

MEDICAL SOCIOLOGY NEWSLETTER

SPRING 2012

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REMINDERS

- **MSN Summer deadline**
June 1, 2012
- **2012 ASA Annual Meeting**
August 17-20, Denver, Colorado
- **2013 ASA Annual Meeting**
August 10-13, New York City

NOTES FROM THE CHAIR BY ERIC R. WRIGHT



Dear Colleagues,

The flowers are blooming, and the temperatures are rising. This spring certainly has proven to be an historic one. The U.S. Supreme Court just finished hearing oral arguments on the constitutionality of key provisions in the Patient Protection and Affordable Care Act (PPACA). It is hard to believe that it has been two years since health reform was passed by Congress and signed into law by President Obama. The near constant public debate over how to reform our deeply fragmented, remarkably inefficient, and exceptionally expensive healthcare system has made the months pass rapidly.

As medical sociologists, I am sure you find the discussions as fascinating as I do. What has been most interesting to me, though, has been how the public rancor—whether over specific steps in implementing key provisions or more general concerns regarding the appropriate roles of state and federal government—has exposed many of the deep structural problems both in our healthcare system specifically and in our society more generally. Undeniably, the debate has focused national attention on the consequences of economic and health inequalities, the tension between individual rights and the public good, and corporate control and

influence over health and healthcare.

While many people are growing weary of the discussion while many others are simply fearful of fundamental change, there is reason to believe that real change is on the horizon irrespective of what happens within the halls of government. Both healthcare delivery organizations and health insurance companies, fearful that changes they do not want may be forced upon them, already have begun investing significant effort and money to boost efficiency, improve outcomes, and reduce costs. Perhaps more important for the prospects of long-term change, there is growing evidence that many teenagers and young adults, the so-called “We-Generation,” now view access to health care and the public’s health as fundamental social justice concerns.

Regardless of the outcome of the Supreme Court’s deliberations, the heated dialogue regarding the future of our health and healthcare system will no doubt persist for many years to come. To encourage more sociologists to get involved in this crucial conversation, I have organized a special session for the next ASA annual meeting entitled *Sociological Perspectives on the Implementation and Impact of the Affordable Care Act*. The invited panelists include

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SECTION SLATE OF CANDIDATES FOR 2012 ELECTIONS

Renee Anspach, Chair, Nominations Committee (ranspach@umich.edu)

Nominations Committee: Laura Carpenter (l.carpenter@vanderbilt.edu), Richard Carpiano (richard.carpiano@ubc.ca), Michelle Frisco (mfrisco@pop.psu.edu), Kathy Lin (linkathy@umich.edu)

Thanks are due to our terrific committee and chair for their hard work and to all who were willing to run for office. Don't forget to vote!

Section Chair Elect (1 elected):

Susan Bell, Bowdoin College

Howard Waitzkin, University of New Mexico

Secretary-Treasurer Elect (1 elected):

Robin Moremen, Northern Illinois University

Karen Lutfey, New England Research Institute

Council Member at Large, Regular (1 elected):

Virginia Aldige Hiday, North Carolina State University

Dawne Mouzon, Rutgers University

Council Member at Large, Student (1 elected):

Lucie Kalousova, University of Michigan

Chioun Lee, Rutgers University

Chair Elect, Nominations Committee (1 elected):

R. Jay Turner, Vanderbilt University

Rene Almeling, Yale University

Member, Nominations Committee, Regular**(2 elected):**

Elizabeth Armstrong, Princeton University

Kerry Dobransky, James Madison University

Ruha Benjamin, Boston University

Jennifer Singh, Georgia Institute of Technology

Member, Nominations Committee, Student**(1 elected):**

Erin Pullen, University of Kentucky

Vanessa Munoz, Brandeis University

Chair, Health Policy and Research Committee**(1 elected):**

Jennie Kronenfeld, Arizona State University

Anna Zajacova, University of Wyoming

Chair, Membership Committee (1 elected):

Molly Martin, Pennsylvania State University

Anne Figert, Loyola University Chicago

NOTES FROM THE CHAIR

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some of the Section's most prominent thought leaders on health reform: Howard Waitzkin, University of New Mexico; David Mechanic, Rutgers University; David Williams, Harvard University; Chloe Bird, The RAND Corporation; and, Dmitry Khodyakov, The RAND Corporation. The panelists will share their unique perspectives and analyses of different aspects of PPACA and challenge us all to think more deeply and more sociologically about the promise and pitfalls of health reform.

This panel will be just one of several thought provoking sessions we will have for you at our annual meeting in Denver 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 (<http://www.asanet.org/AM2012/index.cfm>). I hope you will be able to join us in Denver and hope you get a chance to get outside and enjoy the beautiful spring!

Warm regards, Eric R. Wright

HEALTH POLICY

BY SYDNEY HALPERN

MESSING WITH MEDICARE

Pundits have predicted that the Supreme Court's rulings on the constitutionality of the Affordable Care Act (ACA) will result in a train wreck for Obama's health care reform. But with the Court not expected to release its decisions until June, we are in a holding pattern on that matter. So it is a good time to turn our attention to another major health policy issue: the future of Medicare.

For a second year in a row, House Republicans have introduced budget legislation with provisions that would fundamentally change Medicare. These provisions would transform Medicare from a system of defined benefits to one of defined contributions. Medicare recipients would purchase health insurance in a competitive marketplace with the help of federal "premium support" whose value would rise more slowly than health care costs. Whatever happens to the ACA, efforts to privatize Medicare are not going away. Leading Democrats in the Senate have declared the current bill with Medicare reform to be dead on arrival because the larger budget package includes no increases in revenue and extends Bush tax cuts for the very wealthy. But some Democrats support versions of Medicare privatization, and if Republicans win control of the Senate in the November 2012 elections, momentum to move forward would be immense.

Both this year and last, one of the policy makers spearheading Medicare reform has been Paul Ryan, Republican from Wisconsin and Chairman of the House Budget Committee. In Ryan's plans, current Medicare recipients and those approaching eligibility would retain traditional benefits. Privatization would begin when individuals who are now under 55 reach Medicare age. In last year's bill, these future enrollees would receive vouchers to purchase private insurance. Vouchers would be capped and annual increases tied to the overall

rate of inflation—much lower than inflation in health care costs.

This year's House Bill, sponsored jointly by Ryan and Democrat Ron Wyden from Oregon, adds a new twist: when those now under 55 become seniors, they would pick either private insurance from a Medicare exchange or a new version of traditional Medicare—private insurance would compete with a public option. (Sound familiar? Yes, it replicates Obama's proposal for the ACA that Congress failed to pass.) Benefits would again be capped, this time with increases slightly higher than yearly growth in the GNP.

Those favoring privatization of Medicare insist that annual 8% increases in expenditures are unsustainable and that market competition will lead to efficiencies and contain costs. Opponents dispute the claim that competition between insurers would control health care costs. Instead, they argue that caps on premium support would shift rising costs onto the elderly and disabled. They suggest that a good portion of seniors would be poorly positioned to make informed decisions about health insurance options. Furthermore, the federal government would have to vigorously regulate private insurance to offset difference in the risk characteristics of those enrolling in various plans. Without such regulation, private insurers might skim off the healthiest seniors and leave the public option to handle the sickest enrollees. Critics question whether government would succeed at regulation of this type.

If there is any really good news on the current Medicare front, it is that the American public has healthy skepticism about changes to entitlement programs and is likely to recognize privatization as a dismantling of Medicare benefits.



Send your suggestions for future health policy columns to: shalpern@uic.edu.



THE MARCH 2012 ISSUE OF *JOURNAL OF HEALTH AND SOCIAL BEHAVIOR (JHSB)* IS NOW ONLINE!

This issue features articles on *Stigma and Health; Marriage, Family, and Health; and Immigrant Health*. You can find a summary of the lead article by Sarah A. Mustillo, Kimber L. Hendrix, and Markus H. Schafer on the lingering effects of stigma associated with obesity on young women who transition from obesity to normal weight during the course of adolescence at <http://www.asanet.org/images/journals/docs/pdf/jhsb/JHSB%20Policy%20Brief%20March%202012.pdf>.

If you are subscribed to *JHSB* through the American Sociological Association, you can access the full-length articles (<http://www.asanet.org/journals/OnlineJournalAccess.cfm>). Articles are also available from SAGE (<http://hsb.sagepub.com/content/current>) for a slight fee or for free through many university, college, and think tank libraries. If you'd like to receive updates from the *JHSB* team, such as e-mails when we release new policy briefs (<http://www.asanet.org/journals/jhsb/policybriefs.cfm>) or podcasts (<http://hsb.sagepub.com/site/misc/Index/Podcasts.xhtml>), please e-mail our editorial assistant at: JHSBpolicybrief@austin.utexas.edu.

JHSB encourages members of the Medical Sociology section to submit their articles -

learn more about the types of articles we typically accept at:

<http://www.asanet.org/journals/jhsb/index.cfm>.

Post Notices on the ASA Medical Sociology Section List

<MEDSOC@LISTSERV.BROWN.EDU>

Visit our website at <http://dept.kent.edu/sociology/asamedsoc/>

CAREER & EMPLOYMENT**BY WILLIAM COCKERHAM****ON CAMPUS VISITS**

Assuming you have successfully passed through the job application process to the point of being invited for an on-campus interview, emotions on your part are likely to be a combination of both elation at being perceived as good enough to be invited and at the same time being nervous about actually having to sit and/or stand before the faculty of a particular sociology department and convince them you are the person to fill the job. This is especially the case for recent graduates. Once you are actually on campus for the interviews, you are on your own (or, as they say in basketball or handball or whatever, the ball is in your court).

Regardless of whether you are really “cool” or petrified with fear or somewhere in-between, you need to meet the challenge of the interview. A good way to approach it is to fib to yourself and say you will enjoy it because it will give you a chance to meet new people and talk about yourself and sociology. Actually this is true, and you may really enjoy it. But the experience will also be fatiguing as you will meet numerous people (faculty, administrators, and students) and in each encounter rise to meet the requirements of the occasion with each person you meet with because—at some point—each will either contribute or decide whether or not to make you a job offer. So you are constantly on public display. Your performance will continue even at meals when the faculty you are with will want to determine if you have social skills (can hold a conversation, have a sense of humor, are interesting, etc.). The reason for this is that they will want to see if you will be a good colleague which is important for all, including yourself, because you will join the life of the department perhaps for many years. So wherever you go, you will need to be your best.

A good tip about meeting with individual faculty members is to do your homework beforehand and

know something about their work when speaking with them. Don't always talk about yourself, but be interested in the other person and what they bring to the discussion. This shows you are a serious candidate who knows what the department is all about and helps the faculty member think well of you. When discussing work in a particular area, try to make sure that you know if the faculty member you are speaking with has expertise or publications in that area. If you do fail to show that you know about these, the interview can seriously backfire as it shows, right or wrong, that you do not really know the field—at least not to that faculty person's satisfaction. So study the department before it studies you in person.

Then, of course, there is the “job talk” in which you present your research to the department as a whole. This can induce nervousness, but usually it wears off soon since you know your topic (typically your dissertation for a novice applicant) and the faculty will hopefully seem friendly. After all, they want to hear a good job talk. So give them one. Make sure your delivery is smooth, even conversational, as no one wants to hear someone reading their notes to them. Your research methods and analysis need to be sound and it is good idea to have theory in the talk. Many a person has lost a job offer by giving a “bad” job talk. A critical time in the talk is the question and answer period. Your answers to questions will go a long way toward launching your career. In sum, prepare well.



Do you have questions about the academic or other job markets for medical sociologists? Do you have other career-related questions that other medical sociologists might share? These could relate to promotion and tenure, choices about building your cv, or other topics. Send your suggestions for future career and employment columns to: wcocker@uab.edu.

SEEKING NOMINATIONS FOR 2013 REEDER AWARD

Nominations are due by June 1, 2012

The Medical Sociology Section invites nominations for the 2013 Leo G. Reeder Award to be awarded at the annual meeting of the Medical Sociology Section in New York City. 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 to Allan V. Horwitz, Chair-Elect of the Medical Sociology Section, at: ahorwitz@sas.rutgers.edu.

SEEKING NOMINATIONS FOR 2012 LOUISE JOHNSON SCHOLAR

NEW DEADLINE for receipt of all submission materials is April 16, 2012

The Medical Sociology Section will select a student member of the section to be the 2012 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 ASA meetings in Denver and to attend section events, and 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 2012 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. Hard copies will also be accepted. Applications should be sent to: Sara Shostak, Department of Sociology, MS 071, Brandeis University, Waltham, MA 02454. Email submissions can be sent to sshostak@brandeis.edu with the subject line: 2012 Louise Johnson Scholar Nomination.

Global Perspectives on Religion and AIDS : Call for Proposals

The "Global Perspectives on Religion and HIV/AIDS Seminar" is a new program area of the American Academy of Religion (AAR). It will bring together an interdisciplinary group of scholars to develop an analysis of the various roles religion has played historically and continues to occupy in shaping the global AIDS pandemic. In addition to building theoretical and conceptual tools for understanding religion and AIDS, we aim to create an anthology appropriate for a wide academic audience interested in the religious and moral dimensions of the AIDS epidemic, including their effects on the lived experience of disease and the formation of religious and public health efforts to fight HIV/AIDS and prevent infection. Much of the work of our multi-year seminar focuses on creating an internally cohesive project that incorporates our diverse methodological and regional perspectives but shares a set of common themes and questions concerning the convergence of religion and HIV/AIDS over the past three decades. We seek to advance existing research and to foster new studies of this important, emerging field and welcome proposals from a range of disciplinary and/or regional perspectives. Please note, you do not have to be a current member of the AAR to propose a project for this seminar. Scholars interested in joining this conversation are encouraged to contact the chairs, Lynne Gerber, l.gerber@berkeley.edu, or Anthony Petro, anthony.petro@nyu.edu, for more information and/or details about submitting a proposal.

TEACHING TIPS

BY KATE STRULLY



For this spring issue of the Medical Sociology newsletter, I am pleased to present this guest-authored column on the components of online course delivery. Online courses and components are increasing common within medical sociology classes, posing several opportunities, as well as challenges, for those of us teaching in this area. Through this column, we hope to begin a new conversation within our section about teaching through online media. I invite you to email me at kstrully@albany.edu to share your experiences, suggestions, and questions related to online teaching of medical sociology.

Components of Online Course Delivery

Paula L. Griswold, Ph.D. & Annette Tommerdahl, Ph.D.

Department of Health Studies, University of Louisiana at Monroe

Due to the popularity of online education among students, many universities are developing and expanding online course and degree offerings. The online course allows for greater geographical diversity and student flexibility in study hours; thus, enabling the adult learner to work full time while continuing their education and obtaining a degree. However, the quality of education achieved through the online format is often questioned. There continues to be considerable debate regarding the academic rigor of the online versus face-to-face formats. These questions and debates have forced institutions to critically review the quality and effectiveness of online courses offered.

To address this issue, many universities have adopted a nationally recognized online course design rubric as a method to standardize the design of all online courses offered at the university. The University of Louisiana at Monroe has adopted the Quality Matters® (2012) online course design rubric for this purpose.

The rubric incorporates the concept of course alignment for learning objectives, assessments and measurements, instructional materials, learner interaction and engagement, and course technology so that they work together to achieve the desired learning outcomes.¹ Furthermore, applying this rubric ensures the quality in online courses for students, faculty, administrators, and accrediting agencies.

In addition, departments often develop a specific standardized course template for online courses using the parameters or guidelines established by a nationally recognized rubric. While this template serves as a guide for faculty in designing, developing, and maintaining academic quality and integrity in the online format, it also allows faculty to experiment with different tools and media to enhance delivery of the course. This is important since a well-designed course will make the online learning environment much more satisfying for both students and faculty.

For online courses in Medical Sociology or Ethics, it is important to make topics relevant for students so they develop a deeper understanding of the course material. Discussion forums work well for students to debate new techniques or issues. Students are presented with specific issues or questions to research and reflect upon. Students post an original response and then respond to classmates' responses. This type of activity helps to make the topics real and relevant for students. Additionally, the use of video clips from YouTube, news broadcasts, or documentaries is very effective in presenting a topic. Students watch the video clip, and then answer several questions related to the issues depicted in the video or write a reflection paper. Again, this brings relevancy to the topic and makes online learning more interactive and engaging.

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TEACHING TIPS

BY KATE STRULLY

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There are several components that an online course must contain. First, there must be a designated starting point for students allowing for clear navigation. Course navigation is critical in the design and delivery of an online course. Often faculty will insert a "Start Here" link that contains specific instructions about what to do first. Some of the information to be included in the starting point is a description of the course and purpose, instructor information and biography, student introductions, "netiquette" requirements, and faculty expectations for the course.

All required course materials including the course syllabus, essential campus information and student resources, technical requirements for the course management system, and a content outline should be clearly accessible. Web links to student resources such as the library, student handbook, Americans with Disabilities Act policies, tutor services, technical and other university policies should also be clearly available. Additionally, links to software or websites that the student may need to be successful in the course should be provided (ie internet browsers, Adobe Acrobat®, OpenOffice®, and Skype®).

Finally, the course design must focus on the alignment of critical course components such as course objectives, modular objectives, assessment activities, learning activities and instructional tools. The assessments and activities must support the stated course and modular learning objectives. Objectives should be measureable and used to guide the faculty to assess student accomplishment through a variety of methods. When course elements support the learning objectives, the course makes sense and provides the student with a more cohesive learning experience.

A disadvantage of using a standardized template is that faculty may argue that the standardizing of the course design infringes upon academic freedom since face to face courses usually do not follow the same approach and restrictions. There is also the perception that online courses may be subpar courses and lack academic variety.

In summary, due to the increasing popularity of online courses it is essential that courses be designed with quality, innovation, and rigor. A template and national rubric, when applied, are tools that faculty can use to accomplish this; therefore, allowing for an effective learning experience for both the faculty and students.

Reference: Quality Matters Program. (2012). Retrieved from <http://www.qmprogram.org/>

***The time has come, once again, to consider donating a book to the
ASA Medical Sociology Section's Annual Book Raffle!***

PLEASE, CURRENT TITLES ONLY AND NO TEXTBOOKS. Remember, these donations are going to a worthy cause – to provide support for the Leo G. Reeder and Roberta G. Simmons Awards. If you have any questions about potential donations, please contact me at susan.stockdale@va.gov. Please send books by **August 1, 2012** so that I can transport them to the ASA meeting. Thank you for your generous support! Please send your donated copies to:

Susan E. Stockdale, Raffle Chair, HSR&D Center of Excellence, VA Greater Los Angeles Healthcare System (152), 16111 Plummer Street, Building 25, Room A-103, Sepulveda, CA 91343

STUDENT NEWS AND VIEWS BY SONIA BETTEZ AND TENNILLE MARLEY

An interview with Jason Beckfield, PhD

Dr. Beckfield is Professor of Sociology at Harvard University, and a core faculty member of the Robert Wood Johnson Health and Society Scholars Program. He is also affiliated with the Ph.D. Program in Health Policy (Medical Sociology Track), the Center for Population and Development Studies, the Minda de Gunzburg Center for European Studies, the Multidisciplinary Program in Inequality and Social Policy, and the Weatherhead Center for International Affairs.

His research covers broad areas and engages medical, political and economic sociology in the study of social inequality in the United States and globally. His articles have appeared in the *Journal of Health and Social Behavior*, *Epidemiologic Reviews*, *American Sociological Review*, and *American Journal of Sociology*, among other outlets.

Q: Please, tell us about your journey to the sociology of health.

Beckfield: I was lucky. I was fortunate to be studying for the Ph.D. at Indiana University at exactly the right time. It was a time when Jane McLeod had just joined the department and she was offering a graduate seminar on medical sociology. I thought it sounded quite fascinating by the description of it and I was aware of her work from reading it before. I liked the idea of taking a course with her, and it turned out to be a very exciting experience for me. There was a lot of interesting reading, much of it new to me, and it had a very eye-opening quality. That's really the course that brought me into the field. One of the most interesting sets of readings to me was on the income inequality debate, and so the paper that I wrote on Wilkinson's income inequality hypothesis was actually the first empirical sociological paper I ever wrote. This set of debates really inspired my imagination and my desire to do empirical work.

Also, there was a very interesting critical mass of graduate students at Indiana at the time that was interested in medical sociology. I'm sure it's the same now. Medical sociology has only grown stronger at Indiana since I was there, but there was an interesting core of people who were onto issues of medical sociology, and social inequalities and health. Jason Schnittker was there at the time, Jeremy Freese was there at the time, Karen Lutfev was there at the time, and there were several people other people as well who have gone on to do really fascinating work in medical sociology.

Q: In your opinion, what are the most compelling issues in medical sociology today and where do you see the field going considering the social issues that we're facing?

Beckfield: Well, I think fundamentally the field is fortunate to be in very healthy shape. It's certainly growing, attracting the interest of new people. There are lots of interesting and important debates, and so I think the future certainly looks good. It's hard to identify only one or two compelling areas for research. I can say the things that are most interesting to me currently are questions of health inequalities. There are lots of interesting connections that haven't been made deeply enough among the areas of social stratification and political sociology and medical sociology because the field of social stratification has tended not to pay very much attention to health as an outcome. Likewise, political sociology has tended not to look much at health as an outcome either, although there is certainly some interesting comparative research on health care systems, some of it from a political sociology vantage point. And then I think the field of medical sociology has tended not to engage these other areas, as directly as it might, so there are opportunities for fruitful connection there.

And one of the topics that I think is very important is the
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STUDENT NEWS AND VIEWS BY SONIA BETTEZ AND TENNILLE MARLEY

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is the cross-national institutional differences that might help us to account for the variation in health inequalities that we see. I think one of the most interesting areas of work right now is showing just how variable social inequalities in health are across countries. It is deeply sociological and, for me, a fascinating point because it demonstrates the central tenet of our field that the social context is crucially important.

I think another interesting area is bringing cultural sociological concepts into thinking about health and illness; some of this has been in the field for a long time and I can think of prominent people who use cultural concepts in their work. My impression is that cultural sociology has developed a lot of nuanced and specific concepts for cultural phenomena, like narratives, scripts, frames, repertoires, things that can be used to specify what medical sociologists would mean when they say culture matters for health and illness. So I think that's likely to be a growth area as well.

Q: Do you make a differentiation between medical sociology and the sociology of health?

Beckfield: That sounds like a question of politics! It is a little bit tricky, because people do appear to mean different things when they use the term medical sociology. In grad school I learned that medical sociology has a very encompassing orientation and, under the rubric of medical sociology we would read work on population health, we would read work on social epidemiology, we would read work on the sociology of the medical profession, we would read work on social inequalities in health. I would also see public health and demography as areas that are overlapping to some extent with medical sociology. I like to think that this difficulty of field boundaries and labeling are signs of strength.

Q: What advice do you have for those of us that are planning to make our careers in this field?

Beckfield: I would certainly recommend advanced methodological training both in qualitative as well as quantitative methods. I think such training can help people to produce more convincing evidence. In some ways the evidentiary base for medical sociology is quite sound, but I think there are areas where it could certainly be strengthened by people who are trained in the latest methods from different perspectives, or even take multi-method approaches. I think that can be good, although I would caution someone who wants to take a multi-method approach that it's difficult to do both well and in an integrated way and too often I worry that a young scholar can kind of get caught in the crossfire, so to speak, between the quantitative people and the qualitative people because the work the young scholar does can never satisfy both camps, and so the young scholar ends up with a multi-method project that makes neither camp happy. I think that's not inevitable, it's just something that people should be aware of as a strategic concern.

I would also encourage early-career scholars to read deeply in what interests them. There's a life course to reading. In the early part of graduate training, it's very good to read in a bunch of different areas, read broadly and cast a wide net and try to make new connections among disparate areas that haven't been connected before because, to some extent, a good idea lies in original combinations of disconnected ideas. But then I think as people move on through graduate school, it's important to develop expertise in a given area and really read deeply. But even more important than those bits of advice, I think what I would tell a young person who's embarking on a career in the sociology of health or in

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STUDENT NEWS AND VIEWS BY SONIA BETTEZ AND TENNILLE MARLEY

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medical sociology or whatever we're going to call this thing is to really follow the core of their interest because an academic career is not easy, doing a dissertation is not easy, publishing an article is not easy, and these things all require sustained effort and it's impossible to sustain effort in a project that you don't believe in deeply.

Q: Do you have any advice about how to learn the publishing process more efficiently based on what has helped you to be able to have a large number of publications?

Beckfield: That's a very challenging question. Not sure that I have an answer. I was fortunate to have exceptionally good mentoring from my dissertation advisor, Art Alderson. The other people on my committee, Rob Robinson, Clem Brooks, and Patricia McManus, were also helpful mentors and I think there was a culture of mentoring at Indiana that I benefited from and was crucially important because it helped to demystify the publication process. I think for a lot of early-career scholars, the process of publication is quite a black box and you have to seek advice from people who are fellow graduate students but may be further along in the PhD. Talk to post-doctoral fellows, faculty mentors, and colleagues at ASA, and just hear their stories of how they publish papers because there are many similarities and common themes across experiences. There are common processes that would hold for almost any peer-reviewed journal, but there are a lot of idiosyncrasies as well and I think hearing those narratives can really help to both elaborate one's understanding of how the process happens and also to unveil a little bit the mystery of the process.

But quite a bit of it, too, is that you have to keep at it and keep pushing. The first five papers I submitted for publication were rejected, and so I think at about my third or fourth year of graduate school I was complete-

ly convinced that I was in the wrong field, that I was going to get no support at all from sociology, that something I was doing was making sociologists unhappy and I could not publish in any sociology journals and my career was over and what in the world did I think I was getting myself into in going to graduate school. But with the help of mentors and friends I kept at it, and eventually I caught some lucky breaks, and I also like to think I learned a few things.

I will also say too that the process of publishing an article gets much easier with the second article compared to the first and with the third compared to the second and with the fourth compared to the third. It does get easier, and you do get much more efficient in writing an article over time. I think the first article I submitted, I went through something like eleven revisions of it before submitting it to a journal and I'm at a lower number than eleven revisions now. What I try to do with graduate students I work with at Harvard is to show them everything that happened when I went through the review process. I show them drafts and talk about how I responded to reviewers to try to demystify the process and to show how it really does take quite a long time. Even if you're fortunate to receive a revise and resubmit, it might not be until 6, 9 or even 12 months after submission, and then your revision may be quite demanding and you may need to put in some serious time revising the manuscript, up to a year or more. Then you submit it again, it goes under review again for who knows how long, and then even at that point you can have a paper rejected or you can have it accepted or you can have another revise and resubmit so it can be quite a lengthy process.

Q: So, do you have several papers in the pipeline?

Beckfield: Yeah, looking back on my grad school experience I'm glad that I tried to have a paper at every stage of the process. This is hard at first, of course, because

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STUDENT NEWS AND VIEWS BY SONIA BETTEZ AND TENNILLE MARLEY

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you're starting from zero. But once you have the first paper under review, then you work on the next paper and at least get a draft of it finished, or get the analysis done, or some kind of progress made on the next paper and then when the first paper comes back to you, you hopefully revise it as an R&R or you revise it to submit to another journal and then you have that off your desk again, and then you can take the paper that's on the "back burner" and put that on the front burner again; and then hopefully you know this kind of cycle back and forth happens and you can use the timing of the publication process to your advantage because there are so many periods of time when you're trying to publish a paper that it's really completely out of your hands. That's an advantageous time to work toward getting another paper in shape.

Q: I hear some people say that, since it is going to take such a long time to publish a paper, you should send it out when you are happy with what you have instead of waiting until you think it is absolutely perfect. What do you think of that strategy?

Beckfield: I do think that's a good strategy but I would add the caveat that you have to be very strict with yourself in what you will allow to make yourself happy when it comes to a paper. It's hard to learn where you reach this point but, for me at least, before I'm ready to submit a paper, I have to feel like I have dealt with every imperfection in the paper to the best of my ability and that if I am aware of any flaw that I have done everything I can do to address that flaw and to evaluate how important it is relative to the rest of the paper and to try to turn a flaw into at least a moot point, if not an advantage.. It's a good idea to have a couple friends read a paper, and to present it at a couple of conferences to at least have some sort of feedback. I think there are some people who can write a perfect first draft and then send that draft out for publication. I'm not a person like that and so now I have to get to at least the kind of third or fourth iteration of a paper

before I really feel comfortable sending it out. The academic sociology peer-reviewed journal article is a genre. Liz Clemens has a great article on the article vs. book genre in sociology. The genre has its standards, it has its form, it has its expected shape, it has its rhetoric, it has its expectations, and I think it's hard to get a feel for that. Michele Lamont has a great paper on various ways in which authors make claims to originality, and various ways in which reviewers accord originality. And I will remember for the rest of my life the day in graduate school when it finally dawned on me how to write a journal article. It was in a class that I was taking with Brian Powell. In this course he has students workshop their empirical MA papers-and so everybody reads each others' papers and it's extraordinarily helpful in getting feedback. And I remember the day that we talked about my paper, and it finally dawned on me what I needed to do. This was a real light-bulb moment and I realized, oh! Oh yeah, I need to figure out what my most interesting finding is and then I need to write the paper about that. Sounds obvious in retrospect, but it wasn't at the time.

Q: Is there anything else you would like to add before we close the interview?

Beckfield: Thinking back about how I became a medical sociologist I recall two key moments in my development. One was reading Richard Wilkinson's book in Jane McLeod's graduate seminar on "Medical Sociology"; I think that was a key moment that brought me into the field. It was 1998, so the book we're talking about is "Unhealthy Societies", and I found that to be an incredibly compelling book that really prompted me to do some empirical research and to apply the methods that I was learning. But I kept medical sociology at arm's length a little bit, because in graduate school, I developed other interests as well and I ended up doing a dissertation that was not connected to medical sociology at all, but I continued having this interest in health. I remember talking with Evie Perry (who is now teaching at Rhodes College in Memphis) about why we study

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A PUBLICATION OF THE MEDICAL SOCIOLOGY SECTION OF THE ASA

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what we study, and we were debating about public sociology a little bit.

Debating that, I realized that questions of medical sociology and sociology of health had been becoming more central for me, partly because of my experience living in New Orleans pre-Katrina. So I'll tell you the story I told Evie. Jocelyn Viterna and I were in New Orleans together when Katrina approached the Gulf Coast. We decided to evacuate. The moment I remember happened when we were driving across the bridge that spans Lake Pontchartrain - just to the north of the city. The lake is a very large body of water that has a bridge that goes across the middle so it's a very long bridge, and it feels like it takes forever to get across. Jocelyn and I had decided to evacuate New Orleans at midnight because we didn't want to get stuck in traffic. We were driving north, it was very dark, we were almost all the way across the bridge and I remember looking back at the city while the radio was giving reports on the forecast, and the forecast was

getting worse and worse and worse and it was just starting to sound catastrophic, which of course it turned out to be. And I remember looking back at the city and thinking, you know, if this hurricane hits, thousands of people are going to die because they're poor. That moment sticks with me, and motivates me. Because I think that describes what happened in New Orleans pretty well. There are so many people in New Orleans who don't own automobiles. Who have no way of knowing the weather forecast. Who are dependent on public institutions that do not function well. So much of the public discourse in the U.S. surrounding poverty assumes that that kind of poverty doesn't exist in the US but it certainly does. There are many people who really can't provide for their basic means, and of course, with no public infrastructure or anything to support them either. It was a horrific illustration of how material deprivation and institutional hollowness can combine to kill people.