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Societal Issues

Fluid Women in Rigid Structures

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The problem of modern menstruation is not that it exists still, but that society continues to pretend it does not. The shame and secrecy surrounding menstruation has grieved women for years and still the issue persists. Though as normal a bodily function as sweating or coughing, menstruation has frequently been used to shame women and is often misunderstood. Feminist theorist Iris Marion Young writes about the experience of menstruation in her essay, "Menstrual Meditations."[1] In this essay, Young discusses the prominent ideology surrounding menstruation and reflects on its societal implications. In this paper I argue that the current rigidity of school structures is not conducive to the fluidity of the menstruating body and perpetrates societal norms of shame, discomfort, and misinformation. First, I will expand on Young's argument that schools and workplaces are rigid in nature and unaccommodating to women's experience of menstruation. I will also give examples of this rigidity and explain how it fosters the shame and discomfort of women while spreading misinformation. Finally, I will offer potential suggestions to ease the experience of menstruation and establish norms of acceptance of women's fluid bodies.

Most schools and workplaces are structured environments that rely on routine and strict timekeeping. My own private high school was run on a series of timed bells that were meant to move us students to action and make sure we ended up where we were supposed to be when the last bell chimed. Structure can be a useful tool for time management and organization, but when it becomes inflexible regarding bodies, it is no longer a tool but a hinderance. Young describes a clear misalignment between the structures we create to hold us accountable and the needs of menstruating women in her essay, explaining that "public places such as schools and workplaces…often refuse to accommodate women's social and physical needs."[2] An example of this misalignment can be found in my own school experience. Students were told to get our bathroom habits on a schedule, to go in between classes or at lunch. However, we were only given three minutes in between classes to switch

[1] Iris Marion Young, "Menstrual Meditations" (New York: Oxford University Press, 2005), 97-122.

[2] Young, "Menstrual Meditations", 98.

classrooms, exchange books, and apparently to use the bathroom. I discovered quickly that three minutes wasn't enough time to change a tampon and make it to the next class. Even if I could manage the change quick enough, oftentimes the only reasonably close bathroom, consisting of only three stalls, had a line out the door. Faced with this situation, many girls, myself included, were punished for tardiness to class, scolded for leaving in the middle of lecture, asked why we were bringing our pencil pouch or binder with, etc. Every instance was embarrassing and entirely unnecessary. The rigid structure of the classroom and school environment did not cater to our needs as female students.

In another section of her essay, Young comments on the discomfort women experience when menstruating, writing that "menstrual etiquette creates an emotional and disciplinary burden for girls and women."[3] In my school, us girls were no stranger to this burden. In addition to a tight time schedule, my school's uniform policy was likewise strict. The girls were permitted to wear either khakis or plaid skirts. However, the brand and style of khaki was severely limited, and I found the acceptable pants to be almost unbearable when bloated and cramping. In my senior year, I took to wearing the plaid skirts exclusively. I took pleasure in the fact that unbeknownst to everyone else, I was always wearing pajama shorts beneath that skirt. I found the skirt to be immensely more comfortable than the pants when on my period.

The other girls used the skirts for the same reason, and we had a small inside joke about it. There was always an unspoken "girl code" among us. It was covert and secretive. We were spies, giving side eye and soft, near imperceptible nods when the back of a friend's pants was clear from a red stain. We offered our sweaters as protection from prying eyes when a bloody situation arose. Even the most bitter of enemies were willing to assist each other in this one area of shared discomfort. Young mentions this as menstrual etiquette, as a shared sisterhood of suffering. She writes, "we [women] dwell in the delicious space of shared secrets and protect one another from ridicule."[4] To save each other the embarrassment of being witnessed in our natural condition, we helped each other maintain appearances.

Though the bonding of women over this shared grievance may seem like a coming-of-age necessity, the fact remains that the secretive nature of menstruation continues to perpetrate the idea of shame. We are ashamed

[3] Young, "Menstrual Meditations," 112.

[4] Young, "Menstrual Meditations," 112.

of our bodies and therefore we band together to hide their natural functions. Questioning women when we leave in the middle of lecture or asking us why we are bringing our pencil case is uncomfortable because it is an acknowledgement that something is different or not normal. We are not born understanding that this natural, uncontrollable process of our bodies is shameful and must be hidden. Like many things, societal pressure forms our thinking. Young writes of this topic, "the message that a menstruating woman is perfectly normal *entails* that she hide the signs of her menstruation."[5] It does not logically make sense that women should feel this desperate need to conceal our natural condition. Society does not demand that anyone hide the fact that they sweat when exercising or that mucus comes out when they blow their nose. These bodily functions are considered normal, albeit unpleasant. Periods, however, are not treated the same way, and because of this, women feel pressured to hide them.

The poor education and misinformation spread about menstruation also serves to perpetrate women's discomfort. Because they can be misunderstood, especially by male counterparts, periods are often used as a weapon against women. It is a well-known and worn-out joke among men that if a woman is emotional, she must be on her period. Almost never is there an attempt to understand a woman's reaction, it is simply written off as unreasonable. As Young points out, men often do this "in complete ignorance of her [woman's] menstrual state."[6] This ignorance of menstrual processes further shames women and makes it difficult for us to work with others in the workplace and in the school environment. Many girls in the school environment are teased and bullied by male peers for simply having periods. To drop a tampon in front of a boy is to risk being taunted with crude remarks.

Given the aforementioned examples, it is no surprise that menstruation can be a cause of great distress in women. We do not always have adequate time to use the bathroom or the resources we need to maintain society's perception of normal. We band together in our struggle but do so largely without the assistance or understanding of our male peers. Though we understand that menstruation is normal, we still feel ashamed of it. While there is no easy solution to these issues, there are things that schools especially could do to combat the problem. For example, I remember sitting at a desk in fifth grade with my female classmates. The boys

[5] Young, "Menstrual Meditations," 107.

[6] Young, "Menstrual Meditations," 116.

had been sent outside for recess, but we had a special meeting today, only for the girls. A short video explained the very basics of menstruation and a friendly school nurse passed around a tampon and a pad. Already we were ashamed, passing the pads and tampons on as quickly as they came to us, careful not to touch them more than necessary. Understanding that they were associated with a process we did not want to identify with. "Hide them in your sleeves, and the boys will be none the wiser" the nurse smiled at us with a wink. At ten years old we understood that this was secret business, meant to be hidden. It felt like a cruel joke.

What remains a mystery to me is why the boys would not learn the details of menstruation until many years later in high school. Even in high school, the explanation is brief and inexhaustive in the most harmful way. Men's unfortunate ignorance of menstruation never fails to shock me. High school sexual education is notoriously lacking in practical information. Female anatomy is studied in its most mechanical form. The details are kept away, hidden from view lest they cause discomfort. This common practice of saving students from the awkward conversations about periods and the realistic description of what they entail does more harm than good and it is time for the school system to acknowledge this. The male students should never be left out of the conversations about menstruation. The proper education of female, male, and nonbinary students is tremendously important when it comes to eliminating misconceptions and fostering an understanding of what menstruation entails. Schools should teach students to be allies to those who menstruate, not bullies.

There is no need for menstruation to be a shameful secret, it is a natural, normal process. The failure to accommodate women is often born out of misunderstanding or the lack of consideration for their needs. I can think of many times where I found a building's bathroom situation to be inadequate or disappointing. I have even been in women's bathrooms that have no trash can or sanitary box in the stall, creating an issue for tampon and pad disposal. Young touches on the effects of this failure to accommodate women when she writes, "this failure of public acceptance increases a woman's sense of shame, and can disadvantage her in the distribution of benefits."[7] The misinformation about periods only serves to continue the narrative that menstruation is shameful and, as Young explains, makes it difficult for

[7] Young, "Menstrual Meditations," 109.

women to receive the benefits of practical information. Education can help to remedy the issue of accommodation and acceptance of menstruators.

Another solution to ease the experience of menstruation includes more leniency for women on their periods regarding bathroom privileges. To mark a girl tardy for something that is out of her control is demeaning and further supports the shame of her menstruation. Allowing more bathroom breaks for girls and ensuring that there are adequate emergency sanitary items in the bathrooms would immensely help with the experience of menstruating. This leniency could also diminish women's hesitancy to admit that periods sometimes cause uncomfortable physical symptoms. Many women attempt to "push through" the pain that menstruation can sometimes cause because they do not want to be perceived as weak or incapable. Schools especially should allow girls experiencing physical symptoms to rest without the stigma that they are weak for doing so.

Ultimately, the experience of menstruation continues to be a source of discomfort for women, especially in the school environment. The lack of adequate bathroom privileges and resources along with the shame and secrecy of the topic make menstruation uncomfortable for women. As a result of the secrecy, misinformation about menstruation is prevalent and intensifies the shame associated with it. Overall, one of the most efficient ways to aid women with the struggle of menstruation is to educate everyone about it. If the process of menstruation were introduced to all students at a younger age, perhaps it would become more normalized in society. Simply another facet of growing up. School systems should dispel the secrecy surrounding the topic and openly treat it as a natural occurrence to encourage girls to feel comfortable with the process. If young girls were not taught to hide tampons and pads and young boys were taught about tampons and pads, then it is possible that periods could be regarded as the unremarkable occurrences that they are.

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Opioid Crisis: An epidemic of societal failure

Djavdat Azizov

Introduction

The opioid epidemic is defined by the CDC as the increasing rates of prescription and illicit opioid overdoses that have occurred from 1999 to the present day. The nature of this epidemic has spread itself beyond the borders of the United States, but the focus lies on its origins within the US pharmaceutical industry. The CDC reports that nearly 450,000 individuals have died from opioid overdoses from 1999-2018, but the rates of opioid overdoses within that time interval have been on an upward trend (10). These trends indicate an exceptional challenge in combating this crisis, for the use of heroin and other opioid derivatives leads to an addictive cycle of abuse. Ultimately, the scope of observation and study must be changed in order to overcome this crisis and prevent similar tragedies from occuring in the future. This leads to an alternative proposal of analysis; the socioeconomic demographics of targeted individuals must be emphasized due to the displayed disparity in prescription rates and drug abuse. This disparity, which can be similarly found across other societal issues, is indicative that the burden of responsibility is not completely on the pharmaceutical industry as many like to assume. Rather, it demonstrates the reaches of an immoral economic system's domain and its impacts on marginalized communities. The impact of the epidemic will therefore be analyzed through a materialistic, or economic determinist, scope of analysis (2). Through this mode of analysis, the intersectionality of this crisis is sufficiently explained.

Gender & Class Analysis

The complexity in the opioid epidemic is manifested by the variation and disparity found across the socio-economic demographics of the population. Gender is one of the demographics that bluntly demonstrates this phenomenon. Source 8 effectively discusses the trends in opioid abuse between men and women along with other factors such as reasoning for abuse, methods of abuse, and underlying factors behind abuse. The trends indicate higher rates of use for men while women are simultaneously more likely to develop substance abuse disorders. The medicinal explanation is provided by the reference, for women's usage follows a wider time framework and tends to occur during the reproductive age. Consequently, this allows for women to have higher access to prescriptions than their male counterparts. While indicative of the pharmaceutical industry's willingness to overprescribe, the reference also provides an alternative rationalization of this trend through a sociological perspective. Women, particularly lower class women, form a mutualistic relationship between poverty and opioid abuse. The specific socio-economic group that the reference focuses on is women engaging in the act of prostitution. The mutualism of this relationship between opioids and poverty is determined by the fact that these women are able to find temporary comfort in the opioid high during their morbid living conditions while simultaneously engaging in dangerous methods of obtaining income to fuel their addiction. Another form of abuse is determined by the examination of the emotional trauma disparities between women and men, for it was conclusively found that women abuse opioids as a form of self therapy at higher rates than men. The criteria for this emotional trauma is the following: physical, mental, sexual, and childhood abuse. This gender-based injustice is not limited to the pharmaceutical sector of the medical industry, for other cases of unethical medical treatment towards women have shown prevalence in the last couple of centuries.

The easiest method of addressing this phenomenon is to simply say women and men are biologically predisposed to abuse opioids in varying ways (8). While this case has been made, it is not a sufficient explanation and the evidence is amply available to refute this claim.

The course of action is to synthesize the sociological and pharmaceutical explanations to form a coherent argumentative basis. The willingness to overprescribe women cannot be the root of this issue because the effects of poverty towards women and opioid abuse can be explained through the scope of economic determinism. Thus, the behavior of the pharmaceutical industry is a symptom of a much larger and parasitical problem. The question that needs to be addressed is what material conditions of our society allow for women to be exposed to an environment that operates on the usage of opioids as a coping mechanism. Source 1 discusses the relationship between the evolution of capitalism and the evolution of feminism. The success of nee-liberal feminism's attempt to minimize gender inequality is questioned by the basis that sexism still maintains a hold on our modern society. The brilliance of this claim comes from the fact that historically what is observed is the consistent contradiction between the accumulation of capital and women's suffrage. Women, in particular mothers, are taught to embrace their maternal labor or home labor as innate and unquestioned. The essential nature of this labor is therefore left unpaid despite its significance. The identification of this type of labor on the basis of gender is also leading to lower rates of educational specialization for women. The cultural pressures that women face are therefore allowing for the exploitation of their labor for the generation of capital towards others. This socio-economic relationship is further rationalized by the wealth disparities found between men and women (6).

What is found through these realizations is that women are not only abusing opioids differently from men, but the abuse comes from the elements of social hierarchy that are found within our society. Women are already predisposed to a lower social standing in comparison to the male counterpart, resulting in a harsher living climate. This economic foundation is simultaneously in a relationship with the social obligations that are expected of women, the hypersexualization of women, the draconian power dynamics of spouse relationships, and higher rates of prescriptions of opioids. The synthesis of all of these elements yields a disparity between men and women for opioid abuse and its severity.

Race & Class Analysis

By internalizing the symbiotic relationship present between a crisis such as the opioid epidemic and our socio-economic reality, it becomes quite clear on how our societal base imposes itself on our super structure. As observed in the gender disparities present in opioid abuse, similar disparities are observed in race demographics. An analysis of race disparities for the epidemic was conducted by the Minnesota Department of Health. Despite the study being limited to Minnesota alone, the resulting conclusions are indeed applicable towards a nation wide generalization. This assumption can be made because the institutions responsible for these disparities within Minnesota are not limited to that state alone. What conclusions the MOH was able to find is that African Americans and Native Americans are at a higher risk of opioid overdose than White Americans. Since the beginning of the epidemic, overdose rates have trended upward for all racial groups, but there are other statistical factors that offer a greater insight. Since 2010-2019, the race disparities increased with Native Americans being 7 times more likely to overdose and African Americans being 2 times more likely in comparison to their White counterparts (4). It seems that our ideology of equal opportunity and growth has failed to manifest itself within the domain of public health. The department of MOH raises an excellent point in utilizing social determinants as a method of analyzing drug abuse disparities. Social determinants include" the physical characteristics of the neighborhood a person lives in, access to healthy food, safe housing, quality education, and economic well-being" (4). Crucially, these social determinants are not isolated characteristics and their qualities are dependent on generations of socio-economic trauma. The following figure demonstrates how these determinants affect racial disparities for drug abuse:

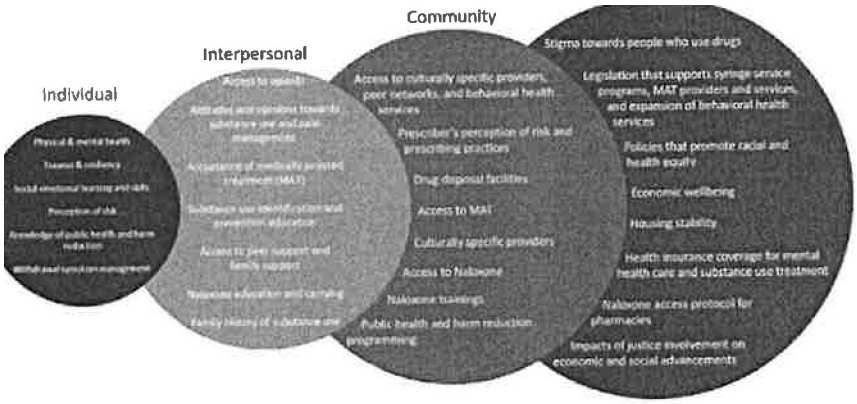

Figure 1: Social determinants on racial disparity of drug abuse (4).

The Department of Health offers a simplistic solution to this issue by emphasizing the significance of investment into these communities. With sufficient investment, access to medical resources, better education, better job security, and safer living conditions, the degree in these disparities would be minimized. Ultimately, this method of thinking becomes too idealistic.

Observation of the medical infrastructure as a whole indicates that profitability is the greatest driving force in how medical policy and resources are allocated. Source 3 examines the relationship between profit and the US medical infrastructure, and states "medical care problems are always defined as business or economic problems, and hence solutions are automatically formulated in economic and socio-organizational terms." In essence medicine has been compromised by the ideology of profit, allowing for a transition from the goal of providing treatment and alleviation of suffering to the maximization of profit. This notion of capitalistic roots within the domain of modern life will be further explored. Financial aid into these communities would be crucial to resolving this issue, but the trends of drug overdose within these communities in the last 10 years indicate a failure in finding these investments. The lack of profit within these communities is thus the limitation of building the necessary environment for adequate health. What must be addressed is why these diverse communities lack the profit in the first place and the historical circumstances surrounding these areas.

It is not a radical idea to state that the medical industry, along with the other economic powerhouses of the nation, have proven their disdain towards POC communities. One can look back less than one hundred years to observe horrific, unjust tragedies such as the Tuskegee Syphilis experiments. The National Center for Biotechnology Information also reports the varying degrees of racial prejudice that exists within modern medical institutions on the basis of geographical location, appearances, and economic standing (7). The difficulty in resolving these racial issues within medicine comes from the inability to concretely define systemic discrimination. In many cases, these are individualized stories with different circumstances and thus it is difficult to pinpoint the solution of the problem. Due to this overencompassing situation, the racial critique cannot be limited to the medical industry exclusively, so the root of this discrimination must be examined as well. Using the precedent of economic determinism once again, modern racial discrimination can be explained on the basis of capital and production relations. In a similar fashion to how women's suffrage has stood in contradiction with the growth of world capital, so has racial empowerment but to a drastically different degree. Source 6, along with its analysis on the relation between gender and capital, also provides a thorough dialogue on race relations with class. What has been conclusively found is that African-American individuals are being abandoned by their political institutions in a time where assistance is necessary. Some examples include the reduction in Social Security benefits in comparison to their White counterparts along with disparity in community funding (5).

In essence, the mechanisms of many policy movements are incentivized to bring about unequal payouts based on demographic categories. The root of this systemic racism must be addressed in some fashion, for it is simply not enough to label racism without targeting its underlying precedent. I present our economic foundation as the highest proponent of systemic racism within this nation, and through this institutional battlefield is where the consequences of disparities in health, drug abuse, wealth, and economic flexibility arise. Sociologist Alan Spector effectively deconstructs the separation of class and racial oppression in one of his publications (9). In this publication, he denounces the fixation on either economic determinism or psychological determinism in the critique of capitalism. in essence, he molds the two different forms of oppression as not objectively different from each, but rather as two different symptoms of the same disease.

The controversial argument that Spector presents is that the concept of race is ultimately a political fabrication that arose to propel the worldwide exploitation of labor via imperialistic methods. Through this construction of race, individuals could be subjugated to exploitation through a psychological basis rather than an economic basis. While this may seem dismissive of racial discrimination that individuals have personally experienced, it is not intended to be that way. instead, this serves as an explanation and rationalization on why racism has kept its shackles on marginalized groups worldwide. To further emphasize the significance of this claim, the wealth gap between White Americans and Latinos is similarly found between Protestants and Catholics in Ireland, Jewish Israelis and Arabian Paiestenians, and Buddhists and Muslims in Myanmar (9). It is through this dialectical analysis that the suffrage of class and race are not minimized, but rather fused together to form an intersectional argument. It is in the quest of accumulation of wealth that racism began to manifest itself to the highest degree.

Spector also refutes the pointless argument of which came first by discussing how both concepts symbiotically shaped themselves into the modern conglomerate we observe today (9). The result of this historical development has led to stratification of the population on the social basis of race. Simultaneously, the capitalist mode of production stratifies the human population into the bourgeoisie and the working class. Synthesizing these two ideas together, racial discrimination and race as a whole find their roots as psychological manifestations of the innate material hierarchies that inevitably arise from capitalism. A dialectical analysis is thus made.

The acceleration of Neo-Liberal thought that has occurred since the 1970's has established capital as the most prevalent root within many public and private institutions.

Indisputably, the institutions of medicine have also fallen into this category, for privatization of medical care has sufficiently grown in the last 40 years (5). This has consequently led to drastic cost increases in medical care, and investments have become limited to profitable geographical areas. An essential service that exists for the betterment of the population has thus become synonymous with a market driven megacorporation. This results in individuals that are unable to provide a profit to be abandoned without

access to medical treatment and other essential infrastructure. The same methods of exploitation found in the working field are now being applied through a wider, societal scope. Upon examination of the sources listed previously, the failures of Neoliberalism for POC communities are exhibited through not only the lack of effective medical resources, but also in the apparent economic stagnation, crumbling infrastructure, and higher rates of drug abuse. The generations of economic and political trauma that have plagued these communities have not been eliminated, but rather evolved alongside the evolution of capital's reach into other domains of our society. The disparity of the opioid crisis and the failure to find resolution is indicative of this observation.

Synthesis of Analysis

Through the scope of economic determinism, what is established is the analogous relationship found between class and social factors such as race and gender in social crises. The disturbing underlying element found in the analysis of both demographics is the degree of similarity that comes through this method of exploitation, indicating the innate nature of this method of oppression. It would not be fair to declare the modern economic model as sinisterly racist and sexist because it is a consciousness-free entity, for this is a system that has naturally arisen alongside human development and governs its hold on political, social, cultural, and psychological elements in a mindless fashion. It is simple and easy to scapegoat these issues onto particular individuals or groups as done so previously in our history, but this would once again be an idealistic way of thinking. Rather, the sinister nature of this reality comes from the fact that these phenomena are governed by the material circumstances of our society, outside of the human mind. Despite this, mankind has the capacity to make change occur, as slow as it may seem to be. The injustice that has occurred within the pharmaceutical industry has led to a crisis that still plagues communities 20 years later, and it is in this timeframe of no resolution where humanity has failed itself. The demand of accountability towards individuals in direct involvement with this injustice along with many others can be similarly compared to putting a bandaid on a cancer tumor, for the tumor will maintain its hold on the biological host and continue

to spread into other internal domains. The opioid epidemic is therefore not an isolated instance of medical failure, but rather it is another byproduct of a fleeting attempt to strangle out the last bits of wealth. In the same way that genocide is committed over resources, slave labor is exported overseas, overpolicing is subjugated over marginalized communities, stigmatization and antagonism is directed towards unionization, and the reduction of economic mobility, opioids have ravaged marginalized communities and left them to deal with aftermath through a conquest of profit. The severity of demanding an address of these issues lies in the fact that these crises have and will continue to envelop our world until there is nothing left to plunder.

Despite the discomfort and controversy that surrounds this morbid phenomenon, it must still be addressed if as a society there is a goal to bring an end to exploitation and injustice.

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Impact of Structural Racism on the Health of Elderly BIPOC Populations (excerpt from Senior Honors Project)

Alexus Meduna

Introduction:

Racism is often considered a personal attitude or bias towards Black, Indigenous, and/or people of color (BIPOC) individuals or communities. It's frequently thought of as actions or beliefs that are a part of individuals' conscious consideration. But what if this is an oversimplified view of the way that racism is perpetuated that our society has outgrown? Is it possible that each of us can actively participate in racist systems, sustaining inequalities for people of color without even realizing it? The United States is composed of systems that have a long and tragic history of disproportionately disadvantaging people of color. A significant area of inequality that has been observed in the United States is how structural racism in many facets of our society contributes to disparities in the health of elderly populations. Examining the impact of structural racism on elderly populations gives a unique opportunity to assess how experiencing structural racism over a lifetime and in many contexts impacts the health of individuals.

Before delving into how structural racism specifically impacts health in older BIPOC Americans, it is important to understand what structural racism is and the ways it differs from systemic and individual racism. According to the Aspen Institute's "Glossary for Understanding and Dismantling Structural Racism," structural racism exists in systems where "public policies, institutional practices, cultural representations, and other norms" perpetuate inequalities based on race. Systemic, institutional, and individual racism each focus on one aspect of racism that is observed in society and institutions. On the other hand, structural racism is a way of obtaining a more complete picture of the underlying issues that contribute to the health inequalities observed in elderly BIPOC Americans.

Historical Background:

The United States has a significant and troubling history of racial injustice that continues to this day. Following the adoption of the 14th amendment in 1868, this country has continued to use laws and policies to put BIPOC communities at a distinct disadvantage. In his article "Systemic racism is a cause of health disparities," Mark Johnson,

MD, MPH explores several policies that can be tied to current socio-economic disparities observed in the US. This first policy was the National Housing Act of 1934, which was designed to support the banking industry by subsidizing housing development programs (Johnson 163). However, limitations of this legislation restricted the sale of these homes to African Americans as well as inhibiting mortgage offers to Black communities.

The Social Security Act of 1935 was another instance of racial discrimination in national policy. The bill was established to offer benefits to elderly and disabled individuals except for domestic and farm workers (Johnson 163). Domestic and farm workers were overwhelmingly Black at that time, restricting their access to the benefits that many white Americans were able to receive. Both the National Housing Act and the Social Security Act of 1935 were designed to provide support for struggling Americans, yet a distinct population of Americans did not have access to said support. The inability of Black Americans to access financial support offered through these pieces of legislation put them at a disadvantage financially and otherwise. Being unable to receive financial support, such as a mortgage often results in families living in less desirable neighborhoods, so this legislation resulted in BIPOC families collectively residing in impoverished communities, a phenomenon that has been coined, residential segregation.

Residential segregation has been observed throughout the United States and plays a large role in socio-economic and, consequently, health disparities that are observed by race and ethnicity. According to the American Public Health Association, Black people are more likely to live in areas that have limited access to adequate or safe "housing, water, air, and green space as well as healthy foods." It is also common for educational disparities to be observed due to residential segregation. Despite the ruling made in the Brown v. Board of Education trial that made the strict segregation of schools illegal, school districts are still "racially concentrated" and "segregated by income," leading to a poorer quality of education for children of color ("Structural Racism is a Public Health Crisis"). Schools are typically funded by property taxes of the areas they serve. Therefore, if communities are segregated by income, which is connected to racial segregation, children of color will be subject to a decrease in educational quality because their schools will have less funding from the property taxes in their community. The decrease in education quality as well as resource disparities seen despite the Brown v. Board of Education ruling also play a significant role in the school to prison

pipeline, causing a disproportionate number of African American men to enter the criminal justice system (Darensbourg et al. 197-200).

Such residential and educational segregation, in concert with political economies such as the mortgage market, impact health disparities either directly or through other mechanisms such as their impact on socio-economic status (Sewell 420). In her examination of mesolevel economic frameworks, Abigail Sewell showed that political economies, such as the mortgage market impact health both directly and indirectly through other means that will be examined in greater detail later. Moving forward, the impact of these historical policies will be assessed in conjunction with many other social structures that impact the health of a distinct population of Americans.

This has been a brief and incomplete history of racial injustices through various policies that have been carried out in the United States, highlighting the deep-rooted racism that exists. Much of what has been discussed correlates to lower socioeconomic status (SES) and education in BIPOC communities and these variables set the stage for disparities in the health of elderly BIPOC people. Segregation based on income contributes to the existence of "low-quality, high-cost hospitals" which serve elderly Black patients at over twice the rate of "high-quality, low-cost hospitals" (Jha et al. 1908). This is just one example of how years of systemic and institutional racism are still contributing to the structural racism we observe in society today. This historical background provides the basis for the work of untangling the incredibly complex web of institutional, cultural, and individual racism that impacts the health and well-being of the elderly BIPOC community in the United States.

Discussion:

The vast web of factors that influence the decreased quality of health care observed in the elderly, BIPOC Americans highlights how policies or practices that are focused on health care, as well as those that are not, can equally contribute to racial disparities. While residential and educational segregation has a long history of impacting the BIPOC community, health insurance coverage, advanced care planning opportunities, and occupational segregation also impact everything from access to quality of care received. In recent years, many of these factors have been exacerbated due to the COVID-19 pandemic. This has shed light on many injustices that have been brushed under the rug for far too long. Considering the impact of racism on the health of BIPOC

communities, the CDC Director, Rochelle P. Walensky, MD, MPH, stated:

> What we know is this: racism is a serious public health threat that directly affects the well-being of millions of Americans. As a result, it affects the health of our entire nation. Racism is not just the discrimination against one group based on the color of their skin or their race or ethnicity, but the structural barriers that impact racial and ethnic groups differently to influence where a person lives, where they work, where their children play, and where they worship and gather in community. These social determinants of health have life-long negative effects on the mental and physical health of individuals in communities of color. ("Media Statement")

Dr. Walensky's assessment of racism as public health threat shows the intense effect that it can have on the BIPOC community's collective and individual health. The recent COVID-19 pandemic has presented a valuable opportunity to examine the disparities present at a time of global disaster, investigate the causes of the injustices being witnessed, and work towards equality.

Healthcare

Health Insurance in the United States: History and Impact on Patients and Physicians

Tess Sether

Health insurance is a vital component of healthcare in the United States. It has helped and continues to help many people afford health care and improve their health since its creation. Although many Americans have health insurance whether via private plans or public plans, a vast number of Americans do not have any health insurance coverage at all. The number of uninsured U.S. residents has been gradually increasing. More specifically, approximately 28 million people were uninsured in 2018 compared to 31.1 million in 2021 (Cohen et al. 1,2; Woolhandler and Himmelstein 1). Although there are benefits to health insurance, the policies and costs can negatively impact both physicians and patients. Furthermore, its impact has been altered by the COVID-19 pandemic from late 2019 to present day. The role of health insurance in medicine plays a drastic role in financial burden, quality of care, health of patients, and the interaction between physicians and patients.

In history, health insurance has gradually become beneficial to Americans. Health insurance was non-existent before the 1920s. During that time frame, the net cost of medical care was fairly affordable and was not a constant worry for individuals. Specifically, the average family in 1929 had medical expenses comprising 5 percent of their average annual income (Moseley III 325). When people became ill and could not work, resulting in the individual not getting paid (Thomasson; Moseley III 324-325). The main concern of not working versus the cost of medical services was seen in the results of a 1919 State of Illinois study, which demonstrated that lost wages from sickness were 4 times greater than the medical cost of treating the illness or disease (Thomasson). This led to the first form of health insurance, covering hospital and medical expenses, which was also instigated by the increasing costs of hospital care (Anderson; Thomasson). Although this concept of health insurance rapidly became popular, insurance companies were not fond of insuring health. Due to the "high potential for adverse selection and moral hazard," health was not believed to be accurately insured by

commercial insurance companies (Thomasson; Moseley III 324). Even with resistance from insurance companies in the beginning, the development of the first prepaid hospital insurance plan, a precursor to Blue Cross, for assistance with the payment of medical expenses was accomplished in 1929. This was formed from a group of Dallas school teachers who received a contract with Baylor University Hospital to obtain 21 days of inpatient care per person per year for a fixed, one-time payment of 6 dollars (Moseley III 325). The number of plans similar to this increased to a total of 26 plans by 1937, which were combined to form the Blue Cross network of health insurance plans (Moseley III 325). This helped 3 million Americans gain coverage by 10 years after its establishment in 1929. Although this was a great progression, it did not cover any health services outside of the hospital. Therefore, in the 1930s, employers in the lumber and mining industries started providing physician services to their employees via payroll deduction. This eventually led into the National Association of Blue Shield Plans (Reed 1,2). These health insurance companies eventually merged and became the Blue Cross and Blue Shield insurance companies. This moment of history represented an exponential leap in health insurance for Americans.

The initial goal of health insurance plans was to protect patient finances and help keep hospitals afloat. The intention was to accommodate both the hospitals and patients in America. Although the creation of private health coverage such as Blue Cross and Blue Shield benefited many patients and hospitals, additional individuals were not able to afford health insurance or medical care with the prepaid amount. This prompted the creation of Medicare and Medicaid. The first significant development of public health insurance was Medicare and Medicaid, signed into law by President Lyndon B. Johnson in 1965 (Berkowitz 11). Medicare is a federal insurance program for individuals older than 65 years old or with a disability. Medicaid is a state and federal assistance program that provides health coverage for low-income individuals of every age (Berkowitz 15-17). Although these plans gave consumers an affordable way to pay for inpatient care, the primary purpose was to ensure hospitals a steady income stream during declining revenues. (Moseley III 325-327). It is disappointing that the initial purpose of these insurance plans was not a concern for the average American but for hospitals to generate a profit. Unfortunately, present insurance plans still leave many Americans without insurance due to the government's requirements to obtain coverage.

The number of insurance plans increased immensely due to competition between health insurance companies and the increased cost of medical care. Within the last decade, the public insurance system and lack of affordable private insurance coverage left millions of people without health insurance (Garfield and Orgera 2). Previous efforts were made to make healthcare more available and affordable to the public. In 2010, the Affordable Care Act (ACA) was created to extend health coverage to remaining uninsured Americans. This Act made affordable health insurance more available by providing consumers with subsidies, or premium tax credits, to lower costs for households with incomes between 100 percent and 400 percent (12,140 dollars and 48,560 dollars per year for an individual in 2018) of the federal poverty level (Garfield and Orgera 2). Additionally, the law expanded the Medicaid program eligibility to cover adults with incomes below 138 percent of the federal poverty level in states that adopted the expansion, and the law prevented insurance companies from denying coverage due to pre-existing conditions (Borelli et al. 58-60; Garfield and Orgera 2). Through the following years, the insurance plans and regulations have been slightly expanding health insurance coverage; however, this did not significantly impact the number of uninsured people due to their inability to qualify for free or government-funded health insurance plans.

Although the Affordable Care Act significantly dropped the nation's uninsured rate, an estimated 31.6 million Americans were still uninsured in 2021 ("America's"). In 2013, the year before major coverage provisions of the ACA, more than 44 million people lacked coverage ("America's"). Following the ACA, the population of uninsured declined by 20 million, reaching a historic low in 2016. This resulted in an uninsured population of 26.7 million with an uninsured rate of 10.0 percent (Tolbert and Orgera 2). Although there was a significant number of Americans left uninsured, the net effect of ACA had a positive impact since the number of uninsured individuals continued to decrease. However, this progress halted and reversed in the years following 2017. Beginning in 2017, the Trump Administration tried to disrupt many of the policies implemented by the ACA. This led to an increase to 28.9 million uninsured nonelderly Americans in 2019 with an increase to 10.9 percent in uninsured rate (Tolbert and Orgera 1-3). This likely contributed to the repeal of ACA's requirement that people have health coverage or pay a fee. The increased number of uninsured individuals proved that the altered ACA via Trump was not as effective as

in prior years and should be reconstructed in years to come.

Unfortunately, the lack of health insurance is more common in Black, Indigenous, and People of Color (BIPOC) communities across the United States. When the uninsured population was at its lowest in 2016, the health coverage gains were largest among low-income and people of color. When there were several changes in the policies of ACA in 2017, racial groups including Blacks, non-Hispanics, children, adults of ages 45 to 64, and middle income families increased in uninsured rates by approximately 0.6 percent from 2016 in states that did not expand Medicaid (Garfield and Orgera 8). This is contrary to the effects of ACA in years prior to 2017 on minority racial and ethnic groups. For example, the uninsured population of Hispanics, Blacks, and Asians declined significantly, with each group's uninsured population decreasing by 8 percent from 2013 to 2016 (Garfield and Orgera 8). More specifically, the uninsured rate of Hispanics declined from 32.6 percent to 19.1 percent This demonstrated progress towards health insurance equity in America since prior to the ACA in 2010, nearly 33 percent of nonelderly Hispanic, American Indian, and Alaska Native people were uninsured compared to only 13.1 percent of nonelderly White people (Artiga et al. 1). The disparity in health insurance among races was found in another study. According to the American Community Survey of 2017, 22 percent of American Indians and Alaska Natives, 19 percent of Hispanics, and 11 percent of Blacks were uninsured compared to 7 percent of Whites (Artiga et al. 4).

Although the ACA significantly reduced uninsured rates in minority populations, the eligibility varies across racial and ethnic groups, resulting in many remaining ineligible. For example, uninsured Blacks are more likely than uninsured Whites to fall victim to the coverage gap in non-expanded Medicaid states, and uninsured Hispanics and Asians are less likely than uninsured Whites to be eligible for coverage options (Artiga et al. 4). This is still a present problem. In data from a study conducted from January through June 2020, 26.5 percent of Hispanics, 13.2 percent of non-Hispanic blacks, 9.7 percent of non-Hispanic whites, and 9.3 percent non-Hispanic Asian adults aged 18 to 64 were uninsured (Cohen et al. 5). This demonstrates the inequalities in health insurance coverage are most significant in Hispanic and Black compared to White and Asian adults. The disparity amongst BIPOC communities for the affordability of health insurance may be a factor in the lower physical health and higher mortality rate of uninsured individuals

compared to insured individuals. Although there is racial disparity in health care regarding health insurance coverage, the lack of health insurance among races of color has decreased since the implementation of ACA.

Having or lacking health insurance does affect access to care in the United States. There is still a vast difference in access to health care between those with Medicaid, Medicare, private health insurance, and those who are uninsured. There is also a massive difference in the affordability of health care between private and public health insurance plans. Since the ACA has been in place, both average premiums, the amount of money an individual pays for the insurance policy, and deductibles for unsubsidized Americans have increased (Kagan). According to eHealthInsurance, a private online marketplace for health insurance, the average premium for an individual was 456 dollars per month compared to the premium for family plans at the price of 1,152 dollars per month in 2020 (Porretta). In 2020, the average deductible for the individual plan was 4,364 dollars, and for a family, the plan was 8,439 dollars (Porretta). These statistics display the expense of purchasing a private health insurance plan. Furthermore, it helps prove that an individual's salary can affect their health by limiting their ability to purchase a higher 'premium' insurance plan. The cost of both private and public health insurance plans is the most common reason cited by uninsured individuals. In 2019, 73.7 percent of uninsured adults stated the reason they were uninsured was that the cost is too high, which makes it the most common reason cited (Garfield and Orgera 11). The cost of health insurance is not only a problem for uninsured adults but also for those who do have health insurance coverage. For example, approximately 46 percent of insured adults reported difficulty affording out-of-pocket costs and nearly 27 percent reported trouble affording their deductible (Kearney et al. 1). This demonstrates the problem with the affordability in health insurance. It prevents individuals from buying health insurance but also creates financial strain for those that do purchase plans.

Not having insurance in this country can result in a variety of consequences for the health of a person. According to a 2017 comprehensive review of studies published in the Annals of Internal Medicine, being uninsured substantially raises the risk of dying (Woolhandler and Himmelstein 427-429). For instance, uninsured adults are over three times more likely to not have visited a doctor about their health in the past 12 months (Garfield and Orgera 13). For the uninsured adults that

do seek care, it is much less than those with private or public insurance or on Medicaid. According to a National Health Interview Survey, 46 percent of uninsured adults report not having a usual source of care, such as a primary care physician, compared to 9 percent of those with insurance (Claxton et al.). A reason for this disparity is due to the high cost of appointments and prescriptions. In 2019, nearly 30.2 percent of uninsured adults went without needed care due to cost compared to 9.5 percent with Medicaid or Medicare and 5.3 percent with private insurance (Garfield and Orgera 13). Similarly, 19.8 percent of uninsured adults postponed or did not get needed drugs due to the cost compared to 14 percent who have Medicaid and 6.0 percent who have insurance through private plans (Garfield and Orgera 13). This displays an issue in the current system of health care insurance. People should not have to contemplate whether their health is as important as other things in life due to the high expense without insurance. This demonstrates that health insurance can impact whether they receive proper health care.

Due to high medical costs, uninsured patients are less likely to get access to regular outpatient care, resulting in the likelihood of having negative health consequences. Often, they have an increased risk of being diagnosed at later stages of diseases, including cancer, and have higher mortality rates than those with insurance in and outside the hospital (Garfield and Orgera 13-14). For example, among patients hospitalized with acute ischemic stroke, those who were uninsured had a higher level of impairment to the central nervous system and a 24 percent higher rate of mortality ("Increasing" 1). Having insurance or not impacts any person with a disease both in treatment from physicians and being able to obtain prescribed medication, especially when the diseases are terminal. In the *Journal of Clinical Oncology*, Ahmedin Jemal, DVM, Ph.D., of the Surveillance and Health Services Research program at the American Cancer Society, and colleagues, found a small but significant shift toward the diagnosis of stage 1 disease for some cancers in patients with health insurance coverage (Lawrence) This continues to inform the need for expansion of access to care, especially for the uninsured. "Lack of insurance is also associated with late-stage diagnosis, receipt of suboptimal care, and reduced survival after a diagnosis of cancer," the researchers explained.

Similar results were found by a study published by *Cancer* in 2017. The study found that uninsured women who are diagnosed with breast cancer were 60 percent more likely

to die from the disease, and the women without insurance were 2.6 times more likely to be diagnosed with a later stage of the disease compared to women with insurance ("Uninsured"). Additionally, Medicaid patients are more likely to be diagnosed with late-stage cancer and have lower survival rates than privately insured women but have higher survival rates than uninsured women. The author, Kimberly Johnson, Associate Professor of Epidemiology at Washington University in St. Louis, stated a robust possible cause for these results is lack of access to primary care and mammography screenings ("Uninsured"). This devastating result is repeated in the *Annals of Internal Medicine*, as showing that lack of coverage increases death rates in diseases such as breast cancer (Woolhandler and Himmelstein 1). With the expansion of health coverage and access to primary care physicians, breast cancer can be detected earlier, and the mortality rate can decrease. The effect of health insurance on the progression of multiple types of cancer. For example, Gerard Silvestri, MD, a professor of medicine and a lung cancer pulmonologist at the Medical University of South Carolina (MUSC), found that uninsured patients had the lowest survival rate, followed by Medicare patients, and privately insured patients had the best survival rate when patients among 16 types of cancer were analyzed (Wallace). This further demonstrates that being uninsured mainly affects someone's health due to the lack of access to care. Even with access to care, health insurance can affect an individual's health by affecting prescription medications that are required for quality health.

The type of insurance plan or whether an individual has insurance can have a negative impact on those who are uninsured with medication coverage A report from the Centers for Disease Control and Prevention showed that 40 percent of uninsured adults asked to be prescribed lower-cost medication, 33.6 percent did not take their medication as prescribed, and 13.9 percent used alternative therapies to reduce costs (Cohen et al. 2-5). Uninsured patients are not alone in concern for the cost of medications and prescriptions. According to the Kaiser Family Foundation analysis of the National Health Interview Survey, over 6 in 10 adults were prescribed a drug by a provider in 2019 (Kirzinger et al.). From those adults, including the people who are insured, 24 percent of adults and 23 percent of seniors state it is "difficult" to afford their prescribed drugs. This is representative of most Americans. According to a Kaiser Family Foundation poll, 79 percent of individuals think prescription medication prices are outrageous (Kirzinger et

al.). Unfortunately, this problem is not completely solved with health insurance plans since nearly 51 percent of patients asked for cheaper options, and 29 percent delayed filling a prescription or did not take their medicine due to money strain (Kirzinger et al.). This is further evidence that being uninsured or underinsured in the current health system can negatively affect an individual's health significantly by affecting their ability to obtain medication to sustain or better their health.

Despite public knowledge of unaffordability for the uninsured, only 27 percent of uninsured adults reported receiving free or reduced-cost health care (Garfield and Orgera 16). According to *JAMA Internal Medicine*, a study conducted by Tim Xu, MD, MPP, et al. noticed that many hospitals charge uninsured patients higher rates than those paid by private health insurers or public programs (Xu et al. 1141-1143). Not only do uninsured people not receive any healthcare that is free or has a reduced charge, but 33 percent of uninsured people are asked to pay for the full cost of medical care before they could see a doctor (Garfield and Orgera 16). This issue is absurd because it persuades patients to contemplate what is more important: their health or other necessities of life, such as food, housing, and clothes. More importantly, this response could be a reason why the majority of the uninsured population is less likely to seek care: they cannot afford to pay for medical care without financial assistance. This results in patients having medical debt. In 2020, 31 percent of insured adults and nearly 50 percent of uninsured adults were struggling to pay medical bills. Unfortunately, many remained in debt. Approximately 34 percent of individuals with private health insurance and 46 percent with public health coverage reported being in debt due to medical bills ("NEW"). Additionally, an amount of 65 percent of uninsured adults with medical bill problems was unable to pay the medical bill at all (Garfield and Orgera 1). These statistics demonstrate that the affordability of health insurance affects both uninsured and insured Americans.

These statistics show that the U.S. healthcare system is poorly coordinated and highly fragmented, emphasizing the prioritization of intervention rather than prevention. The recent impact of the coronavirus disease 2019 (COVID-19) pandemic on health insurance also represents this. The COVID-19 pandemic started in December 2019 and remains in 2022. The initial onset of COVID drastically affected health insurance coverage in America. An economic downturn accompanied by a large decline in employment, reaching an unemployment rate

of 14.7 percent in April 2020 (Bundorf et al. 2), directly corresponded to a reduction in insurance coverage since nearly 155 million working-class individuals have health insurance through an employer-sponsored (ESI) plan according to a report from the Kaiser Family Foundation ("2021"). This corresponded to data from the U.S. Census Bureau's Household Pulse Survey that reported 3.3 million people lost ESI by the middle of 2020 (Gee, Waldrop). This demonstrated that health insurance dependent on employment could be dangerous and ineffective. This was not ideal, especially during a pandemic in which public health was at risk. Since ESI dominates the private insurance market by nearly 90 percent, there was a drop in private coverage to 71.8 percent (Keisler-Starkey). Although private health plans decrease between 2019 to 2021, enrollment in public insurance programs, such as Medicaid/CHIP, surged during the pandemic. Data from the end of 2021 showed that Medicaid/CHIP enrollment increased by 20.5 percent since the start of the pandemic (Corallo and Moreno). This was likely due to an increase in eligibility from income and job loss. Since Medicaid is the largest federal health insurer in the U.S., this explained the 9.2 percent increase in Medicaid spending in 2020 compared to a 3.0 percent growth in 2019 (NHE). Fortunately, the unemployment rate declined to 6.7 percent in December 2020 (Bundorf et al. 2). However, even when the unemployment rate declined, the enrollment rate in public insurance plans was higher than private insurance plans, resulting in no change in the overall rate of health insurance coverage (Keisler-Starkey). The decrease in the unemployment rate led to there being no statistical difference in the uninsured rates for adults ages 19 to 64 between 2019 and 2021 (Keisler-Starkey).

Although the pandemic impacted the amount of health insurance coverage, health insurance coverage also impacted patients' health. Approximately 40 percent of all COVID infections were correlated with gaps in health insurance. Furthermore, the lack of health insurance has been correlated with more fatalities. For instance, a 10 percent increase in the proportion of county residents without health insurance were correlated with a 70 percent increase in the number of cases and a 48 percent increase in deaths from COVID (Keisler-Starkey). This data suggests an increase in COVID cases in counties where there is an increase in the uninsured rate of the county population. A study published in JAMA Network Open reported a greater proportion of excess deaths not reported in COVID-19 death counts occurred in areas of reduced access to health insurance and

primary care services proposing that health insurance coverage was a possible factor in the inaccurate COVID-19 death counts especially in areas with a greater percentage of uninsured residents (Stokes et al. 1). Along with impacting the data integrity of counted COVID-19 deaths, this could exacerbate the existing racial and ethnic inequalities in health care. The disparity before the pandemic was shown in a federal study from the U.S. Census Bureau found 27.2 percent of Hispanic adults and 13.6 percent of Black adults compared to 9.8 percent of white adults were uninsured in early 2019 and this lasted well into the pandemic (Cohen, Cha et al. 4).

There were recent actions to reduce this disparity and the problem in lack of health insurance. One example is the American Rescue Plan (ARP) of 2021, passed under the Biden administration. This Plan was a COVID-19 relief bill that extended eligibility for the Affordable Care Act health insurance subsidies and increased premium tax credits for Marketplace plans for 2021 and 2022 (Lukens et al. 1). This significantly helped the plans become more affordable, which was a consistent problem in the past. Statistics showed health insurance coverage increased to 14.5 million people, representing a 21 percent increase over 2021 ("During" 1). This Act increased affordability and health insurance coverage, allowing access to coverage for minority communities who regularly face health disparities. For instance, the ARP led to 76 percent of uninsured Black Americans obtaining a plan for less than 50 dollars per month and 66 percent could obtain a plan for free in 2021 ("FACT"). Furthermore, there was a 60 percent increase in Black Americans who enrolled in the insurance marketplaces. The ARP helped other underserved minority communities, specifically the Latino community. For instance, through ARP investments, 69 percent of Latino uninsured adults have access to a zero-premium plan and 80 percent have access to health insurance plans for less than 50 dollars per month ("FACT"). This Act has made significant advances in helping reduce racial disparity in health insurance coverage.

Health insurance is commonly viewed to primarily affect patients; however, it can also affect those caring for patients. When the ACA was implemented, a mandate for "electronic health records (EHR)" was issued (Pipes). The intention of this mandate was to reduce medical errors and improve communication between health care providers to improve diagnosis. The mandate provided financial compensation to physicians and hospitals. By adopting EHR, physicians and

other healthcare providers can earn up to 44,000 dollars from Medicare and 63,750 dollars from Medicaid, and hospitals can earn millions of dollars (Ferris). This event forced physicians to show "meaningful use" of digital medical records starting in 2014 or risk cuts in their Medicare and Medicaid payments (Ferris). This meant that in order for physicians to make the salary they want, they must spend less time with patients and therefore feel less connected to them primarily because of the use of this technology and its mandates than can affect their financial earnings. In 2015, a study published *Family Medicine* showed that family physicians spend nearly 54 percent of clinic visits engaging in EHR than interaction with patients (Monica). This data demonstrates that EHR have a significant negative impact on the amount of physician-patient interaction time.

The interaction with patients is very important to physicians. A big component in physician satisfaction, according to a RAND Corporation survey, was the ability to provide quality care to patients (Walden 1). This can be affected by health insurance companies. Dr. Walden, University of North Carolina Department of Family Medicine assistant professor, discusses how uninsured, underinsured, or Medicaid patients often receive lower frequency of health care when specialists or the hospitals they practice in limit the number of Medicaid patients they are able to see (1). This can increase stress in physicians who try to problem-solve how to provide diagnostic tests or specialty care for those whose insurance does not cover the costs. Additionally, the EHR mandate and barriers that insurers create are some of the elements that nearly 40 percent (Pipes) or 48 percent of physicians ("Putting") find the least satisfying part of their jobs and make them consider leaving medicine. In the *Pensacola News Journal,* Dr. Benjamin Kaplan wrote that "bureaucratic paperwork has contributed to a 25 percent increase in physician burnout" (Adriano). Although electronic health records reduce medical errors in prescriptions and improve diagnosis of diseases by the inclusion of previous labs and medical conditions, it needs to be reevaluated to improve the work-life balance of a physician that can result in better patient care. These statements from surveyed doctors show that mandates from health insurance companies such as EHR are harming patient care because it takes valuable time away from the doctor and patient interaction lowering quality of care physicians can provide. These reasons directly display the effects health insurance companies have on the physician and the relationship between physicians and patients.

Although Medicaid and Medicare provide health coverage for hundreds of millions of Americans, they impose enormous regulatory burdens on physicians while paying them less than private insurers (Pipes). The cost of interacting with insurance plans and their mandates can be very expensive. According to estimates from the Center for American Progress, health care providers in the U.S. spend approximately 496 billion dollars on billing and insurance-related costs (Gee and Spiro) and U.S. physician practices spend more than 15.4 billion dollars reporting quality measures related to EHR (Casalino et al. 402). Additionally, in order to control insurance-related paperwork, 77 percent of primary care physician practices hire more staff and 65 percent have worries of facing legal risks due to the policies of insurers ("Putting"). Furthermore, this fact leads to 66 percent of doctors saying the increased use of EHR mandate has reduced the time they spend with patients (Pipes). The American College of Physicians states that the average doctor does two hours of administrative work, relating to insurance companies, for every hour spent with patients (Adriano). Some practices report physicians spend 785 hours annually on required administrative tasks required by health insurance companies (Casalino et al. 401-402). This can impact the quality of care patients receive. Not only do 90 percent of 600 interviewed doctors report that requirements of health insurers diminish time for patient care, but 89 percent say patients are receiving less individualized care due to the insurer's algorithm-based rules. ("Putting").

This data proposes the following questions: Should physicians be required to do more administrative work and get paid less? What is the quality of care physicians can provide when needing to meet all the regulatory requirements imposed by health insurance companies and policies, which directly lessen their time with patients? The effects of health insurance on salary have been a concern among physicians since the creation of the first public health insurance in 1929 (Thomasson). Contrary to the present, shortly after creation of Medicare and Medicaid, the government reimbursed physicians who treated Medicare patients more compared to patients with private health insurance due to the fear of physicians refusing to treat Medicare patients (Thomasson). The electronic requirements and grueling paperwork from insurance companies have been a burden to many practicing physicians. Unfortunately, it is not solely the tedious administrative work that dissuades physicians from treating uninsured patients or public-insured patients.

Being uninsured by public insurance plans such as Medicaid or being underinsured by private plans creates underlying problems that cause reluctance for physicians and hospitals. One reason that fewer doctors are accepting Medicaid patients is that the claims are paid at a lower rate than other insurance. Specifically, the average initial claim is 98 dollars for Medicaid patients, 137 dollars for Medicare patients, and 180 dollars for private insurance patients (Scott). The difference between them can increase more. For all hospital services, private insurers paid nearly double Medicare rates, ranging from 141 percent to 259 percent of Medicare rates across studies (Lopez 1). This directly correlates with the likelihood of getting treatment. According to the National Ambulatory Medical Care Survey, physicians are 70.8 percent likely to accept patients insured by Medicaid compared to accepting 85.3 percent insured with Medicare and 90.0 percent insured with a private health insurance plan. (Holgash and Heberlein 6). The lack of acceptance of individuals with public health insurance is due to the reduction of claims. The government does not pay doctors enough to cover the cost of providing care to their beneficiaries. Therefore, it is not surprising that 15 percent of providers limit the number of Medicaid patients they will see, resulting in 16 percent that do not accept Medicaid at all (Holgash and Heberlein 6). These statistics demonstrate the impact of health insurance on multiple aspects of the healthcare field in America. It affects both patients and physicians resulting in less quality health care.

A significant factor that affects an individual's health in America is health insurance. Many people are unaware of the role of health insurance in medicine and how much control it has over a person's health. It is of utmost importance to discuss these impacts of health insurance policies because they are affecting all people in the medical field, especially in the recession of the COVID-19 pandemic. Although health insurance affecting patients is evident to the public, it also affects doctors. The primary ways doctors are affected by health insurance is by the paperwork required by the health insurance company for each patient and inconsistency of medication and tests covered. This transitions into further effects on patients. Patients are primarily affected by the cost of health insurance. The cost of health insurance is the main factor in whether patients can find affordable and quality health care. It leads to the contemplation of whether doctor visits or appointments are worthwhile or whether health insurance would make a difference for their health. Overall, the initial motives for health insurance were acceptable, but now

health insurance has too big of a role in medicine, dictating what tests or medicines they will cover for patients and also indirectly controlling the interaction between doctors and patients. Although health insurance policies and coverage have slightly improved in America, the data represented in this paper demonstrates that this industry needs to be reevaluated and changed to reduce the disparity of health insurance coverage among BIPOC communities, reduce physician administrative work to increase physician-patient interaction, and increase the affordability of health insurance plans.

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The Humanities in Medicine at Mayo Clinic

Laura Farder

The more that I come to Mayo Clinic, the more I realize that everyone and everything has a story to tell.

The people sitting in the seat across from you at the waiting area have a story to tell. Much like you, they have a story regarding their medical condition that explains how they ended up sitting in that seat. And, if you engage in conversation, you'll get to know that story. You'll identify who you are by the medical conditions you have, subconsciously marking the least fortunate one in the group, separating your fortunes by the different medical conditions that divide you. But it is in these different medical conditions that you are also bound together. Once the common ground of medical struggles is established, you'll begin to learn more about the people behind the medical conditions: the family, the hobbies, the careers, and everything else about the lives that were upended by the medical condition. The things that remind us that we're alive, not merely living.

However, during COVID-19, these connections were broken. Six feet apart was the minimum for seating arrangements, yet for those with illnesses, six feet was simultaneously too much and not enough distance. Gone were the friendly conversations in the waiting areas; isolation was a necessity. But, when living through situations that bring you to a place like Mayo Clinic, isolation can come to be perhaps the worst kind of torture. Human connection is oftentimes the only thing keeping you together.

I first passed this lamppost as I was leaving one of my appointments this past week, and it stopped me right in my tracks. Though you can't see it very well from the pictures, these color-coded stickers are all marked with a different day of the week. To the normal eye, this may seem incredibly strange, but anyone who has been to Mayo Clinic during COVID-19 would understand. During the worst of COVID-19, these stickers were required to wear when in Mayo Clinic after the initial COVID screening (for, admittance into the building was limited, and the sticker marked the fact that you had been screened and deemed COVID safe). When I saw this lamppost marked with so many of the stickers, it struck me: despite being physically isolated, we were not alone. These stickers represented just how many different people were here, experiencing the same things as I was, during different days of the week. To me, all of these stickers symbolized connection and togetherness in a time where isolation was a necessity. And, though it can definitely be seen as a form of vandalism, it helped me feel understood in some strange way. I hypothesize that's exactly why it started as well. It's not directly artwork, but it's just as beautiful and full of meaning as art to me.

This is perhaps one of the most direct applications I could find regarding the integration of an element of the humanities—art—and medicine. All throughout the different buildings of Mayo Clinic, they have sculpture artwork stationed near the waiting areas, a beautiful and calming sight for those waiting. They serve to provoke thoughts and ponderings when boredom or worry sets in, giving rise to a more positive atmosphere when others are potentially awaiting dire news. Really, it's genius.

This tactic is apparent throughout more than just the sculptures, though. As with almost every examination room in a medical building, there is artwork plastered on the walls. This is the piece of artwork that kept me sane when waiting alone in the room between multiple different testing retries. After studying and figuring out every piece of medical equipment in the room, my eyes went to this piece of art—and I eventually understood why they have these pieces of artwork in there. There's so much to study, so many different places your mind can wander and questions that artwork can bring about. It keeps you occupied during a long wait, which I definitely learned to appreciate this time around.

Architecture is another thing that really takes the art at Mayo Clinic to the next level. This is in one of the lower-level waiting areas in the building, where you stand in line at the entrance while waiting for COVID-19 screening questions. Though you can't see it very well from here, the wall on the right is made of some type of turf with beautiful, fake plant-like structures protruding off of the walls (something I never would've thought of, but turned out incredibly gorgeous!). The wall on the left is a bunch of little tiles pieced together to make a swirling image. Even the ceiling was carefully constructed to give an appearance of a sparkle, or almost like stars in a gray sky. It was very captivating and made any wait more bearable!

I had to add this one in here. As I walked into the examination room where I would meet with my physician, I noticed this couch in place of where you'd usually find hard, uncomfortable chairs. When I commented on this to the nurse, she replied, "Yeah, they like to be different here at Mayo. Plus, a lot of times you have to wait a while here, so you may as well be comfortable!" While I did initially find the colorful couch a little surprising to see, I ended up loving it; it was bright, oddly sort of trendy and, yes, it was pretty comfortable!

I completely agreed with the nurse. Mayo Clinic definitely is different, and that really struck me throughout the visit. But what is it about Mayo Clinic that makes it a cut above every other hospital, leaving it ranked number one in the nation? Yes, it's partially the expertise of the doctors, but I also think it's a little more than that. It's the fact that they have the whole humanities in medicine thing figured out. It's the unfailing kindness of the staff that are able to empathize with their patients. It's the integration of the arts in a way that is able to give the mind something else to focus on other than medicine when medicine becomes your life. It's the way these integrations of art are able to uplift mood. That's what makes the experience more than merely a dire medical one, and what makes them really stand out. There's so much more to a medical experience besides just the medicine, and Mayo Clinic understands that, making the experience a lot more positive wherever they can. I think all of us pre-medical professionals could learn something from that and try to

remember the whole experience instead of just the medical endeavor, because it truly does make an enormous difference.

Connections and Reflections

The Unorganized Collection
Lily Bonebrake

(an excerpt from a longer collection of reflections on medicine-themed poetry)

This whole poetry experience was something new for me. When it came down to picking the ten or so poems to use for this project, it was actually very easy. As I was reading, I marked all the poems that stuck out to me in some way, and then I went back through to narrow it down even further. Though I may not understand these poems in the way the author intended, I feel that I have understood them in my own way.

Anya Silver (b. 1968)

Leaving the Hospital

As the doors glide shut behind me,
the world flares back into being---
I exist again, recover myself,
sunlight undimmed by dark panes,
the heat on my arms the earth's breath.
The wind tongues me to my feet
like a doe licking her newborn fawn.
At my back, days measured by vital signs,
my mouth opened and arm extended,
the nightmare cries of a man withered
child-size by cancer, and the bells
of emptied IVs tolling through hallways.
Before me, life---mysterious, ordinary---
holding off pain with its muscular wings.
stepping to the curb, an orange moth
dives into the basket of roses
that lately stood on my sick room table,
and the petals yield to its persistent
nudge, opening manifold and golden

I liked this poem a lot. When I say that it spoke to me, I mean that I understood what it was

trying to say the first time I read through it. The way the author used connections to the past and present made the picture even stronger. The essence of the poem is that leaving the hospital is finally being free and being able to be your normal self again. There is nothing to tie you down. Everything seems fresh and new, and even though the events of the past may be haunting, they are just the past. This poem had a strong message to me; it did not feel heavy, but instead light. Almost like a breath of fresh air.

Shirley J. Brewer (b.1968)
Setback

A goddess in gold earring and a walker,
my feet stutter along hospital floors,

while my mind conjures rhinestone
stilettos, my pelvis whole again.

I'll trade these non-skid socks
for silk stockings that shimmer in the dark.

When my bones heal,
I'll shop for sandals with sequins,

slingbacks. I'll sway and strut in six-inch heels,
pivot like a model dazzling the runway.

Oh, tango shoes with red satin straps,
lift me up, release me.

When I read this poem the first image that came to my mind was a fashionable old lady shuffling around the hospital. She was a shoe lover, and even though she cannot have the shoes that she wants she can dream about them all day. Those shoes would be her escape from the factthat she was hurt and in the hospital. This poem has come to be one of my favorites as it is different and unique. I am a shoe lover, so this one jumped out to me right away. It had that light-feeling that most of the poems I read were missing, which meant that it was one of the first poems I had marked to be added to my collection.

Jane Kenyon (1947-1995)

Otherwise

I got out of bed
on two strong legs.
It might have been
otherwise. I ate
cereal, sweet
milk, ripe, flawless
peach. It might
have been otherwise.I
took the dog uphill to
the birch wood.
All morning I did
the work I love.

At noon I lay down
with my mate. It might
have been otherwise.
We ate dinner together
at a table with silver
candlesticks. It might
have been otherwise.
I slept in a bed
in a room with paintings
on the walls, and
planned another day
just like this day.
But one day, I know,
it will be otherwise.

This poem is all about what someday will be the past. When reading this the second time through and knowing the last line, I felt that I had a better understanding knowing what was coming. Our normal days will someday get turned into something we used to do. I also see this poem as having the meaning of if I don't do it now, I know that one day I will regret not doing whatever it was. I found this poem to be touching, and it reminded me of something my mom would say to me, trying to get me to not take things for granted.

David Ferry (b.1924)

At the Hospital

She was the sentence the cancer spoke at last,
its blurred grammar finally clarified.

This had to have been the shortest poem in the book, but that is not why I picked it. I picked it due to the fact that I understood it on some level. Whomever the poem is about died because of cancer, and her dying finally made the whole situation make sense. I have some experience with cancer and found this poem to be hard to forget. Even though it is so short, themessage is loud and clear. Sometimes when things happen, we don't understand why until a while after. This poem represents that and I found it almost chilling. To me it is about clarity and understanding.

Imposter Syndrome: I've Fooled Them All!

Erin Runningen

Picture this: You've just graduated college during a pandemic, with honors, I might add.

You even graduated a whole year early. But as you walk across that glistening stage, you're immediately filled with self-doubt and worry that someone may find out you're a fraud. With countless cords around your neck, all you can think about is how you've made it this far; Foolingeveryone into thinking you're capable and smart. Sound familiar?

This all-too-common feeling has more recently been recognized as imposter syndrome or imposter phenomenon. Nearly 70% of people will experience these feelings of inadequacy and ineptitude with their accomplishments across their lifetime. College, especially, is a time of immense stress, both socially and academically. This phenomenon occurs in a cycle that begins when a person doubts their ability to complete a task or doubts that their performance will meet others' expectations (Jensen 2020). A key feature of this syndrome is incorrectly believing that one's accomplishments came about not through genuine ability, but instead, as a result of being lucky, manipulating others' expressions in some way, or simply just working harder than others in a similar position (Langford 1993). As Jensen and Langford expound upon the components of imposter syndrome, we see how both harmful and helpful it can be

to the human experience.

But how is this fair? You've accomplished considerable feats, and sustained immeasurable drudgery to get there, but you still feel meager and fraudulent. Higher levels of imposter syndrome have also been tied to a devalued self-image and higher rates of anxiety and depression (McGregor 2008). 186 students from a small liberal arts university in Arkansas filled out the Imposter Phenomenon scale (IP) and the Beck Depression Inventory (second edition, BDI-II). After some statistical analysis, there was indeed a positive correlation between IP scores and BDI scores. Now, whether or not these mental disorders are exacerbated by feelings of imposter syndrome, or feelings of imposter syndrome exacerbate anxiety and depression, both are notable to mention. The research simply indicates a relation between the two conditions.

Being able to accept earned qualifications has also been more common among introverts. This makes sense, as we see those who identify as introverts keeping more important aspects of their personality to themselves, therefore resulting in feelings of invisibility for not being seen for who they truly are, a feeling all-too-common with the imposter phenomenon (Langford 1993). In addition to introversion, Langford also noted a correlation between self-esteem and theimposter phenomenon. His team of researchers gave another group of college students a Personality Research Form (PRF) that explored the relationship between impostor tendencies

and a wide range of personality traits among these students. Although the findings showed a strong urge to make themselves "look smart" in relation to others, their intense levels of defense also explained their taxing, high anxiety levels. This apparent insecurity and

wavering sense of self found in our so-called "imposters" help to explain the introversion and high levels of defensiveness found in the research.

The self-doubt experienced with this syndrome is heavily fueled by overpreparation and procrastination. "Once the task is complete, success is attributed to effort if they over-prepared or to luck if they procrastinated" (Jensen 2020). And because this success is then only attributed to outside factors, imposters continue to experience anxiety, self-doubt, and those aching imposter feelings. Unfortunately, this cycle continues to repeat itself with each coming task without consciously battling against the false, ruminating thoughts. No matter what happens, we as imposters feels that our successes and/or failures couldn't possibly be due to our internal workings or malfunctions.

This feeling of deception may have stemmed from when you were a child, too. Parents who raised their children in a healthy environment of responsiveness and respect often had children with a more secure sense of self and deep-rooted self esteem (Langford 1993). When validation of the self is lacking, this is where we see these imposter feelings popping up. As children, therefore, we felt the need to live up to an idealized image of who we were supposed to be,yearning for a taste of affirmation from those around us. Even though the imposter phenomenon is most common in high-stress environments, such as college, Langford's research shows that it almost never begins in those environments; Instead, they begin right at home.

So, how do we combat this nagging, self-deprecating feeling we all know so well? A crucial step in fighting these feelings of unworthiness and "not-enoughness" is to know that you are not alone. Even our beloved celebrities such as Tom Hanks, Lady Gaga, and Serena Williams suffer from this debilitating inner battle. And feeling as though you're an imposter is not your fault, either. It may be possible that you're a student, where grades seem to define our experiences, or you were simply raised by human beings in this fast-paced world. Maya Angelou, a famous poet, even wrote "I have written 11 books, but each time I think 'Uh oh, they're going to find out now. I've run a game on everybody and they're going to find me out'"

You see, feeling like an imposter is a common experience, but it doesn't need to be our common future. Letting go of our inner perfectionists and giving ourselves humility and grace is no easy feat. Learning and accepting that failure is a crucial part of the journey and that those around us feel the heartache of unworthiness within them, too. When we truly accomplish something, take a moment to breathe, accept our own greatness, continue to thrive, and challengethose around us to do the same.

Although imposter syndrome has a bad rap, are there any positives associated with feeling this way? Let's explore. Melissa Eisler (MA, PCC), an executive coach and member at Forbes, tells us that those suffering from these tendencies may actually have stronger decision-making abilities. In a controlled, healthy way, these individuals are willing to question themselves and find additional research that supports their findings. Leading to another benefit, which is the aptitude for curiosity, open-mindedness, and mental flexibility. (Eisler 2021). Thosewho are more open to being wrong and uncovering their own strengths and weaknesses flourish compared to those who deny them. Self-doubt is something we battle each day when it comes tothe imposter phenomenon, but what if I told you it made you a more empathetic and compassionate human being? No matter what the feeling might be, having first-hand experiencewith it allows you to be more empathetic and compassionate to those going through something similar.

Whether we feel exactly like the college graduate apprehensively making their way across the stage, or feel we shouldn't have the job we do or anything in between. Feeling as though we're faking it, and that someone will uncover our ongoing hoax is just one of the ways our brain likes to bully us. Discovered in 1978, imposter syndrome has only grown, and not only just in women as researchers once thought. It's about time in 2021 that we as a society crackdown on this harmful way of thinking. You have worked hard for your accomplishments and it's about time you gave yourself the credit you deserve. So please, do all of us a favor and walk across that stage with your head held high and a smile so big that no one would believe youthought anything different. After all, it boils down to not who we are that's holding us back, but instead, what we think we are not.

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Reflection on Untitled, 2005, Anne Harris, American, Hand-colored print: Art and Design Study Collection

Gracie Grinsteiner

Anne Harris portrays a figure with a dazed emotional expression, which masks the raw pain and terror below the guarded forefront. This 20th century contemporary art piece was created in recent history. This is synonymous to the way that mental health is newly a topic of dialogue, where it used to be taboo. This artwork era and piece reflect on modern day society and questions the way that people communicate their emotions- pushing a topic of challenging the way that feelings are being expressed. Mental health has previously been depicted in art as religious imagery, now it is not a spiritual affliction, but a human one. This step-in portraying mental health as less of an abstract concept and more of a tangible emotion is significant in thefact that mental health can now be addressed with scientific methodology. The answers to healing and working through discomfort correlated with mental health are at the world's finger tips, if only current culture embraces being uncomfortable to discover them.

The eerie demeanor that the artist composed makes the viewer uncomfortable because the human spirit in pain is hard to witness. *Untitled* is a piece that portrays how people struggling is often so unexplainably challenging, that it is complicated where even to address the starting point of titling the pain. This piece is hard to find a starting point to look at, and the entirety of the work is filled with harsh lines which makes it uncomfortable to stare at the whole image. The only colors depicted besides black and white are red and yellow. Yellow is psychologically seen as the promoter of communication and stimulator, symbolizing alertness. On the other hand, red is universally seen as a sign to "stop." It is associated with violence, anger, and also indicates danger. The viewer can see the colors being used in this work to show how someone tries to communicate their mental health status (yellow) yet does not know how or have the support system to do so. The red masks the actual (yellow) call for help. Since there is more red in the photo, layered on top of the yellow, it is synonymous to the initial danger that people see in a struggling person that instead needs to be viewed with empathy and a plan for action. The artists use of

symbolism with colors adds to the feeling of discomfort as they have subconscious widely known meanings. The person is showing red flag warning signs of crisis, and the black aggressive lines behind the head symbolize evil, darkness, and despair. The yellow communication and light side of the person is trapped under the darkness. This artwork makes the viewer uncomfortable through looking at a hurting human, and not having the tools to aid. The artist conveys a glazed expression on the face implying that it is too late to help. This is uncomfortable to the viewer because feelings of guilt can surface through the lack of initial effort to do anything about this person's pain.

Conclusion

Through this experience I have learned that society's depiction of mental health is often buried behind imagery of people "living their best lives." Art is a medium used to express emotions, and it is essential to realize that mental health is something not as easily expressed with words. I have learned through this experience that a troubled mental state causes an intruder mask of emotions to be put up, causing the person suffering to appear scarier than thecall for help they are conveying. Mental health is something that is hard to be open about for certain people as they do not want to be seen as weak, the discomfort caused however is essential to healing and reaching a better understanding. I have learned that discomfort through seeing other emotions is something that is based off of a fear of misunderstandment, which can be worked through in an earnest effort to comprehend.

Sound Track Assignment

Gracie Grinsteiner

"How to Save a Life" by the Fray, "Wings" by Macklemore, and "Same Love" also by Macklemore not only share the commonality of being deeply felt emotional songs, but they also embody the powerful effect that society as a whole has on mental health, especially of school-aged children. I choose each of these pieces as they venture to make the listener think about how their actions impact others.

"How to Save a Life" was born after the lead singer, Isaac Slade, experienced working as a mentor at a camp for troubled teens. He articulated how, as an adult figure, he encountered a young camper with "all these problems" and how "no one could write a manual on how to save him." He explained how all of these adult figures and people in this child's life were unsuccessful in trying to help his problems. Slade articulates how the approach was wrong, in the lyrics "as he goes left, and you stay right, between the lines of fear and blame," emphasizing that efficient support was not present, and that true understanding was never met. This improves my connections and broadens my sphere of understanding because I realize that not only in a song like this, but also with students in the classroom, the reason for pain, suffering, and poor behaviors is a result of a lack of communication. Without communication, there cannot be proper interventions to reach a healthy conclusion. Mental health improves with a support system, which was not what the boy had in the song.

The song goes on to articulate that the singer lost a connection as he was unable to "save a friend" because there was not an understanding of what to do to help the person in need. This emphasizes the need for mental health advocacy for both students and teachers in order to learn better intervention methods to bemore prepared to deal with tough situations. This song left me with a feeling of despair as I contemplated how many children feel misunderstood because of the mental bealth battles they are facing plus the inability to be understood by people surrounding them.

The last part of the song, "Lay down a list of what is wrong, the things you've told him all along, and pray to God he hears you. And pray to God he hears you" drives home the fact that Slade hopes that the child can see that the poor attempt at helping, is out of love. As a learner, this is essential to me in understanding how important not only my words are, but also my tone and intentions with helping people. When listening to this song, it makes me celebrate how far mental health stigma has been reduced. This articulates the importance of gentleness, empathy, and resourcefulness that needs to be in my back pocket as a professional in order to help children who are "crying" for help.

What also needs help, is how our country views homosexuality. In Macklemore's "Same Love," he conveys how there is too common a pattern of homophobia in the hip hop realm. The lyrics "A pre-conceived idea of what it all meant, for those that like the same sex had the characteristics. The right-wing conservatives think that it's a decision and you can be cured with some treatment and religion," articulates the hatred that is set before people that are homosexual. This broadens my connection with others because I realize that I have grown up in a society that has a negative pre-conceived idea of people who are nonbinary, and that although I may not treat these people differently, they could feel attacked to embrace who they are which affects their learning, along with every other realm in their lives. The fact that a lot of our world still thinks today that homosexuality can be "cured with treatment and religion" means is detrimental to the mental health of people who like the same sex as they are not accepted for their authentic selves which creates feelings of being misunderstood and a detachment from society. I felt heart-broken listening to the song, and for the reason that some people are outcasts in society not because of their character, but because of their sexual orientation.

As a global citizen, I know the importance of being welcoming and supporting of not only people of every sexual orientation, but of every gender, race, and every other demographic. My warming presence e or lack thereof has the potential to affect the mental health of others. This discrimination taught me the importance of advocating for my potential future clients so that they do not feel ashamed in being their authentic self.

Authenticity is not reached through fighting to be just like everyone else. As we have discussed in class, how would you feel if the best compliment that you ever received was "you are so normal?" Macklemore articulates in "Wings" that the individual is lost when everyone becomes obsessed with consumerism. "Look at me, look at me I'm a cool kid" emphasizes the desire

that children often have in obtaining the latest trends, to be viewed as popular, which is simultaneous to fitting in and being liked. Everyone wants to own the latest name brand items, which creates a social and financial stress to always own the next best thing. Every child bas **a** desire to fit in, and when finances do not allow this to happen it causes mental and social trauma. Not being able to purchase the newest Nike's (like this song describes) can sometimes cause lower self-esteem. The song conveys the feeling of having something that others can't: "My friends couldn't afford 'em."

This song broadens my connection with others because I know that it is easy to judge based off appearance, but what really matters ls what a person's character holds. We live in a society that values material items, which superficially buries personality through tbe toxicity of consumerism. Consumerism and the desire to be viewed as better is so deeply rooted in wanting to be loved that people are willing to kill, which was extremely alarming "and then my friend Carlos' brother got murdered for his fours, whoa." Whoa. Society is so obsessed with outward appearance, it is scary.

Macklemore comes to terms here with understanding that appearance is not worth this much hatred and violence. It seems that he becomes empathetic to understanding what is important - what is in someone's heart.

Consumerism ruins relationships, because personality is second hand. It fights to cause tension but my sphere of understanding knows that appearance is not what is important. This made me realize that I get caught up in consumerism, the yearning of what I do not have. This causes me to miss out on the blessings that I do have in my life, which led me to have an epiphany. This song made me remember my experience of growing up in the public school system, wanting to always have the same items that everyone else had, which I have now grown out of in college in wanting to be unique.

This lesson will help me as a professional because I will have the ability to understand why children are upset with not being able to fit in, and will let me be able to explain the importance of being unique. There are so many dynamics that influence a child's ability to learn and knowing that this could be an issue will help me to better understand the minds of my clients. Being able to relate to clients will help me to build a relationship which provides a support system in the life of a child. Having a support system is essential to being confident

with uniqueness.

I choose these songs because they embodied how important it is to be empathetic and understanding of others' mental health. I love the way that "How to Save a Life" conveys emotion in the song through hearing the authenticity behind the singer's voice. I love the way that "Same Love" articulates the passion behind Macklemore's tribute to homosexuality, a symbol of unity in a world full of divisiveness. I love the way that Macklemore' s urgency in "Wings" yearns for the listener to wake up and realize that physical appearance is not as important as what is on the inside. I chose these three songs because they have stuck in my mind for a long time after an initial listen. These songs all force the listener to contemplate how actions lead to other people's feelings being boosted or hurt. I learned through these difference perspectives how desperately society needs kindness, empathy, and to mutually understand each other.

Business and Marketing

Andrew Carnegie's Importance to the Business World

Isaiah Sehrt

Andrew Carnegie, a Scottish born entrepreneur, made a fortune on the steel industry in the late 1800's in America. A dominant force in this field, he eventually sold his venture to J.P. Morgan, another force in this industry, and donated the mass majority of his fortune, devoting himself to philanthropy. Known as one of the most important entrepreneurs in American history, Andrew Carnegie's influence on the world with his steel production, the railroad, and his philosophical activities changed America then and is still making an effect on this country one hundred years later.

Background

Carnegie was born in 1835 in Dunfermline, Scotland, to a family that valued the importance of books and learning (Biography). His family grew up poor, as his father was a handloom weaver and his mom did sew work for local shoemakers (History). Carnegie and his family realized that they weren't grasping their true economic potential in Scotland, so they decided to move to the USA when Carnegie was 13.

After making only $1.20 working as a bobbin boy at a cotton factory, he found a job as a telegraph messenger and eventually moved all the way up to be an assistant and a telegrapher to Thomas Scott, one of the railroad's highest ranked officials. This is where Carnegie's ability to learn came in handy because this is where he learned all about the railroad industry and about entrepreneurship. In the middle of working for the railroad industry, the civil war started. Carnegie actually got drafted in the war, but he decided to pay a man $850 dollars, which would have been around $25,000 in today's money (History) During his time working in the railroad industry, he learned how to make wise investments in many different industries. He realized that these investments are something that he could make a living off of instead of working on the railroad. When he was 30, he left the railroad and focused more on his investments, and, along with others, founded Keystone Bridge Works and worked in the steel industry.

Carnegie's Big Risk

Moving on from the railroad business could've been something that ruined his life. Carnegie was the superintendent for a railroad company, and in a world where the railroad

was booming, he was definitely making good money working for them. Instead, he threw this all away and depended on his investments. As an entrepreneur sometimes you have to make the hard decision to throw away something big for something that could be even bigger. We would have never heard of Andrew Carnegie if he didn't make this decision, and steel might not be what it is today if he didn't make this decision. Then again, if his investments started failing (which happens all the time), he could've altered his life for the worse instead of for the better.

Carnegie Steel Company

During this time, steel was a resource that was expensive to make, but extremely useful. Carnegie noticed this, and it became a desire for him and Keystone Bridge Works to find a cheaper alternative to make this valuable resource. He adopted the Bessemer process at his Homestead Steel Works plant, and largely because of this, US began to outpace the UK in steel production (Terrell). Carnegie had it all set up at this point, as he part-owned a railroad bridge company (Keystone Bridge Works) and he could get all the raw materials for steel as he pleased. This made him a very wealthy man, which lead him to create Carnegie Steel in 1889, the company where he made most of his fortune.

Carnegie's Key Innovation to Success

As mentioned before, the Bessemer Process really pushed his business to become the biggest steel company in America. The Bessemer process, created by Sir Henry Bessemer in 1856, was the first inexpensive way to melt iron, get rid of the impurities, and make it into pure steel. The process used molten pig iron to melt iron which eventually made iron reach a boiling point. When this iron reached the boiling point, oxygen was blown onto the molten iron, which made the impurities of the iron oxidize and separate (Forestell). This made it way easier to make steel, as it cut the price of steel by nearly a tenth of what it was before. Anyone with any entrepreneurial knowledge would know that this is company altering, as cutting the price of any object that much is unheard of. Carnegie realized the potential of this process, and then adopted it into his making of steel. Though Carnegie didn't invent this process, the Bessemer process is the innovation that made Carnegie's Steel company a key part of America's rise to success.

Carnegie Steel Struggles

Though Carnegie made a fortune off this company, it didn't come without its struggles. In 1892, he made the mistake of trying to lower the wages of plant employees at Homestead Steel Works. The employees were irate. Plant employees went on strike and shut

down Homestead Steel Works plant, his biggest and most prominent steel plant. Henry Frick, Carnegie's partner, brought it back to business, but a battle arose inside the plant. There were many casualties because of this battle before the state militia got involved. During this, there was an unsuccessful attempt to kill Frick. Though the militia got back under control, things were never the same in the steel plant. Carnegie wasn't even there for this strike, but many still blamed him for the actions of his employees at this plant. This left a permanent scar on the company, and Carnegie's reputation suffered for many years (Terrell).

The Largest Deal in American History

Carnegie's end goal was different from most rich people then and even today. Usually, rich people keep most of their wealth and their company, and let it fizzle out to their family when they eventually pass away. Carnegie didn't care about having a lasting company in the world after he passes away. He wanted to help people around America with his fortune, which lead him at 66 years old to make the largest deal in American history. He sold his company for 380 million dollars to J.P. Morgan, which seems like a lot, but it would be an astronomical 309 billion dollars today. To put that in perspective, that's like buying every single team across the three major sports leagues in the USA (NFL, NBA, and the MLB), and still having over 100 billion dollars left to spare. This easily made Carnegie the richest man in the world, and he didn't just sit around with his money and pass it on to his kids. He started practicing philanthropy, which is defined as the desire to promote the welfare of others, expressed especially by the generous donation of money to good causes.

He once said, "The man who dies thus rich dies disgraced" (McCreary). This essentially means that if by the time you pass away you are still a very rich man, you are a disgrace. Why die with a ton of money when you can donate it to people in need of even a little bit of this money? Andrew Carnegie, a man that one worked a job for $1.40 a week, wasn't going to let that happen to himself. He knew that his family really didn't need a lot of money (comparing to what he had) to live and do whatever they wanted with their life, so he left behind 30 million dollars to his foundation (which the majority of the money went to his family). This left him 350 million dollars to devote to philanthropy. He donated the majority of it to schools, libraries, colleges, and other public works to get people to learn, like he had as a child (McCreary). Before selling his company, he may not have been much of a social entrepreneur, but after donating the mass majority of his fortune to

education, he was the definition of a social entrepreneur.

Andrew Carnegie in his 85 years of life did so much for America. Not only did he revolutionize steel to be what it is today, he donated his massive fortune to education, which influenced and made it easier for kids in America to continue to advance their education, and make America advance as a country. Without him, I doubt America would be the powerhouse of a country we have now.

Carnegie's Main Goal

With someone that made as much money as Andrew Carnegie, you may think his main purpose in life was to make a ton of money and leave it all to his family to live richly. You may even think his main goal was to increase the education for Americans. While those were all goals of Carnegie, these weren't his main goal. During his life (and especially during the end of his life) Carnegie worked to "hasten the abolition of international war" and though he didn't exactly achieve that during his life (which would have been an impossible feat) he created Carnegie Hall, which still to this day hosts melodies of peace (Carnegie Hall). Some notable names that have spoken here include President Woodrow Wilson, Pete Seeger, and Andrew Carnegie himself. Perhaps the most notable name that achieved maybe the most peace throughout this country is Dr. Martin Luther King Jr., who spoke there on February 23, 1968.

Achieving world peace (along with education) was his motivation to getting rich. Selling Carnegie Steel give him the maximum amount of money he could have possibly have gotten at that one point, and he used it to achieve his end goals. By creating this hall, Carnegie encouraged people with words of peace to speak to many people there, and the hall is currently still helping achieve global peace throughout America.

Entrepreneurial Competencies

Carnegie showed that he uses a lot of the entrepreneurial competencies in his life. The one that he obviously showed throughout his life was risk management. During the beginning, he left his job to focus on his investments, which can be extremely risky. What if those investments were to fail? What if America went through a depression, which would automatically make his investments worth way less? Carnegie weighed his options, and he decided that leaving his well-paying job was worth it to potentially earn more money, which he obviously did. If he never left his job, he would be making middle class money, and wouldn't have been able to achieve his goals with the little money he would have to spare.

Another competency Carnegie showed a lot of it was resilience. When Carnegie was faced with workers going on strike because of him, he didn't just quit. Even though his reputation was tarnished, he still worked to make his company better than it was, and didn't make this controversy his reason for retiring and selling the business (Experimarketing). Another way he stayed resilient was in his younger years, when he worked for little money a week. He stuck it out and got a higher paying job, worked hard to learn about business practices, and eventually became the richest man in the world.

Carnegie adopting a new way to make steel way cheaper to make, which goes along with value creation. Because of him, steel became one of the biggest industries in America, which created many jobs for the public in the steel plants. This also goes with opportunity recognition. He noticed that there was a better way of making steel, and knew that he had to build his steel plants to be able to use that. He had to seize the opportunity before anyone else in America has, and he did so in a big way.

Maybe the most important of the entrepreneurial competencies he used was maintain focus yet adapt. His main focus was to change the world, not by selling steel to people, but by creating better education systems and accelerating global peace. At first, he focused on building his steel company which made him rich. Then, when he realized that his company wasn't doing as well as it was before because of his reputation, he adapted and sold the company to J.P. Morgan. When this happened and he became the richest man in the world, he switched his focus from his steel company to his main focus- changing the world for the better and making an impact on the world. By adapting in this way, he will always be remembered as one of the more important philanthropists in not just America, but in the world.

Carnegies Ventures that Still Exists Today

Because Carnegie was such an important philanthropist, you can see his name in almost every major city today. He funded over 2,500 libraries, Carnegie Hall, Carnegie Mellon University, The Carnegie Institution of Washington, The Carnegie Hero Fund Commission, The Carnegie Foundation for the Advancement of Teaching, The Carnegie Foundation, and so on (Beattie). He made sure everyone of all backgrounds had access to books, and could learn how to succeed like himself. What he did for this world was truly amazing, something that most of us could never do with his amount of money.

Conclusion

Andrew Carnegie wasn't just an entrepreneur that made a big fortune, though he did that well with Carnegie Steel. He was a philanthropist who donated 309 billion dollars in today's money to support education systems and accelerating world peace. His contribution to the steel industry and his philanthropic activities are still important today, and will be remembered for a long time because of this.

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Anthropomorphism in Luxury Brands

Aubrey Hamilton

Abstract

Anthropomorphism, or "the tendency to imbue the real or imagined behavior of nonhuman agents with humanlike characteristics, motivations, intentions, or emotions," according to Epley and co-authors, has been a well-researched topic but there has been little research into the impact of anthropomorphic traits on luxury brands. Because luxury brands are so important in developed countries, it would be interesting to confirm the impact of anthropomorphic traits on these luxury brands instead of brands with more mass market customers. The results of this research overall show that the Cartier brand was not affected by anthropomorphic traits in any way, while the watch itself was viewed more negatively with less sophisticated anthropomorphism.

Background

Anthropomorphism is "the tendency to imbue the real or imagined behavior of nonhuman agents with humanlike characteristics, motivations, intentions, or emotions" according to Epley and co-authors in their 2007 publication in the Psychological Review. For example, Tony the Tiger, the face of Kellogg's Frosted Flakes, takes on human attributes by walking on two limbs, wearing a bandana, and, most obviously, speaking. Anthropomorphism is a widely accepted marketing practice that has been well-studied. Rauschnabel and Ahuvia (2014) found that anthropomorphic traits can increase brand love, which is a better predictor of brand loyalty than other attitude models. Anthropomorphism has also been shown to decrease the consumer's willingness to replace the product and the weight given to the quality of the product when asked questions about replacing it (Chandler, 2010).

The top 100 luxury goods companies had combined revenues of $281 billion in 2019, according to a Deloitte report, and the sector is expected to reach a size of $296.9 billion by 2026, despite the impact of the COVID-19 pandemic (Global Luxury Goods . . .). With such a large

amount of income throughout the world, it's important the luxury sector is researched adequately. Luxury, despite being a household name, is difficult to define. According to Taylor and co-authors (2019), "a luxury brand is a branded product or service that consumers perceive to: 1) be high quality; 2) offer authentic value via desired benefits, whether functional or emotional; 3) have a prestigious image within the market built on qualities such as artisanship, craftsmanship, or service quality; 4) be worthy of commanding a premium price; and 5) be capable of inspiring a deep connection, or resonance, with the consumer." The connection between anthropomorphism and luxury brands as defined above has not been well-studied, and as important marketing tactics and large sectors of the economy, it is glaring there is a lack of research between these two topics. This gap in research poses the question: does anthropomorphism in luxury brands impact the product or brand perceptions of consumers? Could luxury brands be missing out on an opportunity to increase brand love and decrease the willingness of their consumers to replace their luxury items? This became the foundation of study for this research project.

Methods

In order to collect data on this topic, a survey was created with three different descriptions of a Cartier watch (pictured in Figure 1). Cartier was selected as a luxury brand because it not only fits the definition theorized by Taylor et al (2019) but also is a widely-known company and a household name. The watch was selected because Cartier is most commonly known for their watches, among other jewelry pieces. The particular watch, TANK FRANÇAISE, was selected because it is fairly gender-neutral in the mid-range of price for Cartier watches at $4,150.00. One description of the watch in the survey used no anthropomorphism, one description used unsophisticated anthropomorphism, and another used sophisticated anthropomorphism. These descriptions were pretested on a sample from the same participant pool as the main study in order to ensure that the two anthropomorphism conditions were seen as more human than the no anthropomorphism condition. The survey was

then distributed to 119 University of North Dakota undergraduate students for completion. 43.86% of respondents were female and the average age of respondents was 21.16 years old. The respondents were offered extra credit by their professors for their class upon completion of the survey as incentive for completion. The students were randomly selected by Qualtrics to read one of the descriptions of the watch with the image of the watch (Figure 1) accompanying it. In order to confirm the respondent read and understood the passage, participants were asked on a separate page to describe the passage they just read. There were 11 responses that did not accurately describe the passage; these data were removed from the data set and not used for further analysis. The survey then asked the respondents various questions about their opinion of the watch and the Cartier brand based on the passage they read describing the product. The questions included both product and brand attitude measures and personality on 7 point scales (e.g. "How would you rate your attitude towards the Cartier watch? Bad/Good"). The personality measures were adapted from Aaker (1997). The respondents were asked to rate to what extent they agreed that the Cartier watch is a luxury item and that the Cartier watch is a high-quality item. They were also asked, with a sliding scale, how much money they were willing to spend on the watch if they were in the market for a luxury watch. They also completed a measure of purchase intentions. Using the self-brand connection scale (Park et al. 2010) as a guide, we also included questions to learn about the relationship the respondent had to the Cartier brand after the exercise. Finally, they were asked demographic questions and given a 6-digit code to submit to their professor for class credit. All responses were completely anonymous and no personal identifying information was recorded. The data was then download and uploaded into SPSS for analysis.

Results- Product

An ANOVA showed a marginally significant difference between conditions on liking for the Cartier Watch ($p=0.073$). The no anthropomorphism condition led to increased

liking (M=5.88) compared to the sophisticated anthropomorphic condition (M=5.17 p =0.085) and the non-sophisticated anthropomorphic condition (M=5.29, p = 0.020) (See figure 2). It also showed a significant difference on rating the watch in terms of lower or upper class (p<0.001). The non-sophisticated anthropomorphic condition had a lower class rating (M=5.50) as compared to the non-anthropomorphic condition (M=5.86, p<0.001) while the sophisticated anthropomorphic condition was not significantly different from the no anthropomorphism condition (M=5.73, p =0.684). The less sophisticated anthropomorphic condition was significantly lower in being charming (M=4.63, p=0.001) as compared to the non-anthropomorphic condition (M=5.86) while the sophisticated condition again did not have a significant difference when compared to the no anthropomorphism condition(M=5.73, p=0.684). There was also a significant difference between the rating as a luxury item (p=0.001). The less sophisticated anthropomorphic condition (M=5.51, p<0.001) led to decreased rating of the watch as a luxury item as compared to the non-anthropomorphic condition (M=6.47). The sophisticated anthropomorphic condition had no significant difference (M=6.44, p=0.858) in the rating of a luxury item compared to the non-anthropomorphic condition.

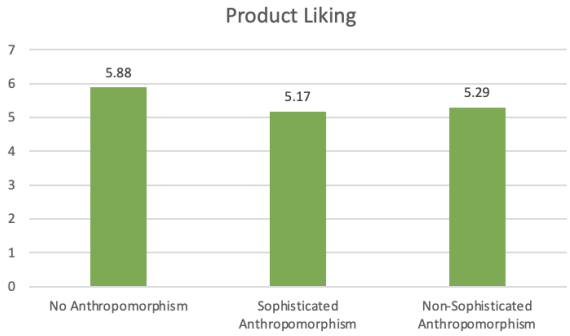

Figure 2: Average rating of product liking

However, there was no impact of anthropomorphism in the rating of Cartier watch attitude in terms of goodness (p=0.534), favorableness (p=0.146), ruggedness (p=0.123), good-looking (p=0.078), high-quality item (p=0.562), or price (p=0.445).

Results- Brand

The results regarding brand showed no significant difference on condition on liking (p=0.742), attitude (p=0.831), favorableness (p=0.579), ruggedness (p=0.666), upper-class (p=0.968), charming (p=0.920), good-looking (p=0.862), success (p=0.380). See figure 3. There was also no significance in the rating of the level

of agreement of the brand selling high-quality products (p=0.815), luxuriousness (p=0.633), a reflection of who they are (p=0.413), their identity with the brand (p=0.208), their personal connection (p=0.145), their use of the brand to communicate who they are (p=0.604), being interpersonally warm (p=0.630), being kind (p=0.472), being generous (p=0.747), efficiency (p=0.866), effectiveness (p=0.906), or competency (p=0.767).

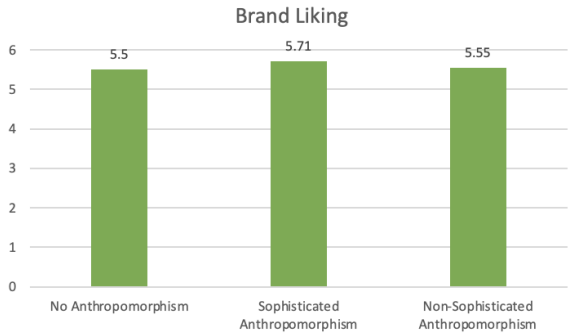

Figure 3: Average rating of brand liking

Discussion

The results of this research overall show that the Cartier brand was not affected by anthropomorphic traits in any way, while the watch itself was viewed more negatively with less sophisticated anthropomorphism. One possible explanation for this is that customers hold luxury brand names so highly in their own minds they cannot be changed by the impact of one product. This could have implications on luxury brands that are currently using anthropomorphic traits. These brands should ensure that their anthropomorphic traits are sophisticated and adding value to the company. If these anthropomorphic traits are not sophisticated, this could mean that they are losing connection from their customers to the product.

One limitation to the research is that only college-aged students were used in this research and there could be some questions, and room for expansion, as to if this research also applies to people of all ages, especially older people with more buying power. It should also be noted that only North Dakotan students were respondents, and because of the geographic location and lack of knowledge of luxury brands in this area there could be some question as to if this research could be applied to other geographic locations outside of the Midwest, particularly in areas with a higher median household income. A next step in this research would be to re-run the survey and confirm that the readers understand the difference between anthropomorphic descriptions and nonanthropomorphic descriptions in the

beginning of the survey rather than the end, because by the end of the survey respondents are tired, and we were unable to confirm, via our original survey, that respondents understood the difference between anthropomorphic and nonanthropomorphic descriptions of products.

Another area of expansion would be to see if these changes can be made to illustrations or other ways of showing anthropomorphism other than just a description of the product. The most interesting application of this research would be to look into a possible significant impact on brand connection with anthropomorphic traits because our research found a link between anthropomorphic descriptions and brand connection ($p=0.145$). While this overall link is insignificant, contrasts showed that the less sophisticated product description actually created a marginally stronger brand connection with the participants than did the no anthropomorphism condition ($p =0.091$). This link could have large implications on the connections that brands would like to make with customers and what they are willing to give up, including the connection to the product itself, to get to that increased connection.

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Thank you for reading the first ever issue of *Roundtable: a journal of the UND Honors Program*! This journal is a reflection of what the Honors Program is all about. It represents a variety of majors, interests, and thoughts.

Submissions are hand-selected by a group of student editors through the Honors 260-02 course. Each submission is read blind, with the submitter's name removed.

To submit your work to this journal in future issues, watch for our submission invitation posters in Spring semester.

To be involved in the creation of the next issue of *Roundtable*, contact Merie Kirby (merie.kirby@und.edu) for details regarding signing up for the Spring 2023 section of HON260-02. Again, thank you for reading and look out for next Spring's issue!