MEDICAL SOCIOLOGY SECTION OF THE ASA

Summer 2016

Volume 52, Issue 4

Medical Sociology Newsletter

NOTES FROM THE CHAIR

By Kristin K. Barker kbarker@unm.edu

Inside this issue:

Special points of interest:

- Announcement of 2016 Medical Sociology Election Results—page 8
- A focus on Infectious Disease:
  - ◊ Rosemary Taylor and Andrew Noymer outline sociological approaches to infectious disease
- Become a student editor!—see page 8

It will not be long before we meet in Seattle for the 111th ASA Annual Meetings at the Washington State Convention Center and Sheraton Seattle Hotel. The meeting dates are August 20-23, 2016. The preliminary program is available online at http://www.asanet.org/AM2016/preliminary_program.cfm.

The Medical Sociology Section activities take place on Monday, August 22 and Tuesday, August 23. However, there is one event early Saturday evening that will be of great interest to many of you. *Forging Meaningful Relationships between Sociologists and NIH* is the brain child of Section member Shobha Srinivasan (Health Disparities Research Coordinator, Office of the Director, Division of Cancer Control and Population Sciences, National Cancer Institute). Shobha's co-conspirator Mike Spittel (Program Officer/Health Scientist Administrator OBSSR/NIH) will attend the meeting as well. The purpose of this gathering is to discuss changes in the priorities at the National Institutes of Health and recent opportunities for social science research. In addition, NIH is eager to hear from sociologists about research areas that might need more investment or attention. The meeting will allow NIH and sociologists to discuss gaps in knowledge, science, and skills; steps needed to address those gaps; the kinds of sociological data and measures that are required to address critical challenges in health, health care and health care delivery. The session will be on Saturday, August 20 from 6:30-8:15pm and is currently listed in the program as "National Institutes of Health (David Takeuchi)". Light snacks and wine will be provided. A special thanks to Section member David Takeuchi (Boston College) for helping make this event a reality. Please take advantage of this unique opportunity.

We will honor the Section's award winners at our Awards Ceremony and Reeder Address on Monday from 2:30-4:10pm. Allan Horwitz is the recipient of 2016 Leo G. Reeder Award. The title of Professor Horwitz's Reeder Address is "Social Context, Biology, and the Definition of Disorder: Some Implications for Medical Sociology." Come and celebrate with all our award winners, and catch up with colleagues, at the Section's Joint Reception with the Section on Mental Health on Monday evening from 6:30-8:30.

Professor Horwitz has graciously agreed to have a lunch meeting with graduate student Section members before his Reeder Address. Interested graduate students need to RSVP by emailing Tania Jenkins (tmjenkins@uchicago.edu).

All the Section's regular Sessions are scheduled for Monday and Tuesday. After sorting through many high-quality papers, the Session organizers have put together six vibrant Sessions. The Section Roundtables are from 8:30-9:30 Tuesday morning. Do let this less-than-perfect time slot discourage you for attending. Roundtables tend to be more interactive than regular Sessions and can be especially useful for getting and giving feedback to authors of papers that are in the early stages of development. This year there are fewer Roundtables but the content of each table is more focused. The Business Meeting will start right after the Roundtables and run from 9:30-10:10.

It promises to be a great meeting, and I hope to see many of you in Seattle.

Teaching

Laura Senier l.senier@neu.edu

I'm teaching an undergraduate sociology of health and illness class this fall, and I'm in a scheduling block where the class period is too short to show a video and leave adequate time for discussion. I'm therefore investigating options for "flipping the classroom," i.e., expecting students to watch a video outside of class and come to class prepared to discuss it. This spring, I posted a message to the listserv asking if any of you have tried it, and if so, what benefits or pitfalls you've encountered.

A serious challenge that several of you noted is ensuring that students take the films seriously and evaluate them as rigorously as they would a written text. To that end, many of you supply discussion questions in advance, to focus their attention before they view the film. Several of you also administer a short quiz afterwards (in class or on Blackboard) to check that students have completed the assignment, or to assess comprehension. In this column, I'll highlight some online resources that make some of these strategies easier.

Door #1: Live Tweeting and Storify

In this scenario, you supply discussion questions in advance and a hashtag that students can use to live-tweet their responses (or anything that comes to mind as they watch the film). Suppose, for example, you wanted students to watch this 25-minute documentary about the impacts of the Zika virus (https://www.youtube.com/watch?v=96KnaIlK4eE). You would supply the video link and a hashtag, e.g., #SOC3441Zika. You and the students would need to create free Twitter accounts if you don't already have them.

A potential drawback to this strategy is that you (and the students) may find yourselves overwhelmed with the volume of tweets that come in. Storify is a free web platform that allows you to quickly download and categorize materials from the web. From within the Storify environment, you can quickly search for the hashtag, import the tweets, and then organize them in themes you might want to touch on in class discussion. You could also create a word cloud (using Wordle, or a similar tool) that quickly highlights the most common words or topics from the students' tweets. Storify also allows you to interleave other web-based materials along with the tweets, so you could move back and forth between the themes that arose in the students' tweets and the original video clip, or even jump to other materials (e.g., linking to videos about other recent epidemics). You can then project your Story (as you would a PowerPoint slide deck) to guide in-class discussion.

Door #2: Kanopy

Some of you raised concerns about copyright, or generally ensuring that students can easily access the films if, for example, they don't want to pay for a NetFlix account. Jessie Daniels and Susan Bell tipped me off to a service called Kanopy, an online repository of videos on many different topics (including the ever-popular Unnatural Causes series on health inequalities). Check to see if your institution subscribes to Kanopy, because if so, your students can log on with their student ID and password to watch films anywhere, on or off campus.

Door #3: Zaption

This is a web tool that embeds your discussion questions and/or post-viewing assessments directly in the video. You can create a free account and then bring in a video (from Youtube or another digital platform). There's a very easy to navigate interface that allows you to stop the video at desired spots and pose a question that students should answer before proceeding. Questions can be multiple choice or open ended; you can also ask them to draw a response or launch a threaded discussion. You then email the link to the students or post it on Blackboard. Students do not need Zaption accounts to watch the movie; they just click on your link, watch the film, and answer the questions. Once they have done so, the site will generate a report showing you how students answered the questions. For multiple-choice quizzes, the free account gives you very easy to read summaries. In larger classes, this might become unwieldy with open-ended responses, but if your institution has a subscription to the Pro account, you can dump all of those responses to an Excel spreadsheet (or an environment like Storify) to analyze and prep for your in-class discussion.

Thanks to all of you who responded! I'll be test driving some of these strategies this fall and would be happy to let you know how things turn out. In the meantime, if you have other resources, please send them my way!

www.twitter.com

www.storify.com www.zaption.com

Career & Employment

Miranda Waggoner mwaggoner@fsu.edu

As someone whose work focuses on reproduction and emergent health risks, I have been fascinated with public health responses to the Zika virus – including government recommendations for women to avoid pregnancy and recent calls for an Olympic Games venue switch. Are medical sociologists at the table in these deliberations? I hope so! Medical sociology research matters to public health and intersects with it at various angles. Medical sociologists are often at the forefront of launching trenchant critiques of public health campaigns and health promotion tactics. At the same time, we share common interests with public health scholars, such as attention to health disparities and the social determinants of health and disease. In this issue dedicated to disease outbreaks and epidemics, I want to highlight public health career opportunities for which many medical sociologists are nicely situated.

The Centers for Disease Control and Prevention (CDC) hosts a Public Health Training site that includes information for fellowship opportunities and public health employment for various career stages: https://www.cdc.gov/fellowships/. This site contains information about fellowships and training that aim to open up public health career opportunities in areas such as applied epidemiology, health statistics, minority health, global public health, and health policy, among others. Additionally, I want to spotlight a network called The Spirit of 1848: http://www.spiritof1848.org/1848.htm. An official caucus of the American Public Health Association, The Spirit of 1848 is dedicated to social justice and public health, and the associated listserv – which you may join without officially being a member of APHA – sends out occasional employment opportunities. If your research is in the area of health and social justice, or if you are interested in a public health academic or applied job, this resource might be attractive. Finally, APHA sections send out position announcements as well, although receipt of these requires membership.

Student News & Views

Rachel Cusatis rcusatis@uwm.edu

Papers, projects, grades, and deadlines have are finally turned in and accomplished. What seemed like only a figment of the imagination for months has arrived: summer! For many graduate students, summer can be a confusing time. Do I reward myself for all my hard work throughout the year and set down the books for a month or two? Or do I get ahead and hop right into coursework and research projects for the next academic year? As always, someone with more wisdom than myself has blogged about this topic to help put our conflicted minds at ease.

If I had to choose one word to summarize the advice within each of these articles and blogs below, it would be "balance." Balance between self-care and academic preparation. Summer is a great time to recharge the relationships, health, or hobbies we are quick to neglect during the school year. It's important to revisit these things during the summer without guilt. At the same time, neglecting our duties in the academic world will only make for a more gruesome September. In addition to stressing balance, these articles also emphasize the importance of planning. Having a plan about the self-care and academic goals you hope to accomplish in the summer will increase your chances of achieving that balance. For more specific advice, check out some of the articles below:

- An Inside Higher Ed Piece about how graduate students can get the most out of summer: https://www.insidehighered.com/advice/2014/03/31/essay-how-grad-students-can-get-most-summer
- The American Psychological Association's advice on how graduate students can have a fun and successful summer: http://www.apa.org/gradpsych/features/2010/summer.aspx

So have at it, and if you care to share, I'd love to hear which piece of advice you found the most/least useful and if you have any summer advice yourself!

Happy Summer to all in the Medical Sociology Community!

As always, I'd love to hear from you! To share your experiences with me and the Medical Sociology Community through the Student News and Views column, or if you have ideas about interviewees for this column, please contact me at: rcusatis@uwm.edu

Don't forget to check us out on:

Facebook: ***MedicalSociologyASA***

Twitter: @MedicalSocASA

Health Policy

Sigrun Olafsdottir sigrun@bu.edu

The Kaiser Family Foundation is a U.S.-based non-profit organization that focuses on major health care issues facing the U.S. as well as the role America plays in global policy. Their webpage provides various information and research findings related to health related issues in general, and health policy in particular. Three projects may be of particular interest to medical sociologists (located under the menu option on the webpage), specifically, the *Disparities Policy Project*, *Global Health Policy*, and *Women´s Health Policy.* First, the Disparities Policy Project conducts research and policy analysis that provides insights and understanding into disparities in health care that are impacting vulnerable groups, for example based on race and ethnicity, language, income, gender and location. The section on global health policy provides information and data on what the U.S. is doing globally regarding health care, both in general, as well as in response to specific health threats, such as the Zika virus and Ebola. For women´s health policy, there is similarly a wide range of information, but what is highlighted as one of the current key issues is the legal challenges to the ACA´s contraceptive coverage requirement. There are several other topics that are likely to be of interest to medical sociologists, including health costs, health reforms, HIV/AIDS, and focus on groups with different types of health insurance status. In addition, the webpage provides very accessible facts at the state level, as well as interactive graphics on different health related issues.

http://kff.org

Guest Column: Disease Outbreaks & Medical Sociology

By Andrew Noymer, UC-Irvine noymer@uci.edu

[[*Please note that Ebola and Zika are cusomarily Capitalized, as is the Black Death and abbreviated disease names like SARS, but other diseases such as cholera, malaria, measles, etc., are not. These conventions are confusing even to those of us 'in the biz'.*]]

In this guest column, I look at outbreaks from a long-run historico-social perspective. What is a disease outbreak? A series of examples may prove more useful than a definition: HIV/AIDS, emerging in the 1980s and having killed millions since; Ebola, the largest flare-up of which occurred in West Africa in 2014–15; several hundred cases of measles in the US, the winter before last, traced to Disneyland; the ongoing Zika outbreak, most notably in Brazil, where it threatens (as of this writing) to disrupt the 2016 Summer Olympiad, and which is the putative cause of an increase in the birth defect microcephaly; SARS (sudden acute respiratory syndrome), which caused worldwide panic in 2003; MERS (Middle Eastern respiratory syndrome), a disease spread from camels that emerged in 2012; the 1918–19 influenza pandemic, which killed, by some estimates, 100 million people worldwide; the Black Death, an epidemic of plague that wiped out one third of the European population in the fourteenth century; and so on.

Ultimately, infectious diseases of humans come from animals. HIV emerged from nonhuman primates. The sylvatic reservoir of Ebola is still not fully resolved, but bats are suspected in bringing the virus to humans. Measles only infects humans — but is related to canine distemper virus, and is thought to have emerged when dogs were domesticated some 10,000 years ago. Humans have always come into contact with animals, of course, but sustained transmission of infectious diseases requires human settlements of the size that followed the development of agriculture. A band of hunter-gatherers is too small to keep a chain of infections going indefinitely. Thus, the New World was free of crowd diseases before Columbus because it was initially populated by hunter-gatherers. This despite high population densities, especially in Mesoamerica.

The two most important social factors in disease outbreaks are population density and human movement. The nineteenth century cholera epidemics that gripped European cities, notably London, Paris, and Hamburg, illustrate both. The cholera bacteria were introduced to Europe by travel — trade and colonialism increased contact between the Ganges delta, the original habitat of the bacteria, and Europe. The epidemics were made historically severe by these cities having become much more densely populated. These epidemics spawned John Snow's work, showing that mixing sewage and drinking water was the source of the outbreak. As obvious as that may seem today, it was, at the time, the nail in the coffin of the miasmatic (bad air) theory of disease, which held sway in much of the medical establishment.

Travel, including but not limited to migration, plays a major role in disease outbreaks. Germs move with the humans they infect. The last outbreak of smallpox in Europe, in Yugoslavia in 1972, was sparked by a returning pilgrim. In 2009 when the "swine flu" pandemic began in Mexico, one of the first other countries to report a case was New Zealand, about as far away as one can get. Modern air transport permits infected people to travel virtually anywhere on the planet within 24 hours, and latency periods ensure that many infected people won't show signs of disease during their journey. The yellow fever epidemic currently happening in Angola is yet another example, with cases already having been imported to China. Jet transport is not an invention of this century, but the combination of this technology and ever-denser populations around the world is a potent mix.

Population density continues to play a role in disease outbreaks today. World population has surpassed seven billion. The concern of the 1970s — of population "bombs" and, later, of "explosions" — have proven slightly overblown considered in neo-Malthusian terms of widespread famine, etc. However, the continued emergence of new infectious diseases are driven by population pressure on the environment. With human population size expected to crest in 2050 (with quite some uncertainty), there will continue to be at least 7 billion people on earth for a century or more. Disease outbreaks (MERS, Ebola, Zika) are not a thing of the 2010–19 decade; they're with us to stay (or at least until every acre of wildlands are clearcut, at which point we will have bigger problems).

What does all of this have to do with sociology? The answer is probably... everything? This column reflects my bias as a demographer: population density and migration. As well, it reflects my interest in historical epidemiology, which shows that Ebola and Zika are not uniquely twenty-first century outbreaks. They are simply the latest examples of a process that has been going on for millennia, exacerbated of late by higher population density and faster and greater population movement, and, in some instances, changes in vector (e.g., mosquito) habitat due to climate change. I could have written instead about how infectious disease outbreaks mirror inequality, hitting the disadvantaged the hardest. Or I could have taken a social-psychological tack, discussing the panic that outbreaks cause, as we have seen again and again, most recently with Ebola and Zika.

More fundamentally, the spread of infectious disease requires human interaction. For infection to occur, a pathogen must spread from one human being to another. Sometimes a mosquito is an intermediary (for example Zika, malaria, and many other diseases) and sometimes water is an intermediary (for example, in a cholera outbreak). In many cases, there is close interaction such as a sneeze (influenza), sexual intimacy (HIV), or shared needles (hepatitis C). In all cases, some pathogen (e.g., virus, bacterium, protozoan), or its progeny, that was in one person, enters another; this is a necessary condition for infectious disease outbreaks. Infection is, inherently, a person-to-person — viz., social — process. Thus, sociologists have a lot to offer to the scholarship of infectious disease outbreaks — and vice versa. If we want to understand how the people of the world are mixing with nature and with each other, there is no better field of study than infectious disease outbreaks.

About the author: Andrew Noymer is a sociologist working in public health. He is associate professor in the department of population health & disease prevention, part of the program in public health, at UC Irvine. His PhD in sociology is from Berkeley. He is the co-convener (with Stéphane Helleringer) of the International Union for the Scientific Study of Population (IUSSP) Panel on "the demographic causes and consequences of Ebola and other emerging infectious diseases".

Interview with a Scholar: Rosemary Taylor *By Rachel Cusatis*

1.) To what would you attribute your success and longevity in the field?

Probably being able to combine the practical and theoretical. I have been lucky enough to hold joint appointments in the institutions where I have worked - in social science departments and departments/schools in the health field - for most of my career. This permitted me to investigate and teach about how communities can find solutions to intractable health-related dilemmas while at the same time conducting research and pursuing my broader theoretical interests in the development of sociological approaches to political problems. Occasionally this has led to administrative overload but there have been few dull moments.

2. If you were to provide advice to upcoming scholars within medical sociology, what would your advice be?

It depends on whether you are thinking about potential topics of interest in the field today or general career advice to younger scholars. If the latter, then it must be recognized that the research world has changed since I took my first position. There is a lot more mentoring and support for junior faculty, but there is also considerably pressure on scholars of all ages to work on projects that will generate income for their institutions. It is critical therefore that young scholars think carefully about their own intellectual agenda rather than or as well as responding to prompts from their universities about what kinds of research are important.

This brings us to the second issue – questions of interest in medical sociology. I am much influenced by my own trajectory which, probably because I grew up outside the United States, has led me to think about health-related questions in a comparative and global context. However, it would be somewhat irresponsible for me to suggest that graduate students or faculty in their first position embark on large cross-national topics. Unless they have funding or a post doc or are engaged in quantitative work that they can pursue in front of a computer, such comparative work can involve a great deal of travel, and the use of qualitative methods such as interviewing and/or painstaking ethnographic work, in different countries and possibly different languages – all of which require time and money and may slow down the pace of publication. But research on the most local of projects cannot be divorced from larger trends and processes. No one working in medical sociology today can afford to ignore the fact that we live in a global economy and that local and national developments respond to and are shaped by the needs and demands of a set of international organizations, ngo's, donor nations and philanthropies – what some have called "an international health regime".

3. In a recent article, you explain that "diseases acquire durable identities, conditioned by collective imaginaries and institutional context when they first come to attention." Can you tell our readers a little more about this complex relationship and how you've seen the interrelatedness of collective imaginaries and institutional context produce disease identities in your research?

I am interested more broadly in how societies and governments assess the risk of and respond to cross-border health threats posed by peoples and products. In the article you mention I tackled the question of why several European member states screened immigrants for tuberculosis but not for HIV/AIDS. One component of my argument about the making of policy is that cultural frameworks, in this instance the "disease identities" nurtured in a particular political culture, conditioned how policymakers understood those suffering from AIDS and TB as well as how difficult it would be to curb those infections and the costs of taking action to do so; and that these perceptions had consequences for the decisions that were taken. However, once established, disease identities are not inscribed automatically on the policies of nations, nor are they necessarily universal. In my current research, a comparative study of policy-making with regard to blood-borne HIV and Hepatitis C (HCV), I am exploring the mediating roles of various factors, such as institutional structures, in the translation of disease identities into policy.

4. You've done some comparative analysis across nations regarding policy adoption pertaining to health threats. What does your research say about how the U.S. compares to other countries in terms of policy adoption regarding health threats?

It's difficult to generalize about this because what countries have done about health threats covers a broad array of strategies. A country's response to one dimension of an epidemic (eg. how to stem the spread of HIV among gay men) may be forged by actors and shaped by factors different from those that propel their efforts in different spheres (eg. developing safe and affordable treatments). So there may be "winners" and "losers" or effective and ineffective responses across nations with regard to different aspects of different health threats.

However, the United States has tended to lag behind other developed democracies when it comes to its policies regarding infectious disease control at its borders. It is not the only nation whose public health strategies have become entangled with concerns about immigration. But its implementation of and calls for travel bans have been unusual as well as counterproductive. In 1987 Congress put HIV on a list of "dangerous contagious diseases," making it grounds to exclude immigrants from entering the United States. Despite two decades of lobbying by epidemiologists and other experts who said there was no scientific or public health basis for the ban and that it served only to discourage HIV-positive immigrants already in the United States from disclosing their status or seeking treatment, it was not effectively lifted until January 2010. Despite the damage this did to the reputation of the United States in the global health arena, there were immediate calls for a similar travel ban to be imposed on travelers from West Africa when the recent Ebola epidemic was discovered in 2014. Somehow the maxim that pathogens do not honor national borders, whatever the attempt to restrict them, has not been taken to heart in the US or perhaps it is simply no match for the fears so easily excited by the prospect of disease-carrying migrants. ***(Continued on pg. 6)***

Interview with a Scholar: Rosemary Taylor *(con't from pg 5)*

5. Where do you hope to see U.S. public health infrastructure progressing in the next few years?

Thinking specifically about public health infrastructure with regard to disease outbreaks and epidemics, one sees a lot of emphasis on surveillance, both nationally and internationally. Charting the course of epidemics is of course important but I would hope to see more attention to bolstering the ability of the US to mobilize its collective resources to cope with disease and illness. This would require more support to public health institutions at both the local and national level but it would also involve looking more broadly at the nature of social networks and resources available in communities. The latter can be affected—sometimes inadvertently—by government policies directed to other issues, such as urban development or unemployment, which are not on the face of it health-related issues.

6. In your opinion, what are the biggest contributions sociology can bring to national and international discussions about disease outbreaks and epidemics?

It's a long list, which could include:

- Analyzing what the call for (pandemic) "preparedness" means at the individual, community, national and international level and what the current obstacles are to achieving this.
- Studying past responses – political, economic and cultural - to epidemics so that one can develop a better understanding of the factors that have made for a successful response, in both the immediate "lesson-drawing" sense but also as part of a broader analysis of social structure and collective capacities.
- Improving our understanding of what it means to talk about "global health governance". The knee-jerk response in recent years been to blame WHO for not moving fast enough or more effectively to contain epidemics without considering the nature of the organizations, institutions and regulatory structures that are supposed to adjudicate affairs of public health at the transnational level and the extent of their authority and jurisdiction.
- Clarifying the interdependence of local, national and transnational knowledge-making, how scientific information about health and disease is generated and how it is (or is not) factored into political decision-making (the focus of my current work, so I hope it will be a contribution!)

As will be clear from this list I concur with the formulation in your question – what can sociology as a whole contribute: these analyses will be generated by collaborations among different subfields in sociology, the arguments and theoretical tools emerging in, for example, STS and political sociology, as well as medical sociology.

7. What part of your experiences in medical sociology research and teaching has been the most rewarding to you?

Engaging students in research. I enjoy teaching the how-to of research via "methods" courses which impart a series of technical and organizational skills. However, I have found that the most effective way for students to learn how to formulate research questions and to examine data and theories critically is through participation in an ongoing research project. As they engage in the work they also learn the intangibles of doing research: the interplay between independent work and group collaboration, how to analyze, communicate and make decisions, and to reflect on the research process as an integral part of the doing of the research. Watching them as they interrogate what it means to produce knowledge and to become a researcher is profoundly rewarding.

DONATE to Medical Sociology Section's Annual Book Raffle!!!

The time has come, once again, to consider donating a book to the ASA Medical Sociology Section's Annual Book Raffle. You may contribute your own (people often have extra copies of books they have written) or extra copies of other people's books that you may have received. PLEASE, CURRENT TITLES ONLY AND NO TEXTBOOKS. Remember, these donations are going to a worthy cause – to provide support for the Roberta G. Simmons Outstanding Dissertation in Medical Sociology Award. We will also accept t-shirts for the raffle, so share your school pride! Please send your donated copies to:

Prof. Danielle Bessett, Department of Sociology, University of Cincinnati, PO Box 210378, Cincinnati, OH 45221-0378

If you have any questions about potential donations, please contact danielle.bessett@uc.edu .Please send books and shirts by August 8th so that they can be transported to the ASA meeting, or you may deliver them to Danielle Bessett at the ASA. Thank you for your generous support!

PS: An overdue thank you to Anne Barrett for donating an FSU shirt to 2015's raffle!

Get Connected

Simon Geletta & Natalie Ingraham

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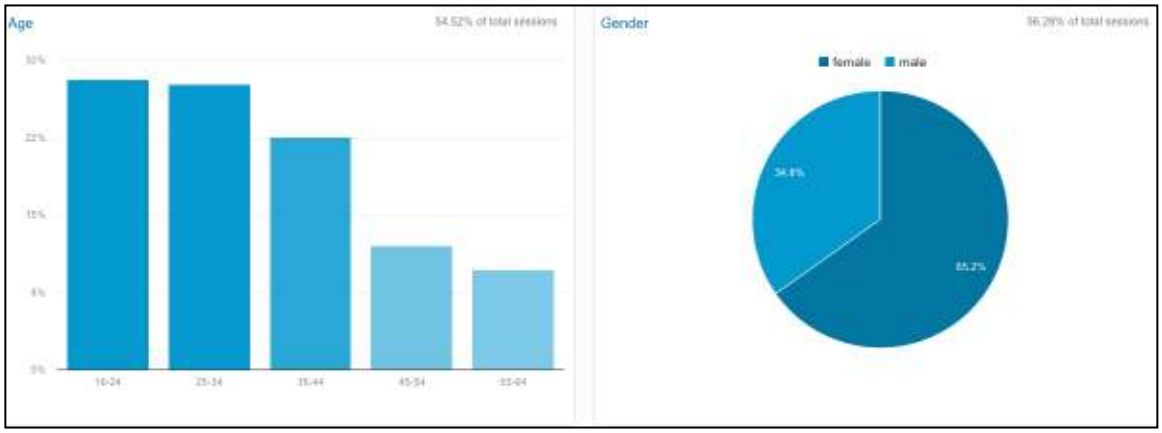
There were fewer web traffic on our medical sociology section website during this spring semester than any spring semester prior – since we started collecting data. Between the beginning of March 2016 and the end of May 2016 there ware 334 individual user visits and 398 page views. The current user count represents 20% of what we reported for the same period last year. The fact that we are moving to a new server environment and migration related outages may explain the drop. The age distribution (shown below) suggests that most visitors are of young age (perhaps student interests are drawing visitors more than faculty interests).



Please note that the age distribution is based on 55% of total sessions and the gender distribution is based on56% of total visitors. As the map below shows, we have three new members of the "top 6" country of origin of visitors. These are Italy, Russia and Singapore.

Our Facebook page remains our most popular social media outlet and is currently at an even 1500 "likes" or followers, a growth of around 500 people in the last year. Our average post "reach" varies widely depending on the post (anywhere from 28-160 shares/likes/views). The balance between the narrow gender categories of Facebook insights indicate that our page fans are identified show that we have a pretty even balance between men and women, with a few (3%) defined as another gender. Most followers continued to be between ages 25-34 (50%) and reside in the US (37%) followed by India, Pakistan and Egypt.

Our Twitter currently has 786 followers (a gain of 27 since our last issue) and we average 5 tweets per week. Our LinkedIn group (ASA Medical Sociology Network) stayed steady in our membership since last quarter and currently at 393 members, receiving 5-7 requests per month. This is a private group for Med Soc section members to network created in 2012.

Please contact Natalie (natalie.ingraham@ucsf.edu) if you have anything you'd like to post on our social media accounts!

2016 Medical Sociology Election Results

Chair-Elect: Jane McLeod, Indiana University

Secretary/Treasurer-Elect: Danielle Bessett, University of Cincinnati

Council Member at Large: Richard Carpiano, University of British Columbia

Membership Committee Chair: Corinne Reczek, The Ohio State University

Health Policy & Research Committee Chair: Thomas Mackie, Rutgers University

Nominations Committee Chair-Elect: Andrew London, Syracuse University

Nominations Committee: Elaine Hernandez, Indiana University and Emily S. Mann, University of South Carolina

Nominations Committee, Student Member: Catherine Tan, Brandeis University

Student Representative to Council: Cirila Estela Vasquez Guzman, University of New Mexico

CONGRATULATIONS TO ALL !!

THANKS TO CURRENT STUDENT EDITOR & CALL FOR NEW STUDENT EDITOR(S)

Thanks are due to **Rachel Cusatis** at UW-Milwaukee for innovative columns & insightful interviews with fascinating medical sociologists this past year in "Student News and Views." We are now soliciting applications from graduate students to hold this position for 2016-2017. The position increases your visibility to members of the section and offers an opportunity to share your ideas in the form of four columns in the newsletter. If you are interested in the position, please send an email to Ann Bell, Co-Editor, at avbell@udel.edu.

Please address the following questions in your email:

1. Why are you interested in this position?
2. What are some of your ideas for the "Student News and Views" column?
3. How might we increase student interest in the Medical Sociology Section?

A PUBLICATION OF THE MEDICAL SOCIOLOGY SECTION OF THE ASA

NEWSLETTER EDITORS: Ann Bell & Barret Michalec