

MEDICAL SOCIOLOGY NEWSLETTER

SPRING 2013

INSIDE THIS ISSUE:

NOTES FROM THE CHAIR	1-2
2013 ELECTION CANDIDATE SLATE	2
HEALTH POLICY: THE ACA & MEDICAID EXPANSIONS	3-4
EVENTS FOR GRADUATE STUDENTS AT ASA! NEW!	4
CALL FOR SECTION AWARDS	5
STUDENT NEWS & VIEWS: THINKING LOCALLY ABOUT POLICY & MEDICAL SOCIOLOGY	6
ASSISTING THE ASSISTANT PROFESSOR	7
CAREER & EMPLOYMENT	8
TEACHING TIPS: OVERVIEW OF ASA'S TRAILS DATABASE	9
OFFICERS OF THE SECTION	10

REMINDERS

- **MSN Summer deadline**
June 3, 2013
- **2013 ASA Annual Meeting**
August 10-13, New York City
- **2014 ASA Annual Meeting**
August 16-19, San Francisco

NOTES FROM THE CHAIR BY ALLAN V. HORWITZ



Dear Colleagues,

The rising temperatures and early blooming flowers and trees signal that the annual ASA meeting will be upon us soon. Among this year's sessions will be a panel organized by Miranda Waggoner dealing with medical epidemics. Among the most prominent of these is the ubiquitous obesity epidemic. It seems that each day's news contains reports of new crises related to the growing weight of the population.

On the one hand, calories are impossible to escape. 7/11s are on every corner, MacDonald's and its siblings on every block, and vending machines in every building. Such readily available caloric abundance allows humans to indulge their natural cravings for food, especially foods high in sugar, salt, and fat. These cravings, however, were biologically designed to be adaptive in environments where calories were scarce and unpredictable. "Natural" eating means ingesting as many calories as we can, which had many upsides but no downsides for our ancient ancestors.

The mismatch between natural food cravings and the ready availability of calories is a substantial rise of average population weight in the United States and worldwide and consequent claims of the obesity epidemic. The consequences of major weight gain among children and adolescents are indeed worrisome because of the unknown impact of excess pounds throughout one's life. The health impact of overall weight gain among adults, however, are not quite as clear as public health authorities and media reports lead us to believe. While obesity is clearly associated with

hypertension, osteoarthritis, and type 2 diabetes, links with other types of morbidity are less clear. In addition, aside from the morbidly obese, heavier body weights are not associated with excess mortality. Indeed, overweight (but not obese) people have the longest longevity. For another thing, underweight people, especially among the elderly have the greatest risk of dying, even after controlling for pre-existing medical conditions. Finally, it remains to be demonstrated that weight loss leads to better health outcomes. About the only clear result of evaluations of dieting programs is that they are far more likely to fail than to succeed.

In contrast to the often opaque relationship between body weight and health outcomes is the clear association between heavier weights and social evaluations, especially for women. Our natural craving for calories is not only mismatched with our current caloric environment but also with cultural norms that promote thinness. Since the nineteenth century, overweight people have faced social stigma, are viewed as lazy, weak-willed, and slothful, and fare worse than thinner people in the workplace as well as the dating scene.

The current social environment is marked by extreme contrasts between a food industry that promotes extraordinarily high calorie products marked by combinations of fats, salt, and sugar and numerous food subcultures that urge people to eat organically, slowly, naturally, fat-free, meat free,

(continued on page 2)

NOTES FROM THE CHAIR

(continued from page 1)

and low-carb (or high-carb) diets, while avoiding nuts and gluten. Simultaneously, a gigantic thindustry, (often owned by the same corporations that promote caloric abundance), tout a huge variety of weight loss programs and procedures designed to shed pounds.

Medical sociologists are ideally suited to examine the complex interactions between natural food cravings, social environments marked by the ready availability of calories, cultural norms promoting thinness, and corporations simultaneously vested in having us gain and lose weight. Genetic and psychological factors undoubtedly have important roles in illuminating the current "obesity epidemic" but

sociologists might provide the best overall perspective on the health implications of the multiplicity of factors associated with weight gain and loss.

The panel on medical epidemics, including the obesity epidemic, will be just one of several thought provoking sessions at the annual meeting in New York this August. More details about our Section's sessions will be published in the summer issue of the Medical Sociology Newsletter and in the ASA's online preliminary program which will be available in a few weeks on the ASA's website at (<http://www.asanet.org/AM2012/index.cfm>). I'll look forward to seeing you in New York and hope everyone will enjoy a beautiful spring!

Best wishes, Allan

SECTION SLATE OF CANDIDATES FOR 2013 ELECTIONS

Laura M. Carpenter, Chair, Nominations Committee (l.carpenter@vanderbilt.edu)

Nominations Committee: Rene Almeling (rene.almeling@yale.edu); Elizabeth M. Armstrong (ema@princeton.edu); Kerry Dobransky (dobrankm@jmu.edu); Vanessa L. Munoz (vmunoz@brandeis.edu)

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

Section Chair Elect (1 elected):

Anne Figert, Loyola University-Chicago
Sydney Halpern, University of Illinois-Chicago

Council Members (2 elected) :

Sigrun Olafsdottir, Boston University
Bridget Gorman, Rice University
Alisa Lincoln, Northeastern University
Brea Perry, University of Kentucky

Teaching Committee Chair (1 elected) :

Jennifer Reich, University of Denver
Laura Senior, University of Wisconsin-Madison

Publications Committee Chair (1 elected):

Kathy Charmaz, Sonoma State University
Teresa Scheid, University of North Carolina-Charlotte

Career and Employment Committee Chair (1 elected):

Kelly Joyce, Drexel University
Patricia Rieker, Boston University

Nominations Committee Chair-Elect (1 elected):

Sara Shostak, Brandeis University
Nancy Kutner, Emory University

Nominations Committee (2 elected):

Miranda Waggoner, Princeton University
Ruha Benjamin, Boston University
Joanna Kempner, Rutgers University
Dan Menchick, Michigan State University

Nominations Committee, Student Member (1 elected):

Meredith Bergey, Brandeis University
Erin Pullen, University of Kentucky

Student Representative to Council (1 elected):

Tania Jenkins, Brown University
Mieke Thomeer, University of Texas-Austin

Don't forget to vote!

HEALTH POLICY BY JENNIE JACOBS KRONENFELD



The Affordable Care Act and Medicaid Expansions

I am not trying to be repetitive and only write about the same thing, but there are so many aspects of the Affordable Care Act (ACA) to talk about over the next year, as more of the major provisions begin to be in place, in 2014. In some ways, these are among the most important issues in health policy at this point in time. Over the past six months, however, some very interesting movement has been occurring in the relationship between state governments and the ACA. It is surprising because opposition to the ACA has been strong in the Republican party, and especially so among many Republican governors. In fact, it was partially the opposition to the ACA of some of these governors, along with Republican legislators, that led to the challenges to the law initially and thus to the Supreme Court decision about the legality of the ACA.

Reviewing a bit about the Supreme Court decision may be helpful, followed by some comments on some of the current state issues. First there were decisions about the legality of different aspects of the legislation in lower federal courts, with differing outcomes. In fall 2011, the Supreme Court agreed to decide the constitutionality of both the individual mandate and another key provision expanding Medicaid coverage to all citizens whose income is less than 133 percent of the Federal Poverty level. Oral arguments were held over an unusual three day period in March, 2012. The three day period was unusual because typically the Supreme Court hears arguments in a single day. Based on the questioning at the oral arguments, many expert observers of the Supreme Court thought it likely that the Court might strike down some important aspects of the law such as the Individual Mandate, which many health policy experts felt might doom the law. On June 28, 2012, much of the nation was surprised when the Supreme Court issued a split decision, but not in the ways many had anticipated. Chief Justice John Roberts joined the four Democratic appointees to the Court and concluded that the individual mandate was a constitutional exercise of Congress's power to levy taxes. On a different

issue, however, Chief Justice Roberts agreed with his four Republican appointees that the mandate could not rest upon Congress's power to regulate interstate commerce, as the mandate did not regulate commercial activity but rather compelled activity.

Perhaps the most surprising part of the Supreme Court decision was the seven-two decision that Congress had unconstitutionally coerced the states through tying the ACA's Medicaid expansion to a state's receipt of its prior Medicaid funds. Thus, the lack of a choice failed to respect the sovereignty of the states. As to its implications, while some of the justices thought this was sufficient to strike down the Medicaid expansion in toto, overall there were different thoughts, leading to a final 5-4 decision arguing that the Medicaid expansion could survive as long as it was viewed as optional for the states.

After this decision, a number of governors, especially Republican governors, announced they probably would not participate in the Medicaid expansion portion, since it was optional. Health policy experts were concerned about the impact that having a number of states not participating would have, but were overall relieved to have clarity about the legality of most of the ACA. In the last few months, several interesting things have happened linked to state decisions about whether to participate in the Medicaid expansion portion of the legislation. Coverage for the newly eligible adults will be fully funded by the federal government for three years, beginning in 2014, phasing down to 90% by 2020. A number of Republican governors who were among the most opposed, including Governor Rick Scott of Florida, the governors in such important, large states as Michigan and New Jersey, and the governor in my home state of Arizona have all announced they will probably participate in the Medicaid expansion. The most recent decision was by Chris Christie of New Jersey at the end of February, and he joined seven other Republican governors so far who have decided to participate in the Medicaid expansion portion of the ACA.

(continued on page 4)

HEALTH POLICY BY JENNIE JACOBS KRONENFELD

(continued from page 3)

Understanding why these governors have now decided to participate helps us understand some of the complexities of health policy decisions in the United States. Scott is a vulnerable incumbent in an important swing state. His refusal to accept Medicaid expansion might cost hospitals in his state close to 3 billion dollars if then uninsured Floridians were to show up in emergency rooms and have to be treated without Medicaid coverage or any insurance. The costs would be particularly high since one impact of the ACA is to change the disproportionate share funds that in the past went to hospitals with a high proportion of uninsured patients, the rationale being that these people should be covered with insurance by aspects of the ACA. Using some figures from my home state of Arizona, as reported in the Arizona Republic, helps to provide some details linked to jobs in states that helps us better understand why so many states appear likely to end up participating in the Medicaid expansion, despite ideological opposition to the concept. In Arizona, to meet budget constraints,

the state froze enrollments for low income childless adults in July, 2010. At that time, more than 120,000 people lost health insurance coverage. Hospitals reported up to a quadrupling of uncompensated care costs. Taking the new federal match money and putting an estimated 200,000 more people in the state on health insurance should greatly lower uncompensated care costs and save or create 21,000 jobs, many high quality jobs for people such as nurses and health care technicians. In any state with a fragile recovery from the recent recession, maintenance of health care jobs is important. In most of the states, alliances made up of hospitals, other health care facilities and physicians have all lobbied governors to participate in the Medicaid expansions. These voices stressing the economic benefits to states of participation in Medicaid expansion appear to be carrying the day. It is helpful for sociologists to understand these complexities, and be able to explain some of these issues to students and the public.

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

ASA 2013 Medical Sociology Section Activities for Graduate Students !

Coordinated by Graduate Student Representatives Lianna Hartmour and Chioun Lee

Discussion with Reeder Award Winner Charles Bosk: Dr. Bosk has kindly agreed to attend an informal gathering with graduate student section members. Please come to discuss research projects, career development, medical sociology and more.

Graduate Student Luncheon: Graduate student section members will meet after the business meeting over lunch to connect and network.

Research Interest Matching: Graduate student section members will be invited to be part of an email exchange. Students with similar research agendas will be matched so they can make arrangements to meet during the conference.

****More information will be announced via the section listserv once details are finalized****

CHECK OUT THE RETOOLED MEDICAL SOCIOLOGY WEBSITE!
<http://www2.asanet.org/medicalsociology/index.html>

SEEKING NOMINATIONS FOR 2014 REEDER AWARD

Nominations are due by May 31, 2013

The Medical Sociology Section invites nominations for the 2014 Leo G. Reeder Award to be awarded at the annual meeting of the Medical Sociology Section in San Francisco. This award is given annually for Distinguished Contribution to Medical Sociology and 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 by email, using the subject line "2014 Reeder Award Nomination" to Susan E. Bell, Chair-Elect of the Medical Sociology Section, at: sbell@bowdoin.edu.

SEEKING NOMINATIONS FOR 2013 LOUISE JOHNSON SCHOLAR

Applications are due by May 15, 2013

The Medical Sociology Section will select a student member of the section to be the 2013 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 and a former colleague of Louise Johnson. The Scholar will receive travel funds up to \$350 to present at the annual ASA meetings in New York City and to attend section events. The Scholar will be chosen 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 2013 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 may be sent via email as Word documents or PDFs. Applications and letters of recommendation should be emailed to: Richard Miech at richard.miech@ucdenver.edu with the subject line: 2013 Louise Johnson Scholar Nomination .

NEW BOOK ANNOUNCEMENT

Kronenfeld, Jennie Jacobs; Parmet, Wendy E and Zetta, Mark A. Editors. *Debates on US Health Care*. Los Angeles, California: Sage, 2012. 569 pg.

This book is designed, through a series of debates in which critical issues about various topics are presented in a Point-Counterpoint format, to examine more of the issues linked to health policy and health care, partially due to the enactment of the Patient Protection and Affordable Care Act in 2010. The book is divided into three sections: Philosophical, Legal and Political Debates, Economic and Fiscal Debates and Quality of Care Debates.

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

STUDENT NEWS & VIEWS BY LORINDA B. MOORE & ANDREA N. POLONIJO



Thinking Locally about Policy and Medical Sociology

Medical sociology has contributed much to our understanding of health and illness. Time after time, sociological studies have shown that the wealthy and more educated outlive their less advantaged counterparts, that profound racial-ethnic disparities exist in healthcare, and that our social relationships (for better or worse) impact our health and wellbeing. We have made great contributions to understanding some of the social factors and mechanisms underlying disease, but how effective has medical sociology been for informing health and social policy?

Since the inception of the medical sociology field, over 50 years ago, numerous policies, designed to either directly or indirectly impact the health and wellbeing of individuals, have been implemented on both local and national levels. For example, food assistance and public housing programs have aimed to help low-income populations meet some of their basic needs, warning labels have been added to alcohol and tobacco products so that all consumers are made equally aware of their health risks, and both Canada and the US have implemented some form of policy aimed at universal access to healthcare (though arguably Canada has been more successful in the endeavor). The question remains, however, to what extent has medical sociology directly affected the outcomes of policy decisions?

Findings from medical sociology research can (and have) been adopted by other fields such as social work and public health, diluted or translated, and presented to policy makers, but it is seemingly less often that we see our work applied directly from the sociology field to the policy arena. Moreover, measuring the direct impact of medical sociology on policy is challenging, given the increasing tendency toward interdisciplinary research and the adoption of sociological theories and methods in other disciplinary fields. While we do not wish to dwell on the debate of whose research counts as “sociological,” we would like to offer some practical strategies for budding medical sociologists (like ourselves) who want to en-

sure that their work directly affects policy change:

1. Consider the policy implications of your research – both big and small. While we would ultimately like to work toward a utopian society, a radical transformation of the social structure is likely out of our reach. However, that doesn't mean that small policy changes don't matter for improving the health of a significant number of people. Local or small-scale policy changes that can be implemented within a term of office are likely more easily attainable.
2. Repackage and contextualize your research findings so that they are applicable to the locale that you want to reach. Local governments, school boards, or parks boards are just some of many examples of audiences that may find the policy implications of your research valuable. Distributing policy briefs and media releases alongside your research may generate interest in the possible application of your findings.
3. Think outside the box and consider possible creative policy changes. Even if a policy recommendation doesn't at first glance seem like a health policy, realize that many policies that improve standards of living and well-being for individuals may likely have indirect effects on health.

These recommendations are not to discourage you from aiming for large-scale change, but rather to remind you of some of the low-hanging fruit that may be easily within your reach.

Have you had success translating your research findings into policy change? For our final column we will be featuring success stories of medical sociologists who have had a direct impact on policy, clinical education, or practice. If you are interested in being featured, please contact us to share your story at: lorinda.moore@alumni.ubc.ca

ASSISTING THE ASSISTANT PROFESSOR BY BARRET MICHALEC

Many thanks to all of you who responded to last edition's post regarding qualitative methods and more clinically-minded journals. One response offered the idea of submitting these ideas and concerns in the form of a "Commentary" to these types of journals – thereby serving multiple purposes: a.) getting published, b.) venting frustrations, and c.) raising awareness. Some might say that this is the "trinity" of any written effort.

"Most [clinically-minded journals] have some form of 'Commentary' that are articles that are written with a particular viewpoint in mind. I think that you can turn some of the frustration that you experienced into a commentary about what is ethically-minded, good qualitative research on the field's topics. It likely won't be like what editors often see - that, I think, would give you a good chance at getting the commentary published."

Another aiding response offered articles on the specific topic of social science and its perceived "academic legitimacy" within the health research fields and was accompanied with the supportive note, "Welcome to the frustrating situation of sociologists wanting to publish in clinical journals. You're not alone, I can assure you." The articles were informative and helpful, but they also sparked a slumbering project idea that could lend to a collaborative effort with the respondent which is most exciting. As is evident, I am trying to protect the identity of all submitters and responders, but please let me know if you are interested in the articles I received and I will pass them along.

I am also very appreciative to all those that submitted their own experiences and trials as Assistant Professors. There was a wide range of submissions – some people simply wanted to express their thoughts (but not to be featured in the Newsletter), some entries were less specific to medical sociology and more to do with academia in general, and many referred to the various struggles associated with the path to tenure. All were very much appreciated, relatable, and heard. I will do my best to feature those entries that speak to

the broadest audience of medical sociology Assistant Professors. This edition's feature focuses more on teaching and course structure.

"...I have noticed a fairly dramatic increase in the number of Pre-Medical Studies majors (as well as Biology and Chemistry majors) in my and colleagues' medical sociology courses. There was always a few here and there each semester (perhaps 5-10 out of 40 or so), but over the past year this has increased to roughly half of the class (20-25 or more). It is evident to me (and others) that these students do indeed learn and express themselves differently than your typical sociology, anthropology, or even psychology students – they appear to have difficulty with essay-based or short-answer type questions, questions where they have to explain not just what, but also how and/or why. Of course, this does not apply to all Pre-Med, Pre-Health Professional, Bio, or Chem students (many actually do quite well), but it has been something I have noticed and was interested to see if other instructors of medical sociology courses, or courses within the arena of sociology of health, have: a.) Experienced this enrollment phenomenon of increased Bio, Chem, and general Pre-Med Students, b.) If so, if they notice any "difference" between these students and students that have a more sociological background, and c.) if so, what are some effective ways to reach and engage these particular students so to provide them an arena to succeed, while still maintaining sociology's integrity and not losing the more social science-oriented students."



I encourage all readers to send me their responses to this inquiry, and I will send them along to the original author. I will also post a few responses (along with my own) in the next edition of the Newsletter. Thanks again for sharing, please continue to do so at: bmichal@udel.edu

Post Notices on the ASA Medical Sociology Section List

<MEDSOC@LISTSERV.BROWN.EDU>

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

CAREER & EMPLOYMENT BY WILLIAM COCKERHAM



Spring is breaking out, at least in the South, which means that job hunting/recruiting season is not far off. As previously noted, the job market is getting better. Universities that managed their money well through the recent troubled economy began to acquire promising young medical sociologists in greater numbers the past few years, and others started to do likewise this year as the economy improved. The result was that there were several positions in medical sociology in 2012-13 and the forthcoming academic year looks even more promising.

However, just because opportunities have increased for jobs, does not mean that they are easier to get. In the past down-market, some recent graduates took the opportunity to go into post-doctoral positions in programs where the experience will not only enhance their application, but in which they had the time, support, and encouragement to publish. So post-docs are likely to be serious competitors for any position, especially in research intensive sociology departments. But regardless of whether a post-doc or newly minted Ph.D., finding a position without publications is a challenge because one of the first things search committees look at on a c.v. is the applicant's publications.

It is now common, not rare, that grad students publish. Today, it is essential in getting a good job. I often see the c.v.'s of job candidates who do not have publications put in a separate pile for consideration by search committee members only if there red flags on applications from those who have published. There are usually no such flags—which means the unpublished, like the unwashed—do not get much attention. Why? The reason is many (most?) grad students today have published, as noted in a previous column, so if the competition in your market is publishing, you need to do the same if you want to go to a good program with a research tradition. The assumption by search committees is that if you have published, particularly in a high impact journal as a grad student or post-doc, you are likely to be successful doing so as a faculty member. Where you publish is also highly relevant, as the quality of the journal is important just as it is for faculty. It can also be said that it is better to publish somewhere than nowhere, but this may not always be a good strategy because publications in highly marginal, low-impact journals are not well regarded. It may signify

that the applicant's work may potentially remain at this level. On the other hand, grad students have to start somewhere, so you may get a pass on this, but still face competition from others who have published in higher ranked journals.

The places to publish in medical sociology that search committees look for are well known to experienced sociologists. The *American Sociological Review* and the *American Journal of Sociology* are clear winners. Another no-brainer is the *Journal of Health and Social Behavior*. *JHSB* has an exceptionally high rejection rate (90 percent?), so publishing there is strong evidence of success in medical sociology and stands out on the c.v. of job applicants in the field. Also highly respectable are *Social Science and Medicine*, an excellent journal with a large international readership, and *Sociology of Health & Illness*, a journal that has seen its impact factor score rise significantly in the past few years. The latter also publishes a lot of qualitative research which one does not see in *JHSB* as often. A new rising journal is *Society and Mental Health*, sponsored by the Mental Health Section of ASA, and there is *Social Theory and Health* that covers new theoretical work in a field that has moved from being almost atheoretical in the beginning to including extensive use of theory today.

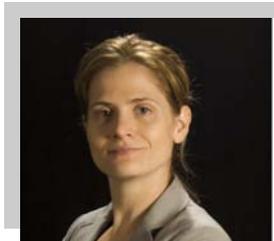
There are other journals as well that publish good work and are well thought of, and some that are not well regarded that will not help attracting attention to your application. What about e-journals? No easy answer here, but the bottom line is that if you have to pay to publish, paying a fee may be more important to the journal than quality in getting the work published—which lowers the value of the publication in the opinion of some. Paying to have someone publish your work, even if the money comes from a grant, can be a questionable practice because it signifies that the work might not have been publishable otherwise even if this is not true. So you need to be careful here. Once again—good luck.

Send your suggestions for future career and employment columns to: wcocker@uab.edu.

NEW ARTICLE ANNOUNCEMENT

Moen, Phyllis, Wen Fan, and Erin L. Kelly. 2013. Team-Level Flexibility, Work-Home Spillover, and Health Behavior. *Social Science & Medicine* 84:69-79.

Drawing on two waves of survey data conducted six months apart in 2006, this study examined the impacts of a team-level flexibility initiative (ROWE- Results Only Work Environment) on changes in the work-home spillover and health behavior of employees at the Midwest headquarters of a large US corporation. Using cluster analysis, we identified three distinct baseline spillover constellations: employees with high negative spillover, high positive spillover, and low overall spillover. Within-team spillover measures were highly intercorrelated, suggesting that work teams as well as individuals have identifiable patterns of spillover. Multilevel analyses showed ROWE reduced individual- and team-level negative work-home spillover but not positive work-home spillover or spillover from home-to-work. ROWE also promoted employees' health behaviors: increasing the odds of quitting smoking, decreasing smoking frequency, and promoting perceptions of adequate time for healthy meals. Trends suggest that ROWE also decreased the odds of excessive drinking and improved sleep adequacy and exercise frequency. Some health behavior effects were mediated via reduced individual-level negative work-home spillover (exercise frequency, adequate time for sleep) and reduced team-level negative work-home spillover (smoking frequency, exercise frequency, and adequate time for sleep). While we found no moderating effects of gender, ROWE especially improved the exercise frequency of singles and reduced the smoking frequency of employees with low overall spillover at baseline.

TEACHING TIPS**BY KATE STRULLY****An Overview of the ASA's TRAILS database**

Several section members may already be familiar with the ASA's TRAILS database, but for those who are not, here is brief overview of this helpful teaching resource.

TRAILS, which stands for Teaching Resources and Innovations Library for Sociology, is an online searchable database of peer-reviewed teaching resources (e.g., syllabi, lectures, class activities, assignments, websites, videos, images, etc.). The resources on TRAILS are categorized into about 80 subject areas, including, of course, medical sociology.

TRAILS can be searched using key terms or browsed in a modular fashion by subject and/or type of teaching tool. New submissions to TRAILS undergo a two stage peer review process. This helps maintain the quality of the resources on TRAILS, and also means that getting materials accepted into TRAILS can be a useful addition to one's teaching curriculum vita for promotion and tenure.

The list of medical sociology resources on TRAILS is

reasonably long and diverse. It covers a range of areas including key concepts (e.g., social construction of illness, sick role, etc.) and specific substantive topics (e.g., HIV/AIDS, diabetes, health care policy, etc.). I have personally found some of the medical sociology writing assignments and class activities in TRAILS to be particularly useful. Of course, the more section members submit to TRAILS, the richer the medical sociology resources will become.



For more information on TRAILS, go to <http://trails.asanet.org/Pages/TDLContent.aspx>. To access the TRAILS database, you must have a subscription, which costs \$25 for ASA members and \$100 for non-members.

A PUBLICATION OF THE MEDICAL SOCIOLOGY SECTION OF THE ASA

Section Officers**Chair**

Allan V. Horwitz
Rutgers University
Department of Sociology/Institute for Health, Health
Care Policy & Aging Research
112 Paterson Street
New Brunswick, NJ 08901
Phone: (848) 932-8378
ahorwitz@ifh.rutgers.edu

Chair-Elect

Susan E. Bell
Department of Sociology and Anthropology
311 Adams Hall
Bowdoin College
7000 College Station
Brunswick, ME 04011-8470
Phone: (207) 725-3652
sbell@bowdoin.edu

Secretary-Treasurer

Kristen W. Springer
Rutgers University
Department of Sociology/Institute for Health, Health
Care Policy & Aging Research
112 Paterson Street
New Brunswick, NJ 08901
Phone (848) 932-7516
kspringe@rci.rutgers.edu

Newsletter Editor

Sarah Burgard
University of Michigan
Sociology/Epidemiology/Population Studies Center
500 South State Street
Ann Arbor, MI 48109-1382
burgards@umich.edu

Student Newsletter Editors

Lorinda B. Moore & Andrea N. Polonijo
University of British Columbia
lorinda.moore@alumni.ubc.ca