

MEDICAL SOCIOLOGY NEWSLETTER

FALL 2013

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REMINDERS

- **MSN Winter deadline**
January 3, 2014
- **2014 ASA Annual Meeting**
August 16th–19th, San
Francisco
- **2015 ASA Annual Meeting**
August 22-25, Chicago

NOTES FROM THE NEW CHAIR BY SUSAN E. BELL



I am happy to report that the medical sociology section membership is holding steady and continues to be one of the three largest sections in the ASA. With more than 1,000 members we will be able to sponsor seven sessions at the 2014 Annual Meeting in San Francisco, August 16-19. All of the medical sociology sessions are open: health inequality (Janet Shim, University of California, San Francisco), medicalization and reproduction (Elizabeth Armstrong, Princeton University), applications and practice of medical sociology (Donald Light, Rowan University School of Medicine and Princeton University), health quality control (Chuck Bosk, University of Pennsylvania), and one session organized jointly with the mental health section about violence, trauma and health (Heather Turner, University of New Hampshire). The roundtables will be organized by Matthew Archibald (Colby College) and Katherine King (Environmental Protection Agency). The online open submission will open on December 6th and close on January 8th, 2014.

The medical sociology section day is Sunday, August 17th. Please mark your calendars so that you can attend the session's Business Meeting, Awards Ceremony, Reception, and Reeder Award Lecture on that day.

October 1st marked the first day millions of uninsured Americans could begin enrolling in health insurance through state Health Insurance Marketplaces (also known as health insurance exchanges) under the Affordable Care Act. The ACA is a supremely important social policy change and medical sociologists have been – and will continue to be – keenly attentive to its implementation and its impacts at the individual, state, and national level. Over the next few months the effects of this stage of the Affordable Care Act on coverage, the utilization of health services, reduction of health inequalities, and the provision of medical care will begin to take shape. The ACA continues to be sharply contested in Congress, as the government shutdown – also on October 1st – attests. These two October 1st events stand out for their importance to health and wellbeing and to the work of medical sociologists.

Members of the medical sociology section may stay in contact via two medical sociology listservs, a medical sociology website, and a medical sociology Facebook page. These sources provide a variety of ways to learn about job postings, fellowship and conference announcements, new book announcements and requests for information. We owe thanks to Dave Bott, Mark Sherry, and Simon Geletta for the

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NOTES FROM THE NEW CHAIR

BY SUSAN E. BELL

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work they do to keep members of the section connected virtually.

(1) The official *medical sociology section listserv sponsored by the ASA*. Members of the section are automatically signed up for this listserv. Members post announcements and requests for information to it; before a post is circulated the section chair will be asked to approve the posting (MEDICAL_SOCIOLOGYANNOUNCE@LISTSERV.ASA.NET.ORG) Members may receive messages from this listserv in the form of a digest. Digests package a week's worth of listserv messages into a single article. Digests reduce inbox clutter. To request messages in digest form, start here (<http://www.asanet.org/about/sections/listservs.cfm>)

(2) The medical sociology *listserv hosted by Northeastern University* sponsored by Phil Brown and managed by Dave Bott. Anyone may join the listserv and post announcements and requests for information to it; before a post is circulated the poster will be asked to approve the posting (MEDSOC@LISTSERV.NEU.EDU)

(3) The official *website* of the medical sociology section of the ASA. The website has been recently updated to include news about the Affordable Care Act (see the "Obamacare" link) on the Medical Sociology website. Mark Sherry is the webmaster for this website. Mark works closely with associate

webmaster Simon Geletta (<http://www2.asanet.org/medicalsociology/index.html>)

(4) The medical sociology *Facebook* page. Anyone who belongs to Facebook may "like" this page. (https://www.facebook.com/MedicalSociologyASA?hc_location=stream)

Sarah Burgard, current editor of the medical sociology section *Newsletter*, will be stepping down at the end of this year. She will be sorely missed, but I am pleased to report that she will be succeeded by Ann Bell and Barret Michalec from the University of Delaware.

Many thanks to Allan Horwitz for his leadership and especially for the splendid program he oversaw at the 2013 meetings in New York City. In addition, I am grateful to the following outgoing members of the medical sociology Council for their service to the section: Kristen Springer (Secretary-Treasurer), William Cockerham (Career and Employment Chair), Richard Meich (Council), Kristin Barker (Publications Chair), Laura Carpenter (Nominations Chair), Betsy Armstrong (Nominations), Kerry Dobransky (Nominations), Vanessa Munoz (Nominations), Kate Strully (Teaching Chair), Lianna Hart (Council), and Eric Wright (past-Chair).

I look forward to working with all of you this year and to seeing you in San Francisco.

Susan E. Bell

sbell@bowdoin.edu

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

PLEASE KEEP SIGNING UP YOUR STUDENTS AND ENCOURAGING YOUR COLLEAGUES TO JOIN!

2014 ASA MEDICAL SOCIOLOGY SESSIONS: SUBMIT YOUR PAPERS!

(1) Health Inequality: Tracing Trends and Theorizing Processes

Organizer: Janet Shim, University of California, San Francisco (Janet.Shim@ucsf.edu)

Description: In conjunction with the ASA 2014 meeting theme of examining growing economic inequality and its consequences for Americans, this session focuses on the unequal distribution of health and disease. It solicits papers that both trace trends in health inequalities over time, as well as theorize the mechanisms, pathways, and processes through which inequalities are produced and sustained. Papers utilizing qualitative, quantitative, and mixed methodologies are welcome. The session seeks to achieve a more refined and nuanced picture of health inequalities and also more theoretically informed understandings of where, how, and for whom they are consequential. In so doing the session will extend the capacity of sociological research and theory to contribute to greater health equity and justice.

(2) Medicalizing Nature, Naturalizing Culture: Disrupting Dichotomies in Reproduction

Organizer: Elizabeth Armstrong, Princeton University (ema@princeton.edu)

Description: Reproduction straddles and blurs the line between nature and culture. It is at once a basic biological phenomenon and deeply inflected by social values, situated at the center of seemingly intractable political and cultural debates about contraception, abortion, childbirth, breastfeeding, reproductive technology, etc. This session will focus on both the forces that drive the medicalization of reproduction and the reproductive body in contemporary society and the social actors, moments and movements that seek to disrupt and undo that medicalization and thus “re-naturalize” reproduction.

(3) Applications and Practice of Medical Sociology

Organizer: Donald Light, Rowan University School of Medicine and Princeton University (dlight@princeton.edu)

Description: The relevance of public sociology and the use of sociological perspectives or tools could not be more important to the discipline. Submissions are sought on the application of

medical sociology that addresses an important problem, from medical sociologists in a variety of settings. The implementation of the nation's first universal health care act is especially relevant, though other contexts and issues will also be considered.

(4) Ethnography and Health Quality in a Global Context

Organizer: Charles L. Bosk, University of Pennsylvania (cbosk@sas.upenn.edu)

Description: What facilitates or impedes hospitals' adoption of basic public health measures or quality and safety practices? Understanding how to improve the value of medical services while lowering the cost is a major problem for private and state funders. This session focuses on how health quality programs operate in local contexts. It will solicit papers from ethnographers who have studied the adoption of or resistance to new ways of providing health care in a variety of global contexts.

(5) Trauma, Violence, and Health (joint session Medical Sociology/Mental Health)

Organizer: Heather Turner, University of New Hampshire (heather.turner@unh.edu)

Description: This session explores violence, suffering, and trauma from the perspective of large-scale circumstances (e.g., war and disaster) as well as from the perspective of local circumstances (e.g., families and communities). In keeping with the theme of the 2014 Annual Meeting, it particularly encourages papers that explore variations in violence, suffering and trauma by economic and political uncertainty and by race and ethnicity, gender and immigrant status.

Roundtables: Matthew Archibald, Colby College (marchiba@colby.edu)

Katherine King, Environmental Protection Agency (katherinekingphd@gmail.com)

2013 ASA AWARD WINNERS!

Right: Elizabeth M. Armstrong presents Chuck Bosk with the Leo G. Reeder Award after his award address.



Rachel Best Wins 2013 Freidson Award

The 2013 Eliot Freidson Award was given to a journal article. From a very strong pool of nominated articles, the committee selected “Disease Politics and Medical Research Funding: Three Ways Advocacy Shapes Policy: by Rachel Best, as the winner of this year’s Freidson Award. This article was published in *American Sociological Review*. All of the committee members are very impressed with Professor Best’s paper. The paper demonstrates how disease advocacy has transformed the politics of medical research funding over the last several decades. Professor Best documents the influence of different disease interest groups over a 19-year period and demonstrates the impact such groups have had on federal research priority-setting.

The committee was uniform in its admiration of the empirical project undertaken by Professor Best. This is first paper to study multiple disease interest groups using longitudinal data. The dataset compiled by the author includes information about 53 diseases from 1989 to 2007. For each disease in each year, Best collected data concerning the amount of federal research funding, the amount of advocacy, and mortality rate and demographic characteristics. Professor Best was able to determine that the most organized advocacy groups have indeed been the most successful in securing research funds. A downside of this type of advocacy is that it will likely contribute to existing social disparities. For example, there has been a decline in funding to diseases that disproportionately affect women (excluding breast cancer) and Blacks in this new funding-priority climate. Best also argues that part of the new funding climate created by increased disease advocacy is that the advocacy groups successfully redefined “patients” as the beneficiaries of funding, rather than researchers or organizations. Some diseases are losers in this new funding-scheme. Here stigmatized illnesses serve as case in point. As the beneficiaries of funding come to be seen as the patients themselves, funding has been diverted from conditions that carry stigma or suggest a lack of worthiness, despite having high mortality rates (e.g., lung cancer and liver cancer).

In sum, the paper is empirically and theoretically ambitious and adds much needed evidence to an important debate. It is also executed in a clear and powerful fashion. If you have not yet done so, be sure to read this important article by Rachel Best. Congratulations, Rachel!

~Kristin Barker for the Committee



Garbarski Wins 2012 Simmons Award

Dana Garbarski is this year's winner of the Roberta G. Simmons Outstanding Dissertation in Medical Sociology award.

Using secondary data from the National Longitudinal Surveys of Youth, Dr. Garbarski's dissertation was entitled, "Dyadic and Dynamic Relationships: An Extension of the Socioeconomic Status-Health Framework," which she completed at the University of Wisconsin-Madison.

While past research has examined how mothers' traits (and other aspects of "social background") influence children's health, Dana was inspired to reverse this analysis by also examining whether and how the poor health of children affects mothers' health and socioeconomic outcomes across the life course.

Drawing upon theories of cumulative (dis)advantage, Dr. Garbarski used extremely rigorous statistical methods to test these dynamic, reciprocal relationships across the life course. The committee found Dr. Garbarski's work to be incredibly well-written, thoughtful, and a promising addition to the fields of medical sociology, family, and the life course.

~ Dawne Mouzon for the Committee

The inaugural Howard B. Kaplan Memorial Award in Medical Sociology is awarded to graduate student Alexander Lu.



Mieke Thomeer is the 2013 Louise Johnson Scholar

Mieke Thomas is this year's winner of the Louise Johnson Award. The selection committee reached consensus on its first vote that Mieke's work was truly outstanding. In her paper "Chronic Conditions and Distress within Marriage: A Dyadic Approach" Mieke investigates the processes through which the chronic conditions of one married partner influence the other partners' psychological distress. Her analysis brings multiple strengths to the topic. Her theoretical approach is innovative and brings together insights from the life course perspective, stress theory, and gerontology. To test her ideas she draws on the longitudinal Health and Retirement Study to examine how the implications of chronic conditions unfold over time and ricochet within married couples. To test her innovative theoretical ideas Mieke uses the advanced statistical method of dyadic longitudinal modeling. Mieke demonstrates a rare and precious skill in her ability to both synthesize existing literature in innovative ways to develop important new hypotheses, and at the same time to use state-of-the-science methods and data to evaluate them.

~ Richard Miech for the Committee

CAREER & EMPLOYMENT BY PATRICIA RIEKER



Good News for Medical Sociologists

The findings from the latest 2012-2013 ASA Job Bank Survey⁴ and previous 2012-2012 Survey² show that the academic job market for new Sociology PhD's has greatly improved compared to the 2008-2009+ recession years. In fact, Sociology is faring better than the other social sciences. Although Social Control, Law, Crime and Deviancy remains the most advertised specialty, medicine and health was the fourth-highest ranked specialty in both 2011 and 2012 and was the 3rd ranked specialty sought by High-research/Doctorate, and Master's Comprehensive institutions in 2011. However, in addition to the mismatch between graduate student interests and the most advertised positions, the authors do caution that obtaining a university position is still a challenge due in part to the "overhang" of scholars who were "unplaced" or "under-placed" from the recession job market years. Their advice to incipient sociologists, who want to stay active in the discipline, is to do the following: extend time in grad school; find post-docs; accept a temporary position; or **find a research or other non-academic position**. An enterprising group of PhD's and post-doctoral fellows across disciplines at the University of California, Berkeley did just that; in March 2013 they organized the first non-academic job fair career conference, a sold-out event titled "Beyond Academia."³

Career and Employment Choices

In response, over the period of my term as chair of careers and employment for the Section, I would like to use this column to extend and shift a dialogue started by Karen Lutfey, who sought and addressed questions about non sociology department employment/careers when she wrote

this column in 2009-11. She was followed by Bill Cockerham in 2011-13 who focused on tenure-track employment. But I want to shape that dialogue in a way that considers the non-academic position more of an active choice rather than as a default. This will include inviting sociologists who have held applied sociology positions to assess their experiences through a sociological frame. Thus, I plan to explore and document the wide variety of non-tenure track career and employment choices, including benefits, challenges and constraints in applied settings in comparison to those in university and college departments. In subsequent columns I will augment this focus with information about skills, competencies, rewards and drawbacks through interviews with sociologists who have been employed in these settings, and especially those who often have experience in both settings. As appropriate I will highlight the different goals, orientations, capabilities and tradeoffs associated with various settings. I am not advocating such choices but instead providing information to broaden the dialogue about career pathways and employment, especially for medical sociologists. It makes more sense to me to refer to these as applied settings rather than to use the term 'nonacademic' as it implies that such sociologists are not working in an intellectual environment.

A Sociological Imagination

I should disclose that I have bridged the departmental and applied settings as well so I will draw on some of the skills and knowledge I gained in both sociology departments and multi-disciplinary settings over the past 40 years. This includes being employed full time in two Sociology (*continued on page 7*)

CAREER & EMPLOYMENT BY PATRICIA RIEKER

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Departments (University of North Carolina, Chapel Hill and Simmons College, and part time in semi-retirement at Boston University. I am an Associate Professor at Harvard Medical School, Department of Psychiatry. In between my tenure in the two Sociology departments, I was Director of Psychosocial Research at the Dana Farber Cancer Institute and I have been and still am an active consultant within numerous divisions of the Centers for Disease Control.

I am using my biographical information here so that colleagues might understand the basis of the insights I acquired from moving among the different settings and statuses. For example, I have worked in contexts (e.g. Sociology departments) where I was central to the core activities of teaching, research and governance as well as settings where I was on the margins (e.g. the CDC), and those that are somewhere in between (e.g. Clinics and Medical Schools). By the way, in many instances being marginal provided unexpected benefits, such as a broader view of organizational politics without involvement in the dramas and power struggles. As you know, how you make career and employment choices depends on the context and your intellectual interests. So, if your goal is to have your scholarly work be used to change behaviors, policies, or organizations, then being employed in such settings allows you to see the direct impact of your efforts. In addition, these multidisciplinary experiences and my education in the Sociology of Knowledge/Science also gave me a deep appreciation for the different epistemologies and approaches to knowledge and research by my non-sociology colleagues, a broad perspective that is in short supply in medical schools and other applied settings (more about the latter in future columns). I hope that these columns will be helpful with the career and employment

process both for new PhDs and other colleagues.

Endnotes

1. Spalter-Roth, Roberta, Kisielewski, Michael. On the Road to Recovery: Findings from the ASA 2012-2013 Job Bank Survey. Research Brief, August, 2013
2. Spalter-Roth, Roberta, Kisielewski, Michael and Jacobs, Jerry. On the Upswing: Findings from the ASA 2011-2012 Job Bank Survey.
3. Anwar, Yasmin. 2013. "PhD Students Rethink the Tenure Track." Berkeley: UC Berkeley News Center. Available at <http://newscenter.berkeley.edu/2013/03/20/beyond-academia/>.

Other ASA resources

Janet Mancini Billson's *Mastering the Job Market with a Graduate Degree in Sociology* (out of stock).
ASA booklet. Applying for a Faculty Position in a Teaching-Oriented Institution (Third Edition).

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)

HEALTH POLICY BY JENNIE JACOBS KRONENFELD**Residency Slots and Physician Shortages**

Since I am sure I will write more about the Affordable Care Act (ACA) in later columns, I am switching to a different topic for this column, issues of physician shortages and linkages to residency slots, although even this issue has some linkages to the ACA. Many experts would say that the US has been dealing with issues of physician shortages for a number of years, with variability depending upon the specific part of the country. Currently, it is rural areas in the US that are most likely to have serious medical shortages but this could expand in the coming years. Almost all health policy experts agree that with many Americans benefitting from health insurance coverage as part of the implementation of the ACA starting in January, 2014, shortages of doctors in the U.S. are likely to increase. American medical schools are often viewed as one of the ways in which the shortage should be addressed, and there have been some new medical schools in the past decade and some established ones that have made a few increases in class size. However, much of the issue of physician shortages is as linked to the later years of medical education, residency programs, as it is to numbers of students enrolled in medical schools.

The residency programs that train new doctors once they graduate from medical schools are largely paid for by the federal government, and the number of students accepted into such programs has been capped at the same level for 15 years. This is a major reason why most medical schools are holding back on further expansion. The number of applicants for residencies already exceeds the available positions, according to the National Resident Matching Program, the 60-year old Washington-based nonprofit that oversees residency programs and their link to medical students. According to an August 28, 2012 assessment by the Department of Health and Human Services, the U.S. has 15,230

fewer primary-care doctors than it needs. The Association of American Medical Colleges has predicted that the shortage, including specialists, might climb as high as 130,000 by 2025.

Medical training is not inexpensive, and the cost of training one new resident is estimated to be about \$145,000 according to the policy officer at the American Association of Medical Colleges. Thus, increasing the number of taxpayer-financed training slots beyond 85,000 would require Congress to allocate money at what is already a period of very contentious budget debates. A different financing approach could be to add private financing to tap new sources of funding, such as from health insurers, but this would take a great deal of additional time and policy debate. A very different approach to increasing the number of physicians in the US would be to import doctors from overseas (as we have done in some years to solve nursing shortages), however this is quite controversial. Concerns include both the level of training and expertise of such doctors, issues of language and cultural competence and problems that might result therefore in patient-physician communication, and the ethical concerns about whether a wealthy, developed country such as the US should be taking well-trained resources from most likely less wealthy and less developed countries. Experts point out that often professional training in many countries is subsidized heavily if not paid for completely by the home country, and then the US would benefit from the country of origin having paid for the professional training and then losing both the person and their expertise if that person moves to the US for practice as a physician.

Teaching hospitals are interested in increasing the number of slots, and a group representing those hospitals has greatly increased its lobbying budget to *(continued on page 9)*

HEALTH POLICY

BY JENNIE JACOBS KRONENFELD

(continued from page 8)

support legislation introduced last year that would add 3,000 residencies a year through 2017 at a cost to taxpayers of about 9 billion dollars, but, in the current fiscal climate, this is not likely to be passed. Currently, Medicare now funds more than 75 percent of physician residencies, a level capped by Congress in 1997. Not completing a residency is not an option for medical students. In the U.S., medical students must undergo a residency at a teaching hospital of three to seven years, depending on their specialty, as a prerequisite to eligibility for board testing which is generally the goal for practicing physicians. Teaching hospitals pick up the funding for about 10,000 positions annually. The funding for these positions has come from clinical services fees, but there are many pressures around these fees and questions about their continued availability in future years. Federal Medicare payments have been cut by the health-care law while Medicaid funds have been cut in a number of states, although some of the ACA changes may increase Medicaid funds in future years in some states.

Leaving aside the current financial concerns, one of the reasons that Congress capped Medicare-funded residencies was that, at that point, policy makers thought the U.S. had an excess of slots and would not require as many physicians in the future due to more efficient care as part of a push at that time to managed care. This is not what has happened. Actual spending for residents has increased 54 percent since 1998, but total Medicare spending has grown faster, making support for doctor training a smaller fraction of the program. The current contentious budget climate in Washington, D.C. only exacerbates the problem and makes any effort to change the federal limits unlikely to succeed in the short run.

A related but different issue is the decline in the proportion of physicians that choose primary care residencies. Some recent information from an article using 2001-2010 data from the National Graduate Medical Education Census which includes reports on

the entire population of residents in programs accredited by the Accreditation Council for Graduate Medical Education estimated that there was a 13.6 percent increase in all residents between 2001 and 2010 but since 2001 there has been a 6.3 percent decrease in the number expected to enter primary care (Jolly et al, 2013). A different recent study examined the opinions of family medicine residency directors about the primary care physician workforce in the United States. Most disagree or strongly disagree that increasing medical school size or number of total resident positions in all specialties would result in an increase in the number of medical school graduates choosing a career in primary care, believing that increased compensation for those practicing in primary care would have the greatest impact on increasing medical school graduates who choose primary care (Carek et al, 2012).

Recently, the *New York Times* published an interesting article pointing out some of these types of issues and how they are being dealt with in one state, Texas (Aaranson, 2013). In 2013, Texas lawmakers did allocate millions to deal with a physician shortage by allowing the opening of two new medical schools in Austin and the Rio Grande Valley. The medical community in Texas has said that this is not a long-term solution to having enough physicians (especially in primary care) to deal with the growth in the Texas population. Currently, Texas spends \$168,000 educating each of the state's medical students. For medical school graduates, the state will pay \$32.8 million to finance nearly 6,500 medical residency positions in the 2014-15 biennium. However, there will be more graduating medical students in Texas than first year residency slots by 2014, according to a report from the Texas Higher Education Coordinating Board. If the new medical students in the new schools end up leaving the state for residencies, many will not return to Texas, thus making the new schools not clearly a good expenditure for citizens of Texas if the goal is to increase the number of physicians in practice in Texas. The Texas legislature has also

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HEALTH POLICY**BY JENNIE JACOBS KRONENFELD***(continued from page 9)*

agreed to spend 16 million dollars to expand residency opportunities in the state, but most of the funding will pay for first-year residency positions. There will be some start up funds for hospitals without residency positions to plan to add such programs. As in many states, the biggest need is for primary care doctors in rural areas. Texas lacks adequate primary care doctors in 126 of its 254 counties, using the USDHHS threshold of one for every 3,000 residents. The majority of counties without adequate primary care doctors are rural. Hopefully the reports of these studies and the example of Texas can help medical sociologists to better understand some of the complexities of physician shortages overall, the lack of residency slots and the need for more primary care physicians

References

Aaronson, Becca. 2013. Shortage of Doctors Tough to Fix. *The New York Times*. August 23, pg. A23A.

Carek, Peter J.; Peterson, Lars; Shokar, Navkiran K.; Johnson, Sharleen P.; Knoll, Michele E.; and Mainous, Arch G. 2012. Graduate Medical Education and Primary Care Workforce" A CERA Study. *Family Medicine*. 44 (10): 712-715.

Jolly, Paul; Erikson, Clese; and Garrison, Gwen. 2013. U.S. Graduate Medical Education and Physician Specialty Choice. *Academic Medicine*. 88:468-474.

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

Post Notices on the ASA Medical Sociology Section List

<MEDSOC@LISTSERV.NEU.EDU>

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

BOOK RAFFLE AT ASA 2013 MEETING RAISES MONEY FOR REEDER AND SIMMONS AWARDS

The Section book raffle raised \$300 for the Leo G. Reeder and Roberta G. Simmons Awards this year. Twenty individuals and publishers donated fifty books which were raffled off, along with 3 books left over from last year, at the Medical Sociology Section Business Meeting, August 10, 2013 at the ASA meetings in New York, New York. The success of the raffle was made possible only through the generous donations of the following publishers and individuals: University of Chicago Press, University of Alberta Press, Temple University Press, University of Toronto Press, Paradigm Publishers, McGill-Queen's University Press, Springer, Emerald Group Publishing, Wiley, Rene Almeling, Natalie Boero, Charles Bosk, Grace Budrys, Laura Carpenter, Allan Horwitz, Theresa Scheid, Sara Shostak, Gayle Sulik, and Owen Whooley. A special thank you to Russell Doherty and Lianna Hart for their help with selling raffle tickets, and to our donors for making this year's raffle a success. We could not have done it without you and we sincerely hope that you will contribute again next year. I look forward to another successful year ahead!

~Susan Stockdale

TEACHING TIPS

BY JENNIFER REICH



Over the past weeks, incredibly divisive politics unfolded over the funding for the continued implementation of the Affordable Care Act (ACA). Although implementation began in 2011, and the law was ruled constitutional by the U.S. Supreme Court the following year and debated over the course of the 2012 Presidential campaign, the ACA remains contentious for those who believe the federal government should not be responsible for ensuring the health of its citizenry. Despite the popularity of the already implemented provisions (including the ability for adult children to remain on their parents' insurance and preventative care without a co-pay), the debate reemerged once the portion of the law allowing individuals to buy insurance through a market exchange began on October 1 of this year. As most now know, the outcome was a budget impasse in Congress that led to a partial shutdown of the federal government.

As faculty, we are usually comfortable teaching about the social meanings of health and illness, the organizational structures of healthcare delivery, and how inequality shapes access to care, risk of disease, or general well-being. As the nation watches a vocal minority derail the national economy over fear of implementation of the individual mandate for healthcare coverage, we have a unique teaching opportunity. In the realm of health regulation, this tragic moment has several useful points to examine.

We have an unusual opportunity to **unpack the symbolic meanings of public health, access, and citizenship**. Who deserves care? How should care be provided? What does it mean that most of the uninsured already work full-time? (Below is a link to a state-by-state fact sheet on the uninsured and phase of implementation). We often include these topics in our courses, but here are real-time real-world opportunities to take these questions apart.

We can look at how **individuals develop opinions about laws without understanding the technical meanings**. In one humorous example, late night entertainer Jimmy Kimmel asked people on the street which they liked more, Obamacare or the Affordable Care Act. They were also asked to evaluate how much they liked the different provisions (link below). How do we understand the schism between attitudes about a law and attitudes about specific services? Similarly, what does it tell us when the same law evokes such different reactions based on the names by which it is referred? What other laws or policies experience similar challenges?

Secondary to the engaging sociological questions we can ask about the varying political and social views of the ACA and the appropriate place of health insurance coverage more generally, there are equally engaging questions to be explored about the **ramifications of a government shutdown**. Although the federal government closed on October 1, not all offices closed and not all agencies were treated equally. In fact, any employee or agency deemed "essential" could continue operating, while non-essential workers and offices could not. So what do we know about non-essential (also known as exempted and non-exempted) agencies and employees? How are those decisions made and why does it matter? How does their work impact individual and community health? (Below are a few links about the shutdown generally.)

Thinking about what is deemed essential is actually pretty informative. First, it allows students to see the many ways the government touches our daily lives. *(continued on page 12)*

TEACHING TIPS

BY JENNIFER REICH

(continued from page 11)

Second, it highlights the federal government's role in protecting public health. There are a great many agencies to consider and one could imagine assigning students opportunities to research the health implications of different agencies' work.

Here are a few examples of agencies whose shutdown will likely impact public health and well-being:

- *The National Institutes of Health* (includes research, lab samples, data, patient tracking, the ability of individuals to enter clinical trials or get care)
- *Supplemental Nutrition Program for Women, Infants and Children*, known as WIC (provides food for women and young children)
- *Environmental Protection Agency* (including pollution and pesticide monitoring)
- *Centers for Disease Control and Prevention* (including flu vaccine clinics, influenza and outbreak investigation and monitoring, support to states, research, emergency response)
- *Food and Drug Administration* (including food safety inspection)
- *Department of Labor* (wage and hour laws and occupational safety)
- *Head Start Programs* (preschool to low income families, social support and outreach)
- *Social Security Administration* (disability benefits, new applications, Veterans appeals board)
- *Department of Agriculture* (loans, statistics, research, crop estimates, crop insurance)
- *Housing Administration and Department of Housing and Urban Development* (mortgage underwriting, Section 8 housing)
- *Small Business Administration* (post-disaster loans)
- *National Guard* (emergency preparation, response)

There are, of course, many ways to encourage students to think about healthcare and policy. There

are historic examples of attempts to reform access to care and cross-national comparisons that are also informative (some which were featured in the last newsletter). The political events of the fall provide important opportunities to also teach students how to dissect news and current events as they unfold and to constantly search for the deeper meanings within the stories.

A Few Resources

Great resources on the ACA, including overview videos: <http://kff.org/health-reform/>

A state by state map of the uninsured and implementation: <http://www.hhs.gov/healthcare/facts/bystate/statebystate.html>

A year-by-year breakdown of implementation from 2010-2014: <https://www.healthcare.gov/timeline-of-the-health-care-law/>

A brief explaining the Supreme Court decision: <http://kff.org/health-reform/issue-brief/a-guide-to-the-supreme-courts-affordable/>

Overview of the shutdown: <http://www.cnn.com/interactive/2013/09/politics/government-shutdown-impact/>

<http://www.washingtonpost.com/blogs/wonkblog/wp/2013/09/30/absolutely-everything-you-need-to-know-about-how-the-government-shutdown-will-work/>

Jimmy Kimmel sidewalk survey: http://www.huffingtonpost.com/2013/10/01/jimmy-kimmel-obamacare-prank_n_4022424.html?utm_hp_ref=comedy

STUDENT NEWS & VIEWS BY JESSICA SEBERGER



In 2012 I traveled to Denver for the annual ASA meeting. I had a great time and after spending the summer studying for my comprehensive exams it was great to finally be able to put faces to all of the names I'd been reading all summer. It was the first annual meeting where I felt I had a strong grasp on my area and felt I could really engage with the presentations. It made me excited about a career in this area. I enjoyed attending as many sessions as I could and presenting my work at a roundtable.

When the submission window for 2013's annual meeting came around I was between projects and didn't have anything to submit. Choosing to stay home for this year's meeting was made much less painful by the strong presence of the meeting on social media. In addition to the live feeds of the plenaries on ASA's website, many scholars live tweeted the meetings with hashtags like #ASA13 and #s___ for the session they were attending. Alex Hanna (@alexhanna) reported that there were 10.7 thousand tweets with the #ASA13 hashtag compared to 7.7 thousand in 2012.

Increasingly scholars are turning to social media to connect with peers, old friends, students, and form new connections that often go beyond an interest in one's work. Social media is quickly becoming another tool scholars can use to network. As a graduate student who has recently begun thinking about the job market, I'm always looking for information to help me secure a job after graduation. Past issues of this column have addressed similar topics. Previous years have provided information on the odds of getting a job in a slow economy, focused on what students do to prepare for the job market, and featured interviews with medical sociologists who have made a career within our field.

In the upcoming year I want to build on these past editions by focusing on recent PhDs. **I want to explore how they found and secured positions within or outside of academia.** In addition to this focus on recent PhDs, **I would also like to use this column as a forum for ongoing dialogue with graduate students about the ties between medical sociologists and social media.** I want to explore how we connect to others through technology, including a look at sociologists who communicate extensively through Twitter or use groups on Facebook as a resource for classroom material, those who have and maintain personal/professional websites, and those who contribute op-ed pieces to major news outlets.

For future columns I'm interested in hearing from you about the following topics:

- Have you recently completed your PhD and started a new job?
- Are you a new assistant profession in a sociology department?
- A researcher in a dedicated research institute?
- Do you use social media? In the classroom? To connect with other scholars? Only during meetings? To market yourself for positions and opportunities?

If so, I'd like to hear from you.

To share your experiences with me through the Student News and Views column, or if you have ideas about interviewees for this column, please contact me at: jessicaseberger@gmail.com

ASSISTING THE ASSISTANT PROFESSOR BY BARRET MICHALEC

Last issue I posed the question, “What are suggestions for time-saving and effective work habits that others have found useful and effective that do not involve trickery, grade inflation, or isolating oneself from students and fellow faculty?” Interestingly enough, I received zero responses.

I am inclined to attribute this lack of offerings to the nature and general ethos of the summer months – some of us continue to teach (at our home institutions and/or abroad), some commit to a flurry of research and grant efforts, some connect/reconnect with family and friends, and some attempt to juggle some combination of these. The hopes to provide the nuggets of experience-driven-knowledge to aspiring Assistant Professors were perhaps piled under deadlines, email responses, as well as various non-academic adventures and responsibilities. Or... perhaps the “tricks” that were listed in the previous issue are indeed common practice tools of the trade and the piece shed light on informal professionalization processes. In that case the general response from the audience upon reading the piece was “Yep, that sounds about right.” *Keep Calm and... Hide*. Or maybe it was simply just too broad of an inquiry. Regardless, do feel free to offer your thoughts on the issue. I look forward to sharing the responses.

Given that there no responses to last issue’s post I thought I’d start a new conversation.

We all have aspirations. It’s highly doubtful that any assistant professor wants to remain in the same position for the duration of their career. Some may strive for scholastic leadership, to be a house-hold or at least department-hold name in the field of medical sociology. Some may seek administrative and institutional leadership positions like Chair, Dean, or perhaps even Provost or President. And there are some that want it all – they want both showcases (yes, that’s a *Price is Right* reference). As eager Assistant Professors these goals drive us. Of course tenure is

the more immediate and forever-right-there-in-your-face carrot at the end of the stick, and to some just getting through one more day of a massive stadium-size class of Introduction to Sociology is its own righteous reward, but these more lofty aspirations, the “I’ll get there someday, I just know it” goals are the consistent and perpetual motivators, the internal Richard Simmonses. But often these aims can be double edged swords.

Career goals are important to keep your work and efforts focused, keep you striving for success, and keep your eyes peeled for opportunities for advancement. However, these aspirations can also push you to take on too many projects and/or service opportunities, and perhaps even lead you to rub someone the wrong way and appear cocky and/or overly eager - thereby spreading yourself too thin and negatively impacting relationships you should have nurtured more carefully.

When I was in grad school I remember watching a news story about an organization’s struggle of designating new leadership – basically the younger members wanted to step into leadership positions held by the old guard. One of the older members said something to the extent of “We’re not just going to give it [leadership positions] to them [the younger members], they are going to have to step up and earn it. Better yet, they’re going to have to take it.” This last part is what stuck with me, “..they’re going to have to *take it*”, and from that point forward that was my motto – “*take it*”. I decided that if I was going to achieve what I wanted for my career no one was going to simply hand the opportunities to me, I would have to go after them. I went after a position in the student government, a position in the Provost’s office, a position on a search committee, teaching opportunities that opened up, roles on various projects – as though I was fueled by echoing lyrics of Public Enemy, Black Flag, and Rage Against the Machine, I
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A PUBLICATION OF THE MEDICAL SOCIOLOGY SECTION OF THE ASA

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went after them and I took them.

I maintained this approach as I entered my Assistant Professor position, taking spots on a variety of projects, asking for positions on committees and opportunities to direct curriculum reform at the undergrad and grad levels, even soliciting specific scholars to work with me – each, from my perspective, providing one more step to where I want to be. And although I am quite comfortable with my choices and the steps I have taken, I do think that I have neglected to cultivate a particularly valuable attribute – patience. And although I believe I have fostered the reputation of being an energetic go-getter, I am sure I have stepped on a few toes on my march.

In this line of work it can be difficult to work diligently and hope that the work is noticed, and that when it is it will lead to advancement of some sort. Much like any profession, there are times when it is the squeaky wheel that gets the grease. However, at the same time you do not want to walk around campus

talking about all the “great work” you’re doing because that attitude/behavior will not earn you the respect of your colleagues and/or those in positions to encourage your advancement.

So the question for this issue:

What is a more effective and efficient approach for eager Assistant Professors interested in attaining positions of leadership? Should we go out and take them, explicitly ask for opportunities and push boundaries, or is it best to let our work speak for itself, be patient and trust that our time will come and the torch will be passed?

Much like everything else regarding being an Assistant Professor, I am sure it is all about finding that elusive, mystical balance – in this case the balance of self-promotion and unassuming diligence, but I would like to hear others’ thoughts. Please feel free to email me at bmichal@udel.edu. I would like to thank Ann Bell for her editorial expertise with this and other posts. I wish you all the best for this semester.