

Medical Sociology Newsletter

NOTES FROM THE CHAIR

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Welcome to the new year!

I considered saying a few words about the current status of the Affordable Care Act but realized that anything I write now will be out-of-date by the time this newsletter reaches your inbox. Such is the state of things!

Instead, I will encourage all of you to submit papers to one of the section sessions we have planned for ASA 2018. The sessions cover a wide range of topics: Race, Racism, and Health; the Politics of Health; Medical Education; the Reduction of Health Inequalities; and Health, Health Care, and New Technologies. We are also co-sponsoring a session with the Sex and Gender section on Gender, Health, and Medicine. If you prefer something more relaxed and interactive, consider submitting to our roundtable session. The deadline for submissions is January 11, 2018. In addition to these sessions, we are working on plans to offer a visit to the National Board of Medical Examiners (thanks to Monica Cuddy, Kelly Underman, and friends) and have proposed a symposium on medical sociology in practice settings (thanks to Katrina Kimport). A lot to look forward to!

See inside for David Mechanic's tribute to the impressive career of this year's Leo G. Reeder Award recipient, Paul Cleary and for a series of articles on the timely topic of "Guns, Gun Violence, and Guns as a Public Health Issue."

Many thanks to Ann Bell and Barret Michalec for organizing another outstanding newsletter. If you are looking for an outlet for your creative energy, Ann and Barret's term as newsletter co-editors ends this summer. Contact me if you are interested.

Special points of interest:

- Announcement of 2018 Reeder Award Winner!
- A focus on Gun Violence as a Public Health Issue
 - ◊ Interview with Dr. Sandro Galea
 - ◊ Guest Column by David Yamane

Feeling Race
 AN INVITATION TO EXPLORE RACIALIZED EMOTIONS



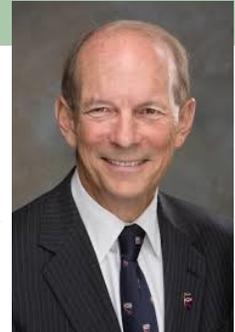
Post Notices on the ASA Medical Sociology Section List
[<MEDSOC@LISTSERV.NEU.EDU>](mailto:MEDSOC@LISTSERV.NEU.EDU)

Please note that the link to our website has changed from what it was (<http://asenet.org/medicalsociology>) to <http://www.asenet.org/asa-communities/sections/medical-sociology>

2018 Reeder Award Winner: Paul D. Cleary

Paul D. Cleary to Receive the 2018 Leo G. Reeder Award

Paul Cleary, the Anna M.R. Lauder Professor of Public Health in the Department of Health Policy and Management at the Yale School of Public Health, with secondary positions as Professor of Sociology and in the Institute for Policy Studies, will receive the 2018 Leo G. Reeder Award for a Distinguished Career in Medical Sociology, the highest honor of the ASA Medical Sociology Section. He has recently completed a ten year term (2006-2017) as Dean of the Yale School of Public Health, and continues to direct the Yale Center for Interdisciplinary Research on AIDS, an all university enterprise that has provided infrastructure support to hundreds of research and training grants involving more than 150 affiliated scientists. In his more than 300 research articles ranging widely among important areas in medical sociology and public health he has made fundamental contributions to understanding processes and quality of care in such areas as HIV and cardiovascular disease among others. These publications appear in the best journals in medical sociology, medicine, and public health including numerous papers in JHSB, ASR, Social Science and Medicine, JAMA, the New England Journal of Medicine, Milbank Quarterly and Health Affairs among others. His studies of how social, organizational, and clinical factors affect care processes have been influential not only in research but also in changing the ways care is provided and evaluated. In addition, he has had a leading role in developing and implementing new methodologies for research and evaluation, prominent among them the Consumer Assessment of Health Care Providers and Systems (CAHPS) surveys which are widely used for quality improvement by the Centers for Medicare and Medicaid Services and many other organizations and research efforts involved in improving quality of care.



Paul received his B. S. degree in Physics from the University of Wisconsin in Madison and was recruited to a graduate traineeship in medical sociology and then sociological methodology, providing him both the substantive and advanced research tools to excel in the years ahead. He received both an M.S. and Ph.D. in sociology from Wisconsin. After spending a final year as lecturer at Wisconsin, he moved to Rutgers where he was briefly an assistant research professor and then an associate research professor in the Department of Sociology and the School of Social Work between 1979 and 1982. In 1982, he moved to Harvard University as an assistant professor in the Department of Social Medicine and Health Policy and subsequently Department of Health Care Policy in the Harvard Medical School and a lecturer in the Department of Behavioral Sciences in the Harvard School of Public Health, advancing to full professor at Harvard in 1993. He continued an active professional and research life at Harvard, with appointments at Beth Israel Hospital and the Brigham and Womens Hospital, until his appointment as Dean of Public Health at Yale in 2006.

In addition to his academic, research and administrative responsibilities, Paul was Editor of the Milbank Quarterly from 1992 to 2000, and in 1998 became the Editorial Director for the Milbank Memorial Fund until 2013. He also held editorial positions over these years with the Journal of Health and Social Behavior, the Journal of Culture, Medicine and Society, the Journal of Health Services Research and Policy, Health Services Research, and Health Expectations.

Paul's early work at Wisconsin focused on studies of health behavior, on how patients perceived and responded to symptoms, how people used medical care and the management of psychiatric symptoms and behavioral disorders within primary care. He also carried out research and theoretical work on smoking and other behavioral conditions. He continued with many research studies on the impact of gender, social class and other social factors in the epidemiology of disease and care seeking but as his career proceeded he focused intensively on persons with HIV and in improving the quality of care for people with AIDS and more generally throughout the health care system. He took leadership of a key aspect of the HIV Costs and Services Utilization Study (HSCUS), the most ambitious national study of HIV care, examining how physician and clinic characteristics impacted the quality of care. He also did a major national evaluation, supported by the Robert Wood Johnson Foundation of quality improvement efforts in HIV clinics supported by the Health Resources and Services Administration.

It would be impossible to more than touch on a few of the large number of important involvements Paul has had in implementing the understanding and findings from his work and that of his collaborators. Few of our outstanding medical sociologists have had anywhere near the large influence Paul has had on advancing health research and helping to shape national and international health policy. His magnificent research on AIDS, quality of care, patient empowerment and psychiatric epidemiology sets an extraordinary standard for our profession.

Between 1994 and 1999, Paul was a Founding Member and Vice-President of Research for the Picker Institute, a national organization focused on promoting patient-centered care and improving the quality of hospital care. In 2012, he received the Picker Award for Excellence in the Advancement of Patient-Centered Care. In 2003, Paul was appointed to the National Advisory Committee of the Robert Wood Johnson Foundation's Investigator Awards in Health Policy Research Program, a group of many of the most distinguished health policy investigators in the country. After two years on this advisory committee he was selected from its 17 members to chair this group, a position he held until 2016. In this challenging task he demonstrated what was apparent in so many aspects of his work and life, extraordinary knowledge and wisdom, kindness, respect and fairness for all participants, and an impressive lack of ego.

Con't on page 3...

...Con't from page 2

Paul's many contributions have not been unnoticed and he has received an abundant share of honors. Among them was his election to the Institute of Medicine of the National Academy of Sciences (Now the National Academy of Medicine), Election as a Distinguished Fellow of Academy Health, and receipt of its coveted Distinguished Investigator Award, and appointment to numerous important advisory boards, federal study sections and foundation Boards of Directors.

Everywhere Paul has been, he has been an extraordinary friend, advisor and mentor to students, colleagues, and community persons working in health. However busy he is, he always finds time to help others seeking advice and guidance, and people seek him out as a mentor and collaborator. He mentored many of the outstanding scientists at Harvard who are now leaders in health policy research. In 1997, he received the A. Clifford Barger award for Excellence in Mentoring from the Harvard Medical School. Paul has collaborated on research and publications with hundreds of others, ranging from undergraduates to luminaries. As someone who has worked with Paul over the years, I can attest that he always carries more than his share. I constantly encounter students and colleagues from Wisconsin, Rutgers, Harvard and Yale who recount the wonderful help, support, and caring they received from Paul and the important role he had in their careers.

One cannot know a person simply by their vita. In addition to his many accomplishments, Paul, born in Toronto, Canada, had an international perspective and enjoyed experiences in other countries. As a graduate student, he spent a year as a research associate in the Social Psychology Research Institute in Mannheim, West Germany and in 1982 was a visiting professor in the department of sociology at the University of Stockholm. His later work on HIV extended his activities in global health and brought him to many countries throughout the world. One can't imagine a better ambassador.

Paul is also a pilot, and is constructing his own airplane. When we were working together in Marshfield, Wisconsin, a not easily accessible area in rural Wisconsin, Paul would occasionally fly his plane to our research site. He kindly offered me rides but I wasn't into small planes. Paul arrived safely; I ended up with speeding tickets.

During Paul's tenure at Wisconsin, we had a brilliant and dynamic student with extraordinary spirit and determination from Mississippi and Alabama in our medical sociology program, Cynthia Faye Barnett, who Paul linked up with and later wisely married. On entering the program, it was her aspiration to develop the tools for entering political office at home to bring needed reforms. Cynthia became interested in a special program on Law, Science and Medicine established and run by Professor Jay Katz, a visionary innovator in the field of law, medicine and ethics, and selected to delay her PhD studies to go to Yale for this unique program. Her participation in the program, and her prior medical sociology training, led to her 1977 paper Treatment Rights of Mentally Ill Nursing Home Residents in the Pennsylvania Law Review. Cynthia became increasingly interested in the law as a powerful instrument, returning to Yale Law School to earn her J.D. before returning to Wisconsin and completing her dissertation.

Paul and Cynthia made a wonderful pair, and when Paul moved to Boston Cynthia worked for many years for Bingham McCutchen and Goulston and Storrs. Sadly, Cynthia had a long struggle with breast cancer and passed at a far too young age. They had two beautiful children, Janet and Barnett, who have now gone on to building successful careers of their own. As a partner in a major law firm, Cynthia often had an awesome schedule, and had to put in late hours, at times all-nighters. Paul would go to the office in the middle of the night so he could return home in time for the children and dinner. This helped explain the 4am emails some of you may have received, or perhaps they still continue.

I hope this conveys the character of the person this award honors. Paul Cleary has been an extraordinary researcher and teacher in medical sociology and public health who has made massive contributions that impact the care of all of us. He has been a strong leader and model for his colleagues and students and the health field more generally in his research, teaching and professional relations. And to top it all, he is an extraordinarily nice human being.

By David Mechanic, Rutgers University

Don't forget to check us out on:

Facebook: ***MedicalSociologyASA***

Twitter: **@MedicalSocASA**



**DON'T FORGET TO RENEW YOUR SECTION MEMBERSHIP IN THE MEDICAL
SOCIOLOGY SECTION!**

Call for ASA Award Nominations

2019 Reeder Award

The Medical Sociology Section invites nominations for the 2018 Leo G. Reeder Award to be awarded at the annual meeting of the Medical Sociology Section in New York. This award is given annually for Distinguished Contribution to Medical Sociology. This award recognizes scholarly contributions, especially a body of work displaying an extended trajectory of productivity that has contributed to theory and research in medical sociology. The Reeder Award also acknowledges teaching, mentoring, and training as well as service to the medical sociology community broadly defined. Please submit letter of nomination and the nominee's curriculum vitae to Brea Perry at blperry@indiana.edu with the subject line: 2019 Reeder Award Nomination. Nominations are due by April 1, 2018. Note: If a person nominated for the Reeder Award is currently a member of the Medical Sociology Section Council, the nomination will be deferred until the person is no longer on the Council.

2018 Elliot Freidson Outstanding Publication Award

The Freidson Award is given in alternate years to a book or journal article published in the preceding two years that has had a major impact on the field of medical sociology. The 2018 award will be given to a book published in either 2016 or 2017. The book may deal with any topic in medical sociology, broadly defined. Self-nominations are permissible and encouraged. When making your nomination, please indicate (however briefly) the reason for the nomination. Send your nomination letter by email to Claire Decoteau at decoteau@uic.edu with the subject line: 2018 Freidson Award Nomination. Nominations are due by April 1, 2018. The nominator and at least one author must be current section members.

2018 Simmons Award

Nominations are being accepted for the 2018 Roberta G. Simmons Outstanding Dissertation in Medical Sociology Award. The award is given each year by the Medical Sociology section. The awardee will receive a \$750 travel grant to attend the ASA meetings and an award certificate, and will attend the Reeder dinner as a guest of the Medical Sociology section. Self-nominations are acceptable. Eligible candidates must have defended their doctoral dissertations within two academic years prior to the annual meeting at which the award is made. To be considered for the 2017 award, the candidate should submit an article-length paper (sole-authored), not to exceed 35 double-spaced pages (11- or 12-point font), inclusive of references. This paper may have been previously published, or may be in press or under review. A letter of recommendation from a faculty mentor familiar with the candidate's work is also required. Electronic submission of the paper (MS Word or PDF) is required. The letter of recommendation should be sent directly by the recommender as an email attachment (MS Word or PDF). Please send all materials to Hui Liu at liuhu@msu.edu with the subject line: 2018 Simmons Award Nomination. Deadline for receipt of all submission materials is April 1, 2018. The nominator and nominee must be current section members.

2018 Louise Johnson Scholar

The Medical Sociology Section will select a student member of the section to be the 2017 Louise Johnson Scholar. The Louise Johnson Scholar fund was established in memory of Louise Johnson, a pioneering medical sociologist whose mentorship and scholarship we are pleased to honor. The fund was made possible by Sam Bloom of Mount Sinai School of Medicine, a former colleague of Louise Johnson. The Scholar will receive travel funds up to \$500 to present at the annual ASA meetings in Chicago and attend section events. Selection will be based on academic merit and the quality of an accepted ASA paper related to medical sociology; papers with faculty co-authors are ineligible. To apply, please send: 1) a copy of your acceptance notification to present at the 2017 ASA meetings, 2) a copy of your paper, 3) your CV, and 4) a letter of recommendation from a professor who can write about your academic merit. Submissions should be sent via email, as Word documents or PDFs, to Richard Carpiano at richard.carpiano@ucr.edu with the subject line: 2018 Louise Johnson Scholar Nomination. Applications are due by April 1, 2018. The nominator and nominee must be current section members.

2018 Howard B. Kaplan Memorial Award in Medical Sociology

This award is established to support graduate students doing research in one of the substantive areas that defined the distinguished academic career of Dr. Howard B. Kaplan, namely mental health, self-concept and health, or deviance, by providing funds up to the amount of \$500 to contribute to expenses associated with attending the annual meeting of the American Sociological Association (ASA). The award recipient will be invited to attend the Reeder dinner as a guest of the Medical Sociology section. Self-nominations are acceptable. To be considered for the 2018 award, the candidate should submit a CV and letter of nomination to Richard Carpiano at richard.carpiano@ucr.edu with the subject line: 2018 Kaplan Award Nomination. Deadline for receipt of all submission materials is April 1, 2018. The nominee and nominator must be current section members.

2018 Donald W. Light Award for Applied Medical Sociology

The Donald W. Light Award for the Applied or Public Practice of Medical Sociology is given in alternate years to a book or journal article published in the preceding two years that employs the concepts and methods of medical sociology to an applied issue or problem of significance. The 2018 Light Award will be given to an article published in either 2016 or 2017. Nominations will be eligible for three years. The Light Award recognizes sociologists whose professional work or advocacy contributes to politically or ethically important challenges in health, health care, or health care policy at the national or international level. The award recipient will be invited to attend the Reeder dinner as a guest of the Medical Sociology section. Self-nominations are acceptable. To be considered for the 2018 award, the candidate should submit a letter of nomination to Debra Umberson at umberson@prc.utexas.edu with the subject line: 2018 Donald W. Light Award. Deadline for receipt of all submission materials is April 1, 2018. The nominator and at least one author must be current section members.

PLEASE NOTE THAT ALL NOMINEES MUST BE REGISTERED MEMBERS OF THE ASA TO BE CONSIDERED FOR SECTION AWARDS

Teaching Ophra Leyser-Whalen & Adelle Montebalanco

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Gunning for CUREs

The discipline of sociology is often criticized, by both students and the public, for its perceived subjectivity and studying of common sense. Course-based Undergraduate Research Experiences (CUREs) are poised to challenge these dangerous assumptions by demonstrating the empirical nature of the discipline—moving from teaching “what we know” to “how we know it”¹. The idea of gun safety as a potential public health crisis is an ample teaching tool for CUREs. Due to intentionally restricted funding, not enough research has been done on gun safety². Thus, this could be prime material for Sociology of Health classes.

Here we offer several examples of CUREs that could be integrated throughout an entire course or a multi-week module through lessons on research and public health. During a unit on “prevention,” students could survey businesses on their active shooter response training. Within the topic of “constructing risk,” students could interview faculty about perceived gun safety on campus. For instructors who would prefer to avoid human subjects research, we suggest a content analysis of a hashtag (e.g. #guncontrol). Each of these examples support a few of the dimensions commonly associated with CUREs: discovery, relevant work, collaboration, iteration, and use of scientific principles³.

References

- [1] Atkinson, M.P., Czaja, R.F., & Brewster, Z.B. (2006). Integrating sociological research into large introductory courses: learning content and increasing quantitative literacy. *Teaching Sociology*, 34(1):54-64.
- [2] Branas, C. C., Flescher, A., Formica, M. K., Galea, S., Hennig, N., Liller, K. D., ... & Ying, J. (2017). Academic public health and the firearm crisis: an agenda for action. *American Journal of Public Health*, 107(3):365-367.
- [3] Auchincloss, L. C., Laursen, S. L., Branchaw, J. L., Eagan, K., Graham, M., Hanauer, D. I., ... & Dolan, E. (2014). Assessment of course-based undergraduate research experiences: a meeting report. *CBE—Life Sciences Education*, 13:29-40.

Health Policy

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For this special issue on gun violence and public health, there are a number of data resources and pedagogical tools available. First, the National Violent Death Reporting System is a state based surveillance system sponsored by the Center for Disease Control (CDC) and available [here](#). Forty-two states have contributed data as of 2016, with longitudinal data available (ranging from 2003-2016). Data are available on the mechanism of injury (including but not limited to firearms), the type of firearm, the victim's sociodemographic characteristics and relationship to suspect, among other variables. Additionally, the CDC also sponsors the Web-based Injury Statistics Query and Reporting System, an interactive online database that offers information on fatal and nonfatal injury, violent death, and costs of injury from a variety of data sources. The Society for the Advancement of Violence and Injury Research (SAVIR) also has a number of webinars and resources focused on conducting research on firearm-related injuries, available [here](#).

For engaging students in considering global implications of gun-related violence and other types of injuries, curriculum is available through WHO (available [here](#)). Additionally, the Safe States Initiative sponsors webinars and other resources on gun-related violence within the United States, including a map with state-specific publications, available [here](#). The Gun Violence Archive, a non-profit organization, also provides national data on gun-related injuries in the United States with geospatial maps on a number of indicators (e.g., unintentional shootings, defensive use, mass shootings, etc.), available [here](#). For those with an interest in policy regarding gun violence and public health, one can consult the work of a non-profit organization, called the Brady Campaign, available [here](#).

This column benefited tremendously from the expertise of Dr. Bernadette Hohl, an expert on the social and environmental determinants of health and safety in neighborhoods at the Rutgers School of Public Health.

Career & Employment

Katrina Kimport katrina.kimport@ucsf.edu



Gun violence in the U.S. is increasingly recognized as a public health issue—and appropriately so. Public health scientists are equipped to address many of the pressing questions guns pose to our society and advocate for policy change. Medical sociologists can help, contributing theoretical and analytical perspectives that attend to the social and behavioral components of gun violence. But how do we get in the proverbial “room” with public health researchers?

One way is through employment in the public health field. In the past, this column has highlighted public health job listings (check past issues for web resources). Unsurprisingly, there is a great deal of overlap in the work of medical sociology and public health. But how does one make a case for hiring a medical sociologist for a “public health” job?

Hugh Spitler’s 2001 *Sociological Spectrum* article, “Medical Sociology and Public Health: Problems and Prospects for Collaboration in the New Millennium,” offers some ideas. Providing useful historical context on the tensions within public health, Spitler argues that “medical sociologists are uniquely equipped to assist public health in recapturing its historical commitment to social justice.” Medical sociology, he asserts, brings to public health the tools to identify and critique the *structural* causes of health problems.

And what does working in a public health setting offer a medical sociologist? From a practical perspective, the broad range of public health positions (e.g. in non-profits, government, research centers, and academic departments) may better meet job seekers’ personal and professional life needs than available positions in sociology. In terms of career and job satisfaction, drawing on my own experience, I value collaborating with public health scientists because the work often affords concrete opportunities to impact public policy in ways that further social justice.

Student News & Views

Alaz Kilicaslan alazk@bu.edu



For this issue of the newsletter, I interviewed Dr. Sandro Galea, the Dean of the Boston University School of Public Health, on his thoughts about guns, which claim more than 33,000 lives in the US every year. I have extracted here some of the highlights of his account:

Centering the discussion on mental health is a distraction from the real issue around gun-related harm: how the US is an exception in the world when it comes to availability and sheer number of guns.

NRA’s lobbying efforts largely explain why there is an absence of scientific research on gun violence as well as why large segments of lay people and politicians see and defend guns as an issue of personal freedom.

Sociological research on the culture of guns can contribute to changing the narrative from guns as an issue of personal liberty towards gun control and safety.

I also want to share a few webpages and articles I find particularly instructive and briefly discuss how each complements and extends Dean Galea’s points.

- 1.) <http://www.gunviolencearchive.org/> This is a wonderful source of information about a grim subject. Among a myriad of numbers, charts and expert opinions, one particularly struck me: In contrast to common perception, mass shootings cause only less than 1% of gun-related mortality.
- 2.) <https://www.bostonglobe.com/opinion/columns/2017/11/06/steps-can-take-gun-violence-now/Gn5827wclmotDnLPFRwSIN/story.html> This opinion piece by Sandro Galea adds more detail on what can be done to alleviate gun violence: background checks to buy firearms to keep them out of the hands of ‘dangerous’ people, including domestic abusers; requiring ‘smart guns’ that can only be used by their authorized users; and doing away with concealed-carry laws.
- 3.) <https://www.npr.org/sections/health-shots/2017/11/15/564384012/what-if-we-treated-gun-violence-like-a-public-health-crisis> In this NPR story, both in text and audio format, Alison Kodjak discusses the causes and consequences of not treating gun violence as a public health issue. It is striking to see that although guns claim as many American lives as hypertension, liver disease, or car crashes, funding for gun violence has only been minuscule compared to money spent to research these other causes of mortality.

As always, if you have any suggestion about what you would like to see in this column, please do not hesitate to contact me at alazk@bu.edu. Looking forward to your thoughts and suggestions!

Guest Column: Understanding the Social Life of Guns

David Yamane, PhD Professor of Sociology, Wake Forest University (yamane@wfu.edu)

In June 2017, the Pew Research Center reported that 70% of American adults have fired a gun at some point in their lives. That is nearly 180 million people. Looked at the other way around: A minority of American adults have never shot a gun. Like many sociologists, I was in that minority for most of my life. Consequently, until six years ago when I began studying guns, I had no idea how common and normal they are in the United States.

Seeing guns and gun ownership as normal contrasts sharply with the views of my fellow sociologists. When I tell colleagues I am studying “gun culture,” they frequently hear me saying “gun violence,” since their primary association with guns is with deviant behavior. Or they will respond, “Good, more people need to be studying gun control,” betraying the primacy of their political views over their desire for greater empirical understanding. It falls too far outside their experience with and understanding of guns to think of them in any way other than negatively. I understand this point of view, because for the first 20 years of my academic career, I shared this stance towards guns. But what can an approach to guns that recognizes their normality rather than their pathology do for medical sociologists?

Although it falls outside the scope of medical sociology proper, those considering studying guns in connection with health, illness, and injury do well to bear in mind that, on any given day in America, the vast majority of gun owners will not have any negative outcomes associated with their guns.

The best available estimates suggest that there are at least 300 million privately owned guns in some 50 million households in the U.S. today. According to the NCHS, in 2014 there were 11,008 homicides using firearms. Even using the faulty assumption that a person from a different household committed every homicide using a different gun, at most 0.022% of gun-owning house-

holds and 0.0037% of guns are “responsible” for firearms homicides. Looked at the other way around, at least 99.978% of gun owning households and 99.996% of guns are not involved in homicide in any given year. Even if we add non-fatal firearms injuries (73,505 in 2013) and suicides (21,386 in 2014), only 0.035% of guns and 0.21% of gun-owning households at most are “responsible.” Less than 99.965% of guns and 99.788% of gun-owning households are associated with any of these negative outcomes.

It is true that the firearms homicide, suicide, and injury rates in the U.S. are higher than some other countries that afford their citizens less freedom and responsibility in this area. But it is also true that the overwhelming majority of American citizens who exercise this freedom do so responsibly. Just like the vast majority who exercise the rights to free speech and religious practice do so responsibly. Gun ownership overall certainly compares favorably in terms of public health to alcohol consumption – more commonly experienced, better understood, and consequently less criticized by sociologists – even though the same principle that a small number of abusers are responsible for the vast majority of the problems applies.

Some compare the number of vehicular deaths annually to the number of firearms deaths, but this comparison is faulty. The 37,195 vehicular deaths reported by the NCHS in 2014 are in the “unintentional” category. Only 461 firearms deaths in 2014 are categorized as unintentional. The overwhelming majority of people who die from gunshot wounds are shot intentionally, by themselves or others. This intentionality shifts attention to understanding how other factors are necessary for guns to have a lethal or injurious effect. I actually wrote this essay with a 9mm Glock 43 auto-pistol sitting next to me just to verify that it is in fact an inanimate object with no capacity to act on its own.

One need not accept the NRA mantra that “guns don’t kill people, people kill people” to recognize that as inanimate objects guns are not an independent risk factor for death or injury. Although we can control for other factors to artificially isolate guns in statistical models, *ceteris paribus* exists only in our computers. In the real world, all other things are not equal.

Like many health disparities, the reality is that certain people with guns kill or injure themselves or other people more often under certain circumstances. This is a lot harder to think about and study than a myopic focus on guns themselves, which necessarily implicates the vast majority of guns and gun owners who are in no way involved in firearms deaths or injuries and never will be.

The vast majority of sociologists I have met are not gun people and so, like the younger me, have no appreciation of the complex social reality of guns. My hope is that understanding the normality and innocuousness of the vast majority of guns and gun owners will make studies of the modest amount deviant behavior committed with guns more sensitive and sophisticated.

This gets at the truth highlighted by the old joke: How many sociologists does it take to change a lightbulb? Four. One to change the bulb and three to explain the root causes of darkness. Especially in a country of 300 million mostly innocuous guns and in 50 million mostly normal, law-abiding gun-owning households, we do well to focus on the root causes of injury and death rather than a tool that has no life of its own.

Interview with a Scholar: Dr. Sandro Galea

by Alaz Kilicaslan

I am thrilled to share the timely thoughts of Dr. Sandro Galea for our Winter newsletter. Dr. Galea is the Robert A. Know Professor and Dean at the Boston University School of Public Health. As a physician and epidemiologist, his research examined many aspects of public health ranging from the social determinants of substance abuse to the effects of 9/11 on post-traumatic stress disorder. He also published several academic and opinion pieces on firearm-related violence, which he calls 'a public health issue'. Dr. Galea was generous enough to invite me to his office and take time from his busy schedule for the interview. Below, he shares his views on why highlighting mental health is a distraction from understanding the real factors impacting the epidemic of gun-related harm, how sociologists can contribute to research addressing this deadly phenomenon, and how we should make sense of the absence of scientific research on gun violence, among other key issues.

K: With the recent cases of mass shootings, it looks like there is an emerging consensus around acknowledging gun violence as a major issue. But, there seems to be two camps, one focusing on the mental health and the other on gun laws. How do you evaluate this debate? Can we find a way to make these two camps speak to each other?

G: Mass shootings have been increasing and they got a lot of attention. But mass shootings account for less than one percent of all firearm casualties. So, they are important and they galvanize the public attention, but they are really a very small fraction of the consequences of guns. Most consequences of guns are actually suicides. Two-thirds of them are suicides and one-third are homicides. So, it's important to talk about mass shootings, but we should also think about the broader issue. Overall, I think we spend a lot of time focusing on mass shootings but every day nearly a hundred people are injured by guns and that's what we should keep in mind.

In terms of the issue of mental health, it is actually a red herring when it comes to guns. The only relevance of mental health to guns is mental health as a risk factor for self-harm, for suicide. But on the issue of homicides, be they individual homicides or mass violence, that's a red herring. There is no evidence that mental illness makes people more likely to hurt other people. In fact, those with mental illness are more likely to be hurt by others. So, the discussion that is centered on mental illness has been a distraction from the core issue, and the core issue is guns. Core issue is that we have many more guns than anybody else in the world. We have nearly half of the all handguns in the world, although we are only about 4 percent of the world's population. There are about 300 million handguns in this country. This means roughly one for every person, although they are really concentrated in the hands of about one-fifth of the population. So, the issue is guns; that guns are readily available, which means that people with intents to harm others have more readily available lethal means by which to harm others.

K: So, it's not a real debate in that sense?

G: I don't think there is a debate in data.

K: The President just raised this opinion...

G: The President is poorly informed. I think in part that is by intention, in that there has been a very concerted effort in this country to present the issue of firearms as a liberty and freedom issue masked behind the 2nd amendment. But in fact, that is a very narrow and particular interpretation of the 2nd amendment that has emerged only in the past 15-20 years based on a five to four party line vote in the Supreme Court that was based on efforts by groups sponsored by, fueled by the NRA to push very particular points of view. So, I actually think that this is a manufactured debate.

K: How do you make sense of the absence of research, or relative absence of research on gun violence in public health and other fields compared to other causes of mortality or morbidity?

G: I think it's a direct result of the fact that there is less funding available to invest in research. I mean large-scale quantitative population health science research requires funding. And I think there is less funding available. It's as simple as that.

Con't on page 9...

Interview with a Scholar: Dr. Sandro Galea

by Alaz Kilicaslan

...Con't from page 8

K: Has this been changing recently?

G: Not really. Not since the new administration took over.

K: But do you hope it's going to change in the future?

G: Well, I do. But, I think it's going to take a change in administration.

K: How do you make sense of the relative absence of research on gun violence as a public health issue?

G: Actually, part of the reason why the debate I just discussed exists in the first place is the relative absence of research. You make sense of it because this is a direct response to the Dickey Amendment, which was an amendment that was attached to 1996 under the spending bill to CDC that prohibited CDC from being involved in advocacy around gun violence, but it was interpreted by CDC as a ban on them working on gun violence. And that has resulted in much less data being available on gun related morbidity and mortality than all comparable causes of morbidity and mortality and that is a real problem. As a result, we have fewer data to inform the debate compared to what we should have.

K: What policies should be implemented to effectively address gun violence?

G: I think there is a full range of policies from enforcing universal bans to limiting high-performance weapons that have no purpose other than hurting and killing other people to ammunition checks to smart guns. I think all these policies can make a difference. Ultimately it is not going to be a single policy, it is going to be a mix of policies. There is not one miraculous policy in that sense.

K: How can sociologists and other social scientists contribute to such efforts and how can they collaborate with health professionals and policy makers?

G: You know, there is a real culture of guns. There is a real narrative that guns are about liberty and freedom. I think these are all issues that are in the realm of sociologists. I would encourage sociologists to engage and ask questions on how we can change the narrative on guns, how to change the narrative towards gun control and gun safety, ultimately how to save lives.

K: Of course I don't expect a prophecy, but can you tell what the future holds for us in terms of gun violence and gun policy?

G: I think the issue of gun-related injury is so egregious that the scales will tip. There is no question in my mind that eventually we're going to come to our senses. We're going to think it was embarrassing that we ever countenanced so much death and injury that was preventable. So, I think the history will judge us, and it will be unkind to those who did not speak up on this issue. So, I'm optimistic. Although, I think between here and the optimism, there stand a lot of people being injured and killed by guns.



Get Connected

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Website Visits

Over the last fall semester (i.e., between September 1 and November 30th, we observed a significant decline in the number of visits to our section website. You might remember that we reported a record post-migration quarterly visits during the summer session (353 visitors and 514 page views). This quarter our site received 205 visitors and 261 page views – a drop by 42% in terms of visitors and 49% in terms of page-views. The following graph shows the daily, weekly and monthly visit patterns during the reporting period.

Related reports also show that only 22 out of the 205 visitors were returning visitors the rest (about 89%), were new visitors. Therefore, it is reasonable to hypothesize that the declining trend may be indicative of the static nature of most of the content. We would like to reverse this trend by including more dynamic content. If you have ideas that would move our web platform in this direction please contact me through e-mail (sgeletta@dmu.edu), so we can discuss solution ideas.

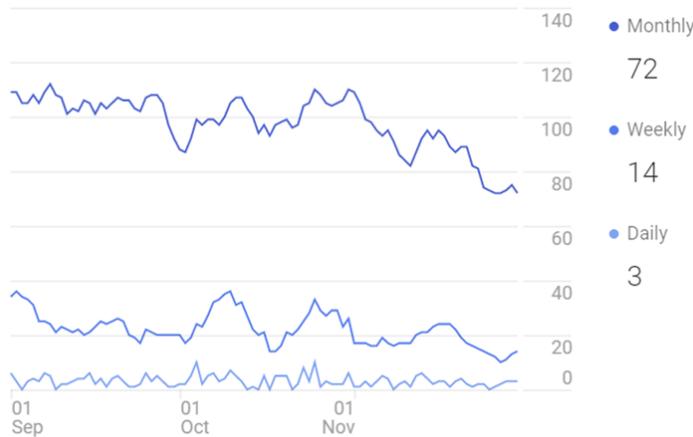


Figure 1: Active Users Report: September 1 thru November 30—with Monthly, Weekly, and Daily Visit Averages

Social Media Activities

Our [Facebook page](#) now has over 2,000 followers. Our “reach” on each post remains stable from the fall update, with job postings getting the most attention. Our [Twitter](#) currently has 945 followers. Our [LinkedIn](#) group now has 428 members. If you haven’t connected with us on these platforms, please do!

Please contact Mel (mel.jeske@ucsf.edu) if you have anything you’d like posted to our social media accounts!

A PUBLICATION OF THE MEDICAL SOCIOLOGY SECTION OF THE ASA



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