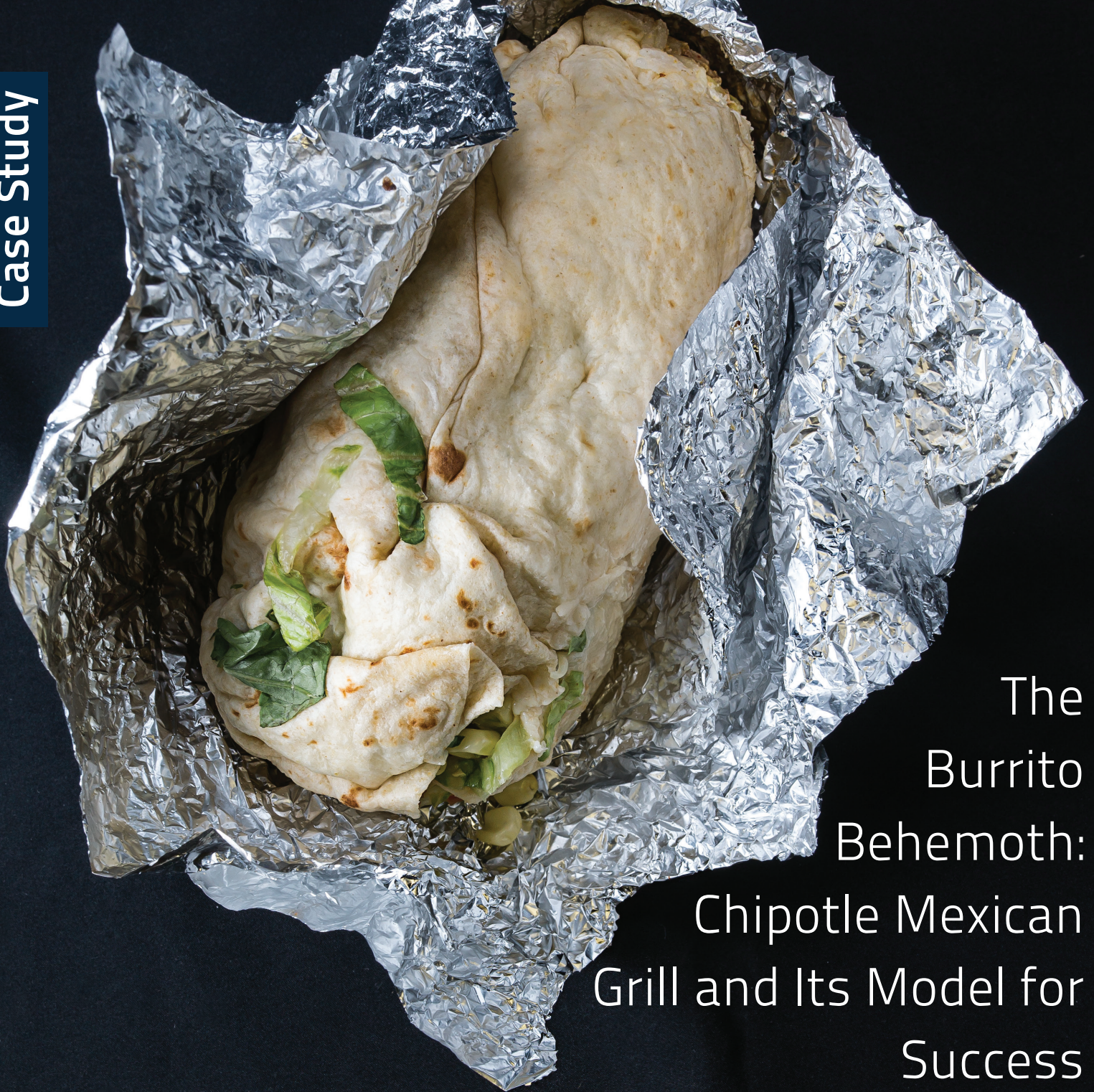
<u>Race</u>	<u>One-year death rate per 100 diagnoses</u>	<u>Relative one-year death ratio to Whites</u>	<u>Three-year death rate per 100 diagnoses</u>	<u>Relative three-year death ratio to Whites</u>
White	8.0	1	19.3	1
Asian	7.7	0.96	16.8	0.87
Black	6.4	0.80	16.3	0.84
Unknown	4.0	0.50	5.4	0.28

Table 4

U.S. Age-Standardized Male Prostate Cancer Mortality Rates per 100,000 People and Relative Ratios in White In-Country Reference Group

<u>Race</u>	<u>MR, 1999-2003</u>	<u>RRW, 1999-2003</u>	<u>MR 2002-2006</u>	<u>RRW, 2002-2006</u>	<u>MR, 2012</u>	<u>RRW, 2012</u>
AI or AN	19.4	0.72	19.1	0.79	14.0	0.77
Asian or PI	12.1	0.45	11.2	0.46	8.4	0.46
Black	66.4	2.46	58.9	2.43	41.8	2.31
White	27.0	1	24.2	1	18.1	1

Note. American Indian was abbreviated as AI, Alaska Native as AN, Pacific Islander as PI, mortality rate was abbreviated as MR, and relative ratio to whites was abbreviated as RRW.



The Burrito Behemoth: Chipotle Mexican Grill and Its Model for Success

Nealay Vasavda - Union College

BIOGRAPHY

Nealay Vasavda is a fourth-year student of Anthropology and Political Science at Union College in Schenectady, New York with a minor in Cyberethics. He has presented research projects at the National Conference on Undergraduate Research as well as at a conference of the Northeastern Anthropological Association. Upon graduation, he will be pursuing his Master's Degree in Comparative Social Policy at the University of Oxford. In his free time, he enjoys running and watching documentaries and political thrillers.

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Abstract

Chipotle Mexican Grill has revolutionized the fast food industry. In a short time, the brand has served as inspiration for the growing “fast casual” segment of the food industry and has become an American cultural phenomenon. Through its use of social media and corporate social responsibility marketing strategies, the brand has adapted to a growing segment of the consumer market and has taken the United States by storm. Today, Chipotle has turned its focus to its presence as an international brand. This paper analyzes Chipotle’s marketing tactics, how they were applied to its London branches as well as implications for the brand’s success abroad.

Introduction

On Monday, April 13th, 2015, former senator and presidential candidate Hillary Clinton was caught on camera dining at a burrito chain called Chipotle Mexican Grill in Maumee, Ohio (Haberma, 2015). When news later broke of former senator Clinton dining at the outlet unnoticed, American media covered the event extensively. While the stories were humorous, some referencing her campaign video and her commitment to serve “everyday Americans” (Haberma, 2015), the coverage revealed much about the status of this current industry giant. Clinton’s taste for Chipotle humanized her in the eyes of many, showing that even prominent presidential candidates still love their burritos. It made her relatable without her trying to be so, as she was seen in the restaurant wearing large sunglasses evidently not trying to make a scene. Similar stories ran when President Barack Obama visited a Chipotle in Washington, D.C., wherein the media mocked the world leader for breaking the taboo of reaching over the glass barrier separating servers and customers (“#Chipotus,” 2014). Chipotle has become a point of relatability for Americans, only solidifying its place as a hallmark of American culture. Yet it was not until the past five years that Chipotle began expanding to signify itself as a global brand. This paper will examine the heart of the brand, its marketing tactics, and its move to penetrate the Lon-

don market as it strives to become the leader of the international burrito market.

Chipotle’s Brand Development

Company Background

Founded in 1993 by Steve Eells, Chipotle Mexican Grill has grown to become one of the largest and fastest-growing restaurant chains in the world (Ragas & Roberts, 2009). The story of Chipotle, however, is unique in almost every way. When Eells set out to create Chipotle, he had a simple mission in mind: “Food with Integrity.” He wanted to create a brand that focused on fresh, natural ingredients that allowed for customization yet still maintained the atmosphere of a fast food restaurant (Adamy, 2007). In doing so, what Eells did was create a new industry. While Chipotle executives still refer to what they serve as fast food, the industry refers to the Chipotle model as “fast casual” and has associated the brand with the likes of Panera Bread Co. and other similar eateries. These restaurants offer more attractive interiors and food that is priced slightly higher than the average burger joint (Adamy, 2007).

“He wanted to create a brand that focused on fresh, natural ingredients that allowed for the customization yet still maintained the atmosphere of a fast food restaurant (Adamy, 2007).”

Chipotle’s unique model proved to be a success and attracted a variety of investors. Among these investors was fast food industry giant McDonald’s Corp. In 1998, Eells sold an interest to the company that allowed Chipotle to operate autonomously while still benefitting from McDonald’s relationships and resources (Ragas & Roberts, 2009). The details of this agreement were critical, for it is likely that because Chipotle was able to operate independent of external pressure, the company’s innovate model changed the food service industry.

As Kumar (2014) notes, innovation is not only the cornerstone of growth, but it can also affect entire industries. Chipotle was able to do just this, essentially changing the face of American fast food with the introduction of the “fast casual” model. As a trend-setter in the category (Yohn, 2014), Chipotle established a model that allows customers to tailor their meals and still have them ready quickly (Strom, 2015a). Today, multiple brands can be seen following in Chipotle’s footsteps, adapting the framework to other cuisines such as pizza and Asian fusion (Pino, 2014) as well as Indian (Birdsall, 2013) among others. Due to corporate restructuring, McDonald’s fully divested its ownership interest in Chipotle in October 2006, resulting in a large financial gain for the company (Arndt, 2007, cited in Ragas & Roberts, 2009).

Business & Purpose

Hoeffler and Keller (2002) note, “The challenge for marketers in building a strong brand is ensuring that customers have the right type of experiences with products and services and their accompanying marketing programs so that the desired thoughts, feelings, images, beliefs, perceptions, opinions, and so on become linked to the brand” (p. 79). Chipotle was able to build its brand name by undertaking the principle of what Ells calls “Food with Integrity.” Continuing under this paradigm, Chipotle focuses on using “ingredients that are sustainably grown and naturally raised with respect for the environment, animals and people who grow or raise the food” (Ragas & Roberts, 2009, p. 265). Essentially, Chipotle wants people to consider where their food comes from and has committed itself to using quality ingredients to make its product (Klamm, 2012). This is evidenced by the fact that the brand manages to spend more money on ingredients than it does on payroll (Yohn, 2014). Chipotle’s distinctive philosophy is referred to as corporate social responsibility.

According to Ragas and Roberts (2009), corporate social responsibility has become important to companies, and when companies commit themselves to social responsibility, consumers take notice. Therefore, brands aggressively market their

socially conscious actions to make sure their customers know about them. Chipotle wants its customers to know it is committed to serving “Food with Integrity” because it helps build the perception that the company stands for something important and meaningful beyond good-tasting food (Ragas & Roberts, 2009).

Moreover, the brand stands for quality not just in food, but also in service. Chipotle’s President and Chief Operating Officer, Monty Moran, said in 2007, “We don’t ever want [to emphasize] speed over great service” (Adamy, 2007, para. 20). This could be part of the reason industry experts have classified the brand outside of the typical fast food category. As customer loyalty can be influenced by positive interactions with employees (Ozuem, Thomas, & Lancaster, 2015b), emphasizing good service can have positive outcomes for the brand. Quality food and quality service are thus “puller” factors for developing customer loyalty (Ozuem et al., 2015b). For a brand to manage these difficult goals requires the company to have a strong corporate leadership.

The innovative and determined leadership of Chipotle oversees that the brand is fulfilling its purpose and promises. Chipotle reflects what Ozuem, O’Keeffe, and Lancaster (2015a) refer to as a dependent leadership culture in which there are established positions of authority and leadership and in which operations are controlled from the top. Further, as Pino (2014) explains, Chipotle does not franchise; all of its Mexican restaurants are owned corporately.

Clientele

More so than many other brands, Chipotle seems to know its customer base well. The company has learned that its customers notice the difference in flavor from natural meats and fresh vegetables and that they’re willing to pay extra for it (Yohn, 2014). By focusing on its corporate social responsibility campaign of “Food with Integrity,” the brand has likely managed to increase its market share. According to Mahoney (2008) and Sass (2008) cited in Ragas and Roberts (2009), a growing percentage of consumers claim they are

increasingly likely to buy from brands engaging in such programs. Thus, it is clear that the brand caters its product to the demands of the market and its consumers. Despite the restaurant chain's initial struggle to maintain customers because of its notoriously long queues (Adamy, 2007), today it has come to symbolize the tastes of the millennial generation (Strom, 2015a).

Brand Extensions

Due to Chipotle's comparatively rapid success, the company has turned its focus to building new brands. Although new brands may fail due to profit-related issues, failing to meet sales targets, or inadequate marketing support (Singh, Scriven, Clemente, & Lomax, 2012), Chipotle benefits from having the "near instant" loyalty of its existing customers (Singh et al., 2012, p. 235). At the time of the writing of this paper, Chipotle has already introduced two new brands: ShopHouse Southeast Asian Kitchen and Pizzeria Locale. ShopHouse serves Asian-inspired cuisine in bowls and Pizzeria Locale serves a personalized twist on pizza (Pino, 2014). Both outlets allow consumers to customize their product according to their tastes, just as Chipotle does. Also similar to Chipotle, each brand focuses on fresh, responsibly-sourced ingredients, time-honored cooking techniques, tons of prep work, and incredibly speedy turn-around times (Pino, 2014).

What is particularly notable about these brand extensions, however, is the way in which they were developed. Chipotle's Director of Concept Development, Tim Wildin, said of ShopHouse, "None of this was driven by market research or customers. Nothing...It would be totally different and it probably wouldn't be successful. This was driven by a love of really good food" (Pino, 2014, para. 3). For Pizzeria Locale, Ells invested in the business of two old friends who were looking to expand their Colorado-based pizza joint (Pino, 2014). Once again, Chipotle did away with traditional marketing conventions and instead chose to follow its principles. Currently, there are ten ShopHouse locations in the United States ("Locations", n.d.) and one Pizzeria Locale (Pino, 2014).

Chipotle's Promotional Strategies

Webpage & Position

When visiting Chipotle's primary website, it immediately becomes clear what their corporate vision is. On the brand's site for its branches in the United States and Canada, a graphic prominently and proudly displays Chipotle's commitment to its "Food with Integrity" philosophy by explaining the recent changes the company is making. A secondary focus is grassroots advertising such as community events, specifically the Chipotle Cultivate Festival where the company hosts free live music and food tastings among other things. Its menu and nutritional information come after that, followed by locations. Due to Chipotle being a well-known brand in the United States, the company likely does not feel the need to advertise its product offerings most prominently on its American site.

Chipotle takes a different approach on its European sites. Its U.K., French, and German sites are all designed identically, more prominently displaying the brand's product than its mission. This is likely due to the company still being new in these areas and needing to establish itself as a familiar brand with these consumers. The only difference between these websites is the language used, which varies to make accommodations for the dominant language spoken in each country. Each site is aesthetic, using large photos of ingredients and finished burritos to appeal to customers and draw them in. The company adopts a similar strategy for its social media presence, remaining loyal to the "Food with Integrity" and customer-first ethos (Klamm, 2012).

Promotion

The means by which Chipotle promotes its product in different places is modern and differs from traditional marketing strategies. Chipotle prefers to focus on public relations rather than advertising because according to Ells, "Advertising is not believable" (Arndt, 2007, para. 2). The burrito giant has built its brand name by using a grassroots strategy that focuses on local events, media relations, contests, giveaways, philanthropy, and

sponsorship (Ragas & Roberts, 2009). In 2008, Chipotle executives said they would rather spend \$35,000 giving away food and “connecting with customers in a personal way” than buying a full-page ad in The New York Times (Ragas & Roberts, 2009, p. 274).

By focusing on its customers, Chipotle actualizes a concept intricately tied to marketing. “Deeply rooted in the concept of leadership, marketing is the belief that marketing revolves around the customer” (Ozuem et al., 2015a). Chipotle maintains this principle as one of its core values. The brand is able to accomplish a high level of interaction with customers largely through its social media presence.

Chipotle’s emphasis on social media marketing is a bold and effective move. As Kumar (2014) cites, companies are shifting to such marketing tactics “in a bid to engage with consumers on a one-to-one level,” which Chipotle clearly does (p. 18). According to a Nation’s Restaurant News study-

“The brand is able to accomplish a high level of interaction with customers largely through its social media presence.”

conducted in 2011, it was found that Chipotle responds to 83% of Facebook posts – more than any other fast casual restaurant (Klamm, 2012). Furthermore, approximately 90% of company Twitter activity comes from responding to customers through @-mentions (Klamm, 2012).

There are a multitude of reasons why Chipotle puts so much effort into social media marketing and one-on-one communication with customers. One reason is that they value their customers as individuals (Klamm, 2012), but also because interaction will foster customer loyalty, which in turn will lead to customer retention (Ozuem et al., 2015b). Moreover, a two-way communication flow is needed to respond to customer difficulties (Ozuem et al., 2015b). Social media also allows Chipotle to promote its corporate social respon-

sibility programs. By telling consumers about its “Food with Integrity” program, Chipotle is able to deepen a customer’s emotional connection with the brand (Ragas & Roberts, 2009). Perhaps most importantly, effective societal marketing allows brands to “charge higher prices, increase market share and engender greater brand loyalty and treatment from stakeholders” (Bloom, Hoeffler, Keller, & Meza, 2006, cited in Ragas & Roberts, 2009).

International Expansion

In the past few years, Chipotle has expanded to Paris (Pham, 2012), Frankfurt (“Chipotle Mexican Grill,” 2013), London (“Chipotle Opens Restaurant,” 2010) and Canada (DeMontis, 2008). In 2013, three years after Chipotle entered the U.K. market, Londoners had not warmed up to its oversized burritos (Wong, 2013). American-style Mexican food seemed to have less allure in the English market given the dearth of Mexicans in the U.K. (Wong, 2013). Beyond that, the price of the brand’s offerings were seen as too high for many Londoners (Wong, 2013).

Given these factors, it appears the brand adopted an ethnocentric approach to branding, just as many other American companies have (Cayla & Arnould, 2008). Cross-national differences prevent the use of blanket marketing strategies (Ozuem et al., 2015b). What Chipotle needed to do was globalize its marketing strategy, meaning it needed to particularize its global product to a local market (Matusitz, 2010). According to Kumar (2014), companies must accommodate region-specific cultural norms, which Chipotle did not do with respect to their portions and prices.

Chipotle, however, did not feel the need to significantly adapt its product to the European market. According to Van Tan (2010), Chipotle’s initial approach in London made sense as the chain seemed better suited for Europe where there was already an appreciation for local and sustainably-raised ingredients. The only marked change they made was to substitute the spelling of words with the Queen’s English spelling so that “flavor” was respelled “flavour” on its London packaging (Van

Tan, 2010). Then in 2014, Chipotle hired Mother London, the largest independent advertising agency in the U.K., as its London marketing partner (Faull, 2014). Today, their campaign highlights the brand's attitude toward choosing the right ingredients, and even playfully mocks the unfamiliarity most Londoners have with Mexican cuisine (Faull, 2014).

The significant standardization found in Chipotle's marketing techniques is not necessarily a negative quality. As Backhaus, Muhlfield and Van Doorn (2001) state, companies pursue a policy of standardization to reduce costs and gain efficiency. At the same time, doing so prevents image confusion and customer irritation (Backhuas et al., 2001; Cayla & Arnould, 2008). Overall, Chipotle's decision to keep the central aspects of its marketing campaign the same across the globe could thus be seen as a strength. They standardize several aspects such as the creative selling proposition and the actual elements and language of the ad (Backhaus et al., 2001). The company was conscious of needing to adapt to cultural norms but also thought their product met the needs of European consumers. Thus, Chipotle is actually not ethnocentric, but operates under a geocentric marketing orientation.

The chain seems to have turned things around abroad as customers are now responding positively. It opened its seventh London location in the summer of 2015 (Witts, 2015).

The Fruits of Corporate Social Responsibility

Consistency

As a brand that partakes in corporate social responsibility, it is critical that Chipotle fulfills its promises. Ragas & Roberts (2009) write that brands that make strong emotional connections with their customers risk serious backlash if they abandon their emotional branding promises; thus, Chipotle must tread carefully. On the 26th of April 2015, Chipotle fully realized its "Food with Integrity" vision when it announced that it would no longer serve food with genetically altered ingredients

(Strom, 2015b). Granted, the company acknowledges that some of the soft drinks it sells are likely to contain sweeteners made from modified corn, and that some of its meat and dairy supplies come from animals fed modified grains (Strom, 2015b).

Despite it being cheaper and more profitable to use non-locally produced and genetically-modified ingredients, Chipotle sticks to its value system everywhere it has a presence. As Srnka (2004) argues, consumer values and desires are critical for companies to consider. Chipotle is wary of this as evidenced by their commitment to not serve genetically-modified foods. Beyond staying true to their "Food with Integrity" campaign, the company understands what customers want when it comes to their food and caters to those desires.

Success & Expansion

Chipotle's staggering success can largely be attributed to its visionary leadership. Founder Steve Ells had a basic goal in mind with his "Food with Integrity" mission and carried it out masterfully. Under Ells's leadership, the Chipotle brand thrives due to its compelling vision, clear organizational identity, effective culture for employee alignment and a deep understanding of consumer behavior (Ozuem et al., 2015a).

"Despite it being cheaper and more profitable to use non-locally produced and genetically-modified ingredients, Chipotle sticks to its value system everywhere it has a presence."

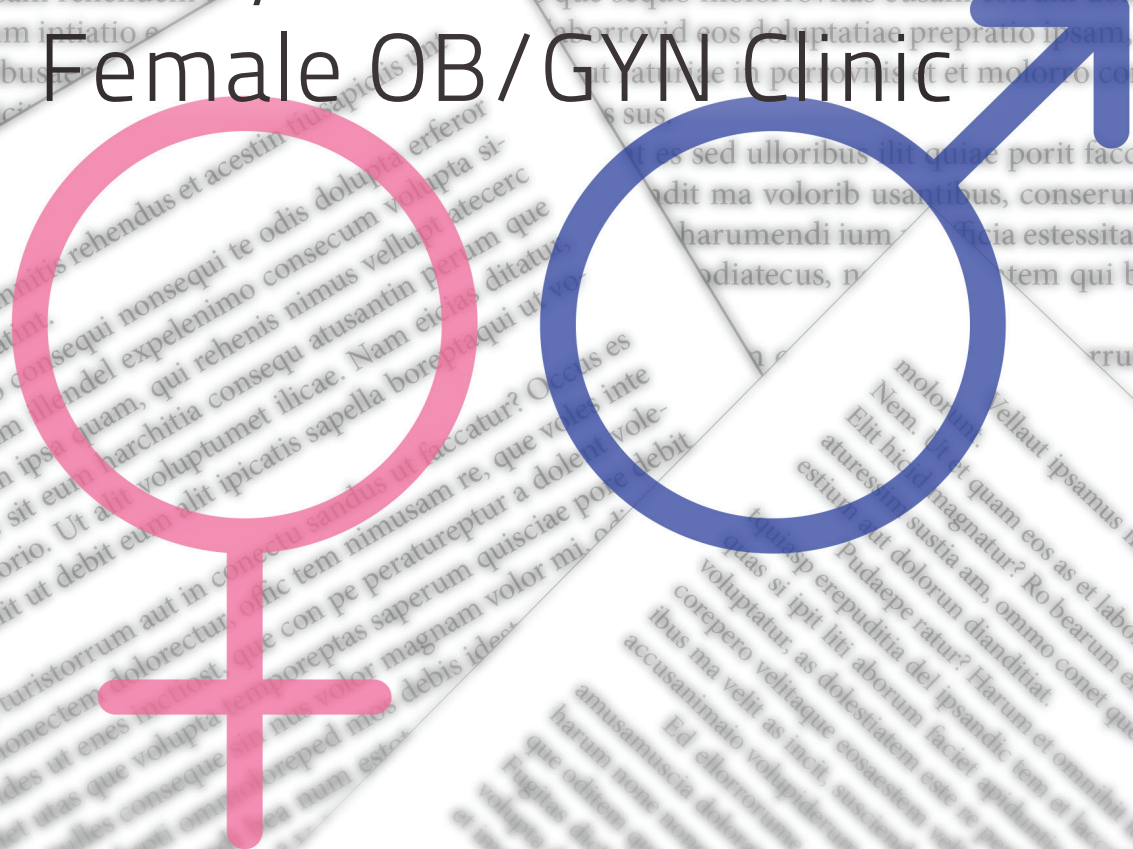
Additionally, Chipotle benefits from its recognition of the importance of interacting with customers. Charles (2007) cited in Ozuem et al. (2015a) argues that when a company operates customer-centrally, it receives a positive return on investment, satisfied shareholders and stakeholders from business and the community, and a sustainable business future. Chipotle's broad social media presence is its recognition of this fact. The com-

pany makes an active effort to respond to all messages on Facebook and Twitter from around the world, valuing its personal connection with consumers. Hence, Chipotle has improved its status abroad and continues to thrive as a dynamic and revolutionary company.

References

- Adamy, J. (2007, November 3). Burrito chain assembles a winning combo. *Wall Street Journal*. Retrieved from <http://www.wsj.com/articles/SB119577962200001637>
- Backhaus, K., Muhlfeld, K., & Van Doorn, J. (2000). Consumer perspectives on standardization in international advertising: A student sample. *Journal of Advertising Research*, 41(5), 53-61. doi: 10.2501/JAR-41-5-53-61
- Birdsall, J. (2013). The Indian Chipotle exists right now in San Francisco at Tava. Retrieved from <http://www.chow.com/food-news/132768/tava-indian-chipotle-exists-right-now-in-san-francisco/>
- Cayla, J. & Arnould, E. (2008). A cultural approach to branding in the global marketplace. *Journal of International Marketing*, 16, 86-112. doi: <http://dx.doi.org/10.1509/jimk.16.4.86>
- Cheshes, J. (2015, February 6). The Chipotle effect: How chefs are reinventing fast food. *Wall Street Journal*. Retrieved from <http://www.wsj.com/articles/the-chipotle-effect-how-chefs-are-reinventing-fast-food-1423258757>
- DeMontis, R. (2008, August 13). Come down to Life Square for free burritos. *Toronto Sun*, p. 40
- Faull, J. (2014, March 20). Chipotle names Mother London as first UK creative agency. *The Drum*. Retrieved from <http://www.thedrum.com/news/2014/03/20/chipotle-names-mother-london-first-uk-creative-agency>
- Haberman, M. (2015, April 13). Hillary Clinton, just an unrecognized burrito bowl fan at Chipotle. *The New York Times*. Retrieved from <http://www.nytimes.com/2015/04/14/us/politics/on-the-road-hillary-clinton-stops-for-lunch-at-chipotle-and-goes-unrecognized.html>
- Hoeffler, S., & Keller, K. (2002). Building brand equity through corporate societal marketing. *Journal of Public Policy & Marketing*, 21(1), 78-89. doi: <http://dx.doi.org/10.1509/jppm.21.1.78.17600>
- Klamm, D. (2012). How Chipotle uses social media to cultivate a better world. Retrieved from <http://mashable.com/2012/03/21/chipotle-social-media/>
- Kumar, V. (2014). Understanding cultural differences in innovation: A conceptual framework and future research directions. *Journal of International Marketing*, 22(3), 1-29. doi: <http://dx.doi.org/10.1509/jim.14.0043>
- Matusitz, J. (2010). Disneyland Paris: A case analysis demonstrating how globalization works. *Journal of Strategic Marketing*, 18(3), 223-237.
- Ozuem, W., O'Keefe, A., & Lancaster, G. (2015a). Leadership marketing: An exploratory study. *Journal of Strategic Marketing*, 23(1), 1-25. doi: 10.1080/0965254X.2014.1001867
- Ozuem, W., Thomas, T., & Lancaster, G. (2015b). The influence of customer loyalty on small island economies: An empirical and exploratory study. *Journal of Strategic Marketing*, 1-23. doi: 10.1080/0965254X.2015.1011205
- Pham, A. (2012, May 31). On a testé le premier Chipotle Mexican Grill à Paris 9e. *L'Express*. Retrieved from http://www.lexpress.fr/styles/saveurs/recette/on-a-teste-le-premier-chipotle-mexican-grill-a-paris-9e_1120953.html
- Pino, I. (2014). 10 things you need to know about Chipotle's pizza and Asian concepts. *The Motley Fool*. Retrieved from <http://www.fool.com/investing/general/2014/07/02/10-things-you-need-to-know-about-chipotles-pizza-a.aspx>
- Ragas, M. & Roberts, M. (2009). Communicating corporate social responsibility and brand sincerity: A case study of Chipotle Mexican Grill's 'Food with Integrity' program. *International Journal of Strategic Communication*, 3(4), 264-280. doi: 10.1080/15531180903218697
- Reimer, M. (2011, September 16). Chipotle opens first Asian-style restaurant in D.C. *Business Insider*. Retrieved from <http://www.businessinsider.com/chipotle-opens-first-asian-style-restaurant-in-dc-2011-9?IR=T>
- ShopHouse Kitchen Locations. (2016). [Interactive map of U.S. ShopHouse Kitchen locations]. Retrieved from <http://shophousekitchen.com/locations>
- Singh, J., Scriven, J., Clemente, M., & Lomax, W. (2012). New brand extensions: Patterns of success and failure. *Journal of Advertising Research*, 52(2), 234-242. doi: 10.2501/JAR-52-2-234-242
- Srnka, K. (2004). Culture's role in marketers' ethical decision making: An integrated theoretical framework. *Academy of Marketing Science Review*, 2004(1), 1-31.
- Strom, S. (2015a, April 21). Chipotle posts another quarter of billion-dollar sales. *New York Times*. Retrieved from <http://www.nytimes.com/2015/04/22/business/chipotle-quarterly-earnings.html>
- Strom, S. (2015b, April 26). Chipotle to stop using genetically altered ingredients. *New York Times*. Retrieved from <http://www.nytimes.com/2015/04/27/business/chipotle-to-stop-serving-genetically-altered-food.html>
- Van Tan, R. (2010, February 1). Growing global. *QSR Magazine*. Retrieved from http://www2.qsrmagazine.com/articles/features/138/global_growth-3-phant.html
- Witts, S. (2015, April 13). Chipotle opening seventh London site. *Big Hospitality*. Retrieved from <http://www.bighospitality.co.uk/Venues/Chipotle-opening-seventh-London-site>
- Wong, V. (2013, February 26). Why Chipotle sales lag in London. *Bloomberg Business*. Retrieved from <http://www.bloomberg.com/bw/articles/2013-02-26/why-chipotle-sales-are-low-in-london>
- Yohn, D. (2014, March 14). How Chipotle changed American fast food forever. *Fast Company*. Retrieved from <http://www.fastcompany.com/3027647/lessons-learned/how-chipotle-changed-american-fast-food-forever>
- (2010, May 10). Chipotle opens restaurant in London, its 1st in EU. *Denver Business Journal*. Retrieved from <http://www.bizjournals.com/denver/stories/2010/05/10/daily4.html>
- (2013, June 6). Chipotle Mexican Grill eröffnet in der Skyline Plaza. *Genuss Magazine*. Retrieved from http://www.genussmagazin-frankfurt.de/gastro_news/Auf-und-Zu-19/Ol-Chipotle-Mexican-Grill-eroeffnet-in-der-Skyline-Plaza-18858.html?newsletter_id=1469
- (2014, June 24). #Chipotus Ew! Obama's fast food flub. Retrieved from <http://edition.cnn.com/videos/bestoftv/2014/06/24/newday-inside-politics-chipotus-ew-obamas-fast-food-flub.cnn>

Gendered Literacies: A Qualitative Study of Literacy Practices in an All Female OB/GYN Clinic



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BIOGRAPHY

Ira Memaj is a junior at Wayne State University who is majoring in Molecular & Cellular Biology as well as in Philosophy. She is a pre-medical student pursuing a career in obstetrics/gynecology with a specialty in gynecological oncology. Currently, she assists in researching the chemo-resistance of ovarian cancer cells.

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The appendix referenced in this article can be found on our website at case.edu/discussions/archives.html

Abstract

In this ethnographic case study, field observations were conducted of an all-female obstetrics and gynecology (OB/GYN) clinic located in Livonia, Michigan. While interacting with professionals as a student volunteer at the clinic, I took the role of a hidden participant observer and examined the behaviors of these female doctors and compared my observations to those of expected gendered roles. Writing from a New Literacy Studies (NLS) perspective and drawing from the works of sociologists James Gee and Brian Street, this paper provides possible evidence for social theories of literacy that emphasize literacy practices, which include behaviors, attitudes, gestures, lexis, and identities (Gee, 12). Literacy practices are shaped by socially constructed rules or ideologies that regulate the order of who should and who should not perform these practices. Similarly, gender is socially constructed such that subjects will engage in gender performativity to enact their perceived roles in society, which can eventually develop a gendered reality. Given this framework, I argue that gender performativity is a literacy practice as defined by the scholarship of New Literacy Studies.

“Literacy practices are shaped by socially constructed rules or ideologies that regulate the order of who should and who should not perform these practices.”

Introduction

Interaction Between Gendered Literacy Practices and Gender

There is no definite meaning of the word literacy because every Discourse¹ and its associated members practice their own type of literacy. For example, doctors can be seen as literate by the way they perform field specific tasks around the hospital such as reading charts, diagnosing

¹ Discourse with a capital “D” was coined by James Gee and is referred to as an identity tool box, containing a subject’s values, beliefs, attitudes, lexis, and body language.

patients, and using a specific lexis to communicate with their peers. If a doctor, however, tried to become financial advisor, they might have a hard time adjusting to the values, beliefs, language, and practices required to gain membership in the financial advising Discourse. The approach we take in understanding literacy practices in our professional Discourses reflects how we perform, critique, and reshape those practices. For instance, suppose a medical student observes their attending (i.e. medical supervisor) who is giving a medical update to a patient’s family. The medical student notices the tone of voice, the content of the message, the body language, and the facial expressions of their attending. How the student interprets these practices will determine whether they will become successful in interacting with future patients in similar situations.

While shadowing doctors and observing literacy practices at an OB/GYN clinic, I became interested in the language, communication style, and professional performativity² of female OB/GYN physicians. Since the doctors who were interviewed and observed asked to remain anonymous, I will refer to them by pseudonyms. According to James Gee, Discourses use language with particular ways of being, doing, behaving, valuing, and thinking that categorize individuals as full members of a particular Discourse (Gee, 1989). Gendered Discourses then become a way of identifying how gender performances shed light on the gendered identities those members portray. Building from the previous work of sociologists Candice West and Don H. Zimmerman on how gender is accomplished, I focused on how these female doctors performed gendered practices through speech utterances, attitudes, behaviors, gestures, and personas to determine whether their literacy fit into a stereotypical gender norm to establish a gendered Discourse. Along with that, I also observed how female doctors performed gendered practices that perturb the gender norm by establishing masculinity in their expected feminine persona to maintain authority in their gendered Discourse. Although much

² Performativity is defined as the acts that are embedded with the “bits” that define and structure a Discourse community (institution).

research has been done to conceptualize gender and gender performativity, there has not been much discussion about gender performance as a possible literacy practice that integrates ideologies with language use. Gender, like literacy practices, is greatly influenced by ideologies and is expressed through performativity in language and paralanguage usage.

Literary Review: Discourse and Gendered Literacy Practices

Language is not just how a person speaks, but it is also who that person is in a specific context and what they do when they speak (Gee, 1989). When using language, the speaker's social role must be considered in order to communicate with others and display the appropriate beliefs and values that complement the constructed persona. Dr. Gee refines the idea of Discourse by making note of primary and secondary Discourses. Primary Discourse can be seen as the blueprint of a group's core identity, which is realized simply by being a member of a kin group. Secondary Discourse, on the other hand, includes any of the kin group's institutions in which permission to become a member is given by members, masters or apprentices, of that Discourse. If we successfully become full members of a secondary Discourse, we gain access to the institution's privileges which can include money, recognition, and prestige (p. 458). Becoming a full participant of a Discourse can be challenging, since it involves the process of enculturation, which focuses on social practices and the interaction between the apprentice and the novice. In other words, these apprentices can be seen as gatekeepers that control how a novice learns a certain practice.

Gee (1989) notes that because we have already developed a core identity through our primary Discourse, we can never become full participants of a secondary Discourse because often we see conflict between the two. However, it is important to acknowledge that this conflict plays a key part in making changes to that particular secondary Discourse. Gee describes this conflict as a type of liberation or power because by comparing our primary and secondary Discourses we engage in

a critical thinking process that requires us to analyze the bits that make up a Discourse. It is, in fact, this kind of higher-order thinking, which Gee terms metacognition, that enhances the awareness of novices to recognize literacy practices and also what it takes to learn (p. 489). Metacognition is a catalyst that triggers novices and members to constantly analyze the bits that define a Discourse. By continually comparing and critiquing these bits, novices and members become aware of the conflicts that are found within a Discourse. Being aware of various conflicts within a Discourse grants an advantage to novices, which allows them to become fully active participants who contribute to the evolution of literacy³ within that specific Discourse.

Like Discourses, gender is a social construct as well. More specifically, gender is not a default way

"In Gender Doing, West and Zimmerman define gender not simply as a fixed trait or biological feature but an accomplishment achieved through performance by the gender doer in social interactions."

of being; instead, it is a social invention reproduced by subjects through the process of internalizing a gender identity that reflects the norm. The understanding of gender has progressed over time due to contributions made by various linguists, sociologists, and gender theorists (Eckert and McConnell-Ginet, 2003; Garfinkel, 1967; West & Zimmerman, 1987). For this case study, I used the works of sociologists Candace West and Don H. Zimmerman on redefining gender. In *Gender Doing*, West and Zimmerman (1987) define gender not simply as a fixed trait or biological feature but an accomplishment achieved through performance by the gender doer in social interactions (p. 126). One may advance their understanding of gender by analyzing how it affects one's social

³ Performativity structures the literacy within a Discourse.

interactions and how certain social interactions affect their gender performances, which include identities, behaviors, attitudes, and speech utterances.

Gender construction begins as early as birth after which we assign the title of male or female to a newborn; however, with that title, we also begin to assume the kind of gendered performances

that are expected from the baby as he or she grows up. For example, we stereotypically assume male children will grow up loving violent sports, swagger the streets, and talk in a deep and confident voice. (Eckert & McConnell-Ginet, 2003). By predicting these gendered performances based on sex categories, we begin to construct a gender binary within our society that defines male as being masculine and female as being feminine. Understanding this binary, one can observe gender as an ideology embedded in almost every institution in the social sphere. This ideology then forces us to negotiate our core identities, values, and beliefs for us to fit into various Discourses. In other words, people are required to act a certain way that conforms to the gender phenomenon. This conformity suggests that gender is a key element in social relations which means that we cannot help but conform to gender to make our actions legible, which can not only lead to social reproduction, but also contention with the gender norm. Resistance to the manipulation of the gender norm may come from an individual attempting to establish a new gender performance, which most times can be seen as abnormal in specific ideology-linked communities, which can affect the relationships we have with society.

The Determination of Literacy Practices Through Ideology

As mentioned before, gender-doing can be seen as a social practice. Brian Street, a sociolinguist and one of the founding fathers of New Literacy Studies (NLS), originally proposed the term *social practice* to be an integral part of the meaning of literacy (Street, 1984). Opposing previous theorists like Jack Goody, Street introduced the ideological model of studying literacy, which

suggests that literacy practices are heavily loaded with ideologies that promote the propagation of assumptions that link literacy to various cultural and social contexts. Street's ideological model is significant because it introduces what James Gee calls the "social turn" of literacy (Gee, 1996). According to Street's model, to understand the essence of literacy, one must analyze how ideologies affect literacy practices and how they affect the process of understanding and acquiring those practices.

Gender ideologies evolve in our communities, and as we adopt those changes, we develop a new way of performing gender (e.g. a new way of being a girl or a boy). In other words, creating and learning a new way of doing gender or learning gendered practices can be seen as a metacognitive process, according to Gee. Although an ideology, gender can also be considered as a type of literacy or Discourse. It is a social construct that is constantly produced, reproduced, and even challenged by members' practices. To analyze how social and ideological complexities influence gendered practices and how gender practices contribute to the social reproduction of the gender norm, Gee's concepts of literacy, Discourse, and metacognition are used along with West and Zimmerman's gender-doing to redefine gender as a type of literacy practice. The question is also raised on how those practices can be mastered by a novice. Since these three theorists suggest that social doings help one recognize certain practices, identities, lexis, and attitude or behaviors of members of a particular Discourse, I focused on analyzing the situated interactions and behaviors of female professionals in the field of OB/GYN.

Materials and Methods

First, my observations were grounded in the stereotypical gender ideology that depicts women as being powerless in the workplace due to their dependent and emotional seeking personality, and men as powerful due to their aggressive and confident personality and language use (Jenkins, 2008). I examined each professional, especially while they engaged in various practices in the

contexts of their professional field, to observe how cultural ideologies influence the language, attitude, and personas of these workers. In other words, how do cultural ideologies on gender construct the identity and the gendered practices of these female OB/GYNs, and, also, how do these invoked gendered practices reproduce, maintain, and sometimes even contest the identity allocated by the gender norm within this gendered Discourse?

Data were collected from an interview with a female OB/GYN physician, and observations which focused on the relationship among physicians, patients, and other professionals in the field. Since my main sources did not wish to be referenced using their actual names, I will identify them using pseudonyms relating to the terminology used in obstetrics and gynecology.

At the OB/GYN clinic, I interviewed Dr. Michelle Curry,⁴ who graduated with honors from the Kansas City University of Medicine. Dr. Curry currently works at a major hospital in Michigan, where she also practices minimally invasive surgical technique. The interview with Dr. Curry was conducted on February 12, 2013 at 4:30 p.m. in her office, which is located inside the clinic. Before meeting with Dr. Curry, I had previously written down a few key questions related to my intervention for the study. During the interview, I used the questions as a guide, and wrote down key words and phrases that were mentioned by Dr. Curry. Using the jotted notes in my notebook, I wrote detailed field notes as soon as the interview ended.

In order to analyze how gender-doings differ in various interactions, I decided to divide my observation into two parts. The first part focused on the interaction between an OB/GYN and a nurse. This observation took place on February 5, 2013 at 4:00 p.m. This particular time was chosen because the staff around the clinic are usually wrapping up last-minute patient appointments, and it allowed me to observe the interactions between

⁴ All the doctors in this essay have chosen to remain anonymous and will be referred to with a pseudonym.

professionals without the presence of patients. The second part of the observation focused on the interaction between an OB/GYN and a patient. To accomplish this, I took the role of a participant observer and scheduled an appointment as a first-time patient with Dr. Carrie Russ, an OB/GYN of 15 years, on February 15, 2013 at 4:15 p.m. The observation lasted about 20 minutes. On both occasions, the doctors were not aware that they were being observed. I chose this approach because I wanted to capture an honest outlook on the various interactions of these female OB/GYNs and not let my role as an observer affect the professionals' behavior when we interacted.

Results

In our culture, the ideal of a man is described as being accomplished and confident while that of a woman is seen as being sensitive and nurturing (Bagozzi, Wong, & Yi, 2010). These gendered ideologies coerce men and women to conform to traditional notions of masculinity and femininity, respectively. The following research data are divided into two sections: The first focuses on how a female OB/GYN constructs her identity and incorporates gendered practices that depict the field of OB/GYN as stereotypically feminine, and the second provides evidence for how, in some situated interactions, these female OB/GYNs construct an identity that challenges the gender norm.

Feminine Discourse

In the United States, certain professions are overrepresented by women. Some stereotypical assumptions are that women usually work as secretaries, waitresses, or any other profession that involves interaction because women are seen as being the "socializing" gender or typically enjoy communication, talking, and gossiping (Unger, 290). The following paragraph is from my interview with Dr. Curry and her response when asked about the partnership:

Ira: Do you think that the partnership you seek with a patient plays any significant

role in influencing women to choose female OB/GYNs over [a] male one?

Dr. Curry: I think in general all OB/GYNs have an advantage in means of expanding their clientele because they only deal with women. And since the field of obstetrics and gynecology consists of mostly women, some are also mothers . . . It is easier for us [female OB/GYNs] to communicate with patients. We bond through “women stuff.” If I leave a good impression on my patient, she will tell her friends, family, neighbor, or even co-workers how great her doctor is; that’s why forming a partnership is important also (Online Appendix).

From the example provided above, Dr. Curry shows that she is aware about the type of patients with whom she regularly engages, who only female patients. In other words, she views women as being more social; therefore, she works in constructing a type of identity that appeals to women. Throughout the interview Dr. Curry stressed the partnership doctors in the OB/GYN field seek with their patients. She mentions that when speaking with patients, especially new patients, it is important to “Turn your charm on” and make them feel comfortable (Online Appendix). One way to do this is by using icebreakers to start up a conversation as two women, not as doctor and patient.

Dr. Curry: The icebreakers are like stepping stones of forming the partnership. You could start talking about a certain topic...and [icebreakers] can start by being general and then move into being more personal, like talking about [the patient’s] intimate relationship with their partner or specific “women stuff” that they’re concerned about. (Online Appendix).

This quote extracted from the interview shows that Dr. Curry uses icebreakers to emotionally connect to her patients. The conversation about

these topics resembles a typical conversation that women have with their friends. Personally bonding with patients conforms to the gendered assumption that identifies women as the gender that seeks emotional connections to others. To get a better sense of what Dr. Curry was saying in terms of forming a “partnership” with her patients, I observed a regular check-up visit from a patient’s perspective. Volunteering at the clinic beforehand granted me an advantage as a first-time patient. I walked in relaxed, signed my name, and took a seat next to an expecting patient. After my name was called, the nurse directed me to the first examining room, where she took my vital signs. Before leaving the room, she left a gown by my side and, with a smile, assured me that the doctor would be in shortly. I put on the gown and took a seat on the exam table, which consists of two stirrups that can transform the table to a birthing chair. Right in front of the exam table, there were three posters hanging on the white walls, displaying the anatomy of the female reproductive system and the progression of the fetus in trimester stages. A few monitors and several pieces of cold metal diagnostic equipment surrounded the exam table. The cables of the monitors seemed to be all connected with each other like a spider web.

Dr. Carrie Russ walked in introducing herself full of enthusiasm. She definitely had “turned her charm on” as she constantly smiled and even complimented me a few times. Dr. Russ took a seat next to the exam table, and started asking specific questions about my medical history, primarily focusing on past medical family history. She transitioned to personal questions such the last day of my menstrual cycle, engagement in sexual intercourse, and birth control. I was surprised by the attention to detail of questions that concerned not only my physical but also psychological health. As Dr. Russ asked me numerous personal questions, I noticed that she was using Dr. Curry’s icebreakers approach to connect with me on an emotional level.

After finishing the questions, she applied hand sanitizer and put on gloves, which signaled the starting point of the examination. Beginning with

an upper body examination, Dr. Russ provided feedback by saying that everything sounded and felt normal. She took her seat again and sliding her chair next to me, she asked in a soft, quiet tone, “Have you ever done a breast exam?” Seeing that I shook my head, Dr. Russ reached for a pamphlet located near her computer. Folding the pamphlet on the section of breast examination, she began explaining each picture that represented different examination methods. Before beginning the

“...are a few acts demonstrated by Dr. Russ that are characterized as stereotypical behaviors and practices of women.”

breast exam, Dr. Russ encouraged me to try one of the methods. After congratulating me on my first breast exam, Dr. Russ directed her index finger at

my face advising, “Every month, you will perform a breast exam. It is never too early to start detecting changes in your body.” I was relieved when she followed the gesture with a smile because I briefly felt like my mom was giving me a warning.

The gesture and the advice given by Dr. Russ can be seen as gendered acts. Typically, women are seen as being more compassionate and nurturing. The advice given by Dr. Russ is similar to one usually given by a parent. Encouraging the patient, giving parent-like advice, and reassuring facial expressions such as smiling are a few acts demonstrated by Dr. Russ that are characterized as stereotypical behaviors and practices of women.

Feminine Discourse is Not So Feminine After All

In the first section, I observed how professionals in the field of OB/GYN constitute an identity where the expected gender-doings of women manifest; however, it is also important to analyze how, in some situations, these professionals constitute a persona that perturbs the female gender norm. For instance, while observing the interaction between an OB/GYN and a nurse, I recognized an identity shift in the OB/GYN that

resembled that of a stereotypical man: assertive and intimidating. Since the male representation in OB/GYN is diminishing overall, I wanted to observe how female OB/GYNs portray masculine identity through gendered acts and practices.

This masculine persona is also a representation of how the doctors display authority, especially with professionals found in the lower hierarchy such as medical assistants, nurses, and interns. For example, after Dr. Curry finished her last appointment, she sat in front of her computer with a Starbucks drink in one hand and a patient’s chart on the other.

However, as one of the nurses, Kate, approached Dr. Curry to present a medical chart, Dr. Curry gestured her not to talk by placing her Starbucks down to hold her index finger up, indicating “one second.” Kate took a step back and then one forward after seeing Dr. Curry’s smile. She handed the chart to the doctor and started explaining the results of a diagnostic test that had just come from the hospital’s laboratory. Dr. Curry’s smile faded when she started to ask Kate about the other tests that were previously sent in the lab. Kate’s voice seemed to break in the beginning, when using the phrase “I think”; however, it regained its volume when she started to justify that the results were not confirmed by the lab yet. Squinting her eyes, Dr. Curry stared at Kate for a few seconds, nodded her head, and said: “Hmmm . . . OK, thanks.” Kate left the chart by Dr. Curry’s side and resumed her work (Online Appendix).

Previously, Dr. Curry mentioned in her interview that as a doctor who interacts daily with women, she must act and look like a woman or “turn her charm on,” but as she dismisses Kate, she seemed to be “turning her charm off.” Her gesture is another act that represents Dr. Curry’s authoritative persona. Without even speaking, her manual gesture forced Kate to step back and give Dr. Curry the time she needed. Kate’s voice breaking shows how intimidated she may feel toward Dr. Curry. Her breaking voice and the phrase “I think” represent a lack of confidence, which may also be why Dr. Curry stared at Kate for a few seconds after reporting the lab results.

I mentioned that society's ideal woman is compassionate and nurturing. Although the patient observation and the interview represent evidence of how these female doctors cultivate a stereotypical feminine persona, while the second observation suggests that these doctors can manipulate their expected identity by constructing a stereotypical masculine identity. By displaying authority over Kate, Dr. Curry is simultaneously constructing an identity that fits the authoritative nature of a doctor and an identity that perturbs the stereotypical gender norm, which depicts women as being powerless. According to Eckert's model, Dr. Curry seems to establish a new way of being a woman by integrating an authoritative and confident nature, typically characterized by masculine behaviors, into her expected feminine identity (Eckert, 2003).

Discussion

Instead of looking at literacy as an isolated skill that can later be applied to social contexts, New Literacy Studies have focused on literacy practices that are deeply rooted in social forms of communication, in which people who engage in literacy practice use it to construct their identities, interact with others, and assign value to certain activities (i.e. setting social norms). Through literacy practices, we construct and enact our realities. How we portray our own identities through the use of speech and paralinguistics are literacy practices done by subjects as a way to navigate through social contexts. Moreover, as the subject practices literacy, they are also seeking approval from society in means of legitimizing that particular act.

The literacy practices involved in the OB/GYN clinic include speech utterances, body gestures, attitudes, and behaviors that are all influenced by a social phenomenon. As discussed in the study, gender is a social construct, which begins affecting development and expectations as early as birth. It is since then that roles, preferences, and personality traits are depicted based on a sex category. When asked about the partnership the doctor develops with the patient, Dr. Curry

mentioned that she "turns her charm on" (Online Appendix). Before asking about anything medical, Dr. Curry first tries to get to know the patient as a woman instead of as a patient. This includes talking about their favorite shows, department store, and even relationship issues. Dr. Curry has a stereotypical image of women, which includes being talkative and compassionate. She internalizes these traits and reproduces them, enforcing the female gender norm while simultaneously building a solid relationship with her patients. As she does her gender, she is also performing literacy practices that are essential in maintaining the success of the clinic and her reputation as a doctor.

The same duality can be seen when Dr. Curry interacted with the nurse, Kate. Here I saw a shift in identity, language, and attitude. Dr. Curry did not make eye contact often with Kate, and when she did, it was very serious and almost suspicious. She used her hands instead of her voice to give orders and spoke in a lower tone. This sort of paralinguistics is used to maintain structure and authority in the clinic, and can be seen as stereotypically masculine (Hall, 1978). This paper shows how both genders are done through language, identity shifts, body gestures, attitudes, and behaviors, and also how all these gendered performances have implications in terms of membership. This situation exemplifies how gendered practices are literacy practices in that the clinic requires novices and members to learn and acquire in order to maintain the success of the clinic and also to legitimize the practices such that the practices become an unconscious activity done by the subject over time.

This case study should not be generalized to all OB/GYN clinics because gender performativity varies with social context. This study could be taken further by investigating gender performativity in other medical fields that are centered on a particular gender. It can also be used in determining a specific methodology in studying gender performativity as a literacy practice and how novices should navigate when introduced to professional Discourses that are heavily influenced by gendered practices or gender in general.

References

- Bagozzi, R.P., Wong, N., & Yi, Y. (1999). The Role of Culture and Gender in the Relationship between Positive and Negative Affect. *Cognition & Emotion*, 13(6), 641-672. doi: 10.1080/026999399379023
- Eckert, P., & McConnell-Ginet, S. (2003). *Language and Gender*. New York, NY: Cambridge University Press.
- Gee, J. (1989). LITERACY, DISCOURSE, AND LINGUISTICS: INTRODUCTION. *The Journal of Education*, 171(1), 5-176. Retrieved from: <http://jstor.org/stable/42743865>
- Gee, J. (1989). What is Literacy? In V. Samel & R. Spack (Eds.), *Negotiating academic literacies: Teaching and learning across languages and cultures* (pp. 51- 61). New York, NY: Routledge.
- Hall, J.A. (1978). Gender Effects in Decoding Nonverbal Cues. *Psychological Bulletin*, 85(4), 845-857. doi: <http://dx.doi.org/10.1037/0033-2909.85.4.845>
- Jenkins, A.L. (2008). Management decision making: The influence of stereotypically gendered personality types and situational manipulation (Doctoral Dissertation). 61-67. Retrieved from <http://gradworks.umi.com/33/20/3320952.html>
- Street, B. (1984). Autonomous and ideological models of literacy: Approaches from New Literacy Studies. *Media Anthropology Network*, 17-24. Retrieved from http://www.media-anthropology.net/street_newliteracy.pdf
- Unger, R.K. (2001). *Handbook of the Psychology of Women and Gender*. New York, NY: Wiley.

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