NOTES FROM THE CHAIR
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It will not be long before we meet in Seattle for the 111th ASA Annual Meetings at the Washington State Convention Center and Sheraton Seattle Hotel. The meeting dates are August 20-23, 2016. The preliminary program is available online at http://www.asanet.org/AM2016/preliminary_program.cfm.

The Medical Sociology Section activities take place on Monday, August 22 and Tuesday, August 23. However, there is one event early Saturday evening that will be of great interest to many of you. Forging Meaningful Relationships between Sociologists and NIH is the brain child of Section member Shobha Srinivasan (Health Disparities Research Coordinator, Office of the Director, Division of Cancer Control and Population Sciences, National Cancer Institute). Shobha’s co-conspirator Mike Spittel (Program Officer/Health Scientist Administrator OBSSR/NIH) will attend the meeting as well. The purpose of this gathering is to discuss changes in the priorities at the National Institutes of Health and recent opportunities for social science research. In addition, NIH is eager to hear from sociologists about research areas that might need more investment or attention. The meeting will allow NIH and sociologists to discuss gaps in knowledge, science, and skills; steps needed to address those gaps; the kinds of sociological data and measures that are required to address critical challenges in health, health care and health care delivery. The session will be on Saturday, August 20 from 6:30-8:15pm and is currently listed in the program as “National Institutes of Health (David Takeuchi)”. Light snacks and wine will be provided. A special thanks to Section member David Takeuchi (Boston College) for helping make this event a reality. Please take advantage of this unique opportunity.

We will honor the Section’s award winners at our Awards Ceremony and Reeder Address on Monday from 2:30-4:10pm. Allan Horwitz is the recipient of 2016 Leo G. Reeder Award. The title of Professor Horwitz’s Reeder Address is “Social Context, Biology, and the Definition of Disorder: Some Implications for Medical Sociology.” Come and celebrate with all our award winners, and catch up with colleagues, at the Section’s Joint Reception with the Section on Mental Health on Monday evening from 6:30-8:30.

Professor Horwitz has graciously agreed to have a lunch meeting with graduate student Section members before his Reeder Address. Interested graduate students need to RSVP by emailing Tania Jenkins (tmjenkins@uchicago.edu).

All the Section’s regular Sessions are scheduled for Monday and Tuesday. After sorting through many high-quality papers, the Session organizers have put together six vibrant Sessions. The Section Roundtables are from 8:30-9:30 Tuesday morning. Do let this less-than-perfect time slot discourage you for attending. Roundtables tend to be more interactive than regular Sessions and can be especially useful for getting and giving feedback to authors of papers that are in the early stages of development. This year there are fewer Roundtables but the content of each table is more focused. The Business Meeting will start right after the Roundtables and run from 9:30-10:10.

It promises to be a great meeting, and I hope to see many of you in Seattle.
1.) To what would you attribute your success and longevity in the field?

Probably being able to combine the practical and theoretical. I have been lucky enough to hold joint appointments in the institutions where I have worked - in social science departments and departments/schools in the health field - for most of my career. This permitted me to investigate and teach about how communities can find solutions to intractable health-related dilemmas while at the same time conducting research and pursuing my broader theoretical interests in the development of sociological approaches to political problems. Occasionally this has led to administrative overload but there have been few dull moments.

2. If you were to provide advice to upcoming scholars within medical sociology, what would your advice be?

It depends on whether you are thinking about potential topics of interest in the field today or general career advice to younger scholars. If the latter, then it must be recognized that the research world has changed since I took my first position. There is a lot more mentoring and support for junior faculty, but there is also considerably pressure on scholars of all ages to work on projects that will generate income for their institutions. It is critical therefore that young scholars think carefully about their own intellectual agenda rather than or as well as responding to prompts from their universities about what kinds of research are important.

This brings us to the second issue - questions of interest in medical sociology. I am much influenced by my own trajectory which, probably because I grew up outside the United States, has led me to think about health-related questions in a comparative and global context. However, it would be somewhat irresponsible for me to suggest that graduate students or faculty in their first position embark on large cross-national topics. Unless they have funding or a post doc or are engaged in quantitative work that they can pursue in front of a computer, such comparative work can involve a great deal of travel, and the use of qualitative methods such as interviewing and/or painstaking ethnographic work, in different countries and possibly different languages - all of which require time and money and may slow down the pace of publication. But research on the most local of projects cannot be divorced from larger trends and processes. No one working in medical sociology today can afford to ignore the fact that we live in a global economy and that local and national developments respond to and are shaped by the needs and demands of a set of international organizations, ngo's, donor nations and philanthropies – what some have called “an international health regime”.

3. In a recent article, you explain that “diseases acquire durable identities, conditioned by collective imaginaries and institutional context when they first come to attention.” Can you tell our readers a little more about this complex relationship and how you’ve seen the interrelatedness of collective imaginaries and institutional context produce disease identities in your research?

I am interested more broadly in how societies and governments assess the risk of and respond to cross-border health threats posed by peoples and products. In the article you mention I tackled the question of why several European member states screened immigrants for tuberculosis but not for HIV/AIDS. One component of my argument about the making of policy is that cultural frameworks, in this instance the “disease identities” nurtured in a particular political culture, conditioned how policymakers understood those suffering from AIDS and TB as well as how difficult it would be to curb those infections and the costs of taking action to do so; and that these perceptions had consequences for the decisions that were taken. However, once established, disease identities are not inscribed automatically on the policies of nations, nor are they necessarily universal. In my current research, a comparative study of policy-making with regard to blood-borne HIV and Hepatitis C (HCV), I am exploring the mediating roles of various factors, such as institutional structures, in the translation of disease identities into policy.

4. You’ve done some comparative analysis across nations regarding policy adoption pertaining to health threats. What does your research say about how the U.S. compares to other countries in terms of policy adoption regarding health threats?

It’s difficult to generalize about this because what countries have done about health threats covers a broad array of strategies. A country’s response to one dimension of an epidemic (eg. how to stem the spread of HIV among gay men) may be forged by actors and shaped by factors different from those that propel their efforts in different spheres (eg. developing safe and affordable treatments). So there may be “winners” and “losers” or effective and ineffective responses across nations with regard to different aspects of different health threats.

However, the United States has tended to lag behind other developed democracies when it comes to its policies regarding infectious disease control at its borders. It is not the only nation whose public health strategies have become entangled with concerns about immigration. But its implementation of and calls for travel bans have been unusual as well as counterproductive. In 1987 Congress put HIV on a list of “dangerous contagious diseases,” making it grounds to exclude immigrants from entering the United States. Despite two decades of lobbying by epidemiologists and other experts who said there was no scientific or public health basis for the ban and that it served only to discourage HIV-positive immigrants already in the United States from disclosing their status or seeking treatment, it was not effectively lifted until January 2010. Despite the damage this did to the reputation of the United States in the global health arena, there were immediate calls for a similar travel ban to be imposed on travelers from West Africa when the recent Ebola epidemic was discovered in 2014. Somewhat the maxim that pathogens do not honor national borders, whatever the attempt to restrict them, has not been taken to heart in the US or perhaps it is simply no match for the fears so easily excited by the prospect of disease-carrying migrants. (Continued on pg. 6)
5. Where do you hope to see U.S. public health infrastructure progressing in the next few years?

Thinking specifically about public health infrastructure with regard to disease outbreaks and epidemics, one sees a lot of emphasis on surveillance, both nationally and internationally. Charting the course of epidemics is of course important but I would hope to see more attention to bolstering the ability of the US to mobilize its collective resources to cope with disease and illness. This would require more support to public health institutions at both the local and national level but it would also involve looking more broadly at the nature of social networks and resources available in communities. The latter can be affected—sometimes inadvertently—by government policies directed to other issues, such as urban development or unemployment, which are not on the face of it health-related issues.

6. In your opinion, what are the biggest contributions sociology can bring to national and international discussions about disease outbreaks and epidemics?

It’s a long list, which could include:

- Analyzing what the call for (pandemic) “preparedness” means at the individual, community, national and international level and what the current obstacles are to achieving this.
- Studying past responses – political, economic and cultural - to epidemics so that one can develop a better understanding of the factors that have made for a successful response, in both the immediate “lesson-drawing” sense but also as part of a broader analysis of social structure and collective capacities.
- Improving our understanding of what it means to talk about “global health governance”. The knee-jerk response in recent years been to blame WHO for not moving fast enough or more effectively to contain epidemics without considering the nature of the organizations, institutions and regulatory structures that are supposed to adjudicate affairs of public health at the transnational level and the extent of their authority and jurisdiction.
- Clarifying the interdependence of local, national and transnational knowledge-making, how scientific information about health and disease is generated and how it is (or is not) factored into political decision-making (the focus of my current work, so I hope it will be a contribution!)

As will be clear from this list I concur with the formulation in your question – what can sociology as a whole contribute: these analyses will be generated by collaborations among different subfields in sociology, the arguments and theoretical tools emerging in, for example, STS and political sociology, as well as medical sociology.

7. What part of your experiences in medical sociology research and teaching has been the most rewarding to you?

Engaging students in research. I enjoy teaching the how-to of research via “methods” courses which impart a series of technical and organizational skills. However, I have found that the most effective way for students to learn how to formulate research questions and to examine data and theories critically is through participation in an ongoing research project. As they engage in the work they also learn the intangibles of doing research: the interplay between independent work and group collaboration, how to analyze, communicate and make decisions, and to reflect on the research process as an integral part of the doing of the research. Watching them as they interrogate what it means to produce knowledge and to become a researcher is profoundly rewarding.