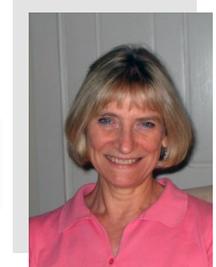


MEDICAL SOCIOLOGY NEWSLETTER

SPRING 2014



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NOTES FROM THE CHAIR BY SUSAN E. BELL

As I sit down to write these notes at the end of March, snow is falling in fits and starts. Like many of you I long for the end of this seemingly endless winter. The call of a cardinal promises that the official beginning of spring will soon be followed by more signs of its arrival. Just as the bird chirps signs of spring, Medical Sociology Section Twitterers are tweeting messages about our membership. The Medical Sociology Section has a lively Twitter presence. Indeed, Mark Sherry (Webmaster) and Simon Geletta (Associate Webmaster) report that many connections made through Twitter and Facebook are with medical sociologists outside the US and that social media is “by far” the most effective way the Section communicates with our members. Thank you Mark and Simon for updating and enabling our communications networks.

In this Newsletter, I'd like to take the opportunity to encourage members of the Section to travel to medical sociology/health meetings outside as well as inside North America and then Tweet (@MedicalSocASA), post to Facebook (MedicalSociologyUSA), and/or write to one of our listservs (MEDSOC@LISTSERV.NEU.EDU or

MEDICAL_SOCIOLOGYANNOUNCE@LISTSERV.ASANET.ORG) about what you hear. Communicating via social media and in face-to-face meetings are terrific strategies for strengthening our global community.

The histories of three associations are particularly intertwined with the ASA's Medical Sociology Section: the **International Sociological Association's Research Committee 15**, The **British Medical Sociology Group**, and the **US/UK Medical Sociology Conferences**. Funding is more and more difficult to come by, but there are sources of funding for travel. For example, the ASA (via NSF) is providing grants for members to travel to the 2014 International Sociological Association Meeting in Yokohama, Japan.

The **International Sociological Association's Research Committee 15**, Sociology of Health, is one of 55 Research Committees in the International Sociological Association. Founded in 1963, the primary objective of RC15 is research into the sociology of health and illness. According to its statement of objectives, posted on its website, RC15 “supports individual scholars, institutions, and associations that are concerned with such research. It

(Continued on page 2)

REMINDERS

- **MSN Summer deadline**
June 6, 2014
- **2014 ASA Annual Meeting**
August 16th–19th, San Francisco
- **2015 ASA Annual Meeting**
August 22-25, Chicago

NOTES FROM THE CHAIR BY SUSAN E. BELL

(Continued from page 1)

promotes information exchange and scientific meetings at regional, national, and international levels. It encourages the generation of sociological knowledge that enables health professional administrators, officials, and planners to improve the delivery of health services in the domains of prevention, management, cure, and rehabilitation. It also stimulates the thinking of health scholars in search of the most vital concepts and analytical frameworks for understanding health and illness in society.”

Reviewing leadership in RC15 I was interested to see that its first officers, from 1963-1966, were two US medical sociologists, George Reader (Chairperson) and Eliot Freidson (VP and Secretary). For many years US medical sociologists were officers in RC15, but in the recent past this has changed. There are no US medical sociologists on the current board of RC15. Jonathan Gabe (Royal Holloway, University of London) is Chairperson and Ivy Bourgeault (University of Ottawa) is VP, 2010-2014. Members of the Board of RC15 are from UK, Canada, Italy, South Africa, Japan, Germany, India, and Australia.

<http://www.isa-sociology.org/rc15.htm>

I first attended the International Sociological Association in 1986, when it met in Delhi, India. I was thrilled to be in the company of so many sociologists trained in different national settings, and to see the discipline from different “centers”. Since then I have attended the ISA meetings whenever possible, most recently in Buenos Aires, Argentina. Each time, my

perspective has been enriched through face-to-face conversations about medical sociology with sociologists whose work emanates from different local settings.

The **British Medical Sociology (MedSoc) group** began in 1969 when 50 researchers and teachers met at York to form a medical sociology sub-branch of the British Sociological Association “to promote scholarship and communication in the field of the sociology of health and illness in the United Kingdom,” according to its website. The group’s founding convener was John McKinlay (New England Research Institute). By 1973 MedSoc had become one of the largest groups of the British Sociological Association. Today it remains one of the largest and most active groups in the BSA. It holds an annual conference in the UK and has a close association with *Sociology of Health & Illness* (SHI), founded in 1979, and *Medical Sociology online* (MSO), a free access journal. The MedSoc 45th Annual Conference in 2013, which was the first I attended, brought together more than 350 medical sociologists.

The flow of ideas between members of MedSoc and the Medical Sociology Section is facilitated through SHI and by the participation of members of the journal’s editorial board in the ASA meetings. The journal’s publisher, Blackwell, provides support for the Medical Sociology Section’s reception at our annual meeting. At present, there are more MedSoc members attending the ASA than in the reverse direction.

<http://www.britsoc.co.uk/medical-sociology/about-the-medsoc-group.aspx>

(Continued on page 3)

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

NOTES FROM THE CHAIR BY SUSAN E. BELL

(Continued from page 2)

Mike Bury (University of London) and Peter Conrad (Brandeis) initiated the US/UK medical sociology conferences in 1999 with a meeting at Royal Holloway. Subsequently there have been conferences in Edinburgh, Boston and Belfast (2012), and the organizing committee is always comprised of a mixture of the two largest medical sociology communities (US and UK).

The goal of the conferences has been interaction among UK and US medical sociology communities and to be open to others as well. The conferences are small (e.g., 100 or fewer participants), informal (e.g., without paper presentations), and residential (3 days). Participants meet in mutual interest or thematic groups, stay together, and dine together. Each conference includes 3-4 plenary speakers. The conference format is designed to maximize interaction.

Like many others, one theme in my current scholarship reflects interactions that began at a US/UK medical sociology conference. Alan Radley (Loughborough) and I met at the 1999 US/UK. Informal discussions initiated there became a fruitful collaboration of co-authored publications and conference presentations, a co-edited special issue of a journal, and a workshop on representations of illness.

In sum, we have a lively scholarly community thanks to new social media and old fashioned face-to-face conferences. Regarding the latter, details about our Section's sessions at the ASA meetings in San Francisco will be published in the Summer issue of the Medical Sociology Newsletter and in the ASA's online preliminary program which will be available soon on the ASA's website: <http://www.asanet.org/AM2014/am2014.cfm>

All the best,

Susan E. Bell

SEEKING NOMINATIONS FOR 2014 LOUISE JOHNSON SCHOLAR

Applications are due by May 15, 2014

The Medical Sociology Section will select a student member of the section to be the 2014 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 \$350 to present at the annual ASA meetings in Denver 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 2014 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 Dawne Mouzon (dawne.mouzon@rutgers.edu) with the subject line: "2014 Louise Johnson Scholar Nomination."
Applications are due by **May 15, 2014**.

SECTION SLATE OF CANDIDATES FOR 2014 ELECTIONS

Rene Almeling, Chair, Nominations Committee

Nominations Committee: Sara Shostak (Chair Elect); Joanna Kempner, Miranda Waggoner, and Meredith Bergey

Thanks are due to our terrific committee and chair for their hard work and to all who were willing to run for office.

Chair-Elect

Kristen Barker, University of New Mexico
Richard Carpiano, University of British Columbia

Secretary/Treasurer-Elect

Robin Moremen, Northern Illinois University
Janet Shim, University of California – San Francisco

Chair-Elect, Nominations Committee

Rachel Kimbro, Rice University
Rachel Best, University of Michigan

Chair, Health Policy and Research Committee

Charles Bosk, University of Pennsylvania
Sigrun Olafsdottir, Boston University

Chair, Membership Committee

Laura Mamo, San Francisco State University
Michelle Frisco, Pennsylvania State University

Member, Nominations Committee (vote for 2)

Daniel Menchik, Michigan State University
Catherine Bliss, University of California–San Francisco
Corinne Reczek, Ohio State University
Sarah Burgard, University of Michigan

Student Council Member-at-Large

Tania Jenkins, Brown University
Catherine Tan, Brandeis University

Student Member, Nominations Committee

Jane VanHeuvelen, Indiana University
Estela Vasquez Guzman, University of New Mexico

*There is no race for Council Member this year because of an error in last year's election. One new council member is supposed to be elected each year, but last year we elected two: Brea Perry and Bridget Gorman. Bridget Gorman agreed to defer her term for one year, obviating the need to elect a council member this year.

SEEKING NOMINATIONS FOR 2015 REEDER AWARD

Nominations are due by May 31, 2014

The Medical Sociology Section invites nominations for the 2015 Leo G. Reeder Award to be awarded at the annual meeting of the Medical Sociology Section in Chicago. 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, at least two other suggestions for nominators, and the nominee's curriculum vitae to Anne Figert (afigert@luc.edu) with the subject line: 2015 Reeder Award Nomination.

Nominations are due by May 31, 2014. 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.

HEALTH POLICY BY JENNIE JACOBS KRONENFELD**Big Data, Health Policy and a Role for Sociologists**

One new issue being addressed in health and health policy circles is the emergence of “big data” and how this may be used in health policy and health care areas. I have not yet seen this covered much within medical sociology, and believe that it is another area in which medical sociologists can have an important role to play, if they learn more about big data. This column will provide a small amount of information about this topic, and a suggestion that people read the *Health Affairs* Blog column which recently published a very interesting piece on this topic.

In the blog piece, the authors argue that academic medicine and health policy research resemble the automobile industry in the United States at the beginning of the 20th century, in which there were a large number of small places developing a product at a high cost without any significant economies of either scale or scope. They argue that academics of all types and in many different locations, including medical centers, tend to work independently or in small groups, with lots of different and often unconnected health-related datasets. All together, these end up providing less than complete pictures of the health status, health behavior, and health care activities of Americans.

The authors of the blog believe there is an important governance issue in the creation of new big data approaches, and major questions about how to legally and administratively bring the data together. Issues they view as important governance issues include “how multiple stakeholders will provide data under standard contribution agreements; how to link extremely large and multi-year files, match records across datasets, and provide statistical deidentification where necessary; and how to license these data to multiple researchers under standard use agreements.”



They argue that health care data needs to move from this small and unconnected health shop situation to a world of connected and matched data with common support for licensing, legal and computing infrastructures. One solution for which they argue is to “facilitate these enclaves through a governance structure know as a *digital rights manager* (DRM). The concept of a DRM is common in the entertainment (The American Society of Composers, Authors and Publishers or ASCAP would be an example) and legal industries. If successful, DRMs would be a vital component of a data-enhanced health care industry.”

Because many sociologists, including medical sociologists, use data already collected from government and other sources as an essential part of their research, medical sociologists need to be informed about new approaches to creation of big data sets and controls. They also need to be sure that the needs of social scientists to have access to these types of data and to even play a role in determining these activities and helping plan these activities occur. A first step to the inclusion of medical sociologists is a recognition of new ways to put data together and also ways that are being discussed in health policy and academic medicine circles.

Related Citations

Newman, David; Herrera, Carolina; Frost, Amanda; and Parente, Stephen. The Need for a smart approach to big health care data. *Health Affairs Blog*. Healthaffairs.org/blog/2014/01/27/the-need-for-a-smart-approach-to-big-health-care-data. Accessed on March 20, 2014.

Please send suggestions for future policy column topics to Jennie.Kronenfeld@asu.edu

ASSISTING THE ASSISTANT PROFESSOR BY BARRET MICHALEC

A number of people reached out to offer their own perspectives and experiences regarding the tenure process (as well as to offer their support to me personally, which was much appreciated). It would appear from the responses that many go through various cognitive/emotional stages leading up to and during the decision making of tenure. The most frequent offerings were to:

- a) read and re-read the guidelines on tenure in the Faculty Handbook
- b) meet with your Chair, Dean, and Provost to discuss expectations
- c) pay special attention to your Research Statement, to fine-tune it specifically to the expectations at the Department, College, and University-levels (“..hopefully these are consistent.”)
- d) not be afraid to shop yourself around, as this is “..part of the game..” and can show how marketable/valuable you are
- e) be very strategic in selecting your external reviewers, and to be aware of what *type* of reviewers are desired (ranking, research concordance, etc.)
- f) try not to wallow too much in self-doubt and ruminate over perceived missteps.

Regarding this last one, I imagine some of us lying in bed like Cameron Frye in the beginning of *Ferris Bueller’s Day Off*. Overall, in short, this is not a fun procedure (nor is it meant to be – perhaps it is designed/sustained to elicit fear and anxiety to perpetuate status differentials between assistants, associates, and full professors) – but in any case the

fear of being told that your work is not up-to-snuff by particular standards is indeed gripping.

Shifting gears a bit, over the years I have experienced a few “I wish someone would have told me about this” situations related to funding/working with graduate students, and therefore I thought it would be a worthwhile topic to share for this issue’s *Assisting the Assistant Professor*. I’m only 5 years out of graduate school and having spent several years as a graduate student I feel fairly well aware and cognizant of the plight of graduate students, and feel I can empathize with their experiences. I therefore try to do what I can to offer support (emotional, academic, and financial). I often use whatever funding I have to support graduate students on my projects, also providing authorship credit and opportunities to work with data outside of the specific project (for theses, dissertations, and own publishable works).

But there are a few instances that have arisen when working with graduate students from my own and other institutions that leave me perplexed by their behavior and tactics, and I am left wondering if graduate students actually understand that they are in graduate school. These could be situations related to paying a graduate student to gather data and the student just not doing the work, turning down opportunities to work on/co-author a publishable piece because it’s not *exactly* what they are interested in doing, turning down funding because it would require them to do transcriptions, getting visibly upset regarding the amount of constructive criticism I have offered on a

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Post Notices on the ASA Medical Sociology Section List

<MEDSOC@LISTSERV.NEU.EDU>

Visit our new website at <http://www2.asanet.org/medicalsociology/>

ASSISTING THE ASSISTANT PROFESSOR BY BARRET MICHALEC

(Continued from page 6)

recent work, among others. I try my hardest to not slip into the old adage “When I was a grad student, we took whatever funding and research opportunities were offered to us...” I try to look at it from their perspectives, but most of all I realize that it can be difficult for an Assistant Professor, especially for those who are younger, to offer some “tough love” to graduate students while not falling into the pit of wanting to be liked.

The relational boundaries between graduate students and professors can be blurry for all (regardless of age and/or rank) but very difficult to negotiate for Assistant Professors given their relatively recent graduate school experiences and their continued cultivation of a professional identity. Is it “ok” to offer some extra cash to a graduate student to watch your

house/pets while you are away, but then chastise them for not meeting research-related deadlines or missing meetings? Can you take graduate students out for a beer/drink to congratulate them on a recent award of sorts and then drown their recent writing efforts in red ink? If you blur the lines can you not expect them to do the same? Consistency regarding setting and maintaining your own boundaries (and expectations) is most likely paramount - but what are some tricks/tips that others have for Assistant Professors in negotiating, cultivating, and maintaining effective and engaging relationships with graduate students?

Please feel free to email me (bmichal@udel.edu) your stories and/or suggestions regarding navigating the relational boundaries with graduate students. My many thanks to Ann Bell for her continued assistance with this column.

AVAILABLE AS AN EBOOK ONLY

WORRIED SICK

How Stress Hurts Us and How to Bounce Back

Deborah Carr

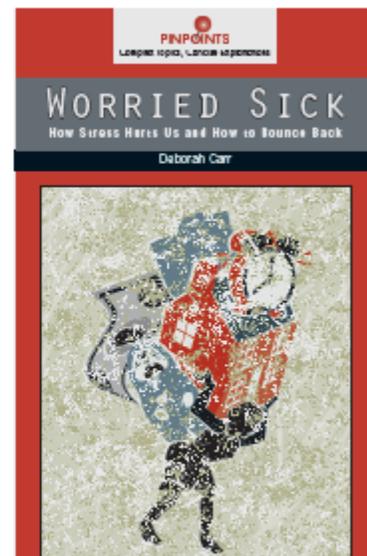
Comments like “I’m worried sick” convey the conventional wisdom that being “stressed out” will harm our health. Thousands of academic studies reveal that stressful life events (like a job loss), ongoing strains (like burdensome caregiving duties), and even daily hassles (like traffic jams on the commute to work) affect every aspect of our physical and emotional well-being. Why do some people withstand adversity without a scratch, while others fall ill or become emotionally despondent when faced with a seemingly minor hassle?

Worried Sick answers many questions about how stress gets under our skin, makes us sick, and how and why people cope with stress differently. Deborah Carr succinctly provides readers with key themes and contemporary research on the concept of stress. In addition to examining individuals’ own sources of strength and vulnerability as an important step toward developing personal strategies to minimize stress and its unhealthy consequences, Carr looks at stressors that we face in everyday life which are symptoms of much larger, sweeping problems in contemporary society.

To readers interested in the broad range of chronic, acute, and daily life stressors facing Americans as well as those with an interest in the many ways that our physical and emotional health is shaped by our experiences, this brief book will provide a clear introduction to the issues. Included within are several stress and coping checklists, allowing readers to gauge their own stress levels.

DEBORAH CARR is a professor of sociology at Rutgers University and a faculty member at the Institute for Health, Health Care Policy, and Aging Research. Her work focuses on dying and end-of-life issues and the effects of family-related stressors on health and well-being. She is the author and editor of numerous works, such as *Encyclopedia of the Life Course and Human Development* (2009) and *Spousal Bereavement in Later Life* (2006).

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TEACHING TIPS**BY JENNIFER REICH****Moving from the Personal to Political in Teaching**

In sociology classes related to health, medicine, and healthcare, we often aim to connect theoretical concepts about illness and wellness both to lived experiences of disease and to the structural inequalities that shape experience, disease susceptibility, and access to care. In my last column, I addressed many of the challenges of engaging students and their biographies while also maintaining boundaries. Here, I consider ways to connect students to questions of inequality, illness, and experience that reach beyond themselves.

Speakers

Most communities have organizations that advocate for people with illness. They often provide narratives on websites or access to speakers. Health providers are often willing to come to talk with students as are individuals with chronic illnesses. Students, I have learned, enjoy this form and often are accustomed to it. For example, many undergraduates' HIV education has included class visit with a person living with AIDS telling cautionary tales. When speakers come to class, it can be challenging to inspire students to pull back from the individuals themselves and place their stories within cultural, structural, and institutional frames that allow for good sociological examination. When they can, it can lead to good questions of the visitors or good discussions after.

Text Analysis

Students can learn a great deal from systematically analyzing blogs, websites, and first-person narratives. Many books and films take on first person experiences of illness and disability that are powerful for students to analyze. Among the excellent fictional accounts and documentaries are a huge range of free online resources, including PBS's library and the streamable

and often persuasive TEDMED lectures (<http://www.tedmed.com>).

Text-based analyses can also be closer to home and more pedestrian. Recently, my daughter and her fifth grade work group analyzed the policy implications of the Humpty Dumpty (HD) story. As you may recall, HD sat on a wall and, after falling, faced permanent and irreparable damage, despite what sounded like significant public investment of resources. When I asked my daughter whether eggs shouldn't sit at great heights she pointed out that the poem never states that HD actually was an egg and that visual representations of the story were added later and serve to blame the victim. As we considered different public health interventions, I was struck by how many nursery rhymes and children's stories well known to students raise important and complex questions about health—including but not limited to insects, rodents, perilous walks to wells, families living in shoes, or seniors like Old Mother Hubbard who face food insecurity. Drawing on textual examples that exist in students' lived experience and are part of collective cultural knowledge can provide great opportunity for analysis.

Activities

There are great opportunities to challenge students to try and walk in someone else's shoes. For example, one could create an activity in which students are randomly assigned characteristics (including, age, race, gender, region, family form, commute time, employment status, caregiving responsibilities, and insurance status). Students can then consider what illness risks that person might experience or systematically account for how the person would find care and meet their on-going obligations.

(Continued on page 9)

TEACHING TIPS**BY JENNIFER REICH**

(Continued from page 8)

Several simulations can also help. My favorite is <http://playspent.org>. Here, the Durham Urban Ministries created an online challenge where the player becomes one of 14 million unemployed Americans and, as a single parent who has lost her or his house, and must make decisions on how to spend the family's last \$1000. The challenge, to survive for one month without needing assistance, is informative and helps to move students from the belief that healthcare access and needs are merely the result of bad choices. (The game is deeply humbling: I confess that although I always apply to be a temp in this game, I inevitably fail the typing test and have to reapply as a food server, which appears to be more in keeping with my skillset.) Instructors have told me that this exercise works well when students work independently, or when they make choices and discuss them as a class.

Depending on the size and dynamics of your class, it could be fascinating to invite students to participate in the SNAP challenge, named for the federal Supplemental Nutrition Assistance Program, which was formerly known as the food stamp program. The Food Research and Action Center (FRAC) has developed tools to start your own SNAP challenge. Participants must live for one week on \$4 per day worth of food, which is the average food stamp benefit. Participants learn how challenging it is to avoid hunger, stay healthy, and gain access to nutritious foods without adequate resources. This serves as a great launching pad from which to explore malnutrition, obesity, fast food, and illness risk. (For details, see <http://frac.org/initiatives/snapfood-stamp-challenges/>)

End of life discussions are also challenging. My students have often found it insight-provoking, if difficult, to work through the worksheets around

medical proxy decision-making, advanced directives planning, and end-of-life care with each other or with family members. The Centers for Disease Control and Prevention compiled a list of resources (found at <http://www.cdc.gov/aging/pdf/acp-resources-public.pdf>) I have used pages from the American Bar Association workbook on advanced directives. (http://apps.americanbar.org/aging/publications/docs/consumer_tool_kit_bk.pdf). Created by the Commission on Law and Aging, pages include questions about what level of disability would be tolerable, what odds of recovery are compelling, what spiritual matters are important, and what medical interventions are desirable. Although some students report that incontinence alone would make life not worth living, others draw lines in other places. Years after one student graduated, he sent me an email to let me know that when his mother's cancer returned and metastasized to her brain, making these conversations impossible, he was grateful they had had them as part of the course assignment. Such projects make for hard conversations, but can also yield deeper understandings of hard choices that are embedded in culture, religion, and personal experience.

Take Chances

There are so many ways to help students connect their social worlds to course concepts. This is a small list to get you thinking. Above all, it is important to take chances and help students reach beyond themselves. This kind of work is often uncomfortable, but it can also be immensely rewarding and incredibly useful for helping students learn to think critically about their own worlds and to gain empathy for others' experiences. And from that perspective, they can become more effective advocates for themselves and others.

CAREER & EMPLOYMENT BY PATRICIA RIEKER



...what's past is prologue; what to come,

In yours and my discharge¹

Career Lessons from History of Medical Sociology

In the last column I wrote about autonomy, control and skills—the central qualities that have been shown to contribute to job satisfaction in different career contexts. For a change of pace, I thought a very brief summary of historical developments in medical sociology might provide an interesting backdrop to current and future discussions of alternative career pathways for medical sociologists. For instance, it is interesting to note that in the first three decades of the twentieth century ‘medical sociology’ was identified first with medicine, then the field of social work and later with the field of public health. From its beginning as an academic entity, fractious identity issues have beset medical sociology and its relationship to medicine as reflected in the long standing debates about whether it should be called sociology *of* medicine, *in* medicine or *with* medicine. The more recent discussion in this column and elsewhere about the distinction between embedded/applied and professorate career pathways and the associated drawbacks or advantages are part of that legacy. While I don’t view the current dialogue about alternative career models as an ‘identity crisis’ I think the abbreviated snapshot of the origins of medical sociology could provide an interesting foundation for future conversations.

Early Links to Medicine and Public Health

In their chapter on the history of medical sociology, Hafferty and Castellani describe numerous examples of work from the turn of the century linking “medicine” and “sociology”.² This includes two articles by Charles McIntire (1915, 1991) (“The Importance of the Study of Medical Sociology”—first published in 1894 and reprinted in *Sociological Practice*—and “The Expanse of Sociologic Medicine”) along with two key books, the first by Elizabeth Blackwell (1902) (*Essays in Medical Sociology*) and the second by James P. Warbasse (1909) (*Medical Sociology: A Series of Observations Touching Upon the*

Sociology of Health and the Relations of Medicine).

These authors suggest that the “second McIntire article is of particular interest because of where it appeared—in the *Journal of Sociologic Medicine*, which was published not by a sociology association but by the *American Academy of Medicine*”; but the parent organization and journal only existed for a scant four years (1915–1919).² The American Public Health Association maintained a similar sociologic offspring—its “Section of Sociology”—for a slightly longer period of time (1909–1921), but that disappeared as well.³ It would be nearly 40 years before the next medical sociology journal (*Journal of Health and Human Behavior*) appeared in 1960. While “sociology of medicine” articles would continue to appear infrequently in medical journals between 1920 and 1950 the few that did surface would have a far greater impact on sociology than on medicine.² Lawrence J. Henderson’s [1935] “Physician and patient as a social system” is a notable example. One famous sociologist who would benefit from the Henderson article, for instance, was Talcott Parsons, who was at Harvard during the 1940s and 50s. Parsons was one of the first sociologists to use medical settings as a context for his theory of the social system (1951), devoting considerable energy during his lifetime to the discussion of medical sociology, especially the social roles of physician and patient, the medical profession, psychiatry, psychosomatic problems and related issues of health and illness. Parsons, like many intellectuals at the time, was taken with Sigmund Freud and the principles of psychoanalysis and that influence is readily apparent.

Gilded Age of Funding and Growth of Medical Sociology

It was not until the 1930s and 1940s that the interrelations between society and the health sciences became of academic interest to sociologists. This

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CAREER & EMPLOYMENT

BY PATRICIA RIEKER

(Continued from page 10)

development was reflected initially in the influential work by Sam Stouffer (and colleagues) who left his academic post during the Second World War to head the research branch of the U.S. Army's Information and Education Division. Together with his medical sociology colleagues, Stouffer employed then innovative research methods and published the prescient sociological work on the American soldier [see for example the first volume in a series of three: *The American Soldier: Adjustment During Army Life*, (Studies in Social Psychology in World War II, Volume 1) by Samuel A. Stouffer, Edward A. Suchman, Leland C. DeVinney, Shirley A. Star, and Robin M. Williams, Jr. 1949, Princeton University Press]. That cross-disciplinary work contributed both theoretical and methodological knowledge to Sociology and put the field on the government's radar screen. At the time, these medical sociologists moved easily between professorate and applied settings.

In 1959, the American Sociological Association recognized the Section on Medical Sociology. Within two years it became the largest section with a substantive interest in the association. In fact, it was during the 1950s and 60s that the field of medical sociology underwent an explosive period of growth. During these two decades, the field enjoyed considerable academic excitement and success, including what today might be considered a profligate amount of grant support, both from private foundations and the federal government. At its peak in the 1970s, for example, the National Institute of Mental Health subcommittee for social science training was awarding 1,500 graduate student stipends per year—80 percent of which went to sociology departments.³ I was fortunate to have one of those 5-year grants for my graduate work and the cross-disciplinary program included courses in medical sociology and anthropology in

addition to the philosophy of science. According to Bloom the number of stipends exceeded what was needed to support medical sociology graduate students—and thus the entire field of sociology benefited from this philanthropic and federal funding.³

The medical sociology section continues to attract the greatest number of participants of any section within the association. However, the first graduate program leading to the Ph.D. in medical sociology was only initiated by Yale University in 1954, with the first students entering training in July 1955. The field grew rapidly. By the fall of 1965, there were 15 special graduate programs in medical sociology leading to the Ph.D. degree in departments of sociology in U.S. universities; in 1972, there were 39 in the United States and Canada. But in the late 1970s and 80s, after outside funding dropped off and universities tightened their budgets as well, many sociology departments eliminated medical sociology programs, including Yale in the 1990s.^{2,3}

Medical Sociology Publications

Initially medical/health issues were published in flagship sociology journals, such as the *AJS* and the *American Sociological Review*, but these became less frequent after the first independent substantive disciplinary journal in medical sociology was published in 1960, the *Journal of Health & Human Behavior (JHHB)*. The position of medical sociology was further strengthened in the spring of 1967 when the American Sociological Association (ASA) took *JHHB* under its organizational wing and renamed it the *Journal of Health and Social Behavior (JHSB)*. This same year also marked the first issue of *Social Science & Medicine (SS&M)*, with its distinctive international and multidisciplinary social science focus. In addition, there were notable British medical sociology journals being published during this period.

The first edition of the Handbook of Medical

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CAREER & EMPLOYMENT

BY PATRICIA RIEKER

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Sociology, organized and edited by Howard Freeman, Sol Levine and Leo G. Reeder, was published in 1963; the second edition published in 1972 had the same editors. Each new cohort of medical sociologists trained at various departments went about applying the advances in theoretical knowledge or creating new ways of thinking about existing theories. Some of the most influential first wave of medical sociologists that I knew personally included such figures as Leonard Cottrell, Sol Levine, Elliot Mishler, Howard Freeman, Irving Zola, Kai Erikson, Edward Suchman, Matilda White Riley, Rose Coser, Renee Fox, and many others too numerous to list.

In most academic settings medical sociology was (and is) interdisciplinary; it involves the application of sociological knowledge and concepts to issues of health, illness and health care and medical education. This encompasses such factors as: culture (e.g., values, beliefs, health as social justice), organizational processes (e.g., the bureaucracy of hospitals, education of health care providers); politics (e.g. comparative health care policy, political ideology); economics (e.g. Capitalism, markets, the costs of health care); and micro-level processes such as socialization, professionalization, medicalization, and group process. Some early medical sociologists used the field of health as a platform for building sociological knowledge while others used sociology to transform health. For an example of the former, two of the most famous early studies of medical education, Robert Merton, Leo Reeder, and Patricia Kendall's (1957) *The Student Physician* and Howard Becker et al.'s (1961) *Boys in White* were less studies of medical education per se than they were efforts to test competing theories of social action, including adult socialization. The Merton camp advocated a structural functionalist perspective and the Becker camp a symbolic interactionist perspective. From the beginning other medical sociologists, such as Renee Fox, considered the influence that social and structural factors (especially inequalities) have on the disease and illness processes

as well as on the organization and delivery of health care.

I intended to make several points with this much abbreviated and highly selective review of the past of medical sociology. First is that it is important to understand both the lessons and the promise of the past. Second, medical sociologists have always engaged in applied health research with some using it to advance sociology and others using theories and methods to have an impact on some aspect of health or medical care. Moreover, they worked often in cross-disciplinary teams, moved easily between professorate and applied settings, and engaged in similar debates about career paths and the identity of medical sociology as we do today. Finally, the long arm of medicine and sociology's ambivalent relation to it remains central to any discussion of identity and education of medical sociologists and their career pathways.

Sources consulted for general history of medical sociology

1. William Shakespeare, *The Tempest Act 2, scene 1*, 245–254
2. http://www.uk.sagepub.com/leonguerrero3e/study/chapters/handbook_articles/Handbook%2010.1.pdf
3. Bloom, Samuel William (2002). *The Word as Scalpel: A History of Medical Sociology*. New York, NY: Oxford University Press
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Attention Job Seekers: Do you have questions about non-tenure track positions? What are your concerns?

Attention Job Holders: I would especially welcome feedback and sociological reflections from those who have moved between academic and applied settings. What topics would you recommend for future columns? Let me know if you would like to be interviewed—don't be shy!

Send comments and questions to:

rieker@bu.edu (subject line: **Jobs and Ideas**)

STUDENT NEWS & VIEWS BY JESSICA SEBERGER



For this edition of the Student Views and News column I interviewed the Managing Editor for Production of the *Journal of Health and Social Behavior* (JHSB), Alanna Hirz. At the Journal, Alanna oversees the production of all print and online journal content and is in charge of journal media relations and social media. During our conversation, Alanna and I discussed social media use among academics, how *JHSB* currently engages with social media, plans for future social media use by the journal, and issues to consider before and during engagement with social media. This conversation is part of a larger movement by the Journal to increase dialogue between experts across disciplines and the lay public.

JS: In your opinion, how can social media use benefit medical sociologists?

Alanna Hirz: Social media has the potential to reach audiences that historically don't have access to or may not be aware of the knowledge generated by a specific field. It can help to encourage scholars to step outside the "ivory tower" and connect with the community in a really direct way. Journal articles and social science at large can be highly technical, and engaging with social media requires researchers to translate their research in a way that can be understood by a general audience.

I think there's a larger point to be made here also. There's a misconception that just because social media exists it needs to be used, or that it's easy to use in a meaningful way. But, for the discussion to be meaningful we have to have a clear understanding of the audience we want to reach and the types of content that is relevant for them. This means that we need to adjust our message and learn how to market our research so that the lay public can get excited by our findings. "Social media" is kind of this amorphous thing and still new to a lot of academics so there isn't a good guide for how to use it – many of us are trying things out just to see what works because it's such a different way of presenting our work. *JHSB* is trying to

contribute a little bit to that foundation by pushing the boundaries through simultaneously engaging with experts as well as folks beyond the academy.

JS: How does the journal currently use social media?

Alanna Hirz: Currently the journal uses Twitter, Facebook, and LinkedIn to promote recent articles and publicize our authors. We also invite two authors in each issue to discuss their work via podcasts and we make that podcast available for the general public. UCLA was lucky to inherit both Twitter and Facebook accounts that were established under the journal's most recent editor Debra Umberson. A lot of what we're doing right now is identifying what our current base is on both Twitter and Facebook to develop ways to target their interests. For example, we might engage students and academics differently than publishers or activists who are interested in the journal content. One thing we've found is LinkedIn is great for conversations with new and young scholars asking questions like, "Is this the right field for me?" or wanting advice about where to find information about a topic, or data sets for a project. By default of the medium the conversations are more disciplinary and research based and, as a journal, we can capitalize on that by referring them to our authors or specific publications. The conversations that take place on Twitter or Facebook are a little broader and have a lot of potential to engage audiences that are excited about how the content directly relates to something they're seeing in the news or something they have experienced themselves.

JS: In the September/October issue of *Footnotes*, there was an article titled, "The Journal of Health and Social Behavior Welcomes New Editor." Within that article there was a discussion of ways that the new editor, Gilbert Gee, would like to grow the Journal. One of those was by

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STUDENT NEWS & VIEWS

BY JESSICA SEBERGER

(Continued from page 13)

building on prior social media successes of the journal. Building on what was mentioned in that article, what are some of the future plans for the Journal's social media presence?

Alanna Hirz: In addition to our current online presence, we're exploring ways to create a moderated blog. The idea is to write summaries of articles at an eighth grade reading level so non-experts can learn about the articles without needing the technical knowledge. Building on our podcasts, another medium we're interested in exploring is doing video interviews with our authors. Video makes people feel more intimately connected to a person, or to their project and could be a great tool for promoting some of the outstanding work we publish more broadly.

We're really drawn to the idea of being able to provide scientific information to people that's likely to be used outside of academia... like at a cocktail party with friends. On a grand scale, sociology is intricately tied to real life, and as scholars it's really important that we make that bridge for individuals.

JS: I think the moderated blog sounds like a really great idea, and I'm excited to see the journal engage in this conversation! But it also sounds like it's going to be tricky. To date it seems like the journal's presence on social media is more of an advertisement than a conversation; though it sounds like you have intentions to grow the conversational use of social media. Can you talk a bit about that?

Alanna Hirz: Yes, creating a social media presence isn't going to happen overnight. We're actively trying to figure out how much of our content should come directly from the articles that we publish and how much should be new content for example from news sources or our authors themselves. In the process of creating this content we have to focus on maintaining the prestige and integrity of the Journal

while also providing relevant information for our audience(s). We want to find that balance where we're having a conversation but we're still attracting subscribers to help sustain the Journal. To create meaningful content we have to work with the authors of our articles, their institutions, and our audiences.

JS: It seems like you've thought a lot about how JHSB and a moderated blog would fit in the world of social media. Do you have any advice for graduate students or faculty with regards to social media?

Alanna Hirz: Social media can be really great: it's in real time, it's unstructured, and it's almost completely user generated. But before taking advantage of that, I think it's a good idea to think of the purpose of its use. Think about what information you're interested in. Are you engaging with a reputable source? Where are you getting your information and how do you build off of that? For faculty (and graduate students) it can be useful to engage colleagues and find out more about what research they're doing. Social media can also be a great venue for fostering coalition partners within the community and help to promote ways of thinking about how community engagement can be mutually beneficial. Taking the risk to directly promote others' work can be a really rewarding payoff of social media.

JS: Alanna, this has been a really fascinating conversation and among other things, has made me think more about what I want to get out of my social media use. Thank you for taking the time to talk to me today about social media use among sociologists and specifically with the *Journal of Health and Social Behavior!*

As in the previous issue, I'm looking for recent graduates and scholars who use social media and are willing to share their experiences with me. To do that, please contact me at jessicaseberger@gmail.com.

Also, if you have ideas about interviewees for this column please send them to me at jessicaseberger@gmail.com.

A PUBLICATION OF THE MEDICAL SOCIOLOGY SECTION OF THE ASA

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