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Jennifer Fickley-Baker  
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**EXAMINING GENDER IN PHARMACEUTICAL RHETORIC THROUGH A CULTURAL  
STUDIES LENS: A CASE STUDY ON THE GARDASIL VACCINE**

by

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A dissertation submitted in partial fulfillment of the requirements  
for the degree of Doctor of Philosophy  
in the Department of Texts & Technology  
in the College of Arts & Humanities  
at the University of Central Florida  
Orlando, Florida

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Major Professor: Dr. Melody Bowdon

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## **ABSTRACT**

On June 8, 2006, Merck announced the debut of Gardasil, the world's first vaccine found successful in preventing human papillomavirus (HPV) infections, a sexually transmitted infection that is one of the main causes of certain cancers in men and women, including cervical, vulvar, penile and anal cancers.

To promote the vaccine's release, Merck launched Gardasil's "One Less" advertising campaign that included television commercials, print ads and a consumer-focused website ([www.Gardasil.com](http://www.Gardasil.com)), each promoting the message that "you" could now be "one less woman" affected by cervical cancer ("One Less" campaign). The vaccine, tested and approved only for females age 9-26, was advertised to this age group, as well as parents or guardians responsible for making medical decisions for female minors. As the campaign launched, commercials depicted females laughing and enjoying hobbies while mentioning the positive decision they made to receive the Gardasil vaccine. Many commercials also included portrayals of mothers talking happily about their decision to get their young daughters vaccinated.

Interestingly, male figures were completely left out of Gardasil's "One Less" campaign ads, despite the fact that in reality, males administer the vaccine as medical professionals, transmit the infection as sexual partners, and suffer cancers as HPV-infected patients. Males were even left out of the ads as parents, who were always portrayed by women in the ad campaign.

Informed consumers may have expected all this to change on Oct. 16, 2009 – three years after Gardasil’s debut – when the Food & Drug Administration (FDA) approved the vaccine for use in males age 9-26 to protect against HPV-caused genital warts. Though Merck’s vaccine was now accessible to more consumers than ever, the advertising that surrounded this medical breakthrough changed very little. Television commercials for the vaccine still promoted Gardasil primarily to women for the purpose of preventing HPV-related cervical cancer. Again, men were not featured in commercials as medical professionals, parents, guardians, romantic partners, or even as patients able to get the vaccine. Males did begin appearing on the vaccine’s official website, however these depictions were limited to showing only young boys, who appeared standing with a mother’s protective arm around them. Males that represent the older age range (up to age 26) were never shown.

What effect does the lack of male representation have on the verbal and nonverbal message these ads are sending consumers about who fits in the target consumer group, as well as who is at risk for an HPV infection? On a broader level, how does gender representation as a whole affect pharmaceutical advertisements and the adoption of the potentially life-saving products they promote? How does a pharmaceutical technology become “gendered”? How do specific gender portrayals impact the educational aspects of pharmaceutical ads, which may shape a consumer’s opinion of who is at risk for an illness, and who is responsible for its treatment or prevention? And how do these gender portrayals connect with, reflect or reinforce

dominant cultural beliefs about the roles males and females play in protecting themselves and others from disease?

In this study, I investigate these questions using a blended cultural studies/social sciences research perspective, first looking at the controversial history of direct-to-consumer pharmaceutical advertising and the gender stereotypes that traditionally exist in this form of rhetoric. I then test the affect Merck's gender portrayals has on its ad message in a blind study done with a small sample population, which provides evidence that Merck's ads are confusing and exclusive of certain populations, particularly men. I then investigate how Merck's existing gender portrayals, and strong focus on women, reflect larger historical beliefs on the roles that males and females play in health care and in the family. I show how, through advertising, Gardasil has become "gendered" as a pharmaceutical technology for female children. From here, I will show how pharmaceutical companies, such as Merck, have both reflected and reinforced the belief that women are the primary caregivers to children, how this stereotype is both damaging and statistically incorrect, and how using it targets Gardasil ads to a very narrow population of consumers, miscommunicating the message of who is at risk for illness contraction and perhaps even damaging sales in addition to prevention.

I later provide evidence that Merck's current Gardasil ad series and other actions in the marketplace are dangerously misleading certain populations regarding the nature of the HPV virus, the protective abilities of the vaccine, and the populations responsible for accessing Gardasil. I then provide the argument that gendering Gardasil as a "women's technology" is done intentionally by Merck, which has a history of making

profits a priority over responsibly treating patient health. I conclude by providing detailed suggestions on how Merck can augment their current ad series to de-gender Gardasil to become more medically responsible, and break out of the cycle of portraying men and women using damaging and outdated stereotypes. Instead, my suggestions for changes to Gardasil's advertising approach would make the vaccine's messages appeal to all audiences at risk.

This paper is dedicated to my grandmother, Joyce W. Sternagel and mother, Barbara J. Fickley, who are my inspirations in so many aspects of life, especially in pursuing this doctorate.

## **ACKNOWLEDGMENTS**

I would like to acknowledge my dissertation chair Dr. Melody Bowdon and my committee members, Dr. Kathleen Bell, Dr. Denise Delorme, and Dr. Blake Scott, for providing two years of guidance and assistance in this endeavor.

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# CHAPTER 1: GENDERED TECHNOLOGY – A BLENDED APPROACH TO STUDYING GENDER IN PHARMACEUTICAL AD RHETORIC

## Introduction

At first glance, analyzing the rhetoric used in vaccine advertisements may seem to be an odd choice for someone pursuing a degree in Texts & Technology, as one may not initially realize how closely the topics of technology, pharmaceutical advertising, and gendered rhetoric are connected. To see how these three are related, one must first look at the relationship that exists between gender and technology, a connection that has been studied by many gender studies authors and feminist scholars over the past few decades. For example, Julie Wosk traced the history of how specific technologies become “gendered” through their design, name, color, size and advertised purpose (such as certain models of irons that were specifically manufactured with women in mind under the cultural assumption that all women desire to stay at home and do housework). Feminist Judy Wajcman argued in her book, Feminism Confronts Technology, that the stereotypical male association with technology has been perpetuated in our culture as a way to keep women in a subordinate role within society. In looking at the work of these two authors alone, it is clear that technology has and continues to greatly influence the lives of women (and also men), impacting their identities, occupations, and daily lives in a myriad of ways.

Daily life is where advertising obviously comes into play. Throughout history, the mass media has been used to disseminate messages about new

products and technologies through advertisements. By analyzing the use of gender roles and stereotypes in ads, one can see that advertisements both reflect and reinforce specific gender roles for males and females, partially influencing what is appropriate (even suggested) for them to wear, buy, and even how they should look and behave.

But what happens when an ad promotes a new medical technology, such as a new life-saving vaccine? Vaccine technology, a preventative health practice that became popular practice in the western hemisphere in the 1700s (Dunn 78), has arguably been one of the most profound medical technological developments in the history of the world. To date, preventative vaccine technology continues to protect populations around the world from some of the most dangerous illnesses, including polio, measles, and meningitis, among others. Of course, the success of a vaccine depends on the population that adopts it as a method of illness protection. Arguably, one of the best ways to reach a specific population in a developed nation is through mass media in the form of advertising.

All three of these compelling topics – advertising, gender, and technology – collided in a major way in 2006, when Merck's Gardasil vaccine, the first vaccine found successful in preventing cervical cancer in women, was introduced in the marketplace. The Gardasil ad series, which as I will argue later in this paper, depicted this vaccine as a cancer-prevention vaccine for female children, ignored other relevant populations of consumers at risk and presented audiences with a very filtered depiction of what the HPV virus is, whom the virus affects, and the damage it can cause. This skewed depiction resulted in the media, the

medical community, and others raising questions about the vaccine as it relates to biological sex, illness prevention responsibility, parental rights, and the role men can or should play in the whole scenario. In my opinion, the advertising of Merck's Gardasil vaccine provides an excellent example of how my three topics – technology, pharmaceutical advertising, and gendered dissertation rhetoric – intersect. In this study, I will show how Merck's Gardasil vaccine advertising campaign's use of male and female gender roles and stereotypes critically impacts the message the pharmaceutical company is sending about an illness, illness prevention, and on a larger scale, the role males and females play in the home, in the medical community, and in the global marketplace.

I will investigate this topic throughout the course of this dissertation, but first, I will explain how my research inquiry will differ from other studies commonly produced in the advertising discipline.

### Current Advertising & Gendered Rhetoric Research

While advertisements for over-the-counter drugs have existed for decades, direct-to-consumer (DTC) prescription drug advertising and the research that surrounds it are relatively new. In August 1997, the Food & Drug Administration (FDA) revised its regulations on DTC prescription drug advertising, with one of the most significant changes being looser requirements for listing a medication's side effects in an ad. Instead of requiring an advertiser to list all potential side effects, the revised regulations require them to mention only "significant side effects" (Frith 211), and additionally refer viewers to related websites or telephone numbers for more information.

This change caused major shifts within the medical and pharmaceutical communities. Instead of advertising mainly to members of the medical community, such as doctors and hospitals, pharmaceutical companies now had the power to communicate quickly and directly with consumers, which they did to the tune of spending \$1.3 billion on direct-to-consumer advertising (ibid) in the first full calendar year following the regulation change.

In the years since, many researchers within the advertising industry have scrutinized DTC pharmaceutical advertising in detail, examining an immeasurable number of topics that dissect *the message* of a drug company's ad, *its audience* and *the effects* the ad may have on an audience. Many of the studies conducted by advertising scholars appear to have been motivated by the end goal of understanding advertising's effects on an audience of consumers, as well as what makes an ad successful and a product or brand profitable.

More recently, scholars in the field of rhetoric have begun to examine medical and pharmaceutical advertising texts for their unique rhetorical qualities, their effects on consumers, and the related rhetorical viewpoint's underlying social, cultural and political connections. For example, Christian Barry and Kate Raworth examined the rhetoric of the power structures involved in making HIV drugs accessible to populations in Third-World countries; Judy Z. Segal examined the unique use of rhetoric in negotiating credibility in the doctor-patient relationship; Blake Scott studied the rhetoric of risk in HIV testing practices; and Mary M. Lay studied competing rhetorics that contributed to the failure of the Minnesota Department of Health's efforts to create a licensing program for direct-

entry midwives. These rhetoricians have each made groundbreaking contributions to the new field of medical and pharmaceutical rhetoric; however, I believe there are additional areas to explore within pharmaceutical advertising, specifically by studying the use and effect of gender representation in DTC pharmaceutical advertisements for emerging technologies, such as Merck's Gardasil vaccine. Doing so will allow us to explore how our culture's perception of who is at risk for an illness and who is responsible for prevention can be affected by pharmaceutical advertising.

Gender is one of the many facets of advertisement that has been studied by scholars within the advertising discipline for decades. The research generated from within the discipline has repeatedly found that males and females of all ages are represented differently (and often unequally) across advertising mediums, with the use of negative gender roles or stereotypes being especially prevalent. Further research from within this field has provided evidence that the use of gender stereotypes in advertising has many different effects on an audience's perception of the ad's product, brand and message, as well as their ad recall ability, purchase intent, and more (Frith 95). Many studies also show evidence that certain gender depictions may have damaging effects on certain segments of our society, such as the connection between physical depictions of female models and female viewers' self confidence (ibid 92). However, unlike interfering with an audience's brand recall ability in a jeans commercial, or influencing a young girl's self-image as a result of a make-up ad, the effects

gender can have specifically on pharmaceutical advertisements can have serious – and even deadly – ramifications for a consumer’s health.

In this dissertation, I will explain and demonstrate a blended methodology approach through which to analyze gender representations in pharmaceutical advertisements; this method identifies what representations exist; the effects these gender depictions can and do have on the ad’s message and audience; and the relationship this use of stereotypes has to certain political and social movements in American culture. To fully investigate this idea, I will seek to answer several questions. The remainder of Chapter One will give introduce the topics that will be discussed throughout this text, as well as a note on my dissertation path, and why I believe the Text & Technology regular utilization of the cultural studies research perspective as presented within the field of Texts & Technology offers helpful insight into how the use of gender can affect the message of pharmaceutical advertisements.

The technology focus of this dissertation is Merck’s Gardasil vaccine; I will devote Chapter Two to exploring the two other major topics I will combine in this study – gender roles/stereotypes, and pharmaceutical advertising – and explain their complex relationship with one another. Here, I will investigate the role gender specifically plays in pharmaceutical advertising, especially how it can be used to educate consumers on the causes and symptoms of an illness and shape in the consumer’s mind the person(s) responsible for illness prevention. I will further show how irresponsible gender depictions can be extremely detrimental to the overall message sent by drug advertisements, and will support

this idea by providing data on the ongoing trend of American consumers who use information featured in DTC pharmaceutical ads as “educational material” on which they may base self-diagnoses of medical conditions, learn when to seek care for an illness, request a specific brand-name drug, and make other potentially life-changing health-care decisions. I will argue that because the information on both a drug and the illnesses it is used to treat are viewed as critical educational material by a viewer, the use of gender may profoundly impact the clarity and balance of this information, affecting the viewer’s opinion of who is even at risk for an illness.

In Chapter Three, I will propose a way to identify fractured gender representations by demonstrating a cultural studies/social sciences-blended methodology that will enable consumers, advertisers, and future scholars to view gendered rhetoric in pharmaceutical advertisements with a more critical eye. This suggested method will blend cultural studies practices with existing quantitative and qualitative research methods commonly used in the social sciences. Together the new methodology can be used to measure gender representations in a variety of pharmaceutical ad medium with the same study. I will describe the structure of each tool and explain how I hope to overcome their limitations through this combined research method. I later put this new methodology to the test in the case of Merck’s Gardasil advertisements in a brief study conducted with a small group of sample consumers. Here, my aim is to replicate the learning process consumers go through when they see a

pharmaceutical ad for the first time. Their response will help me gauge how gender portrayals affect a consumer's first impressions of a new vaccine.

In Chapter Four, I will present the results of my sample study and build my cultural studies rhetorical analysis upon several key findings. First, I will show how Merck's use of gender reflects certain biases that have existed in the medical and pharmaceutical industries for years. I will do this by comparing my findings to similar gender stereotypes that surround the advertising, media coverage, and cultural beliefs regarding other highly gendered pharmaceutical/over-the-counter medications and medical devices. I will then demonstrate how these gender roles and stereotypes used in Merck's ads connect to larger political, financial and social forces operating within our culture.

Chapter Five takes a look at the origin of stereotypes commonly found in pharmaceutical advertising, including these identified in Merck's Gardasil campaign. A main topic of scrutiny here will be the "Woman as Caregiver" stereotype. I will take a look at when, how and why our culture began labeling females as the caretakers of children, and how this has been reflected and reinforced in advertising messages for more than 150 years. This chapter also looks at how this stereotype is factually inaccurate, harmful to male parents, and can have specific damaging effects when used in advertising. I will give clear examples here regarding how Merck uses this stereotype and the various affects that doing so can have.

In Chapter Six, I show evidence that female parents are the main target of Gardasil advertising not because they are parents of children (who can receive

the vaccine as a preventative measure), but because parent-age females are actually the highest spenders in the marketplace. To support this, I will show how in addition to targeting only this segment of consumers so strongly, Merck also engaged in questionable lobbying practices to try to persuade state governments to make Gardasil mandatory for female students entering sixth grade, a requirement that would've given Merck a monopoly on HPV-vaccine sales across the U.S., with legislation guaranteeing years of sales. I then examine the hesitations and objections several groups expressed in reaction to Merck's lobbying efforts, including arguments from parents, the legal community, and the medical community. I will then present research that shows Merck's push to make the vaccine mandatory is part of the drug company's controversial history of pushing drugs onto the marketplace before they are fully proven safe, and use the company's experience with Vioxx as a recent example of its focus on sales rather than on providing safe medicines and vaccines.

In Chapter Seven, I take the problems I have found with Merck's advertising of Gardasil and attempt to "fix" the sample ads I introduced in Chapter Three by suggesting specific changes in the ads' visual and verbal rhetoric. Here, I draw on knowledge from the fields of gender studies and advertising, as well as current medical research to create what I will argue is a more balanced and inclusive series of pharmaceutical ads.

In addition, because many of the examples I refer to throughout this text are broadcast advertisements, these examples will not appear here as figures, but on a separate website that is designed to host video clips. This website can

be accessed at <http://genderad.blogspot.com>. References to different figures will appear throughout the dissertation, and the examples can be viewed in their corresponding number.

### Dissertation Path

By the time I was 26 years old, I knew three women affected by Human Papillomavirus (HPV)-related cervical cancer. I became interested in learning about a new vaccine, then still under development, that had shown successful results in preventing HPV infections from developing in clinical studies. The more I followed this vaccine in the news media and conducted my own research, the more intrigued I became by the unique characteristics of this potentially cancer-causing sexually transmitted infection.

According to the Center for Disease Control (CDC), medical research shows that HPV is responsible for 70% of cervical cancers, 70% of vaginal cancers, and 40% of vulvar cancers in females, as well as 40% of penile cancer cases in males. In addition, HPV is responsible for an estimated 85% of anal cancers, 25% of mouth cancers and 35% of throat cancers in males and females, with HPV ranking as the third leading cause of the latter two cancers, just behind frequent and repeated tobacco and alcohol use (CDC.gov).

Unlike other serious or life-threatening sexually transmitted diseases and infections, HPV has a unique transmission method that makes it nearly unstoppable. Because the virus is passed from one sexual partner to another through simple skin-to-skin contact in the genital area, transmission is possible

without the partners exchanging bodily fluids or even engaging in sexual intercourse at all. Due to the skin-to-skin transmission and the fact that the virus is not passed through fluid, practicing “safe sex” by using condoms, which reduce the risk of contracting other STDs, is unreliable in preventing HPV transmission. In fact, this virus is so prevalent in North America that the CDC estimates 50% of the population will acquire at least one of the 100 strands of HPV during their lifetime. Fortunately, most strands of HPV do not cause cancer, and many infected humans with healthy immune systems are able to shed the virus.

Because of the infection’s terrifying prevalence and easy transmission method, I continued to follow the vaccine in the news media in the hopes that it would gain FDA approval. After the launch of the “One Less” campaign in 2006, I was left puzzled as to why males were left out of the medical trials and the ads, especially since they can spread HPV and suffer cancers as a result of the infection. Failing to include people of both sexes in the campaign may affect some critical communication points, such as the consumer’s perception of who should learn more about the infection, vaccine and transmission methods; the vision of who can step up and take action for their child’s health; and more. This led me to question how the ad’s message would be impacted if males had been included visually, verbally or both. Would seeing a father figure discuss the positive decision he made in getting his daughter vaccinated inspire other male viewers to consider the vaccine for their female children? Or, looking at the problem from Merck’s standpoint, would they sell more vaccines if the campaign’s ads included male figures? After the vaccine was approved for use

in males in late 2009, I was even more surprised to see that Merck did not noticeably change their advertising campaign to reflect this medical breakthrough. Younger males were added to visuals on the vaccine's Web site, but only males toward the lower age range were added. Interestingly enough, all of the text relating to males getting the vaccine primarily promoted Gardasil as protection against genital warts, and not the HPV virus. The Web site's information that is geared toward women, as well as the campaign's broadcast and print advertisements, continued to be marketed mainly to female consumers as a vaccine to guard against HPV.

The fragmented way this vaccine seemed to be advertised stood out to me because I had previously studied the use of gender stereotypes in advertising during my Master's Program in Mass Communications at the University of Central Florida. I had additional experience studying gendered rhetoric in the Text & Technology program, which only renewed my interest in learning how a person's gender and the use of gender roles might affect other types of persuasive dialogue.

Another topic I was introduced to in the Texts & Technology program was the deeply political connection that exists between gender and technology. Throughout the course of this program, I learned more about the connections between gender and technology, from Vivian Gornick, who investigated the challenges women face in technology focused careers, to Ruth Schwartz Cowan, who researched how the introduction of new technologies affects and has shaped women's lives in a myriad of different ways for years, including the

introduction of birth control technologies in the 1920s-1950s. With my experience in this program, I was able to recognize that vaccine technology, and particularly Gardasil, is a great example of a gendered technology that is worthy of study, since the technology of the vaccination has arguably been one of the most impactful medical technologies ever developed, and a vaccine like Gardasil, which protects against STD-related cancer, would no doubt make a huge impact on a woman's health and wellbeing.

It was also during the course of this program that I learned more about the cultural studies research perspective and felt it would be an insightful methodology to apply to the topics of gender and pharmaceutical rhetoric. For the purposes of this dissertation, I decided to combine all of those interests and focus on creating a new way to look at the cyclical relationship between gender and pharmaceutical ads through a lens that combines research tools from multiple areas of study.

### A Cultural Studies-Social Sciences Approach

Like much of the research conducted within the Texts & Technology field, my dissertation will take a cultural studies approach to examine pharmaceutical ads, the effects their gender depictions have on consumers in our culture, and the cyclical relationship that exists among culture, gender roles, and pharmaceutical ad rhetoric. Looking at the other major area that will play a big part in this dissertation, the advertising discipline, a good deal of research that has traditionally been conducted on both "gender in advertising" and the "effects of DTC advertising," has been produced through rigid qualitative or quantitative

studies that traditionally offer a formalized theory and a five-part format that consists of an introduction, literature review, methodology, results, and conclusion. I argue that an approach that blends these two fields may be better suited to examine how gender is communicated in ads, due to 1) the multifaceted way gender is depicted (visually/verbally); 2) the broad range of media utilized by pharmaceutical companies to transmit their ads, such as broadcast, print, social media, website banner and text-message reminders; and 3) the wide range of effects gendered ads have on viewers and on our culture, and vice versa. Therefore, I believe that a cultural studies/social sciences-blended research perspective is the most fitting way to examine the use and effects of gender in pharmaceutical rhetoric.

Cultural studies is a literary methodology that emerged in the 1960s. It combines lines of inquiry from several existing literary theories into one research perspective, including Marxism's focus on investigating power struggles and class differences and feminist/ethnic studies' analysis of minority group(s) within a culture, among others. Because cultural studies' purpose is to investigate the political, financial, social or other motivations that lie behind the text's production, dissemination, and point of view, the researcher is free to push past a simple textual analysis to examine the motivations of the individuals or groups who produced these texts. Ultimately, a researcher operating within a cultural studies focus can then explore these cultural connections and intervene in any cultural imbalance that leaves a population disadvantaged by suggesting ways to correct

communication with the goal of delivering the correct information to as appropriate and inclusive an audience as possible (Dobie 175).

Although this is typically what cultural studies research looks like, the theory has yet to claim a solid definition or methodology – points that have brought criticism to this research method. In Theory Into Practice: An Introduction to Literary Criticism, Ann B. Dobie offers more of an explanation of cultural studies than a definition, writing that cultural studies is more of a field than a single theory, which makes it hard to define, and that “it is not a single, standardized approach to literature (or anything else), but a field that binds its adherents through some common interests and purposes, although they are addressed in widely divergent ways” (Dobie 173). She continues to describe cultural studies research as offering scholars the opportunity to examine many kinds of texts that showcase differing points of view on a subject, as well as the opportunity to challenge “the status quo by trying to displace the powerful and promote the voices of those seldom heard” (ibid 175). Other researchers, such as J. Blake Scott, Bernadette Longo and Katherine V. Wills, construct a definition of cultural studies as it applies to their own research. In Critical Power Tools: Technical Communication and Cultural Studies, they explain that “cultural studies involves critiquing and intervening in the conditions, circulation and effects of discursive-material practices that are situated in concrete but dynamic socio-historical formations, that participate in ideological struggles over knowledge legitimation and that help shape identities” (Scott 5). For the purposes of this dissertation, I will define cultural studies as a research perspective that offers

scholars the opportunity to investigate a cultural phenomenon by examining a variety of relevant textual artifacts in order to uncover their underlying rhetorical qualities. I would further clarify that cultural studies critics can then use this information to examine the cyclical relationship between the messages found in these texts and the dominant/minority social and political forces that produced them in order to gain insight into why they were produced and for what (or whose) benefit. Lastly, cultural critics seek to correct imbalanced communication, by exposing incomplete or exclusive messages and the motivations behind them, and suggest ways of correcting future communication for the benefit of a more complete and inclusive audience.

Because cultural studies offers no strict methodology, researchers are free to examine a cultural phenomenon by considering a variety of relevant texts, which may include a combination of books, speeches, focus group transcriptions, media accounts, pieces of legislation, radio broadcasts, advertisements, “surveys, field-based studies, textual interpretations, historical background studies and participant observations” (Norton 27). I agree with scholars, such as Scott, who believe that cultural studies’ free-formed methodology is one of its biggest benefits, as it enables researchers to design their own methods of inquiry appropriate to the unique breadth and scope of the cultural phenomena they study. Instead, “cultural studies has no distinct methodology, but pragmatically and self-reflexively pieces together whatever methods and theories are necessary for a particular project.” (Scott 20).

Cultural studies' fluid methodology makes it an ideal perspective from which to study medical and pharmaceutical rhetoric. In her research on breastfeeding rhetoric, Amy Koerber uses a cultural studies perspective to examine the various breastfeeding viewpoints new mothers face by analyzing a variety of texts that includes pieces of state legislature, breastfeeding books and brochures, and transcripts of qualitative interviews she conducted with individuals representing different sides of the debate to offer a range of perspectives on breastfeeding. Without the freedom that cultural studies allows to jump across textual genres, researchers like Koerber would have to pick and choose from available texts based on their format in order to fit within strict boundaries. Doing so might force a researcher to leave out texts that could critically impact their data and restrict their findings overall. In my test case of Merck's Gardasil campaign, cultural studies enables me to examine a broad range of texts, including print advertisements, media reports, press materials, commercials, advertorials, Internet ads, and others that contribute to the ad campaign's gendering of Merck's Gardasil. It also allows me to employ various methods of data collection, including surveying relevant members of a drug's consumer group using both qualitative and quantitative methods on multiple aspects of an ad. The texts that are available, their demonstrated use of gender and the interpretations of these documents according to a small population will serve as my starting point as to where my research will lead me – perhaps into an investigation into the stereotype of women as caretakers in Western society, or perhaps into something else. Cultural studies is the exact research perspective

that can allow me to investigate these texts as evidence of a larger cultural story about how gender roles are used and manipulated by the pharmaceutical industry to meet medical or financial goals. Again, this is a departure from the research methods traditionally employed within the advertising discipline, which often limits a study to analyzing a single characteristic of an ad within one specific ad format (i.e. studying female gender representations in print ads in men's magazines).

A second benefit of studying medical/pharmaceutical rhetoric within the cultural studies perspective is the emphasis the approach places on enabling a researcher to take his or her findings and investigate possible connections between the texts and the culture that produced them. This type of study is especially relevant to medicine and pharmaceuticals, considering the intricate ties both of these fields have with various government agencies, including the Food & Drug Administration (FDA), Federal Trade Commission (FTC), the Center for Disease Control and Prevention (CDC), and the National Better Business Bureau (NBBB); as well as the medical community, insurance industry, mass media, patient advocacy groups, and consumers. Many medical/pharmaceutical rhetoric scholars have produced successful studies by using this very approach. For example, as noted earlier, Scott blended rhetorical analysis with cultural studies to create a unique approach to examine the rhetoric that surrounds home HIV-testing practices in his book Risky Rhetoric: AIDS and the Cultural Practices of HIV Testing. Here, adding the cultural studies perspective allowed Scott to identify what persuasive messages surrounded the introduction and use of home

HIV tests, as well as to analyze the motivations and rhetorical perspectives of the kit manufacturers, healthcare industry, medical community, targeted consumers, and other interested parties. Instead of being limited to examining one type of text and reporting results, Scott is able to use the cultural studies perspective to present readers with a bigger picture of how dominant political, financial, and cultural thought influenced HIV testing communication. In my test case of gender in Gardasil ads, this perspective allows me to make connections between my findings and how gender roles in advertisements affect their audiences, the cyclical relationship between gender stereotypes in advertising and stereotypes in American culture, any gender biases the medical/pharmaceutical industry holds or even has a hand in promoting via advertising, and more.

A final reason that cultural studies research can be beneficial in medical and pharmaceutical rhetoric is that the last step in a cultural studies analysis is to suggest ways of improving biased communication by giving direction on how to communicate more accurately to an audience. Specifically in the case of pharmaceutical/medical rhetoric, intervening may inspire clearer communication that has a life-saving impact on consumers. For example, Cindy Patton takes a cultural studies approach in her book, Last Served? Gendering the HIV Pandemic, in which she studies media coverage and public policy texts on high/low-risk HIV populations, how the biases of these writers and politicians helped shape and define the identities of those perceived to be at high-risk for HIV, and how this led to the tragic misidentification of many individuals (such as Caucasian women, non-drug users, and spouses/children of those with blood

disorders) who were at real risk. Patton is able to uncover where media representations went wrong and uses this case as an example of how poor STD communication can be deadly. She follows up by providing several suggestions as to how HIV prevention and risk data could be communicated in a more accurate and inclusive way. In my study, a cultural studies perspective allows me to point out dangerous flaws in Merck's current communication and make suggestions for a clearer and more inclusive approach, with the end goal being to ensure Merck's message is reaching all relevant audiences.

In addition to "cultural studies," there are a few other terms that I should define for the purpose of this dissertation. The first of these is "direct-to-consumer pharmaceutical advertising" or DTC advertising. In Julie Donohue's [A History of Drug Advertising: The Evolving Roles of Consumers and Consumer Protection](#), she defines DTC pharmaceutical advertising as "a pharmaceutical company-produced advertising communication that promotes a prescription drug, and/or the disease or condition it treats, directly to a 'consumer,' or 'one who consumes'" (Donohue 106). I would like to slightly broaden this definition to add that DTC pharmaceutical advertising communication can come in a variety of forms, from traditional television, print, and radio advertisements, to other pieces of persuasive communication that at first glance one may not recognize as persuasive – including pharmaceutical Web site content, text message advertising and more.

I would also like to differentiate this term from "pharmaceutical rhetoric," which I discuss in Chapter 2 to greater detail. The term "pharmaceutical rhetoric"

is a broader term that includes DTC advertising, but also includes many other types of persuasive texts. These may include texts such as legislation and public policy, Web site content by patient advocacy groups, news media coverage, and others that may influence a consumer's knowledge or opinion of the vaccine without the primary purpose being to "sell" the product.

But first, I will examine the complex relationship between gender and advertising, and discuss the many effects the use of gender has in this form of rhetoric.

## CHAPTER 2: EXPLORING GENDER IN PHARMACEUTICAL ADVERTISING

What effects does the use of gender have in pharmaceutical advertising? And how do these effects impact the consumer? In this chapter, I will focus on answering these questions, and argue why it is critical to find a better way to examine the use of gender in pharmaceutical advertisements. To support this idea, I will explore the history of how and why advertising is considered to be controversial, and argue that there are several specific troublesome effects that surround this form of rhetoric. Next, I will discuss the major controversies that surround the advertising of pharmaceuticals specifically, as well as how certain ad practices (such as an ad's use of gender stereotypes) may critically impact a pharmaceutical ad's message. I will support this by providing real-world examples of how irresponsible gender portrayals in pharmaceutical rhetoric can be really mislead consumers.

### Advertising's Controversial Role as Educator/Promoter

Advertising has existed for centuries and plays several major roles in Western society. First of all, as Katherine Toland Frith and Barbara Mueller have discussed, advertising is the type of communication through which businesses alert potential customers to the locations, prices, and availabilities of goods and services – something that cultures need to regularly acquire necessities like food, clothing, and shelter for survival. Advertising also helps to stimulate an economy by creating jobs, and allowing businesses to profit from the goods they sell.

Advertising appears in many media formats today, including broadcast commercials, print ads, direct mailings, and magazine advertorials, as well as via social media platforms, promotional websites, banner ads, pop-up ads, digital media ads, spam and distribution e-mail, and more. News coverage, pieces of legislation, publications from activist groups, and even word-of-mouth communication, although not designed by “advertisers,” may serve as a secondary form of promotion (or “pharmaceutical rhetoric”) in our culture, as these methods may disseminate or reinforce similar messages to consumers.

Although advertising may be necessary and beneficial to some degree, the practice of advertising has been surrounded by controversy for more than a century. Complaints from various governmental and consumer viewpoints range from the opinion that advertising is partially responsible for flooding the marketplace with too many goods and services, which encourages a materialist culture in the United States, to the idea that advertising’s portrayal of unachievable lifestyles has partially encouraged an increase in certain crimes, such as theft and robbery. Other complaints that surround advertising relate to questions of the ethics of advertising of potentially addictive or unhealthy products, such as tobacco, alcohol, and fast-food (especially in ads directed toward children); the use of nudity in ads; the use of minority stereotypes; and more. (Frith 213).

One of the most troublesome complaints from consumers is the practice of deceptive advertising (also known as false advertising), which is something that the U.S. government and several consumer groups have continually worked to

police in the United States for more than a century. This is especially true in the case of the false advertising of medical and DTC pharmaceutical products, which can have potentially fatal effects on a consumer's health. In fact, the dangerously deceptive state of pharmaceutical advertising was what initially sparked the U.S. government's involvement in advertising regulation for any and all products (not just medical/pharmaceutical ones) (Donohue 663).

At the beginning of the 20th century, there was no regulation or monitoring of drugs or pharmaceutical ads by any person or group in the United States. At the time, basically any individual or company was free to produce a medication (effective or not), advertise and sell it as they saw fit. This led to an increasing number of dangerous scams taking place in the United States, with unlicensed "doctors" advertising miracle cures that were worthless or potentially hazardous to a customer's health. In 1906, the U.S. government took its first-ever step toward controlling the advertising of prescription drugs by passing the Pure Food and Drug Act, which required that "no detail of a drug label could be false or misleading, and it had to list the presence and amount of eleven dangerous substances, including alcohol, heroin, and cocaine" (ibid 666). Note that this regulation applied to an ad's labeling (a text that can be considered pharmaceutical rhetoric), but not to ad materials, those in newspapers, the most common format for pharmaceutical advertising at the time. Although labeling collateral changed, print ads for fraudulent doctors and miracle cures continued to run rampant and put consumers at risk.

The next attempt to curb dangerous advertising of questionable drugs came in 1912 with the establishment of the National Better Business Bureau (NBBB) which was created specifically in an attempt to curb “medical quackery and the promotions of nostrums and worthless drugs” (Ladimer 1,217). Although the NBBB was not given (and still in the year 2012 does not have) the legal power to stop an advertisement, its first responsibilities included identifying possible business-to-consumer frauds and alerting both consumers and law enforcement of any advertisers they feel may be engaging in false advertising.

In 1938, the U.S. government took two big steps toward establishing control over drug-specific advertising. The first was the passing of the Food, Drug and Cosmetic Act (FDCA), which decreed that drugs must be proven safe by the FDA before they can be advertised, and it gave the FDA the power to regulate how the drug was labeled, but not advertised. That same year, the government passed the Wheeler Lea Act, an amendment to the Federal Trade Commission Act that declared false advertising illegal for the first time. This act was amended again in 1947, to give the Federal Trade Commission (FTC) the power to regulate advertising in the United States, mainly by investigating individuals or businesses suspected of false advertising *after* an ad had been released. However, the FTC’s control and resources in the late 1940s were reportedly limited, making it difficult for the organization to enforce this amendment (Donohue 670).

Tighter regulations against the false advertising of pharmaceutical drugs came in 1962, when the Kefauver-Harris Amendment permanently shifted control

of prescription drug advertising from the FTC to the FDA. The act required that drugs be proven “not only safe, but also effective before being marketed. In order to receive FDA approval, the amendments also required drugs to meet a high standard of scientific evidence” (ibid 644). It is important to note that this act did not give the FDA jurisdiction to monitor the advertising of over-the-counter drugs or medical devices – that responsibility stayed with the FTC.

Today, the FDA continues to monitor pharmaceutical ad content for false or misleading information. In today’s practices, the FDA does not require a pharmaceutical company to submit ad content prior to the ad’s release, but instead evaluates the ad simultaneously with its release to the public. If the FDA believes an ad contains any misrepresentations or false statements, the FDA sends a letter to the pharmaceutical company to request that the ad be pulled or changed. In extreme cases, the FDA can choose to pursue legal action against the pharmaceutical company. However, because the ad has already been released and viewed by the public, irreversible damage may have already been done. This fact is pointed out on FDA.gov, in which a Q&A section explains how the FDA monitors pharmaceutical advertisements. Here it is noted that, “except in unusual instances, we cannot require drug companies to submit ads for approval before they are used. Drug companies must only submit their ads to us when they first appear in public. This rule is the same whether the ads are aimed toward healthcare providers or consumers. This means that the public may see ads that violate the law before we can stop the ad from appearing or seek corrections to the ad” (FDA.gov/drugs).

Direct-to-consumer (DTC) advertising of pharmaceutical products to consumers has often been flawed and problematic throughout U.S. history. In the next section, I will show how the effects of DTC pharmaceutical advertising once came to be considered too risky for consumers, how and why DTC advertising of pharmaceutical products was banned, how it re-emerged again at the dawn of the age of the Internet – and how this new technology provided new platforms for deceptive advertising.

### Direct-To-Consumer Pharmaceutical Ads & Their Effects

DTC is a form of advertising that is aimed at communicating directly with the consumer rather than wholesale buyers, and historically DTC was often the route through which much of the false advertising of drugs took place. According to Julie Donohue's history of drug advertising, when and how the DTC advertising of prescription drugs started is a bit vague, partially because of the loose lines that once existed between the categories of "prescription drugs" and "over-the-counter" medications, which were both free to be advertised to the general public until the 1950s. Until that time, most drugs (including those requiring a prescription), could be purchased by gaining a prescription from a doctor or a simple recommendation from a licensed pharmacist. At the time, the decision to categorize a drug as a "prescription drug" or an "over-the-counter drug" was also left up to the individual pharmaceutical company, with the FDA requiring only a small and specific set of potentially-toxic medications to require a prescription (ibid 667). When the Durham Humphrey Amendment was passed in

1951, it created a more solid dividing line between what counted as an over-the-counter drug and a prescription drug, with the purpose of protecting consumers from making potentially life-threatening medication selections. After the passing of this amendment and our culture's adjustment to stricter prescription policies, pharmaceutical companies began targeting their drug advertising efforts heavily on doctors, crowding medical journals and office mail with advertisements for prescription drugs. In the meantime, advertisements of over-the-counter remedies continued to be marketed to general consumers via DTC methods, which at the time were primarily available in print format.

All of this began to change again in the 1970s, when consumer groups, such as the Health Research Group, began pushing the U.S. government for more patient involvement, knowledge, and empowerment when it came to medication choices. In 1975, the group formally requested the FDA to "require patient labeling for prescription drugs because of their concern that doctor-patient communication about drugs was inadequate" (ibid 672). This motivated the FDA to require that drug companies include Patient Package Inserts with each prescription drug sold that listed information about the drug's use and risks for the consumer to read. The consumer group's push for PPIs was a starting point for consumers to become more involved in their medication decisions, and was followed by some major consumer movements over the next two decades based on giving patients more rights and control, including the patient's "right to die" movement of 1977; patients' pressure on the Reagan Administration to take the AIDS crisis seriously in the mid-1980s and launch into medical research; the

passing of the Patient Self-Determination Act of 1989 that allowed patients to create advance directives on their care in the case of incapacitation; and the Health Insurance Portability and Accountability Act (HIPAA) of 1996, which guaranteed individuals a right to private medical records.

According to Donohue, an additional step toward patient empowerment came with the introduction of managed-care health plans in the early 1990s. For the first time, consumers were becoming actively engaged in choosing their own health-care plans and doctors. Also, the advent of the Internet and the launch of health-related chat rooms, online support groups and self-diagnosis websites provided some of the first dedicated areas for patients to get more information and recommendations from people experiencing the same ailments. The role of the consumer was changing, and pharmaceutical companies began to view consumers and the possibility of DTC advertising as a real area of financial opportunity. These companies began pressuring the FDA to reconsider its DTC restrictions, and additional pressure came from the legislative branch of the U.S. government, which at the time felt the FDA's pharmaceutical approval process took so long that it was slowing life-saving drugs from entering the marketplace. In 1997, the FDA officially relaxed its rule on listing all potential side effects of a drug in an ad, and instead "the ads could refer consumers to (1) a toll-free telephone number, (2) print ads, (3) a website, and/or (4) their pharmacists or physicians, from whom they could obtain complete information about the product's risks or benefits" (ibid 685). Now, it was finally possible for drug

companies to squeeze the appropriate and acceptable amount of information into time-limited broadcast ads and space-limited print ads.

In the years since DTC pharmaceutical advertising was revived, scholars within the advertising discipline have noted several effects that DTC pharmaceutical advertising has had on consumers. First of all, critics like Frith and Mueller believe that DTC pharmaceutical advertising has directly contributed to the increase of both drug costs and consumer spending on medicine, a fact that is supported if you look at how consumer spending on prescription drugs increased immediately following the 1997 regulation change, growing from \$310 million to \$1.2 billion in 1998 (ibid 685). The cost of prescription drugs themselves has also been on the rise, with the price of the average prescription increasing by 40% between 1994 and 1999 (Frith 209). Additional complaints about DTC pharmaceutical advertising believe it encourages individual consumers to overmedicate by purchasing stronger prescription medications, when an over-the-counter medication could successfully treat the same ailment, or by taking new prescription drugs in order to delay “normal” parts of life, such as hair loss.

Another major effect has been the way DTC pharmaceutical advertising has impacted the consumer role in making health-care choices. With pharmaceutical companies providing consumers with more knowledge on illnesses and medications through ad content, consumers are taking a more involved role in their own healthcare and medical decisions. The average American television viewer is exposed to 30 hours of pharmaceutical ads each

year (ibid 203), and statistics show that DTC pharmaceutical advertising resonates with viewers, with 74% of consumers reporting that DTC pharmaceutical ads make them want to be more involved in their own health-care and medication choices (Rados 2004). One benefit of this direct form of communication is that the availability of medical information has led new patients to seek out medical care for conditions they might have otherwise let go unchecked, which often has life-saving benefits.

However, the patient's expanded role in his or her own medical care has also impacted the doctor-patient relationship in a few difficult ways. After the regulation changes, many in the medical community have reported feeling additional pressure to prescribe specific drugs that patients request based on advertising. "Some complain that patients are demanding brand-name drugs, whether their doctor recommends them or not. Physicians not only have to defend what they are going to prescribe, but also defend what they are not going to prescribe ... One investigation showed that only 9% of physicians reported feeling no pressure to prescribe from patients informed by advertising" (Frith 206).

A final controversy that surrounds DTC advertising of pharmaceutical products circles back to false advertising, which still occurs in the marketplace today. In a recent example, commercials for Bayer's birth-control pill, YAZ, caused controversy in 2008 when the FDA declared that the company "was deceptive and made false claims regarding its efficacy for acne and premenstrual syndrome" (ibid 210). In response, the FDA required Bayer to run corrections on

their misleading ad statements, as well as submit any advertisements for FDA approval before they are released until the year 2014 (see Fig. 1 <http://genderad.blogspot.com>).

With new advertising mediums constantly emerging, problems with deceptive or incomplete drug advertising continue to occur in the marketplace. As recently as August 2010, the FDA took measures to warn pharmaceutical companies who communicate via social media that they must follow all current FDA guidelines when using these new channels to advertise or communicate to consumers. One that did not was the pharmaceutical company Novartis, which produces the blood cancer drug, Tassigna. Like many other pharmaceutical advertisers, Novartis launched a Tassigna medication page on the Facebook social network platform by using the Facebook Share application. This application allows Facebook users to “follow” a medication’s page and get alerts from the company as the page is updated. In August 2010, the FDA accused Novartis of failing to follow FDA’s DTC advertising regulations in its social media approach because the page did not include any information on the risks associated with taking the drug. It also accused Novartis of providing so little information about what the drug was, what it treated and how it worked, that the content that did appear on the page was misleading. The FDA also found the company’s promotion of the drug being a “next-generation” treatment to be false, considering that the chemical composition of the drug varies only slightly from its competitors, and that its make up has not been proven to be more effective than the others. In response, Novartis offered to place a hyperlink on their Facebook

page that links back to their website for a full description and list of side effects and risks. The FDA responded that doing so was not sufficient, and requested that Novartis attend a hearing that was set for June 2011. As of February 2012, that hearing has been rescheduled three times and has still not taken place due to legal delays (IPWatch.org).

In addition to these problems, what is worse is that often many of these miscommunications or misrepresentations are not caught until the message has already been disseminated to an audience. As I have shown, the monitoring of pharmaceutical advertising is still an imperfect practice, which can lead to a lot of confusion on the part of the consumer. In the next section, I will show how a factor from within the ad itself can complicate its message even more, and how it can lead to potentially dangerous miscommunications for consumers.

### The Use of Gender in Ads: Adding to the Confusion

Due to the nature of pharmaceutical drugs, I must use and define both the terms “sex” and “gender,” partially due to the actual difference between these terms, but also because certain drugs are sometimes approved for use based on a patient’s biological sex and not on one’s gender.

When it comes to distinguishing “sex” versus “gender,” it is important to understand that a person’s sex refers to the individual’s biology, though this category is somewhat fluid and can change with health measures such as hormone replacement therapies and sex reassignment surgeries. Gender is defined differently and relates more to a person’s behavior and self-identity than the biology. I agree with many gender studies scholars, like Judy Wajcman and

Deborah Tannen, who believe that gender is a social construction, meaning that a culture dictates appropriate behaviors and expectations for the males and females who reside within it. In the case of gender, an individual learns more about what it means to be “male” or “female” from the experiences they have interacting as a part of the family, society and culture they are raised in, rather than how they are biologically programmed to act.

Culture not only constructs differences between “men” and “women,” but creates different sets of expectations for smaller subsets within each group. For example, it may be considered culturally appropriate and acceptable for a 22-year-old Caucasian male to pursue a career as a professional football player for the National Football League (NFL). Unfortunately, it may be considered less culturally appropriate for a 22-year-old African-American female to pursue the same career. Because this career choice is considered out of the realm of what is currently culturally acceptable for women, this woman may face a challenging career path. It is also important to mention here that gender roles are not fixed, and as Judy Wajcman argues, “both ‘masculinity’ and ‘femininity’ are ... in fact constantly under reconstruction” (Wajcman 9), meaning that gender roles change over time and generation. This means it is very likely that being a NFL football player may someday be promoted as an acceptable and possible career choice for a woman.

But while gender roles within a culture seem to change over time, roles for men and women across different cultures have been found to share some similarities. Many scholars believe that though exceptions do exist, current

gender roles for women around the world lean toward associating females with qualities such as passive or emotional behavior, and with roles such as a mother, wife or homemaker. In contrast, males across different cultures are currently associated with strength, leadership and success. Many scholars believe that the differences between these gender roles can be damaging to women, as well as to those individuals who cannot or choose not to conform to the culture's expectations of appropriate behavior, and may face scrutiny for failing to do so.

Researchers often debate whether advertising models gender roles or reflects them as they currently exist in our culture. Research within the ad industry tends to corroborate the aforementioned gender studies' research that male and female gender roles are depicted differently, with men often portrayed as successful, heroic and attractive figures, and women as passive, sexy or less intelligent individuals. According to advertising scholars Frith's and Mueller's Advertising & Society: Global Issues, differences in gender portrayals can be perceived in the most miniscule detail, such as the physicality of the actors/models chosen for the ad, the role they play in the ad, their stature and body language, the words they speak, the gender of the selected speaker/voice of authority, the amount of camera time they receive, and more. The authors continue to explain that in advertising, males are most often depicted in active roles, while females are shown in passive roles. "In TV commercials, boys run, shout, ride bikes, compete with each other and take risks ... . In commercials aimed at girls, the camera techniques create a soft, warm, fuzzy feeling. Girls play quietly in their pastel bedrooms or watch boys in more active play" (Frith

224). Males also often portray roles of authority. Years of research show that men typically take on the voice of authority in commercials, appearing as a narrator or voiceover much more often than a woman, even when the ad's product is aimed at female consumers.

But the use of gender stereotypes in advertising is nothing new. Ad and gender studies research shows that gender stereotypes have been utilized prominently in ads for centuries. In Women and the Machine, Julie Wosk cites advertisement illustrations from the 1940s that show women taking on technological jobs during wartime, an activity that at the time would have been considered out of the sphere of acceptable behavior for their gender. According to Wosk, "these heroic images of women taking on new roles and lives were only part of the story ... nineteenth century images of women were often portrayed as a daffy bunch, fixated on cleanliness and baffled by machines" (Wosk xi). A 1972 study by Ahmed and Janice Belkaoui examined gender roles in print advertisements from the 1950s-1970s, and found that the same stereotypes existed for women in the 1970s as in earlier decades, though their frequency had declined in the latter years as women began entering the job market on an increasing basis in the 1970s. According to them, common stereotypes in print advertisements over these three decades often depicted women as unemployed or low-wage earners or as sexual objects, and rarely showed them as the maker of purchase decisions, or making decisions independently from a male figure.

Gender stereotypes of both men and women continue to exist in advertising today. Research shows that sometimes these depictions are

unintentional: for example, an advertiser may be unconscious of his or her gender bias, and this may reflect in his or her work. However, sometimes gender stereotypes are used on purpose. Nancy Artz states in her article, "Gender Issues in Advertising Language," in Women and Language, an advertiser may choose to use a stereotype because doing so quickly conveys a strong verbal and visual message to viewers, and is looked at as a fast way to communicate a lot of information. This is because "longstanding stereotypes conjure up specific images and perceptions in the minds of consumers. As a result, advertisers may gravitate toward communicating a clear message about brand benefits at the expense of achieving gender-neutrality in language" (Artz 22). Other advertising critics, like author Janet Kilbourne, argue that some advertisers use gender stereotypes consciously in order to play on the insecurities of their potential consumers. According to her, "The magazines and the ads deliberately create and intensify anxiety about weight because it is so profitable. On a deeper level, however, they reflect cultural concerns and conflicts about women's power" (Kilbourne 24).

Recognizing the impact that both gender representation and an ad's definition of "sex" can have should be important to a pharmaceutical company, as these factors influence how an audience views their product, message, brand, purchase habits, and even their own sense of self.

First, research clearly shows that many female viewers are offended by watching stereotypical representations of women in advertisements. As researchers William Lundstrom and Donald Sciglimpaglia's showed in their

research study “Sex Role Portrayals in Advertising,” current gender stereotypes in advertising are perceived by many female consumers to be untrue, offensive or old fashioned. This study also found that the use of stereotypes led consumers to change their view of a product’s parent company, leading women to believe that “companies which portray women offensively in their advertising are more prone to have discriminatory employment practices” (Lundstrom 75).

Second, the use of negative gender stereotypes also can affect a consumer’s purchase decisions. Women polled in the aforementioned Lundstrom and Sciglimpaglia study reported that they would change or discontinue a product purchase due to the negative portrayal of women in an ad.

The use of gender stereotypes can also interfere with an ad’s message to viewers. Some gender portrayals, such as using women as sexual objects, are so distracting they can actually interfere with an audience’s mental recall of a brand or product. For example, a jeans ad that uses sex appeal to sell its product risks distracting the audience member’s attention away from the product by also including verbal or visual sexual content. According to a study cited by Frith and Mueller, “nonsexual illustrations were more effective in producing recall of brand names than were sexual illustrations” (Frith 238) when a person is exposed to an ad and asked to recall the brand a week later, meaning that sexually explicit content interferes with the ad’s product and message.

Lastly, research has also shown that gender stereotypes in advertising can affect an audience member’s self image and self-confidence, especially when it comes to females and younger viewers. According to Frith, this is

because “when children internalize advertising and media stereotypes, gender myths can be perpetuated and children from a very early age may limit the roles they see themselves playing in society. Even very young girls are shown in advertisements for branded fashion goods, perhaps suggesting to children that fashion and beauty are what are most valued for women in society” (ibid 224).

In the next section, I will look at gender portrayals and stereotypes that are particularly common in medical and pharmaceutical advertisements.

### Gender in Pharmaceutical Ads

Gender representation may have additional effects in the case of pharmaceutical advertisements. In these types of ads, gender depictions can visually and verbally shape or define who a relevant patient is for a drug; who is at risk for a disease or condition; and who is responsible for accessing the drug for illness treatment, control, or prevention. The way gender is used in ads also helps “gender” the technology, meaning the way it is advertised, and the people who appear in the advertisements, help shape consumer opinion as to the population (male, female or both) that can or should access the product. We can see how these factors are affected by gender use in the sample Gardasil campaign. With only females represented in a majority of the ads for this campaign, a viewer may perceive that the drug is approved only for females; females are the only ones affected by HPV; and females or their parents (specifically mothers) are exclusively responsible for preventing the infection by getting the vaccine for their daughters before they become sexually active. While

it is factually true that the vaccine was approved initially for females only, that has since changed and a lot of information is left out of these ads, particularly about how HPV is transmitted, and that men's health can also be affected by infections.

Pharmaceutical ads also seem to present a particular pattern of gender stereotypes. First, women are often shown in pharmaceutical ads playing passive roles. For example, a 2008 commercial for McNeil Consumer Healthcare's drug Zyrtec featured a female actress dressed in a pastel yellow blouse, in an apartment that featured several vases of flowers and a small puppy. She explained, while gently stroking a light green couch and her puppy, that Zyrtec helps her with all kinds of indoor and outdoor allergies. Fourteen seconds into the commercial, a male narrator pipes in relevant prescription information (see fig. 2). Here we can see that again, females are associated with pastel colors and passive behavior, such as stroking an object.

Second, males are often shown in roles of authority in pharmaceutical ads, particularly when it comes to acting as a narrator, or fulfilling a visual authoritative role by appearing as a doctor. Women are rarely shown playing the role of physician in ads, and when they do, are often shown in a vastly different manner. As I mentioned in the Zyrtec allergy commercial above, the main character of the commercial is a female engaging in passive behaviors. Despite the fact that we start out the commercial hearing a women's experience with allergies from her directly, a male plays the role of narrator and delivers the important prescribing information 14 seconds into the commercial. Men are also shown visually in roles of authority. Although the popular stereotype of "Women

as Caregiver” abounds in pharmaceutical commercials, as will be discussed in greater detail later in this paper, males often take the place of authority by portraying doctors in ads, a role that indicates more credibility than a seasoned mom caring for a sick child. This portrayal is striking compared to how women appear in pharmaceutical commercials, as author Suzanne Romaine points out that “90% of doctors in ads [are] male, whereas more than half of women [are] housewives” (Romaine 253). For example, a commercial for GlaxoSmithKline’s Avodart depicts a man visiting a doctor to discuss his need to use the bathroom more than usual. The doctor, a male, is shown dressed in professional attire with a tie, lab coat and stethoscope. In the ad, the doctor listens and responds to the patient’s questions, then diagnoses him (without giving him a physical exam, or even touching him), with enlarged prostate and prescribes Avodart. In this example, the male doctor expresses authority in a variety of ways: by wearing a lab coat and stethoscope, two symbols that indicate medical authority within our culture; by instructing the patient on his body’s condition; by selecting a medication for the patient; and advising the patient on the drug’s use. In contrast, a 2008 Bayer YAZ birth control commercial shows three female friends dressed up, sitting on a couch in a trendy nightclub (see fig. 3). One female starts to discuss how she is an “emotional wreck” during menstruation and recently talked to her doctor, who prescribed YAZ to control her premenstrual dysmorphic disorder (PMDD). Her friend begins to explain how YAZ is a different kind of birth control pill and how it can help with PMDD, then states, “I didn’t go to medical school for nothing,” and all the girls laugh. In this case, the female

doctor is represented very differently than a male doctor, as she sits in a bar, wearing a low-cut shirt and holds a cocktail. Here, she expresses much less authority than the male doctor from the previous example: she's stripped of the visual signifiers our culture traditionally associates with doctors, such as a lab coat and stethoscope. She's also not working in an office, this doctor is in a bar discussing medical conditions with another doctor's patient, and is not even depicted treating a patient of her own.

Other portrayals of female doctors in ads are not as extreme as this, but still do retain some gender stereotypes. For example, a 2009 ad for Restasis features real-life optometrist Dr. Beth Tendler (see fig. 4). This is explained early on in the commercial by a graphic that reads, "Dr. Tendler is compensated for appearing in this advertisement." Visually, there are a few gender stereotypes included in the ad that fit with the idea that women are warm, compassionate and interact more intimately with others. Unlike many male doctors who wear ties and white lab coats in other pharmaceutical ads, Dr. Tendler wears her lab coat unbuttoned with a pink blouse underneath. Instead of sitting behind her desk when she talks to her patient, a nod to a hierarchical separation between doctor and patient, she leans against the front of her desk during their conversation in a more relaxed and informal manner. Another example of informality occurs at the end of the commercial, when instead of shaking the patient's hand, she puts her arm around her to walk out of the office. Once they appear in the hallway, she confides in the patient that she not only recommends Restasis to her patients, but she also uses it herself. This statement further breaks down the division

between patient and doctor by Dr. Tendler expressing personal similarity to her patient. One thing this ad does well is having Dr. Tendler deliver the important medical information, such as details on the eye drops' side effects. This part of a pharmaceutical commercial is often included as a voiceover by a male actor.

The rare depiction of a woman as a doctor differs from the more common stereotype of "Women as Caregiver." For example, women in pharmaceutical ads are more frequently visually depicted as mothers tending to sick children or as nurses caring for sick patients while remaining out of the way of male doctors. This gender stereotype can be seen through an ad's visuals, or read/heard in ad language. For example, a print advertisement for Vick's Cold Medicine released in 1953 features three illustrations of a family using Vick's products (see fig. 5). One illustration features an adult male (father), who is self-administering Vick's Vi-Tro-Nol nasal drops. The other three illustrations show an adult female (a mother) playing the role of a caregiver by administering Vick's Vaporub to a small baby, then cough syrup to a little girl, and lastly, treating herself by using a Vick's inhaler. And this stereotype has clearly lasted for decades. In an example from 2010, Vick's official website [www.Vicks.com](http://www.Vicks.com) offers an advertising slideshow of some of their products and three consumers. Each consumer is a woman. In one slide, a Hispanic female has a cold and is caring for herself with Vick's products (see fig. 6). In another slide, a teenage girl leans her head passively on her mom's shoulder, indicating illness, and looking to her mother for help. The mother looks directly into the camera with a confident smile, giving us the idea that this illness is nothing a caregiving mother cannot handle.

The role of “Woman as Caregiver” also can be read/heard in decades of ad language for pharmaceutical products. For example, a 1930 ad for Bauer & Black Bandages includes a printed description of a person in need of a medical bandage to treat an injury (see fig. 7). The role of “Woman as Caregiver” is introduced in the first paragraph of the ad: “A worried mother may want only a tiny roll of sterile gauze – but she wants it in a hurry. And the druggist sees that she gets it” (Bauer & Black). Similarly a 1985 television commercial for children’s Tylenol shows an African-American family visiting a museum. A little girl turns to her father and says “Daddy, I don’t feel good.” The father feels her forehead and says, “She’s got a fever. Let’s go home for some Asprin.” The mother figure then swoops in and says, “No, Children’s Tylenol. It’s what our pediatrician gives his own kids.” This ad shows the mother as taking on the caregiver role within the family, but still bending to the expertise of another male figure (the male doctor) (see fig. 8).

This Children’s Tylenol commercial is also a great example of another male stereotype frequently seen in pharmaceutical ads. A man generally holds three roles within a pharmaceutical ad: doctor, patient, or “Clueless Caregiver.” When he is depicted in the role of doctor, he is in charge, responsible, knowledgeable, and professional. When he is a patient, he listens to his doctor, confides in him about potentially embarrassing conditions, and leaves the office with a smile. But all of this changes when a man is in the role of a dad and must take care of himself, or an ill child. For example, a 2001, television commercial for Robitussin’s Honey Flu sore-throat drink opens on a man lying in bed with

the covers pulled up to his chin (see fig. 9 <http://genderad.blogspot.com>). He is sneezing and coughing, pulls a thermometer out of his mouth and finally yells, "Honey!" trying to get his wife's attention. The next shot shows his wife in the kitchen, pouring warm water into a teacup and adding a pack of Robitussin's Honey Flu. She then takes the teacup up to him on a tray and serves him in bed. He takes a sip and thanks her gratefully for all of her help. This seems to be a bit of an exaggerated response to a sore throat, and the fact that an adult male has no idea how to treat this minor health problem is a great example of the male "Clueless Caregiver" stereotype. Here, I have to agree with Janet Kilbourne in that this stereotype is harmful to both sexes; not only are male viewers shown that they are incompetent at taking care of themselves, but depictions of males acting uncomfortably in caregiving situations reinforce here that the proper sphere for women to share their expertise is within the home.

One additional trend that can be seen in ads for pharmaceutical and over-the-counter products that I believe is worth mentioning is the use of embarrassment when discussing women's health issues in ads. I argue that one of the most disturbing gender stereotypes that can be seen throughout decades of pharmaceutical and over-the-counter product ads is embarrassment in how women talk about "female" medical issues, such as menstruation, premenstrual syndrome, and premenstrual dysphoric disorder (PMDD), often expressing feelings of humiliation or worry, discussing these issues literally behind closed doors, and frequently using euphemisms instead of words like "menstruation" and "period." These behaviors reflect the patriarchal history of medicine, in

which male doctors tried for centuries to understand the unique facets of female biology, including the purpose of menstruation. The historical misunderstanding of menstruation as a biological example of the female body's inferiority can easily be seen in broadcast commercials for over-the-counter feminine hygiene products, in which teenage girls and young women discuss the "problems" associated with menstruation in whispered or embarrassed tones. Discussions like these often take place in private areas, like bedrooms, with a female friend, sister or mother sharing their tips on managing menstruation behind closed doors. For example, one 1983 Tampax Tampon commercial is set in the bedroom of a teenage girl, who hangs her head and weepily says to a female friend that she is not going to attend a party (see fig. 10). When the friend asks, why not, the girl shrugs. The friend, understanding what is wrong without discussing it opens her purse to reveal a box of Tampax Tampons. Without a word, the girl takes the purse from her. A female narrator pipes in to say, "On days like these – special days – more women trust Tampax than any other brand" (YouTube.com). The commercial ends with the girls happily shopping at a mall. Ironically, this commercial, like many others for similar products, seems to avoid giving a description of what the product is and what it is used for, which I argue causes confusion among consumers.

This treatment of menstruation in advertising is one major example of how the advertising industry has historically shied away from openly discussing many women's health topics, especially menstruation, in clear and responsible language. The first Tampax Tampon ad appeared in American Weekly on July

26, 1936, and was designed by three men – Thomas F. Casey, Earle A. Griswold, and Ellery Mann – who together set the standard for tampon advertising in the United States through an elaborate and successful DTC print advertising campaign. Their first ad set the stage for many stereotypes that would be seen in tampon ads for decades to come, with their first Tampax Tampon ad visuals depicting “young women dancing, playing tennis, horseback riding, and even relaxing on the beach” (Freeman B3). Another common characteristic of this first ad, and the decades of tampon ads that followed, was omitting words and phrases that described what the product was actually used for. Instead of using helpful words like “menstruation” or “period” or “tampon,” the ads often described tampons in code, calling them “sanitary protection” or “feminine hygiene products” – the latter term author Elizabeth Arveda Kissling specifically argues “suggests that femaleness itself is a little dirty and you have to clean it up, and it goes back to ancient taboos about menstruation being pollution” (Newman B3). The tampon industry, which reached a billion dollars in annual sales in the 1970s, has been dominated by the Tampax company, which accounts for as much as 90% of sales, which also means this company and its ad messages are a major influence in our culture’s view of tampons and menstruation discourse. As Martha H. Berbrugge correctly points out, “concepts and practices related to menstruation are powerful constructs. They affect ... the ways in which women understand their own bodies. Whoever controls menstrual rhetoric and rituals, then, exerts considerable power, in both public and private settings” (Verbrugge 67). In the years since this first ad debuted, most tampon

ads (run by Tampax or others) continue to substitute the words “menstruation” or “period” for code phrases like “that time of the month,” “the curse,” or “my monthly gift.”

Unfortunately, the use of euphemisms to discuss this normal female experience has no doubt reflected and reinforced embarrassment for girls and young women in our society, teaching them to be ashamed about a natural occurrence that most female bodies experience at some point in their life. The years of censorship that have surrounded female health and feminine product advertising has even impacted what television networks today feel is appropriate to mention in TV commercials. Tampon commercials didn't air on television until 1977, and amazingly, the word “period” was not featured in a tampon commercial until the year 2000, when the Kotex company debuted the new ad slogan, “Kotex fits. Period.” (see fig. 11), and similar to other words used in this type of commercial, the word “period” serves two purposes, partially masking the meaning. The word “vagina” has also been excluded from tampon commercials, and came under censorship as recently as the year 2010, when three major television networks banned a new U by Kotex tampon commercial from airing because it included the word. In fact, “after being informed that it could not use the word vagina in advertising by three broadcast networks, [U by Kotex] shot the ad cited above with the actress instead saying ‘down there,’ which was rejected by two of the three networks” (Newman B3).

Similarly, pharmaceuticals that are designed to aid women during “that time of the month” also reflect embarrassment, such as birth control pills that are

prescribed to treat PMDD, a condition caused by menstrual hormone fluctuations that cause extreme anger and mood swings severe enough to interfere with daily life. For example, in a 2010 commercial for YAZ, a group of three female friends are talking about how one of the friends never would have made it to a dance club this time last month (see fig. 3). She continues to explain in a whispered tone to her friends that her doctor diagnosed her with PMDD, and prescribed YAZ birth control pills to help curb her symptoms. Here, it is inferred that she could not be “active” or show up at the dance club to have fun without them.

Obviously the use of gender stereotypes in DTC pharmaceutical advertising has an impact on the ad’s message to viewers. In the next section, I will show how damaging and dangerous this can be to consumers, as well as their view of illness risk and responsibility.

### DTC Pharmaceutical Ads, Gender, and Mis-Education

Unfortunately, today’s pharmaceutical advertisements are not always as informative or accurate as they could be, and although they have affected our culture in some positive ways by inspiring consumers to become more involved in managing their health, the level of information (or lack there of) included in some of these brief ads can be misinterpreted by a consumer. Here, I agree with Janet Kilbourne in that “Americans rely on the media for our health information. But this information is altered, distorted and even censored on behalf of the advertisers” (Kilbourne 53). First of all, the time limits afforded in broadcast

commercials, which are statistically the most popular format for today's DTC pharmaceutical ads, greatly restricts the amount of verbal and visual information that can be delivered to a consumer. This forces advertisers to be incredibly selective about what they choose to communicate and how. It also gives them the ability to manipulate the content of the ad by mentioning more benefits than risks, which is an extremely common practice in pharmaceutical advertising. Not only that, but when risks are mentioned, they are read an average of 30% faster than the list of the benefits. (ibid 206). Also, the benefits of taking the drug are often visually depicted in an ad, while the risks rarely are. Take for example the 2010 advertising campaign for Allergan, Inc.'s Latisse, the first prescription eyelash treatment to be approved by the FDA that enables "women" to grow longer, lusher eyelashes (see fig. 12). These women are visually shown in the ad campaigns applying the medication, and later wearing heavy eye makeup, batting their eyes and enjoying parties in dress clothes, while all the benefits of the prescription treatment are mentioned. Before-and-after photos are shown, so viewers can literally see the product working. Visuals of the drug's side effects, which include such visually unappealing things as permanent browning of the eye's iris in color, and accidental hair growth in areas other than on the eyelash line are briefly stated, but visuals are smartly left out.

There are also cases in DTC advertising in which information about a drug is so limited or so selective that a drug may be advertised for just one of its FDA-approved uses. Take for example a 2011 commercial for the drug Abilify, which the commercial describes as a supplement drug for antidepressant users who do

not believe they are receiving the full benefits of their current depression medication (see fig. 13). Only once a consumer visits the [www.Abilify.com](http://www.Abilify.com) website does one find out that the drug is not simply a stronger antidepressant, but in fact is not an antidepressant at all. It is actually an antipsychotic drug (a neuroleptic, which is a different class of drugs, with a separate set of risks and side effects) that is primarily used to treat schizophrenia. Here it is easy to see that the commercial's description of the drug, which did not include the words "antipsychotic" or "schizophrenia," could be considered a bit misleading for consumers.

Perhaps one of the most important things a consumer "learns" from the verbal and visual information presented in an ad is who the drug is made for. Consumers gain this information not only from disease names and symptoms, but from the visual images and wording that are included in the ad. By including sex (or gender) in an ad, verbally, visually or both, pharmaceutical advertisers are defining whom the drug is appropriate for in the mind of the consumer.

But how dangerous is this skewed form of communication, which consumers increasingly use to make medical decisions for themselves and their families? Depending on the illness and drug, irresponsible or incomplete communication can lead to the tragic mis-education of consumers. Author Cindy Patton discusses the issue of how damaging improperly educating the public on disease prevention and responsibility can be in her books, [Last Served?](#) [Gendering the HIV Pandemic](#) and [Fatal Advice: How Safe-Sex Education Went Wrong](#), especially when it comes to sexually transmitted illnesses. In the former,

Patton shows how the audience of individuals considered to be “at-risk” for contracting or spreading HIV was culturally constructed by the statements released by the medical community, as well as articles and broadcast news segments disseminated by the mass media in the early 1980s. She shows how those at-risk groups were collectively defined by media coverage, and that this coverage served as “an educational strategy [that] pits ‘deviants’ (largely gay men and prostitutes, who need *policing*) against the ‘general public’ (largely middle-class white women and adolescents, who need *protection*)” (Patton 7). She explains how the media’s portrayal of HIV-infected women was different than its depiction of homosexual men, writing that “the media’s generic-sounding ‘women with AIDS’ usually turns out to be black or Hispanic, the partner of a drug injector, or a prostitute or drug injector herself ... the occasional story of the white middle-class woman living with AIDS serves as the exception that proves the rule, simultaneously stoking women’s fears and re-placing ‘risk’ outside the ‘mainstream’” (ibid 7). Consequently, the misstatements and misidentification of these groups incorrectly educated the public about who really was at risk, including the spouses and children of individuals suffering from blood disorders, leaving many populations thinking they were at less risk than they really were.

Patton continues to describe two different illness prevention education strategies that the medical community can choose to engage in when communicating to the public about an illness. The first method, known as the population-wide strategy, aims to decrease an illness’s prevalence by communicating behavior modifications to the entire general populace. The

second method, called risk-based strategy, is to target only those individuals who are considered to be high risk for illness contraction. Patton describes early HIV communication as a risk-based strategy, which ended up backfiring and omitting several relevant at-risk groups. Sadly, I see many parallels between early HIV communication and current HPV communication, and Merck's Gardasil advertising campaign and its continuous targeting of women seems to be following in the same path.

In my opinion, there are many frightening similarities between early HIV rhetoric and today's HPV communication, especially when it comes to how the illnesses' messaging (and advertising) defines who is at risk for an illness and its prevention. For example, in early HIV communication, several segments of the population that did not fit into the box of at-risk homosexual men and/or prostitutes were actually at greater risk for HIV contraction than the medical community and mass media publicly recognized. These individuals included the spouses/sexual partners and biological children of individuals suffering from coagulation disorders, such as hemophilia A. According to Patton, an estimated 90% of hemophilia A sufferers were exposed to HIV via transfusions before 1986 (ibid 62), leaving their families at risk for blood-borne or body fluid transmission. Patton explains that in the 1980s, spouses of hemophilia A sufferers were rarely communicated with in a way that strongly encouraged them to change their sexual practices, explaining that "programs or pamphlets directed toward women rarely took into account the specific situation of women who were partners of men with clotting disorders. Unless they had been active in a hemophilia society

or a treatment center, women who found themselves involved with men who had coagulation disorders were no better equipped to recognize the need for safe sex, much less negotiate it, than women in the supposedly HIV-free 'mainstream,'" (ibid 61). Similarly, HPV communication, including ads for Gardasil, ignores certain groups who are at real risk for the infection and the cancers it may cause. One such group are the sexual partners (especially male partners) of women with HPV infections. Until the vaccine was approved for males in 2009, males were rarely, if ever, included verbally or visually in advertisements, which largely defined that the population at risk for HPV was women, despite the fact that men can pass the virus to new sexual partners or suffer illnesses from these infections. In this case, it is men and their level of risk that are forgotten and omitted from illness and drug communication. One specific population at risk that I believe are greatly underserved by Merck's Gardasil ad campaign now that it are approved for males is bisexual/homosexual males. According to the CDC's Web site, "gay and bisexual men are 17 times more likely to develop anal cancer [caused by HPV infections] than heterosexual men" (CDC.org). A second group of individuals ignored by HPV communication are those with immune disorders – especially those with HIV infections or AIDS – for whom an HPV infection and the illnesses it may cause can be lethal. Again, the CDC reports that, "men with weak immune systems, including those who have human immunodeficiency virus (HIV), are more likely than other men to develop anal cancer. Men with HIV are also more likely to get severe cases of genital warts that are hard to treat" (ibid). Lastly, a final group never discussed in

Gardasil ads, or on the CDC website are women with HIV/AIDS and the additional risks they face if contracting an HPV infection. Even in the CDC materials, the CDC seems to make the assumption that the majority of HIV or AIDS sufferers who may be at risk for HPV infections are male.

Not only are men left out of HPV advertising communication as potential patients, but they also are left out as parents. In the sample Gardasil case, there are several verbal and visual references made to parents, which always turn out to be depicted as female. Not only is this not inclusive of male parents who may make medical care decisions for their male or female children, it is also not an accurate reflection of the number of males currently serving in that role in American society. The Federal Interagency Forum on Child and Family Statistics' most recent [American Children in Brief 2009 Report](#) found that 26% of children ages 0-17 live in a single parent household, and within this figure, 4% (or 769,600 children) live in single-father households (ChildStats.gov). In this case, not only are the Gardasil ads not directed toward the parents of these children, but the parent company of the vaccine, Merck, is missing out on communicating to specific populations at risk. In addition, the Forum's same report showed that an estimated 4% of children live in what they refer to as "miscellaneous" households, which are headed by one grandparent, or other relative. None of these roles are shown in Gardasil ads.

But, to what degree do gender portrayals affect an audience's perception of a drug/illness, and how can the cultural studies/social sciences research perspective help identify these missteps? I will investigate this in the next

chapter, focusing on Merck's Gardasil vaccine as one example of how gender can be manipulated by a pharmaceutical company for financial benefit.

## CHAPTER 3: TESTING A BLENDED METHODOLOGY

### Introduction

As established in previous chapters, gender plays a complex role in pharmaceutical advertising, which makes this topic difficult for any one research study to fully explore. Researchers within the advertising discipline often attempt to simplify the study of this topic by focusing on one gender, or on ads that appear in one media format, or they examine data using only one qualitative or quantitative research method. These current methods give only a partial look at how gender works in advertising, and each limitation can produce skewed results. This chapter will identify and address challenges in existing research methodologies, and explain how a cultural studies-based methodology may offer a more in-depth critique of gender's use and rhetorical effects. Later on, I will describe my cultural studies-based methodology's steps in detail, and explain the overall benefits of putting such a methodology to use.

Researchers within the advertising discipline often use either quantitative or qualitative tools (not a combination of both) in their methodologies to measure gender's use or effect in advertising. I believe that doing so can produce very limited, and occasionally, incomplete findings. For example, Kineta H. Hung's study, "Glocal Understandings: Female Readers' Perceptions of the New Woman in Chinese Advertising" consists of only a content analysis, with Hung evaluating gender roles in Chinese advertisements using her own opinion. Obviously, it could have been helpful to test these advertisements against a larger sample of people to get a variety of reactions and thoughts and to search for common

trends among them instead of presenting her own analysis. On the other end of the spectrum, Jennifer Millard's study, "Performing Beauty: Dove's 'Real Beauty' Campaign," presented the results of a focus group of female participants who were asked to share their thoughts on female beauty in an ad series for Dove skincare products. In my opinion, there are both positive and negative aspects to the execution of focus groups, in that researchers get a bit more detail, such as the "why" behind a participant's answer. However the downsides are that not everyone may have an opportunity to answer all of the questions, some participants may dominate the conversation more than others, potentially skewing results (Dominick 125).

A second limitation in current gender-in-advertising research methodologies is the choice many scholars make in studying the use of female gender roles only. Many scholars neglect the opportunity to analyze the use of male gender roles in their research, which I argue is limiting. Some ads feature stereotypes that are intended to be positive, and show men as successful with women and in the workplace. Some male stereotypes identified by Frith and Mueller include "the Cowboy, who is tough, unemotional and alone" (Frith 101), and "the Superman, who conquers the world and the women around him" (ibid). But, as I have already shown, although men are often depicted in ads as capable when it comes to performing stereotypically gender-appropriate actions, such as mowing lawns, or fixing cars, men are often depicted as "Clueless Caregivers" who act out of place when performing stereotypically female-oriented tasks, such as cooking, cleaning, and tending to children. Think back to the Tylenol ad

mentioned earlier, in which the father gives what is dismissed as a useless suggestion in ridding his young daughter of a fever. Often a woman (playing the common stereotype role of “housewife”) steps in to take the reigns of the household, and demonstrate how the advertised product really works. The male actors featured in commercials like this are supposed to add humor to the ad through their stupidity, even though in reality men may be very skilled at cooking, and capable of housework and childrearing. Not only is there value in studying how men are portrayed in advertisements, but how their portrayals compare to women in the same ads. Are stereotypes for both men and women used to add humor to an ad? Or is all the humor at the expense of a woman playing a sex object? I argue that failing to study all gender roles included in an ad, and how these roles compare to one another, leads researchers to present incomplete findings.

A third limitation is that researchers often restrict their inquiry to study ads that appear in one identical media format, such as examining only print magazine advertisements. Researchers in the advertising discipline do this so they can compare how gender roles in these ads (regardless of the type of product featured in the ad) vary from one magazine to the next. Looking at this research method from the cultural studies perspective, I argue that this narrow scope of examining gender only in identical ad formats may lead to limited results. If the researcher’s goal is to examine gender in print magazine advertisements, they should also factor in what I will call the “miscellaneous rhetorical texts” that are often found in the same publications, such as magazine articles that mention or

even give a first-person review of the advertised products. (I will discuss my definition and examples of “miscellaneous rhetorical texts” further on in this section). When other mentions of a product are placed in the same publication alongside traditional ads, researchers should not ignore the rhetorical impact these supplemental texts may have in enhancing or changing a reader’s perception of an advertised product.

A final limitation found in current ad methodologies is the common step of simply concluding by presenting results and listing suggestions for further research. One aspect of cultural studies-based inquiries is that scholars take their findings and search for connections between them and any cultural or political attitudes in contemporary society. Researchers can then use their research to make recommendations for improving communication. I believe that adding this step gives practicality and purpose to a research study, and allows researchers not only to present results, but to share their expertise and insight with readers, giving them the potential to make an important change in advertising communication. For example, J. Blake Scott’s inquiry into HIV-testing communication in Risky Rhetoric, takes a sample of existing HIV-testing communication and compares it with real-world testing practices, result reporting flaws, and actual infection statistics, with Scott concluding that HIV communication can and should be improved. He then devotes the rest of his book to making suggestions as to why and how certain rhetorical changes can be made.

As you can see, current methodologies employed in gender-in-advertising research may produce fragmented results due to parameters that are commonly used within this discipline. I argue that using a cultural studies-based methodology blended with both quantitative and qualitative research instead can enhance a researcher's critique of this topic, and perhaps enable a scholar to produce more complete data, for several reasons. First, researchers are free to examine a wider body of texts, including "miscellaneous" rhetorical materials, such as news media coverage, that may influence a consumer's perception of a product featured in a "traditional" ad. This is helpful because although these "miscellaneous rhetorical materials" are not produced with the intent to sell the product, they retain rhetorical qualities that affect the product's reputation in the minds of consumers, and also provide a better representation of the messages that exist in our society. Examining both "traditional" and "miscellaneous rhetorical texts" should help yield a more accurate vision of the many arguments that surround a product, and give insight into how these arguments affect the product and the audience's vision of this product. Second, because of cultural studies flexible methodology, researchers are free to critique data using multiple tools, which helps us draw more conclusions from our findings. Third, the cultural studies perspective allows us to do more than simply report results and then give suggestions for future research. Instead, our research can follow the cultural studies' guideline of taking findings and making connections between them and the various attitudes held in our culture. This enables researchers to examine how attitudes and expectations about gender roles in our culture are

potentially reflected in, or shaped by advertising. Finally, a cultural studies-based critique will enable researchers to go one step further and suggest remedies to any problems they find. This adds a form of purpose to research, in that results aren't simply reported, but used as opportunities to identify problems, collect data, and suggest remedies for real-world problems. In the example of Merck's Gardasil, it also will give me the freedom to have a group of participants look at a variety of texts and respond in several different ways (i.e. qualitatively/quantitatively). When studying stereotypes, it is critical to look at influences in a culture that may contribute to it.

As I previously mentioned, cultural studies' lack of solid methodology and examination of a formalized theory (instead of the examination of a relationship between a type of text and culture) are two of the perspective's downfalls among critics. To remedy this, I hope to combine qualitative and quantitative research methods from within the social sciences to supplement my inquiry. I have done so by designing a brief two-part study for a small sample of participants that will show exactly how the current use of gender in Merck's Gardasil ads confuses consumers.

In the following section, I will outline my exact cultural studies/social sciences-based methodology and show how it can be used to study gender roles in Merck's Gardasil's advertisements.

### Methodology in Detail

In applying this methodology to study the use of gendered rhetoric that surrounds Merck's Gardasil vaccine, I chose to focus on Gardasil ads for a

portion of the study, since so much of the conversation that surrounds this vaccine is initiated by the drug company, as well as a selection of other miscellaneous rhetorical texts. I first decided to refocus the scope of commonly produced gender-in-advertising studies, with the goal of getting a fuller understanding of the many ways gender is expressed in ads. Therefore, instead of concentrating on simply one ad medium to study (such as analyzing only television commercials or website banner ads), cultural studies enabled me to focus the scope on examining a variety of ad media and rhetorical texts. Again, the value behind doing so is due lies in the fact that gender is expressed in a variety of ways in different ad media. For example, television commercials may express gender through visual images as well as audio recordings of language or conversations between different characters, while print ads and website content may show gender primarily through both images and written text. Therefore, by focusing the study on the various types of advertisements and miscellaneous rhetorical texts that surround a drug, I will get a more complete view of the many ways gender is used to promote that item.

In adjusting the scope of this project to focus on a variety of ads and miscellaneous texts, it is also important to mention that the expanded scope also evaluated the use of both sexes (males and females), which provided data on how both sexes are depicted separately, together, and in relation to one another. As I have argued, it is critical to examine both, as our culture has historically assigned different levels of authority, responsibility, and professional expertise to these individuals for decades.

Now that the project's scope was decided, the next step was to work with the University of Central Florida's Institutional Review Board (IRB) to design a safe and ethical two-part qualitative/quantitative study. In Part I, a sample of consumers would review real Gardasil ads and then answer a multiple-choice questionnaire that tested the accuracy of their knowledge about this vaccine and virus. Because I wanted to replicate the learning process that consumers go through when they encounter an ad for the first time, I chose to conduct this portion of the study as a blind study, having a graphic designer digitally alter the name of both "Gardasil" and "HPV" to "OncoVax" and "DOV disease," so it was as if they were reviewing advertising materials for a new product. In Part II of the study, participants would be debriefed on the fact that these were ads for an existing vaccine and virus, and given two miscellaneous texts to review. They then joined a focus group to discuss the differences they had seen between the ad content and the miscellaneous tests. Specific goals I set when designing the study were to: 1) Gain a wealth of data on what rhetorical arguments surround this pharmaceutical product; 2) Gain insight into the many ways gender is used in an ad and how gender can influence specific arguments; 3) Learn how the use of gender can define a drug's audience; 4) Learn how gender can help or hinder a consumer's education about a drug/vaccine; and 5) Identify gender roles and stereotypes in ads and make connections between these portrayals and cultural beliefs. I then used the resulting data collected the participants' responses as a starting point for my investigation into why gender is used by Merck in this

manner, the effects that doing so has, and the underlying political and cultural forces that influence this use.

The following section will describe in detail the broad range of texts I included in my investigation, as well as the value some of these “miscellaneous rhetorical texts” may bring to a cultural studies/social sciences-based critique.

### Ad & Miscellaneous Text Selection

A diverse sample of rhetorical materials was needed in order to get the best idea of how gender is communicated through this pharmaceutical ad campaign, and how and where these stereotypes originate. For this sample case, I divided rhetorical texts into two groups, “traditional” ad texts and “miscellaneous rhetorical texts.” Ads and other rhetorical texts relating to the pharmaceutical product were evaluated and sorted into these categories based on each text’s primary intent. For example, I define “traditional” ad texts as samples of print, broadcast, and/or digital ad materials that were paid for by the drug manufacturer with DTC advertising as the material’s primary use. “Miscellaneous rhetorical materials” are a larger group of related texts that I define as those that mention, discuss, or even showcase a product without their primary intention being DTC advertising, and are not paid for by the drug manufacturer for the purpose of DTC advertising. For example, “miscellaneous rhetorical materials” may include pharmaceutical company press releases, media-generated newspaper articles, pieces of government legislature, patient advocacy website content, books, protest demonstration literature, and more. “Miscellaneous” materials are important to include and will enhance a

researcher's ability to critique gender's use in an ad campaign, because these "miscellaneous" materials may have the same effect on an audience as an ad does, without technically being a message originating from the company itself for advertising purposes.

Take for example how gender representations in the news coverage surrounding the Gardasil vaccine may affect a consumer's knowledge of the vaccine, as well as their opinion of its purpose, and relevant patient group, from the following "miscellaneous rhetorical text" example. The news article "Texas orders STD vaccine for all girls" by The Associated Press appeared on MSNBC.com on Feb. 3, 2007, and states the basic facts about the vaccine, including the patient group it was approved for (only females at the time), brief information on the HPV virus the vaccine prevented, etc. It also announced that Texas Governor Rick Perry proposed making Gardasil vaccinations mandatory for female students entering the sixth grade. Despite protests expressed by Texas parents that having the vaccine may make their children sexually promiscuous, Perry publically argued that "the cervical cancer vaccine is no different from the one that protects children against polio" (MSNBC.com). The article included data that showed that Perry may have had additional motives to make the vaccine mandatory, as his 2006 re-election campaign included \$6,000 in funding by Merck. In this case, the news coverage of this event is not a formal advertisement, as the primary objective of the text is not to sell a product; however, news coverage of Perry's declaration may serve some of the same effects as an ad, meaning it would inform a mass of potential consumers of what

Gardasil is, how it works, and that the vaccine is approved for females.

Information an audience derives from a rhetorical text like news coverage may be extremely opinionated or present different sides of an argument, in this case, whether or not the vaccine is critical enough to make mandatory for school children, and whether or not it should be the state or an individual parent who makes the decision on a child's health care. An audience member unfamiliar with Gardasil would read this article and note that the vaccine is being pushed for sixth grade girls. How would this impact a consumer's perception of who can and should access the drug? Also, because the governor is mentioned as trying to make the drug mandatory, an audience member may get the impression that they are not the one to decide if their child should be vaccinated, or parents who were planning on having their daughter vaccinated may read the report and decide to wait and see if the legislation passes in order to get their child vaccinated according to the school's established timetable. This contradicts the vaccine's "traditional" advertising campaign that is titled "One Less," and speaks directly to the consumer (or a parent of the consumer) and encourages them to make the decision. Also, just seeing the headline of The Associated Press article evokes the thought that the vaccine protects against an STD, with no mention of HPV infections or cancer, so one could argue that this headline is a bit incomplete. There are also no mentions of whether males could suffer ailments from the infection, and there is no information on the fact that HPV infections cannot be prevented through other STD prevention methods.

The following list illustrates the difference between what qualifies as a “traditional” and “miscellaneous” text.

1. “Traditional ad material” – Includes print, broadcast and digital ads that appear via newspaper, magazine, television, radio, and website media. Traditional ad materials are paid for by the drug manufacturer with the primary purpose being direct-to-consumer advertising.
2. “Miscellaneous rhetorical texts” – This includes mass media coverage of a drug/vaccine. Formats may include newspaper or magazine *articles* (nonpaid advertisements) written about the drug or vaccine, and news broadcasts about the drug/vaccine. Nontraditional materials may include other materials created by the drug manufacturer that are informative, yet were not created for direct-to-consumer advertising purposes, such as press releases. This group also includes informative patient materials, which includes rhetorical texts that a patient may view or receive at doctor offices or pharmacies, such as pamphlets, posters, and information sheets that promote or describe a drug. These may be different than “traditional” ad materials in that a patient may see or receive these materials after choosing to get the vaccine.

Regardless if a potential consumer comes in contact with a “traditional” or “miscellaneous” text first, they are going to have a reaction to it and begin building their knowledge of the mentioned product upon what they read and the visuals they see. In the case of pharmaceuticals, this may include critical information like what illness the vaccine treats, who can access it and more. Future encounters with ads and miscellaneous materials for the same product will either reinforce or contradict this initial perception.

Four ads were chosen for inclusion in Part I of the study. Over a six-month search period, I was able to locate Gardasil ads mainly in female-focused publications and, to a lesser degree, general population-focused publications like the Parade weekly newspaper magazine. I also searched male-focused publications over this six-month span, including Maxim, Men’s Health and Wired; however, no Gardasil ads were found.

Traditional ads selected to use are:

1. **Parade ad** – This print ad was taken from a January 2011 issue of Parade. This ad features one image of a young Caucasian boy, and another of a young Caucasian girl. They both appear to be in the lower end of the drug’s target age group (see fig. 15).
2. **Good Housekeeping ad** – This ad, taken from the February 2011 issue of Good Housekeeping magazine, is nearly identical to the one taken from Parade magazine, except this ad features images of a young Hispanic boy and girl (see fig. 16).
3. **Website A** – This page was taken from Gardasil.com >> “Learn About Gardasil” tab, which features text that appears to speak to consumers.
4. **Website B** – This page was taken from Gardasil.com >> “More For Parents” tab. This page features texts and images directed toward educating parents on the vaccine and virus (see fig. 18).

Three miscellaneous texts also were randomly chosen for participants to review in Part II of the study. They are:

1. **Newspaper coverage** – A newspaper article from The New York Times called “Pitching Protection, to Both Mothers and Daughters” dated Feb. 18, 2007.
2. **Online news coverage** – The article “Should Your Daughter Get Gardasil, the Vaccine Against HPV?” from CNN.com.
3. **Center for Disease Control Fact Sheet** – The HPV fact sheet was pulled from CDC.org and contains data on the fact that HPV is a sexually transmitted disease, and also features six images of different people, all in the upper end of the vaccine’s target age range (see fig. 19).

### Participant Selection

In order to gain the most valuable data possible based on the drug’s FDA-approved audience, I decided to conduct this test using a quota sample, which polls a group of people with “exact characteristics and quotes of persons to be interviewed” (Gay 115). Because the FDA has approved the vaccine for males and females, members of (and parents/guardians of) both biological sexes were included in the sample. Participants were selected based

on their age falling in the 18-26 age group, who can purchase the vaccine for themselves, as well as parents/guardians of minors age 9-17, who serve as medical decision makers for individuals in this age group. Although the vaccine is approved for pre-teens age 9-17, I chose to omit this group because they legally are not responsible for their own medical care until age 18. Additional goals for participant recruitment were to ensure both males and females were represented, as well as a mix of races.

Because of the focus on technology within the Texts & Technology program, I wanted a digital element incorporated into the study, so I chose Facebook.com as the participant recruitment tool. This social media channel was a helpful method of identifying possible participants because individuals who use it present their own demographics, such as age, race and whether or not they have children, making it easy to find a selection of individuals who fill specific demographics. In addition, Facebook users are highly active within this medium. According to a recent survey by BusinessInsider.com, 16% of a computer user's time online is now spent visiting Facebook (Davis BusinessInsider.com). This may mean it could be easier to contact a potential participant through Facebook than voicemail, paper mail, or some other means of recruitment. Also, because the Facebook Direct Message feature is already password protected by users, security and privacy elements are already built in to any interactions. However, I did have one concern with using Facebook as a recruitment tool, specifically regarding the fact that having a Facebook profile signifies some degree of computer literacy for an individual, as well as some kind

of computer access at home, or in an educational or workplace environment. To me, these factors may hint that a certain economic demographic was represented, with others left out. After researching the racial breakdown of Facebook users, I found references to a 2009 study conducted by Facebook that found that the channel “has always been diverse and that the diversity has increased significantly over the past year to the point where U.S. Facebook users nearly mirror the diversity of the overall population of the country” (Marlow Facebook.com), so I did feel comfortable using Facebook as a recruitment tool. Once 22 potential participants were identified, an IRB-approved invitation to participate was sent via Facebook Messages requesting their participation in a study on “how the information and visuals presented in pharmaceutical advertisements impacts a consumer’s view of an illness and a vaccine” (see Appendix). From this invitation, 10 individuals were recruited for participation, including six females and four males. Among this group, seven participants were parents and the remaining three fit into the consumer-for-self group. Multiple races were also represented, with six Caucasian participants, two Hispanic participants, one Asian participant and another participant who reported being of mixed race (Caucasian-Hispanic).

For the convenience of all participants, the study was arranged to take place online at noon, a time that many participants reported worked well because it was their lunch break. At the specified time, the group simultaneously received a “Part I” e-mail that included directions, two sample ads for review – two of the

four OncoVax ads, one print and one online – and the quantitative questionnaire to fill out when they were finished (see Appendix).

In Part II of the study, participants first received a debriefing sheet that explained that the OncoVax study was based on the real Gardasil vaccine ad content and HPV information. Participants next received two pieces of “miscellaneous rhetorical texts” to review. One of these miscellaneous materials was the HPV fact sheet from the Center for Disease Control (CDC), which was taken from the STD section of the CDC.org website. The other was distributed at random, and could have included the newspaper article, or the CNN.com article. Participants were given several minutes to review these materials and then participated in an anonymous focus group via telephone where they were encouraged to present their thoughts on the accuracy of the OncoVax/Gardasil ads. During the focus group, they were asked questions about the accuracy of the ads based on the facts they were presented with, and were questioned on the use of gender in the ads, fact sheet and news articles, and also how they felt gender could visually be used to communicate the vaccine’s information better.

The results were recorded, analyzed, and destroyed to protect the participants’ privacy. In the next section, I will summarize my findings and show just how the use of gender may be impacting Gardasil’s overall message to consumers, especially in its advertising.

## CHAPTER 4: RESULTS

Overall, the data collected in this sample study provided overwhelming support for my argument that Merck's narrow use of gender roles (specifically focusing on females and excluding males) negatively impacts the ads' ability to accurately introduce, describe, and define the vaccine to consumers. While I believed that the representation of gender would play a major role in the ads' perception, what I did not anticipate was how much the assumed age of the individuals in the ads would also greatly affect the viewers' initial perception of the virus and vaccine. Participant responses to the blind-study questionnaire clearly showed there is a gap between the reality of the HPV virus, and the virus as it is depicted in the Gardasil vaccine ads.

I have divided the key results into two sections, since measurements were taken at two different times during the study. Part I of the results reflects the quantitative findings of the first step in the study after participants reviewed the OncoVax ads only. Part II reflects participant opinions expressed during the qualitative virtual conference call, which took part after the debriefing, viewing the ads, the CDC Fact Sheet, and other miscellaneous rhetorical texts. As you will see, there are great differences in the participants' opinions before and after the medically documented facts of the virus are revealed.

Highlights of the results are as follows:

### Part I: Blind Study of Oncovax Ads

1. Participants felt the ads contained a limited amount of information, and did not feel comfortable making a purchase decision for themselves or their child/children based on the information presented. Many mentioned that they had no information on how the virus was transmitted, and reported limited information on the other illnesses the HPV virus caused.
2. Participants felt that the ads' visuals greatly portrayed the OncoVirus as a virus that affects children.
3. Participants' felt that the ad's language was targeted toward parents, particularly mothers.
4. Because they felt the ads painted the virus as a child's illness, adult participants reported that they felt less urgency to purchase the vaccine for themselves. According to their perception of these ads, participants felt children were portrayed as more at-risk than teens, young adults and other age groups.

### Part II: Evaluating Miscellaneous Texts

1. Participants felt the ads differed greatly from the miscellaneous materials, which they felt gave a clearer description of the virus, its transmission method, its related illnesses, and other valuable information.
2. Participants believed that the miscellaneous rhetorical texts appealed to a wider population through inclusive language, but especially through the visuals included in the ads, some of which included solitary adults, giving them the perception that children were not the only ones at risk.
3. Consumer-age participants reported that they were more likely to purchase the vaccine for themselves after reading these miscellaneous materials than the Gardasil ads, which they described as including a range of male and female adults, and that those adults were depicted looking concerned or worried, not empowered like parents or taken-care-of like the children pictured in the Gardasil ads.
4. In comparing the ads to the miscellaneous materials, participants felt that the ads were targeting parents, specifically mothers, as the population responsible for virus transmission prevention. They felt that the miscellaneous materials portrayed responsibility for virus prevention very differently, and instead focused on the individual, the medical community, and the state government.

In examining these results, it is clear to see that participants had a vastly different view of the virus and vaccine in the blind Part I of the study, compared to their responses and opinions in Part II. Responses collected in the Part I

questionnaire showed an overwhelming consensus among participants that they did not feel the ad contained enough basic information about the vaccine or the virus in order for them to answer questions or make an informed purchase decision. After reading the materials supplied in Part II, many of the participants reported feeling confused as to why Merck depicted the virus the way it did in their ads, and responded feeling more personal risk after reading the CDC Fact Sheet and other miscellaneous materials than the ads alone. In addition, the focus group portion of the study provided great insight into exactly what participants felt was confusing about the ads. For example, a female Caucasian participant (a consumer-for-self) expressed her confusion over why the ads would leave out mentions that HPV was an STD, saying “one of the ads gives little to no information at all. The other one is more detailed, but it fails to even mention that this is a STD or explain how it is contracted. This is very basic information that should be included in any ad. Also, I really don’t think it explained at all why you should get the vaccine.” A female Hispanic parent specified that a point of confusion for her were the ads’ visuals, especially after comparing them to the visuals used in the CDC Fact Sheet. “The pictures used in the CDC are of adults, not one is of a young teen. But that is understandable because the CDC is interested in making people aware of HPV and how it is transmitted instead of in selling a vaccine that only people up to the age of 26 can get.” A mixed-race male participant who does not have children, reported feeling that the ads, which prominently feature children, did not relate to him at all. “When I first looked at the ads, I thought this was a product for kids or at

least people who had kids. I didn't think this virus would be anything that would relate to me, so I was kind of surprised when I saw the CDC sheet." A female consumer-for-self participant agreed, and stated "I was like, totally confused with the information in the OncoVax ad. I didn't think the vaccine related to me and I didn't feel like I was at real risk – probably because I didn't fully understand what it was or how it was passed." Another participant, a Caucasian female (consumer-for-self) mentioned some specific reasons she felt the drug company chose to leave out the detail that HPV is an STD. "The people pictured in the fact sheet were much older. In the ads, the people pictured are children and a mother – children who are, as of yet, probably still too young to be having sex. Parents of children at that age group would likely not even consider the possibility of their 'baby' contracting a STD. I also believe that showing images of such young children makes the disease seem innocent, not so scary or threatening." To this point, a male parent participant added, "I didn't even realize it was an STD until I saw the Fact Sheet."

Based on their responses and the questions these participants raise, it is clear that Merck's vaccine presented a partial definition of the virus, which in turn defined a very narrow population for their vaccine, and billed parents (mainly mothers) as the party responsible for prevention. How did they do this, and more importantly, why choose to position a vaccine as a cancer prevention vaccine for females so strongly, when it protects males as well? Why target parents and older children so strongly instead of consumers across the entire FDA-approved age range, especially when the majority of children are not yet engaging in

sexual contact? I believe that Merck's rhetoric consisted of highlighting and omitting specific pieces of medical information, as well as using certain gender stereotypes to build a vision of who urgently needs this vaccine (and thereby, defining those who do not). Next, I will take a look at what some of the findings from the study suggest, and research Merck's possible motivations behind using gender in this manner. In the following chapters, I will argue that ultimately, the reason for Merck's targeting of "mothers" in its ads is financially based.

### Constructing an Audience of Parents and Children

There are several different ways Merck's rhetoric defines the vaccine's audience in their ads, specifically through ad placement in select publications, as well as through the ads' written and visual content, which features the use of gendered language and images. These qualities combine to present Merck's vision of the populations at risk for contracting the virus and for preventing virus transmission by purchasing the Gardasil vaccine.

First, it is clear to see that many Gardasil ads are targeted to adult parents simply by looking at the demographics of the publications in which they are placed. Two ads used in Part I of this study appeared in Good Housekeeping magazine and Parade, a weekly magazine that is distributed within major newspapers. Good Housekeeping has a circulation of 51 million, and reports 87% of their subscribers are female. Parade is published by Conde Nast, which publishes a body of magazines targeted to wealthy females, including Vogue, Epicurious, and Conde Nast Traveler. By choosing to place advertisements in

these specific publications, Merck instantly takes the first step in defining the vaccine's population by making choices on who will see their ad message. As for broadcast commercials, Gardasil ads regularly appeared during primetime television programs, including "Law & Order: SVU" and on the big screen in a National Cinema Advertising ad that ran in select theaters before showings of the "Sex and The City" movie in 2008.

Next, because these publications are produced with a specific audience in mind, the ads themselves must feature content congruent with the publication's demographics in order to capture the attention of this set of consumers and raise interest. The Gardasil ad content, both written and spoken (depending on the type of ad), has the important job of educating readers on critical information about the HPV virus and Gardasil vaccine, or if the consumer is already familiar with one or both, the ad's content serves to reinforce messages the reader has previously seen or heard. Since ad time and space are limited, advertisers must decide what content will appeal most to this particular demographic, and by analyzing the information the company selected to include, it is pretty clear that this target is parents of children (not teens, or consumers age 18 and older). I argue that the targeting of parents of children is one of the reasons for the limited amount of medical information included in the ad, especially the details that the virus is transmitted through sexual contact, and the fact that HPV is a sexually transmitted infection. Many parents, especially of pre-teen children in the lower end of vaccine's age range (which is ages 9-17), may feel that their children are still far too young to become sexually active and may feel horrified at the thought

of purchasing any product that would increase their child's chance of engaging in sexual intercourse – a hesitation that has been brought up by some protesting parental rights and religious groups when Merck lobbied to have the vaccine made mandatory for school students. As we have already seen, ads that contain references to sexual content can distract from the ad's real message, but in the case of sexually transmitted diseases, the sexual content may disturb, not distract, and cause a shutdown response in parents, causing them to avoid a purchase. I therefore believe that this is why Gardasil is described in Merck's advertisements as a cancer-prevention vaccine, not an STD-prevention vaccine. When it comes to talking about illness prevention, it may be easier for parents to face protecting their child from cancer, an illness that in our culture seems to have a reputation for striking people at random, than protecting their child from an STD, which comes with the stigma of catching an STD as a direct result of one's own "negative" actions, mainly promiscuity, or engaging in risky behavior and poor choices (rather than merely having intercourse with an infected individual). Instead, Merck provides a more emotionally safe ad presentation designed for parents that excludes information about how the disease is contracted.

In addition to the facts that are selected to appear in the ads, consumers can also see that the specific language the ads are written in is clearly directed to parents, with the ads' text often referencing "your child" and "your child's health care professional" (ex. "Fainting can happen after getting Gardasil . . . . For this reason, your health care professional may ask your child to sit or lie down for 15

minutes...” [Merck 1]). Additional graphic elements that appear at the top of some of the sample ads directly call out to parents to purchase the vaccine for their children, reading: “Now you can help protect both your son and daughter with Gardasil” (ibid). And at the very bottom of these same ads, there is a separate graphic that says “Talk to your child’s doctor today” (ibid). Parent-focused language extends to the official Gardasil website, [www.Gardasil.com](http://www.Gardasil.com), as well, which features a tab labeled “Info For Parents.” Here, a majority of the text appears to be directed to an audience of parent/guardian caregivers when it uses words like “parent,” “son,” “daughter” and “child.” These words not only indicate biological sex, but also hint at ages, and shape roles and responsibilities when it comes to who purchases and who receives the vaccine.

The targeting of children as the population at risk can also be prominently seen in the ad visuals. According to the participants’ responses, this visual rhetoric had a huge impact on shaping their opinions as to who the vaccine is targeted to, and who was responsible for making the purchase (and prevention) happen. In examining the ads, it is clear to see when “patients” are depicted in print ads, both gender and perceived age play a huge part in visually establishing who is at risk for HPV. As for age, most images in print ads for Gardasil feature children toward the very youngest part of the 9-26 year age range. Teens and adults who could consume the vaccine themselves are rarely shown in the print ads, but are included a bit more in Gardasil commercials. These visuals shape a definition of population at risk in the mind of the viewer, who now may feel that HPV is a child’s illness. I argue that what is even more disturbing is the ads’

visual use of gender, with females shown significantly more often than males. This obviously gives the viewer the perception that female children are the patients in need of the most protection, even though the Gardasil vaccine is FDA-approved for males as well.

Parents are also visually included in the ads, and this is where I believe the gendering of the role of “parent” has a significant impact on readers, as in 100% of the Gardasil ads I’ve been able to find, the parent is depicted as a female. Just as they take on the role of preventer in ad text, so they do in ad visuals. For example, in the “Info for Parents” section of the Gardasil website, the page features a photo of a mother figure standing behind a much smaller son and daughter. The mother wears a pink sweater and jewelry, but towers over her children. All three are smiling. In these Gardasil ads, it is clear that the text and images are directing the piece toward adult female consumers who make purchase decisions for a minor.

The visuals featured in the Gardasil ads greatly contrast with images featured in other miscellaneous Gardasil texts, such as the CDC Fact Sheet that the participants examined in Part II of the study (see Fig. 19). This two-page fact sheet features six images at the top of page 1, all identical in size. Unlike the Gardasil ads, each picture depicts a solitary adult. Various ages and races are represented here, including Asian, Caucasian, African-American and Hispanic. The images depict three males and three females, who each appear to be expressing visual concern, which is apparent in their furrowed brows, squinted eyes, and sad or serious expressions. After reviewing this fact sheet, the

participants in my study reported feeling much more at personal risk for the virus due to these images compared to the ads in Part I of the study. The information presented in the CDC Fact Sheet also varies greatly from the Gardasil ads, with one of the biggest differences being the positioning of HPV as a sexually transmitted infection. The largest and most prominent text appearing on the CDC Fact Sheet is the headline, “What is genital HPV infection?” Here it is made very clear that the virus you are about to learn about is an infection of the reproductive organs. Other differences to note here include that the writer of this fact sheet is consistent in their presentation of whom the virus affects. It is repeated throughout that HPV can infect members of both sexes, “males and females,” and that “males and females” can experience certain cancers resulting from an infection. There’s also information here on how the virus is passed, including information on same-sex couples and different types of sex the virus can be passed through. There is also a section on how HPV can be prevented, and this section is unique in that it is broken down into sections based on physical gender for “girls and women” and “boys and men,” and the sheet also mentions that there are other methods of prevention, but details the risks associated with each.

The other miscellaneous rhetorical texts, The New York Times article, “Pitching Protection, to Both Mothers and Daughters” and the CNN.com online news article, “Should Your Daughter Get Gardasil, the Vaccine Against HPV?” depict those at risk differently. Both headlines have bold references to females, hinting that the vaccine relates only to this population. Upon further inspection,

The New York Times article focuses on how Merck is up for a challenge when it comes to selling an expensive vaccine to teens and twenty-somethings, as well as parents, who may not like the idea of thinking about their pre-teen daughters and sex. The CNN.com article takes a different angle, focusing on parents who are wary of having their daughters vaccinated. Here, the text describes only two of HPV's effects, cervical cancer and genital warts. There is no mention of men or the fact that the vaccine is approved for use in males as well. Neither of these articles is accompanied by photos or visuals, so it is up to the text only to shape the target population in the minds of readers.

As I have shown, Gardasil's ads feature text and images that show that the main population at risk is female children, and the population responsible for prevention is female parents. But why target these two groups? In the next chapter, I will show how Merck's ads follow a long tradition of pharmaceutical ads basing their visual and textual depiction of "parent" on the global stereotype of "Woman as Caregiver," and how doing so excludes other groups of potential consumers. I will then begin to build my argument that shows Merck does this intentionally, targeting its messaging not toward populations at risk for HPV infections, but toward those populations most likely to purchase pharmaceuticals.

## CHAPTER 5: TARGETING THE FEMALE CONSUMER – THE 'WOMAN AS CAREGIVER' STEREOTYPE

### Introduction

As I've shown in the previous chapter, mother figures are the most prominent target of Gardasil ads, as they are included in ad visuals, and discuss the choice of getting their child Gardasil in ad text/broadcasts. By why would a pharmaceutical company choose to target mothers so heavily? Why not target fathers, too, or adult women between the ages of 18-26 who can purchase the vaccine for their own protection against HPV? Why target female caregivers as the population responsible for virus prevention? In this chapter, I will show evidence that Merck's decision to do so is based on the stereotype of "Woman as Caregiver," a long-standing cultural assumption that has both been reflected in and shaped by pharmaceutical advertising for more than 150 years. Not only that, but I will show evidence that in addition to making and reflecting stereotypical assumptions, Merck may be targeting this group in order to access the highest-spending consumers in the marketplace instead of targeting all of the relevant populations who could benefit from the vaccine.

### Using the 'Woman as Caregiver' Stereotype

When it comes to portraying female children and teens in the ads, Merck does, in a few visuals, take a step away from certain passive female stereotypes by featuring girls engaging in active and even stereotypically male-oriented hobbies, like outdoor skateboarding, however the "women as caregiver"

stereotype plays a central role in almost every Gardasil ad, with a female actress portraying every visual reference as a “parent” in the ads. This portrayal is an obvious reflection and reinforcement of the long-standing cultural stereotype that women are or should be the primary caretakers of children; a role women as a whole have been cast in thanks to centuries of biological assumptions, gender politics and discrimination that our culture has allowed to take place.

While placing a woman in a parental leadership role initially sounds great, there historically have been and continue to be “spheres” (a culturally designated time and place) in which women are accepted as experts in caregiving.

Historically, the place for a woman to be an expert has been in the home, and unfortunately, medical/pharmaceutical advertising has continually reflected this for more than 100 years. Scholars like Roxanne Mountford, Karlyn Kohrs Campbell and Nan Johnson have each shown examples of how males and females have historically been kept in separate spheres dictating when, where and how it is appropriate to appear as a leader or expert in something, whether it is in a professional field like religious leadership or a social situation like public oration. All of these authors have provided historical accounts that demonstrate that the reasons for this biologically based separation is a mix of politics, control and discrimination, accompanied by the threat of punishment for those who fail to adhere to a current social code. I argue that the “separate spheres” metaphor also applies to women as caregivers, the majority of whom have historically been pressured, socially and politically, to operate outside of the professional medical community when extolling their medical knowledge and practice.

In order to examine the “Woman as Caregiver” stereotype we see in ads today, we need to briefly examine the history of this stereotype, and consider the fact that the hierarchy of hospitals, medicine, and health care were once much different than they are in the present day.

Throughout history, women have been categorized as a “caregiver” for many reasons. Some are based on essentialism, an ideology that argues that there are naturally occurring biological differences between males and females. In the essentialist’s opinion, a woman’s “inferior” biology associates her “with procreation, nurturance, warmth and creativity” (Wajcman 9). In looking at the female body, there are obviously ties to a woman’s physical ability to bear children, with some essentialists arguing that if a woman has the natural ability bear children, she also must have the natural ability to care for them. Additional biological arguments have pointed to a woman’s natural size and strength as the difference that has kept her in the home, and thus available to care for children. Here, the assumption is made that men are naturally bigger and stronger than women, and (depending on the culture) because of this, men will be more successful at work, especially when the jobs prevalent in the culture were very physical, like farming.

Other arguments are rooted in social assumptions, and the stereotype of “Woman as Caregiver” reached a new height during the Victorian age. During that time, “the ideology of domesticity romanticized both the family and woman’s role within it ... gradually, women, now defined as the moral and spiritual center of that family, were given a central role in the preservation of values that were

intended to inform the institutions of society at large” (Morantz-Sanchez 38). At the time, the popular stereotypical definition of the Victorian woman was essentially a picture of a nurturing individual who would bless the home with her “natural” talents – assumed biological/psychological differences that declared that women were naturally more loving, tender and pious than men. The Victorian home was considered to be the woman’s sphere of expertise, an appropriate location where she could extoll her innate talents of having and raising children, maintaining a happy and healthy home, and of course, caring for ill family members. Of course, all of this was based on social stereotypes and assumptions that all women wanted a family, instead of a career or a mix of both.

Certain cultural factors also contributed to women staying in the home and providing care for the sick. During the Victorian age, American families lived in a world where medical care was much different than we know it today. At the time, no laws surrounded the practice of medicine, and no standard requirements for training medical doctors, and thus the ability and skill of each physician varied greatly. The occupation of doctor was also regarded by society differently then, and according to Ruth J. Abram’s research, “the ‘best’ students rarely applied to medical schools, for medicine was not considered a prestigious field throughout most of the 19<sup>th</sup> century” (Abram 18).

Victorians had a few options for medical care. Paying to have a doctor come to the home was costly for the middle class, and risky, considering that the lack of regulations around physician education attracted a lot of frauds into the field, who promised magical cures and treatments. Hospitals were also a

relatively new institution in the U.S., and because the first such facilities were often founded and funded by churches, they offered very limited selection of care and treatments to patients. Not only that, but hospitals weren't exactly the healthiest environments for the sick. The use of antiseptics to kill bacteria and germs had only begun being introduced in the late 1860s, so hospitals could be very unhealthy places and actually put patients at additional risk. Often the location of these first hospitals was inconvenient for most Americans, as these facilities were usually located within cities, and as the 1870 U.S. Census shows, leading up to the turn of the century, three-quarters of the American population still resided in farms and villages (Abram 22), making access to city hospitals difficult. All of these factors made in-home care the preference of the day. Because women were already pressured by society to stay in the home with children, it was only natural that they would end up taking care of ill children and other family members.

While placing a woman in a leadership role initially sounds like progress, displaying this expertise was not welcome outside the home. Women who attempted to venture out of their "sphere of domesticity" to seek employment in the medical field faced sex-based discrimination and challenges, and when they began seeking employment in hospitals, new spheres were built to further segment women and keep them inferior to males while providing care in the public space – the spheres of female "nurse" vs. male "doctor" (ibid 60).

When the first formal hospitals emerged in the U.S., they were staffed by male doctors, who were assisted by poor minorities who received little to no

training. In the late 1870s, it became trendy among upper-class women to make it their charity mission to improve the quality of local hospital care, and one such reform they fought for was that nurses receive some type of formal training. Because of the existing cultural stereotype of middle-class Victorian women, the upper-class crowd promoted them as the perfect fit for this new type of nurse because of the caregiving experience these women were assumed to have had at home. Women began entering nursing schools in droves, and graduates assimilated into a new hospital hierarchy, taking a place above untrained minorities, but beneath skilled male doctors. Although women were lauded for bestowing their “innate” gifts for care and nurturing onto their patients as nurses, attempting to expand their responsibilities in treating the ill by entering the male-dominated sphere of physician was another story.

Just as Karlyn Kohrs Campbell and Nan Johnson have shown that women who dared to become leaders outside the home were punished for stepping out of their appropriate sphere, females who attempted to become doctors faced sex-based barriers, discrimination and even hostility. As historic accounts show, women had to try for years to get accepted into American medical schools, and faced discrimination from male-dominated admissions boards that often agreed with the cultural stereotype that women should stay at home for the betterment of the family and community. As Ruth J. Abrams describes, “The majority of male medical professionals did not welcome their female colleagues, whom they viewed as an economic threat in a profession already burdened with an oversupply of practitioners,” (Abrams 63). Thus, some medical schools based

their objections to admitting women by citing their “delicate nature,” including the idea that women wouldn’t be able to handle the gruesomeness of causing some patients pain during their treatments, and that the tender-hearted woman couldn’t (or shouldn’t) engage in the brutal behaviors the job of physician occasionally required. Others pointed to the fact that attending school and having a job might prevent a woman from fulfilling her “destiny” of marriage and children – again, making the assumption that every woman wanted marriage and children. Other arguments bordered on the ridiculous, and pointed to the biology of a woman’s body, arguing that her physical inferiority prevented her from withstanding the hours of additional education and training it took to become a doctor. Females who succeeded in surpassing these many barriers to become doctors were looked upon as the ultimate feminists of the age, as they “viewed their campaign to study and practice medicine as part of a larger effort to adapt traditional concepts of womanhood to the demands of an unstable, complex, and rapidly industrializing society” (ibid 62).

But such women faced a difficult road in their venture out of their normal “sphere of domesticity.” Elizabeth Blackwell, the first female student to be accepted into an American medical school, was admitted to Geneva Medical College in the 1840s only after the student body voted to accept her, believing her application to be a joke. After her graduation in 1849, Blackwell was discouraged from practicing medicine because of her sex, and went to Europe for additional study. She later returned to the U.S., only to face additional discrimination, and eventually opened her own nonprofit medical facility, New

York Infirmary for Indigent Children, trained hundreds of nurses to provide emergency care for soldiers in the Civil War, and opened her own nursing school in 1873. Blackwell's story is a clear example of how women have historically been forced to operate outside the dominant sphere of male-run hospitals. Underneath all of these arguments lay fear that allowing women into the role of physician would upset the hierarchy of not only the hospital, but of society also, adding more competition in the job market, and giving women a reason to leave the home and upset the family balance.

Also during the Victorian Age, the "Women as Caregiver" stereotype began to appear prominently in the day's advertisements, which was encouraged in part by the debut of new lithography technology introduced in the 1870s. This technology enabled advertisers to print full-color ads at an affordable price. This technological advancement also brought with it the popularization of a new ad format: the ad card, a small trading-card sized ad that featured a picturesque visual on the front (to appeal to illiterate consumers) and ad text on the back. According to historian Julie Wosk, these ads reinforced for "middle-class readers the commonly held view of men's and women's proper roles [and] identified women as the locus of domestic, civilizing and religious values, while men were assigned the freedom to venture out into the wider world" (Wosk 20). Artwork on these ad cards frequently offered a stereotypical portrayal of women as caregivers to family and others, and occasionally as nurses, but never doctors. For example, an 1888 ad for Becham's Pills laxatives includes two such visuals: a female nurse sewing while watching over a young sleeping girl, and a woman

taking charge of her family (a husband and three young children) (see fig. 20).

Another ad card for Scott & Brown's Palatable Castor Oil shows a mother seated, giving a dose of medicine to a small boy while an even smaller girl waits her turn (see fig. 21).

Women were also often the centerpiece in ads for baby-care products, such as the 1888-ad card for Mrs. Winslow's Soothing Syrup teething gel, which features a visual of a woman in a dress smiling while cuddling a smiling baby (see fig. 22). Ad text, which was limited compared to today's ads due to ad card size and the culture's literacy levels, also points to women as caregivers. An ad for Dr. A.C. Hoxie's Certain Croup Cure features little text, but includes a visual of a young girl and the slogan, "Always Keep it in the House" (see fig. 23).

Curiously enough, adult females weren't the only ones depicted as caregiving in ads. Female children were also shown in ad visuals dressed up in mommy's clothes, caring for their dolls or pets as if they are their babies, such as a 1880s-era ad card for Radway's Ready Relief, a medication that mysteriously promised to cure pain, headache, diarrhea, colic, cramps, heartburn and malaria (see fig. 24). This ad card featured a visual of a little girl dressed in a pink gown, nursing her baby doll back to health, and giving it a kiss on the cheek (NMAH.org).

Males, however, are featured very differently in drug ads of Victorian era. They are either alone, playing the role of doctor, or are included in a visual that suggests violence or force as if they are conquering illness. For example, an ad for Red Star Cough Cure shows a man dressed in a military outfit, holding a long

golden sword (see fig. 25), while an ad for Dalley's Magical Pain Extractor shows three men racing on horses (see fig. 26).

Even though certain cultural conditions of the past contributed to women staying in the home, Merck makes many assumptions in continuing to use this stereotype in today's Gardasil ads. Statistics show that the American family has changed greatly over the years, and shifting cultural attitudes regarding marriage, divorce, homosexual partnerships, adoption, and male/female roles in the workplace and home have had a real impact on who actually does take care of children. A 2009 study by Ad Age's Marissa Miley looked at the current state of the role of "mom" in the U.S. According to her study, the terms "stay-at-home mom" and "working woman" have become difficult to define, because even if women do stay home to take care of children, women now often work part-time, seasonally, or on a freelance or contract basis bringing at least some money in. On a side note, feminist scholars have historically had a problem with the notion of a stay-at-home mom, with gender studies author Suzanne Romaine arguing the entire perception is a falsehood, saying that "in real life, 90% of American women work at some stage of their lives and are not 'just housewives,'" (Romaine 283), while feminist scholar Judy Wajcman questions why our culture doesn't give the "recognition that housework [is] also work" (Wajcman 13). Regardless of how any stay-at-home role should truly be defined, Miley's study shows that a lot more is at play when it comes to caring for children than who is home more often. In my opinion, current Gardasil advertising fails to target their communication efforts to these male parents who raise or share childrearing

duties, and in doing so, fails to target valuable populations of caregivers and their families.

So why does Gardasil target the population of mothers so specifically when they may or may not be responsible for caregiving? In looking at both the ad presentation of Gardasil, and this company's controversial history in advertising, I argue that Merck's execution is based on the fact that married female parents, or at least women in that age group, are huge financial targets for advertisers. According to Miley's survey, women control 73% of household spending, make 85% of the family purchasing decisions, and spend \$4.3 trillion in the marketplace each year (ibid). These statistics show that mothers, regardless if they are in the position of "working woman," "caregiver" or a blend of the two, are the highest-spending population compared to any other population.

Of course, these "caregiving women" have the choice of whether or not to purchase the vaccine for their children – or do they? As further evidence that Merck uses the "women as caregiver" stereotype to target female consumers for financial reasons, I will explore the extreme measures the pharmaceutical company took in 2006 to attempt to make the vaccine mandatory for female school children, a move that was met with resistance by some parents, doctors, and members of the legal and medical communities.

## **CHAPTER 6: MAKING A VACCINE MANDATORY – PROTECTION OR GENDER DISCRIMINATION?**

### Introduction

For years, the rights of a patient to control his or her own medical care in the United States has been both supported by and controlled by the U.S. government. Over the last century, many health-care laws have been put into place at both the state and federal level that deal with a patient's privacy, access to records, and right to make decisions, including the right to refuse medical treatment/right to die by signing a do-not-resuscitate order. Today, in 2012, the patient plays a more active role in his or her own health care than ever; however, both the state and federal governments continue to reserve the right to step in and make decisions for a patient when absolutely necessary – and one salient example of this is when a state requires vaccine administration for a specific population, such as children who attend school.

Since their debut in the United States, several vaccines have been declared mandatory by the state governments for school attendance. But how does a state government determine the need for a vaccine to be made mandatory? How do they make the decision to take a citizen's health-care choice away and force compliance? And, how and why did Merck's Gardasil vaccine come under scrutiny when Merck lobbied for their vaccine to be added to the list of required vaccines? In order to analyze these arguments in the correct context, I must first give a brief overview of the legal and medical approvals required to getting any vaccine mandated. Then, I will show evidence that

Merck's push to make the vaccine mandatory in the U.S. was financially motivated, (just as the company's targeting of mothers was financially motivated), and show examples of how making the vaccine mandatory based on gender assumptions would actually put some relevant populations at additional risk.

### Building a New Vaccine: From Concept to State Mandate

Getting a drug from the concept phase to the marketplace is a long process that involves passing multiple stages of testing before applying for FDA approval. Depending what the illness a drug or vaccine treats, the drug is assigned one of three timetables it will take to gain FDA approval – Fast Track, Accelerated Approval or Priority Review (FDA.gov). From here, the process involves a pre-clinical stage, in which investigational drugs or vaccines are tested on cells or animals for toxicity. If it successfully passes the pre-trial phase, the vaccine will continue on through five different stages of human drug trials that test first for the drug's safety (Phase I), then how well the drug works (Phase II), and then the drug's effectiveness level, and any other illnesses or conditions the drug may benefit (Phase III). After successfully passing Phase III, a drug and its trial data can be considered for FDA approval. Required Phase IV and V drug trials may take place after a drug is released, and the company and the FDA must monitor the drug's long-term use in humans for any negative side effects. As I will discuss later on, it is often during phases IV and V that additional problems are found, which can even lead to vaccine recalls.

From the very beginning, Merck was on a Fast Track to get the Gardasil vaccine through trials and approved. Merck began testing the Gardasil vaccine in 2003, and received FDA approval in 2006 after successfully completing a three-year Phase III trial, titled Females United to Unilaterally Reduce Endo/Ectocervical Disease, in which 21,000 females age 12-26 were vaccinated and monitored by health professionals up to 15 months after injection (Huang 183). According to some doctors, including Dr. Diane Harper, a principal investigator for Gardasil, this three-year timetable was very fast for a vaccine of this nature, and Harper points to Merck's own actions for its acceleration. "Because Merck was so aggressive, it went too fast," Dr. [Diane] Harper said. "I would have liked to see it go much slower" (Rosenthal).

After a vaccine receives Phase III FDA approval, the next step is for the pharmaceutical company to work with the U.S. Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices (ACIP) to determine an appropriate age range for the drug/vaccine in order for it to be most effective. In Gardasil's case, the recommended age range was age 11 to 26, based on the fact that Gardasil is to be used as a preventative vaccine, and in order to be successful, a patient must receive the vaccine before being exposed for possible infection. The target age range of 11-12 "was based on several considerations, including the age of sexual debut in the United States and the high probability of HPV acquisition within several years of sexual debut" (Javitt 386).

Getting a vaccine approved for consumer use is one process, but making it mandatory for a specific population is a separate challenge that is conducted

on the state government level, and is often a difficult decision for legislators. The first legislation that mandated a vaccination for school students in the U.S. was enacted in Boston, Massachusetts, in 1827, in order to suppress smallpox outbreaks among children in the local community (Javitt 388). In 1905, the United States Supreme Court set forth guidelines that states still use today in order to decide if a vaccine should be required for students. The case that inspired these regulations was *Jacobson v. Massachusetts*, in which an adult male refused the smallpox vaccination for himself on the grounds that “a compulsory vaccination law was ‘hostile to the inherent right of every freeman to care for his own body and health in such way as to him seems best’” (ibid). The court responded that although they support an individual’s right to make their own health decisions, “a community has the right to protect itself against an epidemic of disease which threatens the safety of its members” (ibid). This case set forth a model of four principles that a vaccine must meet before mandatory vaccination can be considered constitutional: “First, there must be a public health necessity. Second, there must be a reasonable relationship between the intervention and public health objective. Third, the intervention may not be arbitrary or oppressive. Finally, the intervention should not pose a health risk to its subject” (ibid). Typically, these guidelines have been interpreted by courts that in order to become a mandated vaccine, the illness the vaccine guards against is highly contagious with severe and immediate health ramifications (including possible deaths). It is also interpreted that the illness is easily contracted, that all students are at equal risk to catch the disease unless

vaccinated, and the populous school environment is a setting in which the illness could spread rapidly to many individuals. In the years since these guidelines were put in place, all 50 states have used these principles to declare several vaccines mandatory for school attendance, such as polio and measles (the entire list varies slightly per state).

The medical strategy behind specifically vaccinating schoolchildren is based on the medical theory of Herd Immunity. This strategy attempts to curb the spread of illness by focusing on areas that are highly populated, with the idea being that the more people who are vaccinated, the harder it will be for a virus to spread since there are fewer carriers available. I agree with Christina Hud when she argues that “according to the Herd Immunity theory ... the population as a whole benefits because the likelihood of the spread of infection decreases. The ‘no shots, no school’ policy is a highly effective and cost-efficient way to achieve this result,” (Hud 257).

#### Lobbying for Mandatory Inoculation

As soon as Merck’s Gardasil was submitted to the FDA for approval in 2006, the pharmaceutical company launched an aggressive public relations and marketing campaign to alert the media, the public, and the health-care industry of this new vaccine’s testing-phase success, pending approval, and inevitable release. The company also began working toward their next goal, which was to get states across the U.S. to pass legislation making the vaccine mandatory for school attendance.

In order to push the issue in front of state governments, Merck hired former state officials to lobby their current governments, their friends and their former coworkers to support the issue. The company also recruited doctors to give presentations on Gardasil, paying a minimum of \$4,500 per lecture, and offered additional funds for doctors to speak on the vaccine's behalf at state advisory meetings and other events.

According to an investigation by New York Times journalist Elisabeth Rosenthal, the company went further than this and reached out to many other types of organizations, not to encourage help in making the vaccine mandatory, but in pushing the HPV virus into the media spotlight to make it seem like more of a pressing and severe health issue. According to Rosenthal, "the vaccine makers have also brought attention to cervical cancer by providing money for activities by patients' and women's groups, doctors and medical experts, lobbyists and political organizations interested in the disease, sometimes in ways that skirt disclosure requirements or obscure the companies' involvement" (Rosenthal). Rosenthal's investigation showed that this wasn't the only questionable action by the pharmaceutical company, but there have also been questions about the relationship between Merck and some individuals responsible for getting the vaccine's FDA approval, including Mayo Clinic vaccine expert Gregory Poland, who recommended Gardasil's approval to the CDC after receiving more than \$25,000 in "consultation fees" from Merck between 1999-2007 (ibid).

Merck also aligned itself with Women in Government, a “national, nonprofit, nonpartisan organization of women state legislators that provides leadership opportunities, networking expert forums, and educational resources to address and resolve complex public policy issues” (WomenInGovernment.org), and began making undisclosed financial contributions to this group after Gardasil received FDA approval. And according to an investigation by the AP, “a top official from Merck's vaccine division sits on Women in Government's business council, and many of the bills around the country have been introduced by members of Women in Government” (AP).

Members of the media have also begun speculating that some State governments may have engaged in questionable backroom deals with Merck in order to make the vaccine mandatory. Merck's lobbying efforts in the state of Texas caused some of the biggest controversy to date. There, Merck hired current Governor Rick Perry's former chief-of-staff, Mike Toomey, to lobby for the vaccine, and made a \$6,000 contribution to fund Perry's re-election campaign (ibid). On Feb. 2, 2007, Gov. Perry signed an executive order making Texas the first state in the U.S. to require females entering sixth grade to get the vaccine; however, a bipartisan state legislature immediately overturned the order, requesting more time to look at the vaccine's long-term side effects before requiring mandatory vaccination. According to a 2007 investigation by The Associated Press, the vaccine's passing in Texas also had ties to Women in Government. “Merck...doubled its lobbying budget in Texas and has funneled

money through Women in Government, an advocacy group made up of female state legislators around the country (Rosenthal).”

Other controversies appeared to take place behind closed doors in the state of Virginia, which eventually succeeded in passing a bill requiring the vaccine; however, doing so seemed to come hand-in-hand with some major financial contributions and promises for more dollars from Merck. “In December 2006, Merck announced it would invest \$57 million to expand its Elkton, Va., plant to make Gardasil, helped by a \$700,000 grant from a state economic development agency that is part of the executive branch. Two months later, Gov. Tim Kaine ... signed legislation requiring Gardasil for schoolgirls. Four months after that, Merck pledged to invest \$193 million more in the plant to make drugs and vaccines, helped by a state grant of \$1.5 million” (ibid). Here, it is easy to see where a financial conflict of interest may exist in passing such legislation.

By February 2007, the investigation into Merck’s lobbying efforts had reached such a pinnacle among members of the media, religious groups, women’s groups, and others, that Merck publicly announced it would cease all lobbying efforts. Never admitting any wrongdoing, or that their efforts were premature at the very least, Merck Spokesman Chris Loder as quoted in the media was saying the company was halting its lobbying efforts because the media attention it attracted “distracted from the real issue, the importance of the vaccine and the ability to save lives” (Hart 25).

Why were Merck’s efforts considered questionable? Why not simply let the data of this vaccine speak for itself if it really is something that can work

wonders for women's health, and men's, too, when it comes to preventing HPV and certain cancers?

### Demanding Legislation: Pushing the Legal Limits

Many in the legal field, such as Johns Hopkins University Professor Gail Javitt, have publicly argued that making Merck's Gardasil mandatory for school attendance for females is unconstitutional. In the Journal of Law, Medicine & Ethics, Javitt, along with professors Deena Berkowitz and Lawrence O. Gostin, analyzed each principle from the *Jacobson vs. Massachusetts* case and compare them to the HPV virus and vaccine. According to them, HPV does not meet *any* of the required principles the U.S. government has set forth to legally become a mandatory vaccine. First of all, in their opinion the virus is not associated with immediate death (as we will see later in the medical portion of this chapter, the virus can take years, even decades to begin to cause harm), students are not put at risk simply because they attend school and are exposed to large population of individuals, and unlike other state-required vaccines, like measles and polio, HPV does not spread through airborne or casual contact. Another objection here is that not every student is at the same level of risk for contracting or spreading HPV, because a student is only put at risk when he or she begins having sexual contact with someone else.

Despite this, nearly all 50 states in the U.S. have drafted legislation proposing to make the Gardasil vaccine mandatory for female students entering sixth grade (Jarvitt 387), with only two have successfully overcome the legal snags

mentioned above to implement legislature. As of Oct. 1, 2008, the State of Virginia and the District of Columbia successfully made the vaccine mandatory, with the option for parents to allow their children to opt-out only after reviewing educational literature on the vaccine and virus.

After analyzing many of the legal arguments for and against Gardasil, I believe one of the biggest challenges in passing any of this legislation from the legal perspective points to the fact that the vaccine would be required only for female students. One could look at this from either a male or female perspective and see this targeting of females and omission of males as discrimination. From the female point-of-view, females would be required by law to obtain a vaccine they may not want or need, but must comply because of their gender. From a male perspective, the Gardasil vaccine, which is not yet covered by insurance, would be made available at no cost (per state legislature), but only to female patients, leaving males to pay a \$360 premium for the series of vaccines, or go unvaccinated and remain at risk. The exclusion of males from potential legislation also hints at the state's ignorance of the risk faced by homosexual or bisexual males if only females are vaccinated.

According to Jarvitt's analysis, a "sex-based mandate for HPV vaccination could be challenged on two grounds: First, under the Equal Protection Clause, because it distinguishes based on gender and second, under the Due Process Clause, because it violates a protected interest in refusing medical treatment" (ibid 392). She forecasts that if such an issue was brought to trial, a court would suggest that vaccinating males would also contribute to the prevention of HPV in

our society, and would ask for medical research proving otherwise. As for Due Process, Jarvitt explains that an individual has a right to refuse unwanted medical treatment, and that making the HPV vaccine mandatory violates these rights. In order to overcome this obstacle, the state would have the great challenge of proving that the general population was at great risk of immediate suffering due to the HPV virus, and vaccinating only female students would be necessary for the benefit of public health.

Hud, who has specifically analyzed the legislation that the State of Virginia passed in order to require the vaccine for schoolgirls, agrees that the current legislation is a violation of the 14<sup>th</sup> Amendment's Equal Protection Clause, which states that "no person shall be denied 'equal protection of the laws'" (Hud 261), as Virginia's legislation provides protection for females and not males. From her perspective as a lawyer and legal scholar, the current legislation that exists in Virginia would be unchallengeable if the vaccine was still only FDA-approved for use in females, but now that the vaccine is also approved for males, the legislation fails to legally offer equal protection to all relevant parties.

In addition, Hud brings up the point that unlike other required vaccines, simply attending school should not put students at additional risk for contracting HPV, "because young students are not – or at least should not be – having sexual contact in the school environment, Gardasil vaccination is not necessary," (ibid 241).

But legal challenges and bad press weren't the only opponents Merck faced in the battle to make the vaccine mandatory. Many parents also voiced

opposition to the mandate, seeing it as the government taking away their parental authority over their children, and many other reasons that will be discussed in the next section.

### Risk vs. Parental Rights

Another vocal group in the debate over whether or not the vaccine should be made mandatory has been parents, who question requiring the vaccine for several reasons, with arguments against the state taking away parental authority, and concerns about the possibility of being required to over-vaccinate their child. Again, the issue of biological sex is at the center of these arguments, with others outraged that female children would be targeted for protection, while male children would not.

First, some parents expressed discontent with the idea that the government was trying to take parental authority away from them. In the paper, “The Virginia Gardasil Law: A Constitutional Analysis of Mandated Protection for Schoolchildren Against the Human Papillomavirus,” Hud, mentioned above, provides legal analysis of how and when a state can do so: Although parents have the legal right to make medical decisions for minor children, “the government ‘is not without constitutional control over parental discretion in dealing with children when their physical or mental health is jeopardized,’ and the state may override parental objections if they could result in harm to children or the community at large” (ibid 250). This is interpreted to mean if a parent’s decision to refrain from vaccination puts the community at greater risk, including

risk of severe illness or death, the state can step in and take control. According to Hud, state legislation often offers parental opt-out in vaccine legislation as a way to calm or avoid public protest by parents. For example, the state of Virginia did so in their Gardasil legislation, offering parents the chance to get their children excused from the Gardasil vaccine per religious reasons, or a physician's letter explaining a potential medical complication. In this state, parents can also refuse on behalf of their child by reviewing state HPV health literature prior to opting out.

While an estimated 1% of parents formally opt out of school-required vaccines in the United States (Stobbe), many more raised the question about over-vaccinating children in response to Gardasil legislation, and expressed hesitation at adding another vaccine to the list. Currently, American schoolchildren receive up to 24 vaccines before the age of 6, which prevent them from contracting and carrying a total of 14 dangerous illnesses, including measles, polio, and many others (ibid). Much of the fear concerning childhood vaccination stems from Dr. Andrew Wakefield's 1998 research that showed a potential tie between vaccines and Autism (Dominus MM36). Although Wakefield's research initially called out a connection to a specific vaccine set – the single measles, mumps, rubella vaccine – many parents began to fear childhood vaccines in general. It has since been found that Dr. Wakefield altered patient histories in order to produce his results, and was officially stripped of his medical license in 2011, however, many parents are still wary of over-vaccinating children (Berezow).

Another parental hesitation, which was picked up by religious groups and often voiced through the media, was the concern over whether or not having the vaccination would encourage children to behave promiscuously, and actually put them at additional risk for other STDs and teen pregnancies. This behavior, known in the medical community as “disinhibition,” is defined by the CDC as “an increase in unsafe behaviors in response to perceptions of safety caused by introduction of a preventive or therapeutic intervention” (Gibbs 32). Historians have noted at least one time in which American culture experienced such a phenomenon after the FDA passed another highly gendered pharmaceutical technology – the first oral contraceptive birth control pills in 1960. “Scholars today debate the extent to which [the sexual revolution] can be attributed to the oral contraceptive, but even those who doubt that it was the sole causative factor admit that it’s role was far from insignificant” (Cowan 323). Two such groups who raised this question in the case of Gardasil were the Georgia Christian Alliance and Family Research Council, which both expressed in the mass media that the decision to vaccinate should be left up to parents.

Other parents have also come forward to question the safety of the vaccine, including some parents who have had their children vaccinated with Gardasil and watched them experience serious side effects as a result. As I will discuss in the next section, parents aren’t the only group concerned about Gardasil’s safety record.

### Vaccinating Too Soon? The Medical Objections to Gardasil

As of September 2011, more than 40 million people have been vaccinated with Gardasil at doctor's offices and hospitals (CDC.org). However, many doctors and high-profile members of the medical community have publicly spoken out against making the vaccine mandatory at present, and question Merck's motives in doing so. In this section, I will analyze the medical community's criticism of Merck's push to make Gardasil mandatory, as well as the additional concerns some medical experts have expressed over the messaging that surrounds Gardasil, which I argue provides further evidence that Merck's Gardasil push is financially motivated. For the majority of this section, I will focus on data concerning females and cervical cancer, since that is the one HPV-related illness that state governments are basing their decision to require vaccination upon.

Some doctors have spoken out against making the vaccine required for female students for many reasons, and to fully understand them, I will first have to give a bit of background on how well the vaccine works against cervical cancer. First of all, why and how the HPV virus affects the human body is still somewhat a mystery in the medical community because an infection can take one of two routes once it enters the human body: 1) an individual contracts the HPV virus and his/her immune system sheds the virus on its own, and there are no damaging effects, or 2) the infection causes genital warts, or it takes an undetermined amount of time to cause pre-cancerous cells that, if left untreated, eventually evolve into cancer. As of 2011, science has still not been able to determine why some individuals' immune systems can shed the virus, while the

same strand of the infection may progress to cause cancer in someone else. Medical research still has not determined why some infected individuals develop precancerous cells within a few years after the initial infection, while in other patients, it can take decades. According to Charlotte Haug, M.D., “it is impossible to predict exactly what effect vaccination of young girls and women will have on the incidence of cervical cancer 20 to 40 years from now” (Haug 795).

One of the main medical concerns with relying on the Gardasil vaccine to prevent cervical cancer alone is based on the fact that of the 100 unique strands of the HPV virus, 15 are known to be carcinogenic strands, and of those 15, Gardasil guards against only two: HPV-16 and HPV-18 (CDC.org). This means that it is still possible for an individual to contract a cancer-causing strand of HPV even if they receive the Gardasil vaccine prior to sexual contact. This is one of the problems that doctors like Dr. Charlotte Haug, M.D., Ph.D., MSc, has with making the vaccine mandatory. In her article, “The Risks and Benefits of HPV Vaccination,” Haug argues that by making the vaccine mandatory, State governments are buying into the idea that this vaccine prevents all females from contracting the HPV virus, when the reality could be much different. Haug continues to argue that medically, the best and most consistent defense against cervical cancer for a woman is not the Gardasil vaccine, but having annual Papanicolaou tests (also known as pap-smear tests). Pap smear tests are gynecological tests in which cells are swabbed from a female’s cervix and examined under a microscope for the presence of cervical intraepithelial

neoplasia, which is the first stage of precancerous tissue growth on the cervix. According to Haug, annual Pap smear tests are the only sound way to ensure there are no cancerous cells developing from any strand of HPV. Of course, this perspective leaves out any monitoring of males' health.

Another of the medical community's hesitations toward making the vaccine mandatory deals with the overall safety of the vaccine, particularly concerning the short-term effects after injection. During the Phase II and III of Gardasil's trials, a few very minor side effects were reported after the injection, such as dizziness and swelling at the injection site, and these are pretty common side effects of many vaccines. However, in the years since the vaccine's launch, the CDC and FDA's Vaccine Adverse Events Reporting System (VAERS) has received several significant complaints of more serious side effects that were not found in the initial testing, including pancreatitis, anaphylaxis, transverse myelitis, and a potential connection to Guillain-Barre syndrome. According to members of the medical community, the range and number of short-term side effects appearing after the trial's completion are cause for concern. VAERS is an organization co-sponsored by the CDC and FDA that merely acts as a repository for consumer complaints against vaccines, and does not investigate them; however by 2009, VAERS received so many safety complaints, including 32 Gardasil-related deaths, that the CDC raised concerns that Gardasil may carry more serious short-term effects than other frequently used vaccines, including an increased risk of blood clots. It is not uncommon for additional complications to be found after a vaccine has been approved and administered for a few years,

which is why the FDA requires Phase IV studies to continue after the vaccine is approved. It is often during this phase that additional medical side effects are established, and occasionally, findings may cause a vaccine to be pulled from the market. The fact that additional serious short-term effects are being found with Gardasil are making medical doctors even more nervous considering the fact that the vaccine requires three separate injections per patient over a three-month period, tripling the chance that a patient could experience short-term effects related to the vaccine.

In addition, an increasing number of doctors are questioning Gardasil's long-term effectiveness. Earlier in this chapter, I shared that in Phase III of the Gardasil trial, female participants were monitored by doctors as long as 15 months after receiving their third and final injection in the three-part series. However, we've also seen that science can't currently put a definitive timeline on the development of cancer in infected females, meaning that those who do develop cervical cancer may not experience their first symptoms until 5-40 years after their initial HPV infection. This also means that technically, the women who participated in the Phase III of the Gardasil trials may or may not have been monitored long enough to prove any definitive long-term effectiveness against HPV. Journalist Elisabeth Rosenthal raised fair questions surrounding this concern in her investigation for [The New York Times](#), writing that "some data from the clinical trials indicate immune molecules may wane after three to five years. If a 12-year-old is vaccinated, will she still be protected in college, when her risk of infection is higher? Or will a booster vaccine be necessary?"

(Rosenthal). Other doctors further the concern that a young girl could get vaccinated, but due to the unknown long-term effectiveness of the vaccine, it could potentially wear off well before the girl begins engaging in sexual contact, leaving her at risk without her knowledge.

Another factor that troubles some doctors is that Gardasil is currently administered in a series of three vaccines, and Merck has not yet researched the protection level an individual can expect if she fails to complete the full series. According to a 2011 report by The Associated Press, as of 2010, “just 49% of adolescent girls had gotten at least the first of the recommended three HPV shots. Only a third had gotten all three doses” (AP/MSNBC.com). Clearly, the way that women in our culture are currently using the vaccine does not give them the full benefit of the protection that is available today, leaving them at some degree of risk.

Another obvious oversight that worries some members of the medical community is the fact that males are left out of the state governments’ proposed vaccine legislation. As I have suggested throughout this paper, males are not only at risk for contracting the virus and suffering illnesses because of it, but that they also can spread the virus to other unvaccinated partners. Although I am not a medical or legal expert, I agree with Hud, who argues that “vaccinating young men against HPV also significantly benefits Herd Immunity, resulting in more than 90% of HPV cases caused by the four most common strains to be eradicated. If half the relevant population infected with HPV is exempt from Gardasil, the hope of achieving Herd Immunity will never fully be realized” (Hud

260). In addition, I believe the state's plan to vaccinate only female students clearly shows an assumption that the infection is spread mainly through heterosexual sexual contact, which is clearly not the case. According to a study by J. Partridge and L. Koutsky called "Genital Human Papillomavirus in Men," published in The Lancet Infectious Diseases, the authors reported that in nearly 100% of cases of anal cancer found in bisexual/homosexual men show a DNA-tie to HPV. The same study showed that 76% of penile cancer cases in men (regardless of sexuality) exhibit a DNA-tie to HPV. Obviously males are at real risk and any mandated vaccine would leave this population medically at risk.

Considering the many medical hesitations that doctors have publicly expressed against making the vaccine mandatory for female school children, I think it is clear that, similar to Merck's ad presentation, there has been filtered communication between the pharmaceutical company and state governments, the latter of which seem to believe they were or are passing legislation to end cervical cancer in women, with little regard to the medical questions and potential risks mentioned above. But why pitch a vaccine that may prevent only some cases of cervical cancer to state legislators as a life-saving vaccine that could potentially wipe out cervical cancer when data suggests it may be much less effective? Again, I have to argue that Merck's motivations here are financial. Several lawmakers have been quoted responding to questions about the cost of making such a vaccine mandatory, with responses clearly showing that they believe they are allocating tax dollars to end cancer in women. For example, The Associated Press quoted Gov. Rick Perry after he made the decision in 2006 to

pass Gardasil legislature, saying, “The HPV vaccine provides us with an incredible opportunity to effectively target and prevent cervical cancer ... If there are diseases in our society that are going to cost us large amounts of money, it just makes good economic sense, not to mention the health and well-being of these individuals to have those vaccines available,’ he said.” (CBSNews.com). It is clear in his statement that he believes his legislation and the costs associated with it will eventually eradicate cervical cancer, not simply cause a decline in the number of cases for certain populations.

In addition to Merck’s relentless push to make the vaccine mandatory despite receiving criticism from the legal community, the medical community and parents, there is one other major factor that I feel proves that Merck’s approach to using gendered rhetoric is financially based, and that is the company’s controversial history in questionable advertising.

### Merck’s Controversial Advertising & Sales History

While there is no way to tell exactly how or why Merck’s scientific data translated into a different message for state governments, I do think there is enough evidence in Merck’s past actions that suggests that the company’s target of both “mothers” and lawmakers is financially motivated.

From its launch in 2006, Gardasil was hugely profitable for Merck. In just nine months after its release, the company sold \$1.1 billion worth of the vaccine around the world (DuBois 116). It is important to note here that prior to its release, Merck was already engaging in a competitive race with competitor

pharmaceutical company GlaxoSmithKline, who was developing a similar HPV-prevention vaccine called Cervarix. Gardasil trials were completed first, but Cervarix trials were also underway and experiencing success. In addition to aggressively advertising the Gardasil vaccine to consumers, making Gardasil mandatory through legislation would have guaranteed Merck years – even decades – of sales, locking in a significant advantage over competitor Cervarix, which finally debuted in the U.S. market in 2009.

One major blemish in Merck's past that I believe provides great evidence that their target population is based on finances and not medical need can be seen in the company's previous advertising and public relations mistakes related to the drug Vioxx. In the late 1990s, Merck came under criticism from the medical community, the media, and the U.S. government over the advertising of its anti-inflammatory medication, Vioxx. The drug was approved by the FDA in 1999 for the treatment of osteoarthritis, back pain, and headache relief, but Merck also advertised it beginning in 1999 as a treatment for Rheumatoid Arthritis. This was of concern, considering that although medical doctors can prescribe pharmaceuticals for non-FDA approved uses, "pharmaceutical companies are prohibited from marketing them for any uses except those that the Food and Drug Administration has determined are safe and beneficial" (Wilson B1).

In 2001, the FDA specifically called out Merck's ad language as not fully disclosing the potentially dangerous side effects of the drug. In addition, new long-term side effects related to Vioxx use were now being medically

documented, which caused the FDA to send a warning letter to the CEO of Merck, stating, "Your promotional campaign discounts the fact that ... patients on Vioxx were observed to have a four to five fold increase in myocardial infarctions (MIs) compared to patients on the comparator non-steroidal anti-inflammatory drug (NSAID), Naprosyn (naproxen)" (FDA). Merck responded by adding a warning label on the product, but did not change its advertising content. In the meantime, investigations by the media uncovered internal documents and e-mails exchanged from within the drug company that suggest Merck knew more about Vioxx's damaging side effects than they publicly admitted. And at least one doctor who participated in the drug's trials has publicly admitted falsifying data and patient records. Merck eventually pulled Vioxx from the market in 2004, because they found that after 18 months of taking the drug, doing so increased a patient's risk of heart attack and stroke four times more than competitor drugs. Additional civil and criminal lawsuits followed, based on the fact that thousands of consumers were prescribed Vioxx for Rheumatoid Arthritis based on Merck's advertising for as many as five years before the FDA approved it for that use. As of December 2011, Merck pled guilty to charges of "illegal promotional activity" and agreed to pay billions of dollars in fines and lawsuit settlements, including \$4.85 billion in 27,000 personal lawsuits, \$628 million "to resolve allegations of off-label marketing and false statements of the cardiovascular safety of Vioxx" (Frieden/CNN.com), \$426 million to the federal government, and a \$321 million criminal fee.

I argue here that Merck's previous execution and handling of the Vioxx case adds further evidence that Merck is pushing Gardasil to state governments for financial reasons. Additionally, it is easy to see here why Merck portrays Gardasil as a cancer-prevention vaccine for women and not for men, since it is currently only approved for the prevention of genital warts in men. Promoting a life-saving cancer-prevention drug is much more likely, in my opinion, to catch the attention of a consumer than a vaccine for a lesser inconvenience of genital warts. In the next chapter, I will use all of this information on Merck's history, and the problems with Gardasil advertising execution to present my recommendations for a Gardasil ad campaign that takes into account these concerns and appeals to all medically relevant audiences.

## CHAPTER 7: RECOMMENDATIONS

Throughout the course of this dissertation, I have demonstrated how the cultural studies methodology can be applied to gendered advertising research by studying a variety of relevant texts, identifying the common findings, and tracing the dominant cultural opinions and stereotypes that may influence the way males and females are featured in pharmaceutical advertising. I have also taken a look at how Merck specifically used gender stereotypes in its advertising for Gardasil, as well as the cultural, medical, legal and financial factors that may have influenced the company's choices. I also believe I have shown that in the case of pharmaceutical advertising, audiences use advertisements as a way to educate themselves on who is responsible for accessing the vaccine and preventing the spread of an illness, and who is at risk for illness contraction.

This chapter will focus on applying the final step in the cultural studies methodology, which is to take my findings and make suggestions as to how Merck can better communicate with their audience and use responsible gender portrayals to correctly portray the HPV virus and Gardasil prevention to all audiences at risk. Larger goals here are to suggest advertising text and visuals that will be inclusive of all audiences at risk for illness contraction and prevention, not simply those consumers who spend the most money. This will, in my opinion, not only help make Merck's message more medically responsible, but also help break the trend of pharmaceutical ads that reinforce negative gender stereotypes, and instead, produce more accurate, progressive and encouraging views of females in American society.

As a disclaimer, I would be remiss if I failed to acknowledge the clear ethical questions that have been raised in this dissertation about Merck's potential focus on profits over the safety of consumer health, and the larger inquiry this idea points to, which concerns if or to what degree a pharmaceutical company should balance business goals with being a good corporate citizen when it comes to public health. These topics are challenging enough to warrant their own dedicated papers, so I will not take a side in this matter, and will instead base my recommendations on the fact that Merck's Gardasil is currently FDA-approved and ACIP-recommended for males and females in the United States, despite the questions of safety that are increasingly surrounding the vaccine.

Therefore, for the purpose of this text (and the purposes of comparison), I will suggest redesigns for the same sample ads that I pulled to use in the consumer study project. Choosing to augment these existing ads and other materials that were taken from Parade, Good Housekeeping, and Gardasil.com, I believe I can show the difference between what was, and my recommendation of what inclusive and responsible ad rhetoric looks like. I will base my recommendations on the findings mentioned previously in Chapters Two and Three, as well as the work of several authors who inspired me to write on the topic of gendered rhetoric in pharmaceutical advertising, including the gendered technology arguments of Judy Wajcman, the gender communication literature of Suzanne Romaine, the advertising criticism of Janet Kilbourne, and the health-

education and population-targeting strategies suggested by AIDS-activist Cindy Patton, among several others.

### Identifying Target Populations and Ad Placement

As I demonstrated in the sample study portion of this dissertation, advertising has a clear educational function when it comes to introducing what a new drug or vaccine does, the illnesses it treats, as well as who can access the drug/vaccine. So the first questions to answer in correcting the sample ads are: Which populations should we target, and how do we ensure our messages reach them?

As I mentioned in Chapter Two of this dissertation, feminist author Cindy Patton outlines two different educational strategies that were used in HIV education in the 1980s in her book, Last Served? Gendering the HIV Pandemic and Fatal Advice: How Safe-Sex Education Went Wrong. One is a risk-based education strategy, which was used to target HIV-prevention communication to only those who someone perceived to be at risk. The second, which Patton recommended for HIV education communication, “assumes that many people are at some level of risk. An aggregate, population-wide decrease in the dangerous behavior or condition will also result in decrease among those most at risk” (Patton 13). Here, I agree with Patton that the population-wide educational strategy would be best applied to communication that surrounds an illness that can literally affect anyone, and should be the strategy upon which Gardasil advertising is based. As Patton correctly shows in her book, using only a risk-

based population strategy leaves other populations at risk, especially when the medical data on who is actually contracting an illness (and when and how), is skewed due to poor medical research, public stigma, and dominant opinions expressed in the media. I think the same applies in the case of HPV, for which Merck's advertising defines the population at risk, and public stigma against connecting children and teens with the possibility of ever contracting an STD has filtered much of Gardasil's messaging. Therefore, I will conclude that based on the fact that anyone can contract or carry the HPV virus, that the relevant population to target our ads to is any male or female age 18 and older who can either access the vaccine for themselves or for a minor age 9-17.

Since the target audience for Gardasil is essentially anyone age 18-26 (and parents even older than this), how will I reach them with this ad message? As I explained before, one of the best ways to reach different populations is by selecting various publications or websites that appeal to different demographics. For example, if I wanted to target a high population of male parents in their 30s, Men's Health magazine might be a good place for an ad. According to the magazine's demographics, Men's Health has an 83% male readership, with the median age of 37.7 (MensHealth.com). Due to the nature of the virus and the fact that anyone can contract it, an exhaustive list of publications and websites could be put together that targets individuals in a range of ages, races, lifestyles, and sexualities. In the case of Gardasil and the populations it has specifically ignored, I would also suggest adding publications and websites geared toward fathers, bisexual/homosexual men, and HIV-positive health websites to the list,

since these seem to be among the most underserved populations by the current Gardasil ad campaign. And of course, not all populations can afford “extras” like magazines, so some low-income populations may need to be reached through other channels, such as newspapers, television commercials, mailings, health-clinic posters, or mass-transit advertising. Digital marketing techniques, such as banner ads on social media sites like Facebook, also may be of use reaching a wider demographic.

Again, for the purposes of this dissertation, the ad placement decision has already been made for me, since I am limiting my suggestions to revising the sample ads that were pulled from Parade and Good Housekeeping.

Next, I will take a look at how I can reach a more diverse population of consumers through visual ad content, beginning by suggesting changes to how children are featured in Gardasil ad visuals.

### Featuring Children & Teens in Ad Visuals

As my study results showed, visuals included in the sample ads had a profound impact on the populations the study participants felt needed the vaccine. Therefore, in order to appeal to all audiences at risk, I believe that a diverse sample of people ages 9-26 should be included in the ad visuals.

Children, who appear in 100% of the visuals in the three sample ads, should continue to be featured in visual content. Featuring children in ad visuals helps reflect the earliest age group relevant for the vaccine, and vaccinating individuals before they become sexually active is an important part of the medical

Herd Immunity strategy. However, in order to accurately reflect all relevant audiences per our Population-Wide strategy and appeal to all those who can access the vaccine per FDA guidelines, children should share visual space with males and females of other ages, too, specifically teen and adult consumers, who appear far less frequently. In looking back at the results of my sample focus group, it was clearly expressed by participants that the visuals in the ads really helped shape their vision of who was at risk for an illness, and featuring individuals of diverse age ranges so may help fill in this gap.

When featuring children in ad visuals, I believe it is important to show children of both genders, as well as different races. In all of the Gardasil print ads I've been able to find, children are often depicted as female, and appear to be either Caucasian or Hispanic. There are no Asian, Hispanic or African-American people represented, which is especially a concern for the latter two groups because medical research has shown that African-American and Hispanic women are 1.5 times more likely to suffer HPV-related cancers (Hud 229). This increase is not attributed to cultural behaviors, but to inadequate sex education at schools in low-income communities, plus a higher high-school dropout rate among this population than Caucasian students. "Poor communities ... lack funding for sex education in public schools, leaving [these women] uninformed about HPV's prevalence and its devastating effects" (ibid). I believe in its existing ad series, Merck is following along with the advertising industry's tradition of targeting Caucasian consumers, as Janet Kilbourne showed: "Minorities are still underrepresented in ads ... about 87% of people in

mainstream magazine ads are white, about 3% are African American (most likely appearing as athletes or musicians), and less than 1% are Hispanic or Asian.” (Kilbourne 28). Therefore, I believe including a more racially diverse sample of children may broaden the appeal of the commercials to some portions of the Hispanic and African-American communities who have a real need for quality STD-prevention education.

In addition to children, teens must be featured in the ads’ visuals. The vaccine is approved for use in males and females up to age 26, and children can no longer be the only group the ads target as patients. Considering that as of January 2012, only Virginia and Washington, D.C., have successfully passed legislature requiring the Gardasil vaccine for school attendance, preteens and teens also need to be included in the visuals – again, with a mix of males and females of different races being the preference for reasons mentioned previously. In my opinion, it would be medically responsible to include teens, because even if they’ve already begun to have sexual contact, it is still possible to contract another strand of the virus when contact begins with a new sexual partner. For example, an individual can be infected with a nonthreatening form of HPV, or HPV-6 (the genital warts strand), but receive the vaccination to reap the protective benefits against the cancer-causing strands, HPV-16 and HPV-18. I think this is a helpful quality to note in ad text, as well.

In addition, it is important that visual gender stereotypes are avoided when children and teens are depicted. As I mentioned in Chapter I, many scholars, such as Frith and Kilbourne, have documented that males are often shown

engaging in very active or aggressive hobbies, such as sports, while females are shown doing very passive actions, such as sitting on the floor, calmly stroking a doll's hair, or shyly giggling with friends. In addition to gendered actions, the clothing that children and teens wear and the settings in which they appear also have stereotypical connections that should be monitored. For example, females are often depicted inside the home (perhaps a nod to a female's correct "sphere"), while commercials depict male children in playgrounds, backyards, and elsewhere outside the home. Male children are also often shown in bright, bold colors, whereas female children are dressed in pastels, such as pinks, lavenders and yellows. In order to avoid these stereotypes in Gardasil ads, I would suggest that male and female children/teens could avoid or swap traditional roles, with visuals showing something like a female riding a bike or playing video games. Or children could be featured in ad visuals engaging in what some many consider to be gender-neutral activities, such as walking a dog, swimming, or waiting in line to see a movie (Kimmel).

Children's depicted actions, behaviors, and dress also should be age-appropriate. One advertising trend that surrounds specifically female children that many ad scholars find troubling is the sexualizing of female children, making them look years older than they are. Kilbourne has even gone far enough to suggest that ads that feature children in makeup and adult dress has partially led to an increase in both children's obsession with thinness and adult use of child pornography. Obviously, special care should be taken in the case of Gardasil to avoid "sexualizing" children in ad visuals, especially since one of the parental

concerns with the Gardasil vaccine is that it will cause children to engage in sexual disinhibition. Therefore, anything that makes a female child look older, such as make-up or (even slightly) revealing clothing, should be carefully avoided. Instead, the child should be shown in age-appropriate clothing, engaging in age-appropriate actions, such as playing a game, watching television, or playing with pets or toys.

In taking all of this into consideration, I would describe the overall role of children in my suggested Gardasil ad visuals to be a 50/50 mix of male and female children, engaging in a balance of active and passive hobbies, some of which are gender neutral. Of course, children cannot be the only individuals shown in the advertisements. It is important to show a diverse population of adults as well, in a variety of lifestyle roles.

### Featuring Male Consumers in Ad Visuals

One of my central arguments in this paper has been that in order to appeal to all populations at risk, more males must be shown in the ad visuals as potential vaccine recipients of all ages, and as parents. The simple fact is that males can suffer illness from HPV infections, and more male parents than ever are acting as caregivers to children in single-father households.

First, I strongly believe that male consumers age 18-26 need to be added into Gardasil ad visuals. In my opinion, this population has been completely left out of the current ad series, and in more than a year of monitoring Gardasil.com, I've never seen an adult male represented in an ad visual (as a parent or

consumer-for-self). And although young male children are occasionally referenced in website graphic, they appear much less frequently than female children.

Since males are typically associated with aggressive and active behaviors in advertisements, it may help break the stereotype to show some males engaging in passive actions, like petting a cat or reading at home. Males also frequently take on leadership roles within an ad, especially when a woman is present, creating a hierarchy in which a male is placed in a higher rank than a female. In order to avoid this, I would suggest avoiding placing men in the role of doctor in Gardasil ads.

I also believe that it is absolutely critical to show males in another role in these ads, and that is in the role of parent. Depicting both male and female parents in a way that is gender balanced and responsible will be discussed in the next section.

### Women as Caregivers & Parents: Undoing the 'Woman as Caregiver' Stereotype

Because parents are still one of Gardasil's target populations, since they can access the vaccine for prevention purposes for minors age 9-17, they must continue to be featured in ad visuals. However, I have already identified one major problem with the current portrayal of parents in the fact that they are depicted as female 100% of the time in the current ads. Since the current ad campaign features "mothers" so prominently (as reported by my study participants), and in doing so, reinforces the stereotype that women are the

preventers of illness and the caretakers of children, one way to undo these stereotypes to some degree is to feature fathers in the ads, and thus also cast them in the role of parental responsibility. As I have already shown earlier in this paper, the number of stay-at-home dads in the U.S. is at an all-time high. In addition, research shows that only 12% of the population currently resides in a nuclear family format, so having fathers in the role of caregiver/protector may appeal to males in similar roles in reality (Miley 22).

Depictions of male parents should be added responsibly into the series of Gardasil ads. Any depiction that evokes the male “Clueless Caregiver” stereotype must be avoided, and to do so, fathers should be featured as responsible parents making medical decisions for their male or female children. Fathers should not be shown making mistakes and failing at tasks, and should not be shown being scolded by females when it comes to their children. Instead, fathers should be depicted as capable of making a health-care decision, or working with their spouse/partner or doctor, to make a decision for their children. Of course, adding males to the ads as parental authorities must be carefully balanced with the females depicted in the ad. Males should not be placed in a role of authority over a female, such as the role of a male doctor alongside a female nurse or parent, which may indicate a hierarchy with a male in a position above the female.

When featuring males and females together, whether as co-parents, a parent-child relationship, a parent-doctor relationship, or as sexual partners, body language often hints at authority, and the role of who is dominant. As Suzanne

Romaine explains, “the display and positioning of male and female bodies in ads communicates messages about gender roles and relationships without saying anything,” (Romaine 252). Therefore, images should not include males placing their arms around women, a body language image that indicates a protector and person who needs protection.

The ways in which female parents are depicted also needs to change. In addition to sharing more ad space with male parents, mothers must be depicted in a way that is responsible and respectful, while avoiding specific gendered behaviors, statements, body language, and actions. Suzanne Romaine shows that “43% of the time, [women in advertisements] were involved in household tasks, 38% of the time they were portrayed as domestic adjuncts to men, and 17% of the time as sex objects. Less than 1% of the time did they appear as subjects in their own right with independent lives” (Romaine 280). Obviously, a goal here is to break female characters out of these stereotypical roles. To accomplish this, mothers should not be depicted engaging in passive actions, such as lying down, gazing dreamily, or whispering instead of talking. Gendered colors, such as pastels, should be avoided or at the very least, mixed with bold primary colors that are more often associated with males. A woman’s level of action also should be increased, and they should be shown in at least some visuals performing active motions, instead of just standing with children and smiling, as is common in the existing series of ads.

It is also important here to break women out of the “Women as Caregiver” mold, by avoiding reinforcement of the idea that only women should or do stay

home and tend to children. As Julie Wosk has also documented, throughout American cultural history, as well as the history of advertising, women are often portrayed as having a proper place in the home. Therefore, when portraying women in these Gardasil ads, I would place them in environments outside the home, perhaps in a doctor office, or having fun with their children outdoors. I would also suggest varying the role in which the female appears. Instead of portraying women as “moms,” why not as patients or doctors, professing Gardasil’s medical knowledge in an office setting? Or, if they are portrayed as a parent, why not show them working with a father or a female doctor to make a decision?

In addition to being portrayed as responsible parents, females must be depicted in the age range of 18-26, who can purchase the vaccine for themselves. I find representations of this age group to be somewhat lacking in the current ad series. Currently, women are shown engaging in a mix of hobbies that I would consider to be a blend of both passive and active. Some women paint a picture with pastel colors (passive), while others skateboard (active). Here, I think Gardasil’s portrayal of consumer-age women is executed reasonably well, showing females engaging in a mix of stereotypical/non-stereotypical activities however, I do think the role of female parent could share in this diversity.

The way females communicate with others in these ads also needs to change. It is my opinion that females in pharmaceutical ads should not continue to contribute to the advertising trend of discussing “feminine health issues” in a

way that indicates embarrassment or humiliation. Therefore, any verbal interaction that takes place between female characters must avoid whispering and displaying body language that indicates embarrassment. Any visuals that show women communicating should not visually indicate that they are in a private location, discussing an embarrassing situation behind closed doors. Doing so only furthers the stereotype that women's bodies and health situations are shameful or embarrassing, and in my opinion, that is the last thing any female should be taught by the media.

Of course, the ad's text is just as important as the story the ads' visuals tell. Below, I will outline several changes to the existing ad text with the goal of removing gendered language that is exclusive of men, and creating a more balanced view of the HPV virus and Gardasil vaccine.

#### Gardasil Ad Text: Changing the Message

Although visuals are important in an ad's ability to communicate, text obviously expresses critical information and facts to consumers. I agree with Deborah Tannen that it is important to avoid gender assumptions and gendered language in ads, which seems to be an issue in the sample Gardasil ads. One major change must take place occurs in the ad's slogan, which reads: "Now you can be one less woman affected by cervical cancer" (Gardasil). I find this slogan to be a bit out of date considering that the vaccine is also approved for males. Obviously, to be more inclusive of the relevant populations at risk, I would suggest changing this to "Now you can be one less person affected by the HPV

virus.” But the vaccine’s slogan is not the only use of gendered language that skews the ad toward women. There also seems to be a preference for the words “young girls” and “women,” with the equivalents of “young boys” and “men” mentioned with less frequency when the ads talk about prevention. Obviously, I would recommend making these references equal among males and females, or, if possible, use gender-neutral words, such as “children,” “consumers” or “patients.”

Inclusive or gender-neutral language also must extend to references of “parents.” While the sample ads refer to “parents,” not “mothers” or “fathers,” the word “parent” becomes gendered when it is paired with a visual of a female, transforming that word “parent” into a reference to a “mother.” This happens repeatedly in the current Gardasil ads, with the word “parent” reinforcing this individual’s role as a caregiver in accessing the vaccine for a child. It is important to make sure any references to “parents” are balanced with a mix of male and female images to appeal to a broader audience.

The specific medical information presented in the sample ads is also skewed toward women. For example, in the ad pulled from Parade, bolded text in the ad reads, “In girls and young women ages 9 to 26, Gardasil helps protect against 2 types of HPV that cause about 75% of cervical cancer cases” (Parade). However, this ad presents no statistics on HPV prevalence in males. When it comes to advertising, it is important to note that as an FDA rule, pharmaceutical companies can only advertise their products for the illnesses the FDA has approved them to treat (even though doctors are legally allowed to prescribe the

same drugs to treat other conditions). Currently the FDA has approved Gardasil for the prevention of cervical cancer, vulvar cancer, and genital warts in females, and genital warts in males. I would therefore suggest adding in a statement such as, “Gardasil can prevent males from 90% of cases of genital warts” to balance out the ad’s persuasive information by citing this specific reason why males should consider purchasing it. Although FDA rules restrict mentioning that the vaccine can prevent additional cancers, such as anal and penile cancer (even though medical research has shown that link), I do think it would be appropriate to add a brief mention that “research is currently under way to find possible connections between HPV infections and other types of cancer.”

Also, as I have discussed previously, the facts and information presented in the sample ads, in my opinion and in the results taken from my sample study, poorly educates consumers on what HPV causes and how it is transmitted. For example, as recently as December 2011, the Gardasil.com website contains a tab that says “Diseases Caused by HPV” and lists them by biological sex. For females, it lists: “precancers and cancers: cervical, vaginal and vulvar. And genital warts” (Gardasil.com). For males, it lists only “genital warts” (ibid). The CDC HPV Factsheet calls out many other illnesses that can result from HPV infections, including cancer of the vagina, penis, anus, and oropharynx, as well as two illnesses – respiratory papillomatosis and juvenile-onset recurrent respiratory papillomatosis, a serious illness that can be transmitted to a newborn baby when the baby passes through a woman’s birth canal. Again, I would have to suggest including a mention here that “although Gardasil is only FDA-

approved for the prevention of genital warts, and cervical and vulvar cancer, Merck is currently investigating a connection between HPV and other cancers and illnesses.”

I also argue that it the text must include some kind of reference to the fact that HPV is sexually transmitted. Although it may be difficult for adults to accept talking about sexual behavior in relation to children, I agree with Patton when she suggests that “kids aren’t embarrassed to have sex, so why should we stop making them embarrassed to have safe sex?” (Patton 52). As the study on the sample ads showed, audiences are clearly confused about what the virus is and how it is transmitted due to the facts that are left out of their ads. I understand that advertisers here may be walking a fine line in not wanting to scare parents away by associating their children with sexual activity; however, I believe that very carefully chosen language can soothe some of these fears. The reason I believe it is imperative to add in this fact deals with the Herd Immunity strategy, and the fact that this vaccine must be administered prior to beginning sexual contact. Perhaps including a statement like, “I got my child vaccinated with Gardasil because even though he’s still years away from dating – and even thinking about sex – *now* is the time to protect him.” I think a statement like this would not only add the educational element of talking about what kind of infection HPV is, but reinforce to parents that now is the time to take action.

Another aspect of the text that must be changed in order to be more gender balanced and inclusive of relevant populations is the fact that much of the language in the sample ads directed to parents, regardless of what type of

publication in which the ad appeared. For example, the ad taken from Parade includes a paragraph on the vaccine's side effects, and it is easy to see here that the language is directed to parents: "Fainting can happen after getting Gardasil. Sometimes people who faint can fall and hurt themselves. For this reason, your health-care professional may ask your child to sit or lie down after 15 minutes after your child gets Gardasil" (Parade). Obviously, I think this should change and be more inclusive of those adult men and women who may be purchasing the vaccine for themselves, especially in light of who is reading Parade. This weekend magazine appeals to a broad age range of males and females, including young adults who are old enough to purchase the vaccine for their own use. Evidence of this can be found by looking at Parade's cover, which regularly features younger stars, including *Harry Potter's* Daniel Radcliffe in January 2012, "Glee" actor Cory Monteith in June 2011, and teen singers Miley Cyrus and Taylor Swift, in March 2010 and October 2010, respectively. Therefore, I think it would be a perfectly appropriate change to suggest altering one line of this paragraph that would help make it appeal to all audiences, reading: "For this reason, a patient may be asked to sit or lie down for 15 minutes after the injection."

#### Other Suggestions for Improvement

In addition to making changes to ads themselves, since this cultural studies/social sciences approach looked at ads and the culture that produced them, I would also like to briefly mention that changing the culture that surrounds

the advertising industry may also help in making the pharmaceutical ads more responsible in both fairly educating the public on illnesses as well as promoting images of males and females through the mass media that are respectful.

One solution I can suggest is to make diversifying the advertising industry so it truly reflects the various populations it targets. Suggestions here would be to include more females and minorities in the planning of ad campaigns. Janet Kilbourne has already shown that the workforce at many top ad agencies are heavily skewed with Caucasian employees despite the fact that minorities are a growing population in the marketplace. “Ethnic minorities will soon account for 30% of all consumer purchases. Nonetheless, many consider minorities to be underrepresented in advertising agencies. African-Americans, who are over 10% of the total workforce, are only 5% of the advertising industry” (Kilbourne 28). Judy Temes echoes this, showing that the advertising industry “remains heavily male. A salary gap persists even at the highest levels, with female CEOs of the largest agencies earning an average of \$225,000-\$400,000 less than their male counterparts” (Temes 2).

Some advertisers, such as the New York-based JWT advertising firm, are beginning to recognize their use of gender stereotypes and are actively making strides to change the way they depict males and females in ads. In Chapter Two, I very briefly mentioned that Kotex worked with JWT to create a new ad campaign for the U by Kotex line of tampons and maxi-pads that challenged some of the frequently seen gender stereotypes in feminine hygiene ads. In one of these commercials, a female narrator dressed in all black makes fun of how

some pad commercials demonstrate absorbency of their product, remarking, "The ads on TV are really helpful because they use that blue liquid, and I'm like, oh, that's what's supposed to happen" (see fig. 27). She also points out how ridiculous women look in other tampon commercials, often dancing in white dresses or running down beaches. When one U by Kotex commercial was banned from television for using the word "vagina," JWT Advertising and Kotex partnered to create a "Declaration of Real Talk" petition on the UbyKotex.com website, which vowed "to defy societal pressures that discourage women from speaking out about their bodies and health" (Newman B3). For every signer, Kotex donated \$1 to Girls for a Change, a nonprofit that encourages teens to become active in championing social change for women.

### Conclusion

Overall, my investigation into studying gender in pharmaceutical advertisements using a cultural studies/social sciences method yielded several interesting results that I believe are worth additional discussion at this point.

First, and perhaps most importantly, I believe the findings in this dissertation has provided support for my argument that a blended cultural studies/social sciences research approach can be invaluable to those studying the use and effects of gender in pharmaceutical advertising. I strongly believe that in the case of advertising – which so many scholars insist is both a reflection

of and reinforcement of our culture – one would be remiss in studying one half of this relationship and not the other. If a cyclical relationship really does exist between the advertising and the culture that produces and consumes it, we must study the full circle in order to produce complete research.

Without the cultural studies/social sciences perspective, the extension of this inquiry would have ceased after the sample study results were presented. There would have been little opportunity to use those findings as a starting point to lead into a larger investigation as to how and why Merck used gender depictions the way it did in its Gardasil ad series. There surely would not have been the opportunity to connect these findings with Merck's troublesome history in advertising, and investigate the idea that Merck was using these stereotypes to target a specific consumer population.

Second, this study has provided evidence suggesting that regardless of motive, the advertising industry continues to perpetuate specific visions of women's role in the family, pointing to them as the caregiver and medical decision makers for children, even though statistics show that caregiving duties are increasingly split among parents. Although some advertisers for companies like Kotex have occasionally try to step out of the box and make changes in the way that women are depicted in pharmaceutical/medical ads, it is unclear at this time if Kotex's U by Kotex campaign took up the issues of challenging gender stereotypes because doing so truly reflects the company's values, or if creating this out-of-the-box campaign was something done as a tactic to capture the

attention of the consumer. In this case, only time and future monitoring of this company's use of gender will tell.

A third key learning that can be taken from this study is the fact that pharmaceutical companies truly are businesses, and like every other business, those within the health-care industry have the goal of generating revenue. As this study into Merck's Gardasil has provided evidence for, the rhetoric produced by pharmaceutical companies is just that: persuasive messages designed to appeal to a certain population for a reason. Future scholars in pharmaceutical rhetoric are encouraged to look at the company history and fiscal goals that also may have influenced a text's production. Speaking of future scholars, I believe this dissertation also raised several points that may serve as valuable suggestions for additional research within the Texts and Technology field, and possibly even other disciplines. While gender was a huge focus of study here, the topic of racial diversity of those featured in pharmaceutical ads did get raised several times in connection with both Gardasil advertising, which primarily showcased Caucasian and Hispanic individuals. I believe there are opportunities here for additional research that questions how a pharmaceutical company can appeal to an even more racially diverse audience, as well as if a pharmaceutical company has any ethical responsibility to appeal to racial minorities, considering the lower level of STD-prevention education some groups of minorities receive in the United States. I also believe that areas of opportunity for research also exist around Gardasil's broadcast advertisements. While this dissertation was limited in space to examining mainly print and digital advertising texts, television

commercials have also been a huge part of Gardasil's "One Less" campaign. Dedicating an entire study to these broadcast ads may provide additional insight into Merck's use of gender representations. Additionally, a final suggestion for future research would be a comparison of the gendered rhetoric that surrounds Merck's Gardasil vaccine, and that of GlaxoSmithKline's Cervarix, a similar cervical cancer-prevention vaccine that received FDA approval in 2009.

## **APPENDIX A: IRB SUPPORTING DOCUMENTS**

**1) Protocol Title:** Data Collection on the Role of Educational Rhetoric in Pharmaceutical Advertisements

**2) Investigator(s):** Jennifer Fickley-Baker

**3) Objectives:** This study is a very small part of my dissertation. It would actually be used to provide data for a sample case I'm using to support a much larger argument. The study will be used to demonstrate how pharmaceutical advertisements "educate" consumers on what an illness is, how it is transmitted, its symptoms, whom it affects, etc., as well as what a drug does to control the illness, and who the drug is applicable for. Participants will be emailed two drug advertisements to review (one print ad, one web ad). These advertisements are for a real vaccine, however for the purposes of this study, the vaccine name and illness name have been changed to a nonsensical name. After consumers view these ads, they'll be asked to answer a set of questions testing their knowledge on the illness and drug, as well as the relevant patient groups they feel the ad is targeting these messages to. Next, the consumers will be told that the "OncoVax" vaccine is really Merck's Gardasil vaccine, and "DOV virus" is really Human Papillomavirus. They will be given a fact sheet from the CDC on the causes, symptoms, and effects of this virus. After having a few minutes to review, the participants will engage in a virtual focus group discussion to talk about if they feel the Gardasil ads accurately and responsibly portray the illness, the vaccine, and the consumer group at risk for contracting this illness. (See my response to 7D for more detail on the types of questions that will be used in this study, and what will be done with the data).

**4) Background:** Historically there has been what many consider in the medical community to be a flaw in communicating health information only to the persons most at risk for an illness, often based on stereotyping and other non-scientific means – instead of communicating to various consumer groups at different levels of risk. Researchers in the past have particularly shown this to be true in the case of racial minorities and homosexuals, who in the past have been portrayed by the media as "illness spreaders" instead of "illness sufferers."

I think that Merck's Gardasil vaccine will be an excellent sample case to test, as the vaccine was originally developed to protect teenage girls against the HPV vaccine – even through males and females of any age are at risk to contract and suffer related illnesses from the HPV virus. Although the vaccine was eventually approved for use in teenage boys (two years after gaining FDA approval for use in females), the vaccine continues to be advertised as a vaccine for women, even though men can contract and pass the virus, and suffer unique cancers from it.

I'd like to do this small study to support my investigation into how seriously the use of gender can affect an audience's perception of an ad. Study results should

show that an audience is influenced by the use of gender in an ad, and from here, I will investigate the history of where certain gender stereotypes come from, the effects they have in advertising as well as in our society. I further show that this specific drug company, Merck, has a history of using gender stereotypes in its ads, and will argue that this company specifically does so in order to target not those most at risk for an illness, but those only most likely to purchase a drug.

**5) Setting of the Human Research:** Ads and the questionnaire will be delivered electronically to participants, so they are free to examine them in a private setting. The second part of the study, the focus group, will be conducted via conference call to protect the subjects' anonymity.

**6) Resources available to conduct the Human Research:** Paper, pens and photocopies of the print ads are the only resources needed to conduct this study.

## 7) Study Design

- a) **Recruitment Methods:** 10 people will be selected for this study via Quota/Convenience Sampling, as I need participants that fit in two demographics (see point B). I will request assistance via email from acquaintances who fit into the appropriate audiences. (See the attachment titled "RECRUITMENT EMAIL" for the exact recruitment message participants will receive).
- b) **Inclusion and Exclusion Criteria:** Inclusion as a participant in this study would require that the participants meet either of the following criteria: A) They are a consumer between the ages of 18-26 who make medical decisions for themselves, or B) They are a parent/guardian who makes medical decisions for a minor(s) age 9-17. Individuals fitting either criteria will be placed in one participant group (there are not separate groups).
- c) **Study Endpoints:** The participants will be asked to read and give feedback on certain qualities of two sample pharmaceutical ads. They will be asked about specific elements that build the ad's rhetoric that a consumer needs to take *this* drug, as well as how they feel the ad shapes *who* a relevant consumer is.
- d) **Procedures involved in the Human Research:** A group of participants age 18-26 (who can purchase the Gardasil vaccine for either themselves or a male/female child age 9-17) will participate in a two-part study that will involve the completion of one multiple choice survey and one focus group. First, participants will receive, via email, two pharmaceutical ads to review (one is a print ad, the other is a web ad – see attached docs: Web Content #1, Web Content #2, Print Ad #1 and Print Ad #2). Both the brand name of the vaccine and the name of the pharmaceutical company have been changed in order to replicate the initial educational process when a consumer encounters an ad for a new product for the first time. After having a few minutes to review the ads, the participants will be asked to

take Survey #1 (also attached in this email). This Survey #1 will be a 10-question multiple choice survey that will test how successfully an ad “educates” a potential consumer on an illness and a new vaccine. This survey will test if the participants were or were not able to glean critical medical information from the ads, including who the vaccine is intended for, and what illness it treats (genital warts, cervical cancer, anal cancer, etc). After the participants are done filling out this survey, they will return it to me via email by sending it to [jfickley@aol.com](mailto:jfickley@aol.com). After I receive their survey, I will then email a debriefing statement to tell them that the virus and vaccine they read about in Part #1 are really the existing Gardasil vaccine and HPV virus, and that the names of both were changed in order to gauge the educational aspects of the ad. This email will include directions on Step #2, and a CDC Fact Sheet on the HPV virus that includes facts on who HPV affects, the cancers HPV can cause, and how the HPV virus is transmitted. After the participants have a few minutes to review this fact sheet, participants will then dial in to a virtual focus group conference call to answer 10 additional questions. These 10 focus group questions will collect data on several things, including: 1) the level of personal risk participants now feel after reading the medical facts related to the virus; 2) the populations participants feel are at real risk for virus contraction and vaccine access; 3) their thoughts on how well Merck’s Gardasil ads depict who is at risk for the virus, and who is responsible for vaccine purchases; and more. The data collected from the multiple choice survey and the focus group will be compared and contrasted to see overall how well Merck’s Gardasil ads present accurate medical information to consumers on who is at risk for HPV, who can access the vaccine, how the HPV virus is spread, and what illnesses HPV causes. Additional focus group data may provide insight into how the ads’ use of males and females in ad visuals’ affect the participant’s views of who the HPV virus affects. Overall, this data will be used to support my argument that gender does, in fact, affect a consumer’s view of an advertised product. I then continue to support this argument throughout the rest of my dissertation by citing other research studies and authors who show how damaging the mis-use of gender in advertising can be.

- e) **Data management:** Data will be collected and analyzed, then shredded for privacy protection. Email addresses will not be kept on file, and all participant email addresses will be deleted after the questionnaires from Part #1 are returned and Part #2 directions are emailed out to participants.
- f) **Provisions to monitor the data for the safety of participants (Required when Human Research involves more than minimal risk to participants.)**
- g) **Withdrawal of participants:** Participants are free to withdraw at any time.

8) **Risks to participants:** No more than minimal risk.

**9) Potential benefits to participants:** May help participants view advertising more critically and ultimately may contribute to better advertising practices in the field of medicine.

**10) Provisions to protect the privacy interests of participants:** The quantitative study will be done anonymously and no personal information (name, address, age) will be requested other than the stipulation that you must be 18 years or older to participate. Participants can choose to take the surveys online at a location where they are comfortable. . During the focus-group portion, participants will be reminded not to use personal identifying information, such as names, nor are they to reveal any real-world examples from their own lives about medical conditions or illnesses.

**11) Provisions to maintain the confidentiality of data:**, No personal information will be used in the data reporting. All documents will be shredded after use.

**12) Medical care and compensation for injury: N/A**

**13) Cost to participants: N/A**

**14) Consent process:** The consent (with attached study materials) will be emailed to participants that expressed an interest in the study and meet inclusion and exclusion criteria. They can contact the PI or faculty advisor if they have questions. They must consent in order to participate in the study. This study qualifies for “a waiver of written documentation of consent” so no signatures are required.

**15) Process to document consent in writing:** This study qualifies for “a waiver of written documentation of consent” so no signatures are required.

**16) Vulnerable populations (Pregnant Women, Minors, Prisoners, Decisionally compromised adults, others): N/A**

**17) Drugs or Devices: N/A**

**18) Multi-site Human Research: N/A**

**19) Sharing of results with participants:** Participants will be given my email address and instructed that they can contact me if interested in receiving results, which will be available after Jan. 21, 2012.

## **APPENDIX B: RECRUITMENT EMAIL**

Hello-

I'm a graduate student in the University of Central Florida's Text & Technology program, completing a dissertation on how the information and visuals presented in pharmaceutical advertisements impacts a consumer's view of an illness and a vaccine.

I'm currently looking for male and female consumers age 18-26 to participate in a 25-minute, two-part research study on this topic on Jan. 20, 2012, at 12:45 p.m. Participation would entail looking at a series of ads, and then responding to a brief questionnaire. You'd then be asked to review one additional document listing the medical information on a specific illness, and answering a few additional questions via anonymous focus group conference call immediately afterward.

As the researcher on this project, my end goal is to see where information gaps lie in these sample ads, and to test if the ads are accurately expressing the information necessary for consumers to make an informed purchase decision.

Please let me know via email at [jfickley@aol.com](mailto:jfickley@aol.com) if you would be interested in participating.

Sincerely,  
Jennifer Fickley-Baker  
Graduate Student  
University of Central Florida  
Phone: 407-257-9065

Faculty Advisor  
Melody Bowdon

## **APPENDIX C: PART 1 ONCOVAX SURVEY**

1. My biological sex is:
  - a) male
  - b) female
  
2. Do you currently make medical decisions for a minor child age 9-17?
  - a) yes
  - b) no
  
3. From the advertising materials supplied, I feel I have an adequate knowledge of human oncovirus type 1's transmission, symptoms, and side effects.
  - a) Strongly disagree
  - b) Disagree
  - c) Neither agree nor disagree
  - d) Agree
  - e) Strongly agree
  
4. According to what I've learned in these ad materials, the age of those most at risk for contracting human oncovirus type 1 are \_\_\_\_\_. (Choose all that apply).
  - a) babies (who may contract the virus during childbirth)
  - b) children
  - c) teenagers
  - d) adults
  - e) senior citizens
  
5. According to what I recall from these advertisements, human oncovirus type 1 spread \_\_\_\_\_. (Choose all that apply).
  - a) through bodily fluid during sex
  - b) through genital area skin-to-skin contact
  - c) I'm unsure how the virus is transmitted, or this information was not included in the sample ads I read.
  
6. According to what I recall from these advertisements, other than the vaccine, I can protect myself from contracting the virus by \_\_\_\_\_. (Choose all that apply).
  - a) practicing safe sex (by methods such as using condoms)
  - b) practicing abstinence
  - c) getting the Oncovax vaccine prior to beginning in sexual contact
  - d) I don't recall reading this information, or it may not have been included in my sample ads.
  
7. According to these advertisements, symptoms of the virus may include (circle all that apply)
  - a) no visible physical symptoms
  - b) genital warts
  - c) increased risks of certain cancers for women

d) increased risks of certain cancers for men

8. According to what I learned in these advertisements, conditions related to human oncovirus type 1 infections are \_\_\_\_\_. (Circle all that apply).

a) anal cancer

b) cervical cancer

c) genital warts

d) head and neck cancers

e) vulva cancer

f) vaginal cancer

g) warts in the throat

h) unsure of related conditions, or this information was not included in my sample advertisements

9. Based on the text and visual images in these ads, I feel the consumers these ads are targeted to are \_\_\_\_\_. (Circle all that apply).

a) mothers/adult female caregiver

b) fathers/adult male caregiver

c) female consumers who can purchase the vaccine for themselves

d) male consumers who can purchase the vaccine for themselves

10. Based on the text and visual images in these ads, I feel the biological sex most at-risk for contracting human oncovirus 1 are:

a) males

b) females

c) both males and females

## **APPENDIX D: PART II FOCUS-GROUP QUESTIONNAIRE**

## **INTRODUCING THE ILLNESS/VACCINE**

1. Considering the fact sheet you just received, do you believe that these ads do or do not depict an accurate portrayal of the HPV virus?
2. Do you feel the ad is misleading consumers by omitting some details? If so, which details would you like to have seen included?
3. Who do you feel the ad was targeting?
4. Do you feel these ads target consumers of both genders? What about decision makers of both genders?
5. Do you feel these ads are exclusive of some groups of potential consumers? If so, what groups do you feel are left out?
6. Looking at the information presented in the ads, which population do you feel Merck portrays as being responsible for preventing the spread of the illness?
7. Do you feel gender stereotypes are included in these ads? If so, which stereotypes are used and how are these stereotypes being expressed?
8. Do you feel that it is a stereotype that advertisers assume parents making medical decisions for minors?
9. Have you seen these same stereotypes used in ads for other products? Where else have you encountered these stereotypes? In television shows? Media? Books? Etc.?

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