

## **Sociology 658: Sociology of Health and Medicine**

Units: 4.0

Fall 2020 | Monday | 2:00pm to 4:50pm

Location: Zoom

Syllabus last updated: July 22<sup>nd</sup>, 2020

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### **Course Description**

This is a graduate-level course in the sociology of health and medicine, an incredibly broad and fragmented field that frequently overlaps with medical anthropology, public health, and other disciplines. The first half of this course focuses on the *social roots of sickness*. The second half concerns the *social relations of medicine*. While we'll treat these as relatively autonomous topics, we'll also spend time addressing the mismatches between the forces that make people sick and the organized reactions to sickness. We'll also study a number of general structures and processes that simultaneously affect health and care. For example, we'll study how capitalism, racism, and sexism make people sick. We'll then study how these same systems shape, and are shaped by, medicine.

While we are obviously unable to cover every important topic in the sociology of health and medicine, this course aims to introduce you to some core themes in the subfield. It is also my hope that this course helps advance graduate student development as it pertains to the assigned material (e.g., qualifying exam prep, research proposal drafting, and article writing).

### **Learning Objectives**

1. Understand the social roots of sickness and its relevant sociological scholarship
2. Understand the social relations of medicine and its relevant sociological scholarship
3. Advance student development as it pertains to the course (e.g., qualifying exam prep)

### **Course Materials**

- Ansell, David A. 2017. *The Death Gap: How Inequality Kills*. Chicago: University of Chicago Press. Available Online via the USC Library. [10-digit ISBN: 022642815X]
- Seim, Josh. 2020. *Bandage, Sort, and Hustle: Ambulance Crews on the Front Lines of Urban Suffering*. Oakland: University of California Press. Available Online Via the USC Library. [10-digit ISBN: 0520300238]

All other readings are available on Blackboard. See the detailed bibliography at the end of this syllabus for additional information regarding the assigned text.

You should also treat the reading summaries in this syllabus as supplemental course material. I wrote these as abstracts for loosely planned discussions. I also wrote these because I wanted to offer a demystifying and synthesizing document that students with varying backgrounds in the sociology of health and medicine could refer to during, and hopefully beyond, the semester. There are certainly downsides to this approach. But, given our ambitious reading schedule and course goals, I think the pros outweigh the cons.

## Student Evaluation

Grading Breakdown	
Seminar Participation	10%
Weekly Memos	20%
Take-Home Exams	50%
Excluded Theorist Project	20%

### *Seminar Participation*

Attendance and participation in seminar are integral to your success in this course. You must come to seminar *prepared to discuss the assigned readings as well as your classmates' weekly memos*.

### *Weekly Memos*

You are required to submit 10 short memos (500-1,000 words). Weekly memos are not summaries. They should be written to accomplish one of two goals: 1) an internal or external critique of a single reading or 2) a critical synthesis of two or more readings. You must submit memos via Blackboard by 5:00pm the workday before the meeting (Fridays, but weekend submissions are also fine). Late memos will not be accepted. All memos will be posted for your peers to read, and you're expected to read everyone else's memos before each seminar.

### *Take-Home Exams*

Your performance on two written take-home exams will determine half of your grade in the course. For each exam, you will be given multiple days to answer a few questions. These exams will challenge you to put our authors in conversation with one another. Additional instructions and requirements will be provided on the exam prompts.

### *Final Paper*

The course ends with a final paper assignment that will have you examining a particular topic or case relevant to the sociology of health and medicine. Your final paper must be assembled as one of the following: 1) a *review essay* that offers a critical synthesis of secondary sources, 2) a *research proposal* that sells your topic or case as something to be researched and outlines a plan on how to do so, or 3) an *article manuscript* that draws on some original data analyses to make sense of your topic or case. Whatever the format, your final paper should reference the course's primary readings *and some additional texts* (i.e., scholarship you find on your own).

We will not spend much time in seminar discussing final papers. You are strongly encouraged to meet with me one-on-one to discuss your plans.

### Schedule

Each three-hour seminar will be split into two topics.

Memos are due 5pm the *previous* Friday, but weekend submissions are also fine.

Gray = important deadlines

Part I: The Social Roots of Sickness			
Date	Topic	Reading	Deliverable
08/17	a) Integration and Regulation b) Social Murder	Durkheim / Klinenberg Engels / Farmer	Memo by Fri.
08/24	a) Suffering Complex Hierarchies b) Fundamental Causes	Du Bois / Watkins-Hayes Link & P. / Hatzenbuehler	Memo by Fri.
08/31	a) Status Syndrome b) Capitalism and Sickness	Marmot / Pickett and W. Muntaner et al. / Prins et al.	Memo by Fri.
09/14	a) Racism and Sickness b) Sexism and Sickness	Williams & M. / Gee et al. Bird & Rieker / Homan	Memo by Fri.
09/21	a) An Intersectional Perspective b) Violence and Embodiment	López & G. / Brown et al. Holmes / Krieger	Memo by Fri.
09/28	a) <i>The Death Gap</i> b) Distribute Exam I	Ansell N/A	Memo by Fri.
09/30	Exam I	N/A	Exam by 3pm
Part II: The Social Relations of Medicine			
Date	Topic	Reading	Deliverable
10/05	a) Medicine as a Social Institution b) Medical Gaze	Parsons / Goffman Foucault / Davenport	Memo by Fri.
10/12	a) Medical Irony b) Medical Authority	Waitzkin / Bourgois et al. Starr / Timmermans	Memo by Fri.
10/19	a) (Bio)Medicalization b) Capitalist Medicine	Conrad / Clarke et al. Navarro / Maskovsky	Memo by Fri.
10/26	a) Racist Medicine b) Sexist Medicine	Feagin & B. / Duster Lupton / Hovav	Memo by Fri.
11/02	a) Medical Labor b) Medicating the Margins	Rodriquez / Wingfield & C. Hansen et al. / Sufrin	Memo by Fri.
11/09	a) <i>Bandage, Sort, and Hustle</i> b) Distribute Exam II	Seim N/A	Memo by Fri.
11/11	Exam II	N/A	Exam by 3pm
11/24	Final Paper	N/A	Paper by 3pm

## PART I: THE SOCIAL ROOTS OF SICKNESS

### AUGUST 17<sup>TH</sup>

#### A) INTEGRATION AND REGULATION

Durkheim. 1897. *Suicide*. (select excerpts)<sup>1</sup>  
 Klinenberg. 2002. *Heat Wave*. (pp. 1-13, 79-128)

In his renowned study of suicide, Émile Durkheim offers an early theorization of health and society. He links suicide, an act that seems very personal, to social structure. Durkheim specifically highlights two factors that influence individuals in collective life: integration and regulation. Think of integration as your level of attachment to society. Think of regulation as the degree to which social conditions limit and direct your needs and desires. According to Durkheim, the risk for suicide is lowest when people are in a position of relative balance on both of these dimensions. Too little integration (or too much individualism) can lead to egoistic suicide, while too much integration (or too little individualism) can lead to altruistic suicide. Likewise, too little regulation (or too few rules/norms) can lead to anomic suicide, while too much regulation (or too many rules/norms) can lead to fatalistic suicide.

We'll put Durkheim's book in conversation with Eric Klinenberg's "social autopsy" of the 1995 Chicago heat wave. What might Durkheim say about the differences between North Lawndale and Little Village? What might he say about the social production of isolation and the concept of "social ecology"? Similarly, how might Klinenberg evaluate Durkheim?

#### B) SOCIAL MURDER

Engels. 1845. *The Conditions of the Working Class in England*. (pp. 106-30)  
 Farmer. 1996. "On Suffering and Structural Violence."

Friedrich Engels offers us a radically different perspective than Durkheim on the social roots of sickness. In his study of industrial Manchester, Engels is concerned with describing and explaining working class suffering beyond the point of production (i.e., outside of factories). He essentially writes one of the earliest studies of neighborhood health disparities. In addition to highlighting the education, legal, and medical institutions in working class England, he accounts for the perniciousness of proletarian insecurity. Perhaps Engels's most important contribution to the sociology of health concerns his notion of "social murder." Capitalism kills, wounds, and infects the working class, and those who profit off this system are guilty of such harm. We should remember that Engels places blame on an economic class and a broader system of capitalism. He is not interested in calling out individual capitalists or specific organizations.

We'll draw on Engels to make sense of a famous essay by Paul Farmer. What does Farmer's conceptualization of suffering add that Engels misses? In what ways is "social murder" a sort of

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<sup>1</sup> Pp. 152-5, 157-60, 171, 173, 202-5, 208-15, 217-21, 241-3, 245-9, 252, 276 (only footnote 25). The corresponding PDF includes all of these pages. Just read the whole document.

proto-theory of structural violence? What might Engels say about “multiaxial modes of suffering”?

## AUGUST 24<sup>TH</sup>

### A) SUFFERING COMPLEX HIERARCHIES

Du Bois. 1899. *The Philadelphia Negro*. (pp. 147-63)

Watkins-Hayes. 2019. *Remaking a Life*. (pp. 1-34)

Next, we turn to another foundational scholar: W.E.B. Du Bois. Like Durkheim and Engels, Du Bois is not primarily interested in explaining health, but he provides us with a useful framework nonetheless. He gives us an early theory of racism and sickness. Du Bois breaks from classical biological explanations of racial health disparities and points to the forces of historical legacy and contemporary social context. While there are certainly times in which Du Bois seems to blame the victim (e.g., his commentary on personal cleanliness, diet, and exercise), his model offers a distinctly sociological explanation for high rates of morbidity and mortality among Blacks in Philadelphia in the late nineteenth century. In short, he offers a theory a structural racism and health inequality. We cannot, however, understand a racial hierarchy in opportunity and wellbeing without also considering the significance of social class. Du Bois forces us to examine race and class hierarchies simultaneously and in intersection.

We’ll also discuss the introduction chapter from Celeste Watkins-Hayes’s book on women living with HIV/AIDS. While it may be true that Du Bois details a more complex hierarchy of suffering than Engels, Watkins-Hayes complicates this even more. Think about how she might critique Du Bois. Also, think about what Du Bois might say about Watkins-Hayes’s treatment of agency and her notion of “injuries of inequality.”

### B) FUNDAMENTAL CAUSES

Link and Phelan. 1995. “Social Conditions as Fundamental Causes of Disease.”

Hatzenbuehler et al. 2013. “Stigma as a Fundamental Cause of Population Health Inequalities.”

With Durkheim, Engels, and Du Bois (as well as Klinenberg, Farmer, and Watkins-Hayes) by our side, we now turn to one of the most cited publications in the sociology of health: Bruce Link and Jo Phelan’s “Social Conditions as Fundamental Causes of Disease.” This piece opens with a critique of modern epidemiology and challenges us to think more critically about the “distal” causes of illness and injury. While proximal risk factors like smoking and a poor diet are not insignificant, it’s more important that we account for the fundamental social conditions that shape the “risk of risks.” And, for Link and Phelan, such conditions can more or less be reduced to various resources, which are almost always distributed unequally. These resources include things like money, knowledge, power, and social connections. Link and Phelan argue that reductions in resources increases the risk of risks, which of course increases morbidity and mortality.

We'll think about how Link and Phelan's model is extended and modified to account for stigma in an article they coauthored with Mark Hatzenbuehler. Among other things, we should consider how stigma might shape the "risk of risks." Also, note that the language of "proximate and distal causes" is missing in the second article. How might we integrate that terminology into an analysis of stigma?

## AUGUST 31<sup>ST</sup>

### A) STATUS SYNDROME

Marmot. 2004. *The Status Syndrome* (pp. 1-12, 43-5, 78-81, 160-3, 188-9, 240-1)

Pickett and Wilkinson. 2015. "Income Inequality and Health: A Causal Review."

In many ways, Michael Marmot breaks from the resource-focused model provided by Link and Phelan. He's motivated by a simple question. Why do people of relatively lower status have worse health than their counterparts of higher status? Marmot calls this the "status syndrome" and it's something that cannot be simply explained by inequalities in material conditions. However, lifestyle variations also do not adequately explain the status syndrome. Something else is going on according to Marmot. He pushes us to consider the interacting factors of "social participation" and "personal autonomy." Drawing a bit on the work of Amartya Sen and clearly inspired by Durkheim, Marmot links these conditions to a framework of "capabilities." But how does social participation, personal autonomy, and capability positively influence health? Through the brain primarily. Stress is key for Marmot. Decreases in social participation and personal autonomy increase chronic stress, which of course increases morbidity and mortality.

We'll think about how Marmot's status syndrome explanation might help us understand Kate Pickett and Richard Wilkinson's review piece on income inequality and health. Like Marmot, Pickett and Wilkinson emphasize the importance of relative inequality and psychosocial processes. However, they say effectively nothing about social participation or personal autonomy.

### B) CAPITALISM AND SICKNESS

Muntaner et al. 2015. "Two Decades of Neo-Marxist Class Analysis and Health Inequalities."

Prins et al. 2015. "Anxious? Depressed? You might be suffering from Capitalism."

Carles Muntaner and colleagues detail a Neo-Marxist approach to examining health inequality, and it's one that we should read against both the "fundamental cause" and the "status syndrome" perspectives. They argue that most of the social determinants of health studies utilize deeply problematic operationalizations of class as an individual attribute. Indeed, "class" is usually measured by personal income, wealth, and/or education level. While Muntaner et al. acknowledge important differences between various "mainstream" approaches, they ultimately conclude that most of the scholarship on sickness and class neglects the core features of class relations under advanced capitalism. Much of the research on "socioeconomic status" and health, for example, ignores people's relations to the means of production and that which most

fundamentally determines their class positioning. It is also critical, according to Muntaner et al., that we think about exploitation, domination, and other aspects of class relations.

To help us further understand how capitalism affects health, we'll read Prins and colleagues' study of "contradictory class locations" and the prevalence of depression and anxiety within the United States. They identify an empirical pattern that cannot be explained by resource or status inequalities but can be somewhat easily explained from a Neo-Marxist perspective.

## SEPTEMBER 14<sup>TH</sup>

### A) RACISM AND SICKNESS

Williams and Mohammed. 2013. "Racism and Health."

Gee et al. 2019. "Racism and the Life Course."

More than a century after Du Bois's initial writings on the topic, there remains no shortage of research demonstrating a racial patterning of morbidity and mortality in the United States. However, the mainstream framing tends to focus on "racial disparities." Less attention is given to racism as a causal force. David Williams and Selina Mohammed help correct for this deviation and in doing so they bring us back toward a Du Boisian approach. Their thesis is simple: racism makes people sick. We shouldn't think about racism as a personality trait as much as "an organized system premised on the categorization and ranking of social groups into races and devalues, disempowers, and differentially allocates desirable societal opportunities and resources to racial groups regarded as inferior." Williams and Mohammed argue that racism produces suffering through three general pathways: institutional racism, (interpersonal) discrimination, and cultural (or internal) racism. We should think about how their framework complements and contradicts the fundamental cause, status syndrome, and Neo-Marxist approaches.

We'll keep Williams and Mohammed's theory of racism in mind when we discuss Gee and colleagues' analysis of time as a racialized determinant of health. How might the three forms of racism detailed by Williams and Mohammed influence, and be influenced, by time as a health predictor?

### B) SEXISM AND SICKNESS

Bird and Rieker. 2008. *Gender and Health* (pp. 16-45, 57-73)

Homan. 2019. "Structural Sexism and Health in the United States."

Chloe Bird and Patricia Rieker help us confront the gender health paradox: men have higher rates of mortality, but women have higher rates of morbidity (i.e., women tend to live longer but they are generally sicker). Our authors show us how this is made even more complicated by average physiological differences between people categorized as male and people categorized as female and the specific pathology under consideration. Given these complexities, Bird and Rieker call for a flexible model to make sense of gendered health disparities. Their proposed solution rests on their notion of "constrained choices." They agree with many scholars that individual choices shape, and are shaped by, biological processes (which together influence

health outcomes). However, they insist that higher-level forces affect this relationship. More specifically, they suggest that social policy, community actions, and work and family conditions operate as interdependent forces that shape, or rather “constrain,” choice in a variety of ways. Bird and Rieker also claim that gender roles are important for a model of constrained choice.

We’ll put Bird and Rieker in conversation with Patricia Homan who offers a new model for studying structural sexism and health inequality. What might Bird and Rieker say about the multilevel structure detailed by Homan? In what ways does Homan abandon or modify constrained choice theory to make sense of her findings? It’s also worth considering how Homan’s model of structural sexism is influenced by frameworks of structural racism.

## SEPTEMBER 21<sup>ST</sup>

### A) AN INTERSECTIONAL PERSPECTIVE

López and Gadsden. 2016. “Health Inequities, Social Determinants, and Intersectionality.”  
Brown et al. 2016. “Using Multiple-Hierarchy Stratification and Life Course Approaches...”

Nancy López and Vivian Gadsden challenge us to see how multiple axes of inequality, and therefore multiple sources of sickness, intersect in important ways. They build on several frameworks, including a long tradition of Black feminism, to argue that individuals occupy multiple social positions simultaneously. People do not exist as only racialized subjects, just as they do not exist as only classed or gendered subjects (not to mention sexual orientation, nationality, and so on). That said, López and Gadsden do not want us to only examine a complex assemblage of individual attributes. It’s imperative that we examine social systems. Indeed, intersecting identities only predict illness and injury because the intersecting hierarchies they correspond to structure overlapping dynamics of oppression and privilege (e.g., white supremacy, capitalism, and patriarchy). López and Gadsden help us understand these connections between identities and systems by detailing four domains of power: structural, cultural, disciplinary, and interpersonal.

We’ll also discuss a recent study by Tyson Brown and colleagues. López and Gadsden reference this piece as an example of how to integrate an intersectional approach into population health research. We should also focus on how Brown et al. explicitly engage Du Bois, Link and Phelan, Marmot, Bird and Rieker, Williams and Mohammed, and Gee and Ford. It’s also not hard to put them in conversation with Farmer, Watkins-Hayes, Homan, Muntaner et al., and others.

### B) VIOLENCE AND EMBODIMENT

Holmes. 2013. *Fresh Fruit, Broken Bodies*. (pp. 89-110)

Krieger. 2005. “Embodiment: A Conceptual Glossary for Epidemiology.”

Next, we turn to Seth Holmes’s ethnography of migrant farmworkers in the United States and his analysis of the “violence continuum.” Inspired by Engels, Farmer, and others, Holmes examines three cases of suffering he discovered during his fieldwork: Abelino’s knee injury, Crescencio’s headache, and Bernardo’s abdominal pain. Although trained in biomedicine, Holmes finds social

theory to be a particularly useful tool for diagnosis. Holmes recognizes that everyone suffers, but he argues that suffering tends to concentrate toward the bottom of social hierarchies. He claims the distribution of suffering can be largely explained through a theory of the violence continuum. This model details three primary forms of violence: structural (e.g., segregated labor and Abelino's knee injury), political (e.g., military repression and Bernardo's stomach pain), and symbolic (e.g., racist insults/stereotypes and Crescencio's headache). Holmes argues this model should not be limited to the specific case of migrant farmworker health. As such, we should consider how we can use the concept of the "violence continuum" to inform our previous readings.

We'll also put Holmes in conversation with Nancy Krieger. Rooted in her so-called ecosocial theory, Krieger's concept of "embodiment" helps us locate the body in social structure and social structure in the body. How might this concept compliment or challenge a theory of the violence continuum? How might Krieger make sense of Abelino, Crescencio, and Bernardo's suffering differently than Holmes?

## **SEPTEMBER 28<sup>TH</sup>**

### **A) *THE DEATH GAP***

Ansell. 2017. *The Death Gap*. (Available online via the USC Library).

We'll wrap up our conversation on the social roots of sickness with *The Death Gap*. Read this book cover to cover and consider its many explicit and implicit connections to our other readings. Also, think about how some of our previous authors might critique the book.

### **B) DISTRIBUTE EXAM I**

Our discussion of *The Death Gap* will partly function as a review session for the first part of the course. In the final hour, we'll discuss the logistics of the first take-home exam, which I will actually distribute to you sometime before this meeting.

Exam I due September 30<sup>th</sup> at 3pm.

## PART II: THE SOCIAL RELATIONS OF MEDICINE

### OCTOBER 5<sup>TH</sup>

#### A) MEDICINE AS A SOCIAL INSTITUTION

Parsons. 1951. "Illness and the Role of the Physician."

Goffman. 1961. *Asylums*. (pp. xiii-xiv, 12-23, 74-92)

We begin the second part of the course with Talcott Parsons's classic essay on medicine as a functional institution. For him, sickness is but one label we apply to deviant actors and the "sick role" offers an institutionalized pathway back into normality. Those in the sick role are exempt from certain obligations and from being held personally responsible for their deviance. However, this role also comes with some obligations of its own, namely an obligation to remain isolated from others and an obligation to seek therapy. The latter obligation often leads the sick person into the role of the patient, a more formalized status exposed to the rehabilitative interventions of the therapist. With particular obligations of their own (e.g., an obligation to help the patient, an obligation to allow patient deviance, an obligation not to reciprocate that deviance, and an obligation to manipulate sanctions), therapists work to reintegrate the sick back into their normal roles of worker, parent, student, and so on.

We'll also read some excerpts from Erving Goffman's *Asylums* to help us better understand medicine as a social institution. Unlike Parsons, Goffman is not committed to detailing the rehabilitative functions of medical interventions. He is more concerned with how the status of inmate/patient adjusts selfhood and how staff in "total institutions" (which include asylums, prisons, and more) engage in "people work" to manage their subjects.

#### B) MEDICAL GAZE

Foucault. 1973. *The Birth of the Clinic*. (pp. ix-xix, 97, 136, 164, 190)

Davenport. 2000. "Witnessing and the Medical Gaze."

Beginning with a detailed comparison of Pomme (a pre-modern healer) and Bayle (an early modern healer), Michel Foucault shows how the primary medical question has shifted from "What's wrong with you?" to "Where does it hurt?" This indicates a critical transformation in discourse, and more particularly in the ways of thinking and talking about (ab)normality. Bayle's question is joined with the "medical gaze," which provides a framework for clinicians to see the human body as a series of organs to diagnose, explain, and treat. Besides the medical interview, the gaze is instituted in a series of medical practices (e.g., palpation) and instruments (e.g., stethoscopes). Ultimately, the gaze, and the modern medical discourse it's associated with, transforms people into generalizable cases (e.g., a case of pneumonia). This is all important for Foucault because it ties into his broader understanding of power/knowledge, which we will touch on a bit in seminar.

Beverly Ann Davenport's ethnographic study of doctor-patient communication within a free clinic for unhoused people will help us further understand medical gazing. She argues that she

had to “move beyond Foucault’s concept of the medical gaze” to understand an observed tension between objectification and subject-making. We should evaluate the merits of Davenport’s critique and think about how Foucault might respond.

## OCTOBER 12<sup>TH</sup>

### A) MEDICAL IRONY

Waitzkin. 1993. *The Politics of Medical Encounters*. (pp. xiii-iv, 3-10, 75-106)  
 Bourgois et al. 2017. “Structural Vulnerability.”

Like Parsons, Goffman, Foucault, and Davenport, Howard Waitzkin helps us understand clinical encounters. However, unlike these previous authors, Waitzkin somewhat implicitly draws on Marxism. According to the sociologist and physician, social contexts like work and family (which are shaped by capitalism and related systems of oppression) make us sick and this leads us into the medical office. There, Waitzkin identifies a great contradiction or “irony” of medicine: clinicians authentically want to eliminate and alleviate patient suffering but they are usually not capable of affecting the “root causes” of misery. So, what are they doing? According to Waitzkin, physicians offer superficial solutions to human suffering, and they generally work to return people back to the same conditions that made them sick to begin with. The medical intervention, which always mixes ideology and social control, yields “consent.” More specifically, medicine elicits consent to the unhealthy forces of oppression. Among other things, this process mystifies and depoliticizes the social roots of sickness.

We’ll also discuss a recent article by Philippe Bourgois and colleagues on the promise of integrating a “structural vulnerability” assessment tool into clinical practice. Can such a tool significantly counter the medical irony described by Waitzkin? More importantly, what might Bourgois and colleagues say about Waitzkin’s emphasis of ideology, control, and consent?

### B) MEDICAL AUTHORITY

Starr. 1982. *The Social Transformation of American Medicine*. (pp. 3-29)  
 Timmermans. 2006. *Postmortem* (pp. 1-34)

Paul Starr seeks to explain the rise of medical power in America. Rejecting Marxism and other perspectives, Starr outlines a Weberian-inspired model for how American physicians expanded and protected their professional sovereignty. Following a lengthy conceptualization authority, he analyzes the internal and external conditions of a nascent, but rapidly expanding, medical profession in the late nineteenth century. From here, Starr shows us how medical authority was converted into economic power in the early twentieth century by controlling, or at least heavily influencing, the medical market. He argues that by the middle of the century medical authority was very strong and doctors were able to defend much of their sovereignty against new forms of competition and control. However, Starr leaves us with a bit of a cliffhanger. New forms of competition and control (e.g., government regulation and corporate power) have emerged near the turn of the millennium to challenge medical authority.

We'll also discuss an excerpt from Stefan Timmermans's ethnographic study of medical examiners. He explicitly draws on Starr to study "forensic authority." We should, however, also consider the tensions between Starr and Timmermans. Time permitting, we may also put Timmermans in conversation with Parsons, Goffman, Foucault, and others.

## OCTOBER 19<sup>TH</sup>

### A) (BIO)MEDICALIZATION

Conrad. 2007. *The Medicalization of Society*. (pp. 3-19, 146-64)

Clarke et al. 2003. "Biomedicalization."

Peter Conrad studies medicalization, that being the classification of human problems as "sickness." He frames medicalization as a process, as something that's elastic, and as a gradient. In other words, problems tend to become medicalized over time, some problems can be de-medicalized, and some problems are simply more medicalized than others. To make sense of this variation, we have to account for the causes of medicalization. Conrad outlines a number of forces, but three arenas are particularly important: the medical field, social movements, and the health care and pharmaceutical markets. While he recognizes a number of beneficial outcomes of medicalization, Conrad is primarily concerned with medicalization's more harmful effects: pathologization of difference, defining ab/normality, controlling bodies, decontextualization, and commodification. He also acknowledges a paradoxical decline in physician power as a result of medicalization, but this isn't really framed as a harmful effect. We should put Conrad in conversation with Parsons, Foucault, Waitzkin, Starr, and others.

We'll also discuss an essay on "biomedicalization" by Adele Clarke and colleagues. As they put it, biomedicalization "describes the increasingly complex, multisited, multidirectional processes of medicalization, both extended and reconstituted through the new social forms of highly technoscientific biomedicine." In addition to discussing the merits of this concept, we should consider what Clarke et al. say about Conrad's framework and what Conrad says about theirs.

### B) CAPITALIST MEDICINE

Navarro. 1983. "Radicalism, Marxism, and Medicine."

Maskovsky. 2000. "Managing the Poor."

Vicente Navarro argues that in order to understand medicine under capitalism we must situate the practice of medicine within a system of class exploitation. Navarro focuses on a curious space between the bourgeoisie and the proletariat: the petit bourgeoisie. This class directly and indirectly participates in the control and coordination of production. In the case of medicine, doctors care for and control the working masses. They reduce suffering, but in doing so they protect and subsidize the most precious commodity under capitalism: labor power. Control and care are in a perpetual state of contradiction. However, the nature of this contradiction can vary quite a bit across capitalist contexts. According to Navarro, this variation can largely be explained by differences in class struggle. Capitalist medicine is more "caring" in places where the working class has significant political influence. That said, medicine will always be capitalist

so long as it exists under capitalism. It will always structurally preference the interests of the bourgeoisie over the interests of the proletariat.

We'll also discuss Jeff Maskovsky's ethnographic and historical study of Medicaid managed care. He showcases a neoliberal retooling of medical resources in the late twentieth century and examines some protest efforts it inspired. We should consider how Maskovsky complements and challenges Navarro's framework.

## OCTOBER 26<sup>TH</sup>

### A) RACIST MEDICINE

Feagin and Bennefield. 2014. "Systemic Racism and U.S. Health Care."

Duster. 2005/2007. "Race and Reification in Science" and "Medicalisation of Race."

Joe Feagin and Zinobia Bennefield argue that systemic racism in the United States is an essential part of medicine and medicine is an essential part of systemic racism. For them, systemic racism involves five interdependent conditions: racial hierarchy, white framing, individual and collective racial discrimination, reproduction of racial inequalities, and racist institutions. As one of these institutions, medicine (along with public health governance) has a racist history, relies on racist language and concepts, and involves racist treatments. With respect to history, American medicine helped legitimate "race" as a category of human difference, was built on the abuse of Black subjects, and was used as a form of racial population control. With regard to language, medicine has long emphasized weak concepts for making sense of racial disparities (e.g., bias, prejudice, and cultural competence) and deemphasized strong concepts (e.g., systemic racism, white discriminators, and white racial framing). Lastly, in terms of differential treatment patterns, medicine has been, and continues to be, organized by broad white racial frames that structure both implicit and explicit bias.

We'll discuss Feagin and Bennefield alongside two short essays by Troy Duster. The Duster essays communicate a sociology of racism to a mainstream biomedical audience, with one published in *Science* and the other in *The Lancet*. Time permitting, we may also put Duster in conversation with Foucault, Conrad, Clarke et al., Navarro, and others.

### B) SEXIST MEDICINE

Lupton. 2003. *Medicine as Culture*. (pp. 142-6, 149, 158-67)

Hovav. 2020. "Cutting Out the Surrogate."

Deborah Lupton helps us understand medicine as a sexist institution. While there is evidence that medicine can challenge women's oppression in meaningful ways (e.g., contraception drugs as a partial pathway to women's liberation), there is also convincing evidence that medicine solidifies male domination. Three cases demonstrate how health care helps reproduce patriarchy: the history of gynecology, the medicalization of childbirth, and the rise of prenatal screening. For Lupton, the emergence of gynecology intensified gender distinctions and hierarchies, focused human reproductive concerns on women, and helped establish a world where male doctors know

and control female bodies. The case of medicalized childbirth shows how men encroached on a female practice, how pregnant women were made into patients, and how women's resistance can yield problematic outcomes ("natural birth" as a new form of medical power). Finally, the case of prenatal screening shows how medicine has continued to surveil motherhood, focus on female risk and lifestyle, and generate new anxieties, dilemmas, and contradictions for women.

We'll put Lupton in conversation with April Hovav. Her ethnographic and in-depth interview study on the use of C-sections in the Mexican surrogacy industry pushes us to think about how patriarchal medicine interlocks with capitalism, racism, nationalism, and more. We should consider how Hovav's analysis might be used to critique Lupton.

## NOVEMBER 2<sup>ND</sup>

### A) MEDICAL LABOR

Rodriquez. 2014. *Labors of Love*. (pp. 1-19, 115-37)

Wingfield and Chavez. 2020. "Getting In, Getting Hired, Getting Sideways Looks."<sup>2</sup>

Our readings so far have largely ignored a critical feature of medicine: most medical work is done by people other than physicians (e.g., nurses, technicians, and aides). Jason Rodriquez helps fill this gap by examining the "care work" done by certified nursing assistants (CNAs) in both for-profit and non-profit nursing homes. He argues their labor must be seen as not just instrumental but also emotional. The emotional aspects of care work encourage resident compliance while also helping CNA's claim some dignity at the workplace. Rodriquez argues that emotional work often contradicts instrumental tasks, but to understand why we have to contextualize CNA labor within the regulatory and reimbursement systems of American nursing homes. Together, these systems encourage a quantity of care over a quality of care and this shapes management-labor relations. Facing their own structural pressures, managers seek to maximize revenue by increasing the instrumental acts of care work. This motivates them to explicitly discourage the "unprofitable" emotions that tend to benefit both workers and residents.

A recent article by Adia Harvey Wingfield and Koji Chavez will help us further understand medical labor. Drawing on interviews with Black doctors, nurses, and technicians, Wingfield and Chavez illustrate how the experiences and perceptions of racial discrimination can vary up and down a medical labor hierarchy. You should read this piece strategically to put it in conversation with Rodriquez.

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<sup>2</sup> I know of an unpublished manuscript by another scholar that can help us draw some important links between Rodriquez and Wingfield and Chavez. We can discuss whether or not you would like me to request permission to include this other text.

## B) MEDICATING THE MARGINS

Hansen et al. 2014. "Pathologizing Poverty."

Sufrin. 2017. *Jailcare*. (pp. 1-14, 21-4)

The poor certainly face barriers to care, but it is also true that medical institutions, practices, and logics are essential to the modern regulation of poverty. Helena Hansen and colleagues focus on an important trend to illustrate this point: as traditional means-tested welfare has become stingier and more punitive, people have increasingly relied on benefits that are conditioned on diagnoses of permanent mental disability. While the stigmatization of disability has long discouraged the use of such support, Hansen et al. show that more and more people have reinterpreted disability as part of a respectable survival strategy. It is common for recipients to combine and exchange their disability checks with various social and cultural resources in an effort to stabilize their lives on the margins. But, in neutralizing the stigma of disability, they provoke more powerful people to impose a new mark of dishonor: the stigma of malingering. This fuels a political assault on disability benefits. Nevertheless, the "era of medicalized poverty" endures.

We'll also discuss some excerpts from Carolyn Sufrin's book on incarceration and pregnancy. As both a social scientist and a physician, Sufrin introduces us to the concept and paradox of "jailcare." In addition to putting her in conversation with Hansen et al., we should consider what Sufrin might say to Parsons, Foucault, Conrad, Waitzkin, Navarro, Feagin and Bennefield, Lupton, Rodriguez, and others.

## NOVEMBER 9<sup>TH</sup>

### A) *BANDAGE, SORT, AND HUSTLE*

Seim. 2020. *Bandage, Sort, and Hustle*. (Available online via the USC Library).

We'll wrap up our conversation on the social relations of medicine with *Bandage, Sort, and Hustle*. Read this book cover to cover and consider its many explicit and implicit connections to our other readings. Also, think about how some of our previous authors might critique the book.

### B) DISTRIBUTE EXAM II

Our discussion of *Bandage, Sort, and Hustle* will partly function as a review session for the second part of the course. In the final hour, we'll discuss the logistics of the second take-home exam, which I will actually distribute to you sometime before this meeting.

Exam II due November 11<sup>th</sup> at 3pm.

Final Paper due November 24<sup>th</sup> at 3pm.

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## List of Support Systems

### *Student Counseling Services (SCS) – (213) 740-7711 – 24/7 on call*

Free and confidential mental health treatment for students, including short-term psychotherapy, group counseling, stress fitness workshops, and crisis intervention. [engemannshc.usc.edu/counseling](http://engemannshc.usc.edu/counseling)

### *National Suicide Prevention Lifeline – 1 (800) 273-8255*

Provides free and confidential emotional support to people in suicidal crisis or emotional distress 24 hours a day, 7 days a week. [www.suicidepreventionlifeline.org](http://www.suicidepreventionlifeline.org)

### *Relationship and Sexual Violence Prevention Services (RSVP) – (213) 740-4900 – 24/7 on call*

Free and confidential therapy services, workshops, and training for situations related to gender-based harm. [engemannshc.usc.edu/rsvp](http://engemannshc.usc.edu/rsvp)

### *Sexual Assault Resource Center*

For more information about how to get help or help a survivor, rights, reporting options, and additional resources, visit the website: [sarc.usc.edu](http://sarc.usc.edu)

### *Office of Equity and Diversity (OED)/Title IX Compliance – (213) 740-5086*

Works with faculty, staff, visitors, applicants, and students around issues of protected class. [equity.usc.edu](http://equity.usc.edu)

### *Bias Assessment Response and Support*

Incidents of bias, hate crimes and microaggressions need to be reported allowing for appropriate investigation and response. [studentaffairs.usc.edu/bias-assessment-response-support](http://studentaffairs.usc.edu/bias-assessment-response-support)

### *The Office of Disability Services and Programs*

Provides certification for students with disabilities and helps arrange relevant accommodations. [dsp.usc.edu](http://dsp.usc.edu)

### *Student Support and Advocacy – (213) 821-4710*

Assists students and families in resolving complex issues adversely affecting their success as a student EX: personal, financial, and academic. [studentaffairs.usc.edu/ssa](http://studentaffairs.usc.edu/ssa)

### *Diversity at USC*

Information on events, programs and training, the Diversity Task Force (including representatives for each school), chronology, participation, and various resources for students. [diversity.usc.edu](http://diversity.usc.edu)

### *USC Emergency Information*

Provides safety and other updates, including ways in which instruction will be continued if an officially declared emergency makes travel to campus infeasible. [emergency.usc.edu](http://emergency.usc.edu)

### *USC Department of Public Safety*

UPC: (213) 740-4321 – HSC: (323) 442-1000 – 24-hour emergency or to report a crime.

Provides overall safety to USC community. [dps.usc.edu](http://dps.usc.edu)