

Medical Sociology Newsletter

VOLUME 42, ISSUE 2

WINTER 2006

A Publication of the Medical Sociology Section of the ASA

KAPLAN 2006 LEO G. REEDER AWARD WINNER

by R. Jay Turner

Reminders:

- 2006 ASA Annual Meeting:
August 11-14, 2006
Montreal, Quebec, Canada
- 2007 ASA Annual Meeting:
August 11-14, 2007
New York, New York
- MSN Spring Deadline:
March 31, 2006

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The Leo G. Reeder award will be presented to Dr. Howard Kaplan at the August 2006 ASA meetings in Montreal, Canada. This award is presented annually for "Distinguished Contribution to Medical Sociology." Dr. Kaplan is Regents Professor, Distinguished Professor of Sociology, and the Mary Thomas Marshall Professor of Liberal Arts at Texas A & M University. The award honors the more than 40 years over which his work has made an indelible impact on the field of medical sociology, and recognizes his leadership and effective advocacy for the significance of sociological research in addressing mental health and substance problems.

Unquestionably, Kaplan's contributions to research in medical sociology have been extraordinary. His early collaborations with Sam Bloom contributed substantially toward establishing the relevance and importance of a sociological perspective in the study of mental illness. In the 1970's, Howard published a series of articles and a book that largely set forth the conceptual and scientific foundation for his subsequent work and outstanding contributions. Among these, his work on self-attitudes, particularly self-derogation, created a new and exciting line of inquiry into social psychological processes that could be used to explain suicide, alcohol and drug use and abuse, and psychological distress.

With the publication of *Self Attitudes and Deviant Behavior*, his theory of deviant behavior became widely recognized as a carefully constructed perspective systematically supported by empirical evidence. Within the intervening years, Dr. Kaplan published a truly astonishing number of papers that, collectively, demonstrated how broadly concepts such as self-attitudes and self-derogation could be usefully applied to issues in medical sociology.

Howard Kaplan is also recognized for his service to the discipline. His performance as editor of the *Journal of Health and Social Behavior* from 1979-1981 has been associated with the ascendancy of the journal in terms of its scientific impact (Johnson and Wolinsky 1990, JHSB). In this role he contributed importantly to the impetus for the explosion of research on the stress process paradigm, publishing a series of formative articles on the stress process model. His 1983 edited volume *Psychosocial Stress: Trends in Theory and Research*, which has become a classic book in medical sociology, further stimulated interest in the linkage between the stress process and illness outcomes.

Howard's work continues to be characterized by the leadership it provides. Over the past 15 or so years, he has been a constant advocate of the value of longitudinal studies, emphasizing their capacity to assist us in

(Continued on page 2)

SECTION ON MEDICAL SOCIOLOGY NOMINEES FOR 2006 ELECTION

Nominations Committee: Teresa Scheid, Chair (tlscheid@email.uncc.edu), Susan Bell (sbell@bowdoin.edu), Deborah Carr (cards@sociology.rutgers.edu)

Chair Elect

Chloe Bird (chloe@rand.org)
William Cockerham (wcocker@uab.edu)

Secretary-Treasurer Elect

Carol Boyer (caboyer@rci.rutgers.edu)
Eric Wright (ewright@iupui.edu)

Council Member at Large

Joanna Kempner (jkempner@umich.edu)
Jason Schnittker (jschnitt@soc.upenn.edu)

Student Council Member at Large

Ryan C. Reikwosky (rcreikow@u.arizona.edu)
Laura Senier (laura_senier@brown.edu)

Chair Elect, Nominations Committee

Deborah Carr (carrds@sociology.rutgers.edu)
Maren Klawiter maren.klawiter@hts.gatech.edu)

Turner *(Continued from page 1)*

understanding how life course and developmental processes influence both behavior and health. His own long-term follow-up studies have generated a wealth of sociological knowledge on life course and developmental issues while emphasizing the significant interplay between medical sociology and studies of deviant behavior.

The total corpus of Howard Kaplan's printed work is

Nominations Committee (2 positions)

Abdallah M. Badahdah
(abdallah.badahdah@und.nodak.edu)
Rebecca Utz (rebecca.utz@soc.utah.edu)
Angela Wadsworth (wadsworth@uncw.edu)
Terri Winnick (winnick.3@osu.edu)

Student Member of Nominations Committee

Alexis Bender (alexisbender@comcast.net)
Jennifer Moren-Cross (jmcross@soc.duke.edu)

Chair, Membership Committee

Richard Carpiano (carpiano@wisc.edu)
Jennifer Fosket (Jennifer.fosket@mcgill.ca)

Chair, Health Policy Committee

Henry Perlstadt (perlstad@msu.edu)
Jill Quadagno (jquadagn@coss.fsu.edu)

beyond impressive. He has published some 140 papers and chapters, edited four highly influential books, and written five highly notable books that are central to the study of social psychology and health outcomes. Dr. Kaplan clearly stands out in his remarkable scientific productivity and his impact on our discipline and health research in general. The medical sociology executive committee proudly honors Howard Kaplan with the 2006 Leo G. Reeder award.

CALLS FOR AWARD NOMINATIONS

LEO G. REEDER AWARD The Medical Sociology Section invites nominations for the 2007 Leo G. Reeder Award. This award recognizes scholarly contributions, especially a body of work displaying an extended trajectory of productivity encompassing theory and research. The Reeder Award also acknowledges teaching, mentoring, and training as well as service to the medical sociology community broadly defined. Please send your letter of nomination and nominee's curriculum vitae **as an email attachment to:** R. Jay Turner, PhD, E-mail: jturner@fsu.edu. Nominations should be received by **August 1, 2006**.

ROBERTA G. SIMMONS AWARD Nominations are being accepted for the 2006 award (self-nominations are acceptable). Eligible candidates for this award must have defended their dissertations within the two academic years prior to the annual meeting at which the award is made. To be considered for the 2006 award, the candidate should submit an article-length paper (sole-authored), not to exceed 30 double-spaced pages (11- or 12-pitch font), inclusive of references. This paper may have been previously published, in press, or under review. Submissions may be sent by e-mail as Word documents. Hard copies will also be accepted. Deadline for receipt of submissions is **June 1, 2006**. Send nominations to: William R. Avison, Department of Sociology, 5327 Social Science Centre, The University of Western Ontario, London, Ontario, Canada, N6A 5C2. E-mail: wavison@uwo.ca.

ELIOT FREIDSON OUTSTANDING PUBLICATION AWARD The Freidson Award is given in alternate years to a book or journal article published in the preceding two years that has had a major impact on the field of medical sociology. The 2006 award will be given to a scholarly book which deals with any topic in medical sociology, broadly defined. Co-authored books are appropriate to nominate but edited books are not eligible. When making your nomination, please indicate (however briefly) the reason for the nomination. You do not need to include a copy of the book. Self-nominations are permissible and encouraged. Nomination letters are to be sent by **March 1, 2006** to: Professor Maxine Thompson, Sociology and Anthropology Department, North Carolina State University, Box 8107, Raleigh, North Carolina 27695-8107. Nominations may also be emailed to Maxine_Thompson@ncsu.edu with the subject line: Freidson Award Nomination.

CALL FOR PAPERS Elizabeth M. Armstrong and Barbara Katz Rothman (editors) announce a call for papers for a new volume of *Advances in Medical Sociology* on "Bioethical Issues: Sociological Perspectives," to be published by Elsevier in early 2008, focusing on the contributions that medical sociology brings to bioethics. With the rise of bioethics as a discipline, sociological analysis of biomedical issues and clinical practices has lost traction. While we will include articles reflecting the interest among sociologists in bioethics as a discipline, this volume will go beyond "the sociology of bioethics." We seek articles that address the management and social construction of bioethical issues: what gets counted as "bioethics" and—equally important—what gets left out of bioethical analysis. In this volume, we seek to publish distinctly sociological perspectives on issues that have been framed as "bioethics." Please submit an abstract and a brief description (approx. two pages) of the proposed paper by **January 31, 2006** to: advmedsoc@gmail.com.

The Bang for the Buck: Cost and Quality in Health Policy

By Elizabeth M. Armstrong

Health care spending grows three times faster than health care quality. That is not a headline that you are likely to read in any newspaper. But it is a conclusion that is evident from two new reports on the American health care system released in early January by the federal government. The first report, from the Centers for Medicare and Medicaid Services (CMS), estimated that in 2004, health care spending by all purchasers, public and private, reached \$1.9 trillion. That translates into \$6,280 per person, the highest amount of any nation in the world. That \$1.9 trillion is equivalent to 16 percent of gross domestic product, the largest share of GDP to date. The good news? Health care spending rose by only 7.9% in 2004, a slower growth rate than the previous two years (8.2% in 2003, 9.1% in 2002). Most of the headlines reported that the growth rate of health care spending declined—and indeed this positive spin was just what CMS intended.

Yet even with a declining growth rate, health care spending still grew by more than \$140 billion from 2003 to 2004. This rate of growth is much higher than the growth in wages and inflation, meaning that health care continues to be increasingly unaffordable, for individuals, employers, and governments. The cost of health care has doubled in the last decade alone, from \$916 billion in 1993 to \$1.9 trillion in 2003.

But inflation and wages are not all that health care costs are outpacing. Even as CMS was releasing its estimates of health care spending, the Agency for Healthcare Research and Quality issued its most comprehensive report to date on quality in the American health care system. The National Healthcare Quality Report measures four dimensions of quality—effectiveness, patient safety, timeliness, and patient centeredness—with 179 different indicators. These indicators include, for example, whether heart attack patients receive appropriate care (82% of Medicare patients do), how commonly hypertensive patients have their blood pressure under control (29%), and how many elderly have ever received pneumococcal vaccination (56%). Of 44 “core” measures, 23 showed improvement, while 21 showed no significant change or actually deteriorated. The report documented that in 2004, the overall quality of care had improved at a rate of 2.8%, well below the growth in health care costs.

Of course, the metric does not really make any sense—there is no reason to expect that improvements in quality (the bang) would equal growth in spending (the buck). (Or should I say the mega bucks?!) But the simultaneous

appearance of these two reports (along with a third documenting the persistence of health care disparities) highlights several themes in American health policy. *First*, our concern with measurement and the consequent abundance of data on every aspect of health care. It is hard to imagine an aspect of health care that we do not have a measure for; health care must be one of the best documented social arenas today. We know with great precision, for example, that we are falling far short of the Healthy People 2010 goal for the percentage of dialysis patients who are on the transplant waiting list (actual 16%, goal 66%). In fact, AHRQ estimates that at the current rate of improvement, it will take us another 70 years to reach the 2010 goal. We know much of what is going wrong or not working; we just do not seem to know what to do about it or how.

Second, the complexity of American health care and health policy. There is no shortage of data on health care, but the data are often complicated, contradictory, or confusing, especially for the non-specialist. Because the numbers are so complex, it is easy to spin them in any direction—health care expenditures are higher than ever, but the rate at which those expenditures are growing is lower than ever. Eight out of ten heart attack patients receive appropriate medical care, but two out of ten pregnant women receive no prenatal care in the first trimester and two out of ten children aged 19-35 months have not received all recommended vaccinations. So is the outlook good or bad? Is the health care system getting better or worse?

Third, the tremendous evidence documenting that we are in a crisis. Even the smattering of data points in this brief column suggests that the situation is dire. (Just think how much worse it would seem if I had pointed out the 45.5 million uninsured Americans, almost 18% of the population.) Yet somehow neither the exactitude of our data nor the magnitude of the numbers seems to prompt action in the policy arena. It seems that health care spending outpaces not only improvements in health care quality, but increases in political will as well.

References:

- 2005 National Healthcare Quality Report, Agency for Healthcare Research and Quality Publication No. 06-0018. Available online at www.ahrq.gov.
- Smith C, C Cowan, S Heffler, A Catlin et al. “National health spending in 2004: Recent slowdown led by prescription drug spending,” *Health Affairs* 25(1):186-195.
- “Healthcare spending growth rate continues to decline in 2004,” CMS News, 10 January 2006. Available online at www.cms.hhs.gov.

Teaching Tips

by Gloria Jones-Johnson

I would like to share a **teaching exercise** that I've used in my social psychology undergraduate course covering medical sociology. I have the students break down into small groups of 3 or 4 students. I give them the following three questions to discuss: 1. What, if any, relationship exists between social class (or socioeconomic status) and access to health care? 2. Who do you think has insurance coverage in America and why do you think they have it? 3. Do you think that the government should assist people, especially poor people, in acquiring organ transplants? I have them write up their responses to the questions

Then, I show the class the videotape, *John Q. John Q.* is a film in which Oscar winner, Denzel Washington, stars as John Q. Archibald, an everyday man forced to take drastic measures in a desperate situation. His young son collapses and the couple learns that their only child needs a heart transplant. Without enough health insurance or money to cover the operation, it seems that they are out of options. John Q. takes matters into his own hands in the race against time to save his son's life.

After the students watch the video, they meet in their same small groups and discuss the three questions again. I have them submit a written assessment of how the videotape impacted them, and/or changed their attitudes and perceptions about the issues of social class and access to medical care, especially organ donation and medical insurance.

The point of the exercise is for students to critically think about, and reflect upon, the relationship between social class, access to health care, insurance, and medicine in general. A particular emphasis is placed on the discussion of social class and racial/ethnic disparities in physical and mental health, quality of care, and mechanisms through which such inequalities are created and maintained. Through the exercise, I also get the students to discuss how sociological concepts and methods apply to the understanding of health and illness, and to the organization of medicine and health care.

I was very gratified by the students' critical analyses of structural forces that impact on race and class inequality in access to health care. Students also demonstrated a very impressive level of higher order

thinking, analysis, and synthesis of concepts in medical sociology such as medicalization, managed care, patients as consumers, health disparities in illness and health.

There are two books that I would highly recommend to members of the Medical Sociology Section for consideration in their courses on Medical Sociology. First, Jill Quadagno's "One Nation, Uninsured: Why the US Has No National Health Insurance" (2004) is outstanding for addressing how powerful stakeholders have blocked every proposal for universal health care coverage from the Progressive Era through the Clinton Administration. The book provides a compelling account of 100 years of health policy history with great detail. The reader has to grapple with the idea that hundreds of billions of dollars are earned in our healthcare system, but only a few pennies on the dollar are spent on healthcare and preventive healthcare. In addition to discussions of insurance coverage, students may be introduced to such topics as changes in the health care delivery system produced by the dramatic expansion of managed care in the United States, and the consequences of these changes for patients' health and quality of care, for the provider-patient relationship, for medical care professionals, and the institution of medicine.

Second, Warren Troesken's "Water, Race and Disease" (2004) would be an excellent way to introduce students to African American health disparities and a starting point for the discussion of larger issues related to epidemiology and population health. It would be particularly effective in a discussion of ways in which investment in public health infrastructure could yield enormous benefits for everyone.

Note: Please share with us your best practices and innovative teaching strategies; ideas that you have that come from other disciplines that can be adjusted to medical sociology; and concrete ideas that engage students in active learning such as simulation games, small group projects, field-trip ideas, videos, term paper projects, and creative ideas for teaching specific medical sociological concepts. Please send your ideas to me at gjj@iastate.edu. Thank you very much.

Graduate Study in Medical Sociology in the United Kingdom

By Dana Rosenfeld

I moved to the UK from the US because of the exciting sociological research being conducted here into medicine, health and illness, aging, and the body. The leading qualitative medical sociology journal, *Sociology of Health and Illness*, is housed here, as are *Social Science and Medicine*, *Body and Society*, and *Ageing and Society*. Indeed, there is an interesting overlap going on here between work on medicine, health, aging, and the body; sociologists work in all of these areas, read each others' work, and show up at the same conferences and venues. When I started attending conferences here four years ago, I was delighted to find that the UK's medical sociologists form a small but vibrant and tight-knit community of researchers and practitioners. Most know each other through graduate school, conferences, and/or working together in various capacities (e.g. on journals, or as 'external advisor' to specific departments), and one tends to see familiar faces at a variety of venues. Even the largest of these gatherings (The British Sociological Association's annual conference) is comparatively small, and attendees are friendly and approachable (I have introduced myself to laudable scholars and have never been snubbed). So it's a small, encouraging, informative, and supportive group.

Some of this has to do with the fact that, in addition to being more qualitative and theoretical than it is in the US, as in the rest of Europe, sociology in the UK is a key discipline and approach, taught in sociology departments, and applied and interdisciplinary departments alike (for example, Health and Social Care, and Applied Social Studies). Sociology is valued in its own right (around seven vice-chancellors in the UK are sociologists, and several sociologists have headed the well-respected Economic and Social Research Council).

The three to four year process of earning a doctorate is very different here too: a person receives her doctorate in her thesis advisor's discipline, regardless of that advisor's home department – a seemingly strange system, but one that makes sense when one realizes that PhD candidates may take classes during the first year, but generally spend their time conducting research and writing up the thesis (as it's called here) under the tutelage of their thesis supervisor. There is no committee per se, but increasingly, students have two supervisors and an advisor within the host department; rather than a

final oral presentation to the committee, as would happen in the US, the PhD candidate has an oral examination of the thesis (called a 'viva') with an examiner outside the institution and one within the institution.

This also means that one can earn a doctorate in (medical) sociology by 'signing up' with a medical sociologist of one's choice, although individual departments have their own application systems. That said, formal medical sociology programs do exist, the oldest being at Royal Holloway University of London and the newest at Edinburgh University. Both of these are academically-oriented, but many others are applied, and this can be of little use to Yanks uninterested in pursuing a career in the National Health Service. The good news is that the UK's universities tend to have fairly informative websites, and directors of graduate studies are responsive to inquiries.

The tricky part is, of course, funding, whose sources vary widely across universities. Some universities have what we think of as Teaching Assistantships, some have Research Assistantships (contingent, of course, upon the research situation within the department), and generally graduate (or post-graduate, as it's called here) funding is secured by the applicant speaking to the Department or Program Chair, who, if s/he wants the applicant badly enough, will do what s/he can to work something out. In short, it's all very ad hoc. There are, of course, scholarships: individual universities have a range of these, and many automatically consider applicants for them. US citizens can apply for Fulbright or British Marshall scholarships (other sources include the Overseas Research Student Awards Scheme, offered by the UK government through Universities UK, and Chevening Scholarships, information on which can be obtained through British embassies), and Stafford loans can be used here.

I've found that my decision to move here and be part of the medical sociology community was a good one, and I encourage anyone interested in graduate studies in medical sociology and in the sociologies of health, aging and the body to consider doing the same.



Royal Holloway, University of London
Department of Health & Social Care
Masters & Doctoral Studies in Medical Sociology
Now accepting applications for 2006-2007

For further information please go to:
<http://www.rhul.ac.uk/Health-and-SocialCare/Studying/MSc-MedSoc.htm>

Employment and Training Opportunities

Columbia University Columbia University Psychiatric Epidemiology Training Program announces openings for pre- and postdoctoral fellows beginning September 2006. The program provides social scientists, epidemiologists, psychologists, and psychiatrists with research skills in psychiatric epidemiology. Training involves coursework in substantive issues and research methods, and participation in an

affiliated research unit. Postdoctoral stipends range from \$35,568 to \$51,036, depending on years of experience. Predoctoral stipends are \$20,772. Application deadline: **February 15, 2006**. Contact: Training Coordinator, School of Public Health, Columbia University, 722 West 168th Street, Room 720-B, New York, NY 10032; E-mail: PET@columbia.edu. Columbia University is an affirmative action/equal opportunity employer.

University of Michigan The Survey Research Center, in cooperation with the Departments of Sociology, Psychology, Epidemiology, Health Behavior and Health Education, Nursing, Social Work, and Psychiatry invites applications for postdoctoral fellowships in an interdisciplinary, NIMH-funded research training program on psychosocial factors in mental health and illness. Current faculty include: Toni Antonucci, Cleopatra Caldwell, Jorge Delva, Barbara Guthrie, James House, Barbara Israel, James Jackson, George Kaplan, Roderick Little, Harold Neighbors, Randolph Nesse, Richard Price, Kristine Siefert, Amiram Vinokur, and David Williams. Two-year appointments

beginning July 2006: Second year of fellowship is contingent upon funding renewal. Current stipends are \$35,568-\$51,036 per year, depending upon experience. Must be a citizen or a non-citizen national of U.S. or have been lawfully admitted for permanent residence. Send CV, statement of research interests, sample(s) of written work, and 3 reference letters to: David R. Williams, Institute for Social Research, University of Michigan, P.O. Box 1248, Ann Arbor, MI 48106-1248. The review process will begin on **February 1, 2006**, and will continue until the positions have been filled. A nondiscriminatory affirmative action employer.

The Sociological Practice Section of the ASA

would like to invite members of the Medical Sociology section to join our section. As is the case with many Medical Sociology section members, Sociological Practice section members are dedicated to the realization of public sociology. We work in areas beyond classroom teaching and publishing in peer-reviewed journals. Our work contributes to public policy development and directly addresses social needs and quality-of-life issues. For example, we evaluate the need for programs, both those in the planning phases as well as those that have already been implemented. We design programs and sometimes we even manage them. We also make recommendations to task forces for the best use of limited resources (including government, non-profit, and corporate). Dedication to public sociology is a goal that describes many members of the ASA. Our invitation to join the Sociological Practice section stems from the purpose of giving both our sections more

opportunities at the Annual Meeting to share our work with the professional community. If you believe your work is described as public sociology, then please consider joining the Sociological Practice section. Doing so will be for the mutual benefit of the Medical Sociology and Sociological Practice sections. An additional 100 members from your section joining by **September 30, 2006** means we will be allocated an additional session in 2007, which we will devote to a topic in Medical Sociology, providing you another opportunity to present your work at the ASA. We are particularly excited about this plan, as it will afford opportunities to reach out to non-academics as well, making public sociology a more prominent aspect of the annual meetings. So when renewing your membership (or encouraging your students), please be sure to add the Sociological Practice Section to your selection. For more information about our section please visit our website at: <http://www.techsociety.com/asa/>

Student News & Views

by Claudia Chaufan

Going on the Market

"I'm past forty, the mother of a teenager, I have a former career (why on earth didn't I stick to it?), English is not my first language (so why am I looking for a job in an English-speaking country?), and here I am, a complete beginner – no, this does not make any sense." These were some of the (self-defeating) thoughts haunting me as I prepared my first (mock) job talk. Yes, you guessed it, I'm on the market. Not that I never had a job before – in fact, I had a profession and a "life" before sociology became my profession *and* my life – yet I had never had to "present" myself in such a scripted way. When you are on the market, you have to convince people that your intellectual interests are fascinating, that your teaching is engaging, and that you are an easy and likeable person to work with. Well, I somehow succeeded in putting it on paper...but a talk?

You mean I have to "say" it? Please, no!

Reluctantly, I signed up for a seminar that presumably would prepare me to go on the market. As I struggled to meet its requirements – including preparing a job talk – I knew that I would benefit from the professor and my fellow students' feedback. So I went for it, and it was the best thing I could have done to get both practical and emotional support in this very difficult transition.

Perhaps the most valuable aspect of having to prepare a job talk in a graduate seminar is that it forced me to *actually prepare a job talk*. Most likely, I would not have done it otherwise. And if I do get an invitation out of the dozen of letters I've sent, preparing a talk with nobody's feedback but my own would have been a recipe for disaster. Another

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A Publication of the Medical Sociology Section of the ASA

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Students – Apply to be the 2006 Louise Johnson Scholar!

The Medical Sociology Section will choose a student member of the section to be the 2006 Louise Johnson Scholar. The scholar will receive travel funds up to \$350 to present at the annual ASA meeting 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. Applications are due on **June 1, 2006**. To apply, send: 1) a copy of your acceptance notification to present at the 2006 ASA meeting, 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. Applications should be sent to: Eliza Pavalko, Department of Sociology, Indiana University, Ballantine Hall 744, 1020 E. Kirkwood Ave., Bloomington, IN 47405-7103. 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 Mt. Sinai School of Medicine and a former colleague of Louise Johnson.

Student News & Views

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very useful aspect of this task was that it allowed me to “perform” in a relatively safe space, among people I know who are committed to giving me constructive feedback. And they did indeed!

As to the talk itself, it had strong and weak moments, not surprisingly. I had three things in mind, pieces of wise advice generously offered by another professor: tell stories, don't read, and give them something to take away. I also had in mind several “how-to-give-an-unforgettable talk” type of books that I have diligently swallowed ever since I entered the academy and realized that “giving talks” was an important part of the game. I did relatively well on the “story” and “don't read” fronts. In particular, power point reminders were a godsend, because I have a poor memory and would never have remembered all the stories I wanted to tell.

As to the downside, I failed miserably at the “give them something to take away” part. I ran out of time; I was afraid that I would be unable to bring my talk to a close and

that is exactly what happened. Another downside, albeit repairable, was that my slides were too cluttered. Either I could write less on each slide, or produce two slides when one began to look crowded. I am inclining towards the second option because I don't like to read if I am giving a “talk,” and I have a bad memory. Yet as I prepared my talk, I found myself thinking, more slides will take more time. So rather than eliminating parts of the story (the reasonable thing to do), I ended up cluttering my slides. I was trapped in the same irrational assumptions that I am quick to spot in others. My research is a discourse analysis of the diabetes epidemic and I argue that many of the claims (in medical papers, in policy documents, and the media) are plagued with conceptual confusions.

Could my job talk have been better...of course! I know it will be better in the future if I take seriously the constructive criticism that everybody so generously offered: tell stories rather than read (I did); make eye contact (I did); remember to breathe (I did not); talk more slowly (I talked too fast); and last, but not least, take the time to count to three before answering questions from the audience.