Sociology 475: Medical Sociology
Units: 4.0
Spring 2020 | MW | 3:30pm to 4:50pm
Location: Kaprielian Hall (KAP) 137

Professor Josh Seim
Office: Hazel and Stanley Hall Building (HSH) 218
Office Hours: Mondays, 10:00am to 11:00am, or by appointment
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Course Description

Welcome to Medical Sociology! This course is divided into three parts. The first part covers the *social roots of sickness*. We'll consider how things like class, race, and gender inequalities affect bodily health. The second part concerns the *social relations of medicine*. We'll consider how health care is embedded in, and helps reproduce, the social world. The third part of this course is dedicated to unique case studies on health and medicine. Each student will draw on course materials to examine a case of their choice. For better or worse, this class will focus primarily on the United States.

Learning Objectives

1. Understand the social roots of sickness and the social relations of medicine
2. Communicate analysis of course issues through writing and discussion
3. Apply and critique the assigned texts

Course Materials

Readings

- Ansell, David A. 2017. *The Death Gap: How Inequality Kills*. Chicago, IL: University of Chicago Press. [10-digit ISBN: 022642815X]
- Seim, Josh. 2020. *Bandage, Sort, and Hustle: Ambulance Crews on the Front Lines of Urban Suffering*. Oakland, CA: University of California Press. [10-digit ISBN: 0520300238]
- All other readings are available on Blackboard.

Guides

- This syllabus includes short reading summaries for every regular reading assignment.
- Custom "theory maps" (diagrams and tables) are also available on Blackboard.
- You should refer to these summaries and maps before, during, and after you read the assigned text.

Student Evaluation

Grading Breakdown	
Reading Responses	10%
Book Clubs	15%
Take-Home Exam I	25%
Take-Home Exam II	25%
Final Paper: Case Study	25%

Reading Responses

Each regular reading assignment comes with a set of questions. You are expected to submit an answer to *one* question from each set (due 9:00am the day of the assigned reading via Blackboard). You may either write a response (three to four sentences with specific page citations) or diagram/table a response (with specific page citations). Written responses must be submitted using the assignment text box and diagramed/tabled responses must be attached as a standard image file (e.g., JPG). All reading responses are graded on a pass/fail basis. While wrong answers will not be penalized, I may ask you to resubmit a reading response if your initial submission is obviously careless. *Late reading responses will not be accepted, but you are allowed to skip two without penality*.

Note: I may integrate your reading responses into my lecture slides. Please trust that I will never do this to mock you or highlight something you have done wrong.

Book Clubs

We'll have two in-class "book clubs," one for *The Death Gap: How Inequality Kills* (Ansell 2017) and one for *Bandage, Sort, and Hustle: Ambulance Crews on the Front Lines of Urban Suffering* (Seim 2020). The first book club will close Part 1: The Social Roots of Sickness on February 24th and the second will close Part 2: The Social Relations of Medicine on April 13th. You must read each of these books cover to cover before attending their corresponding book clubs. Come to these meetings prepared to put the assigned books in conversation with the other course readings.

In addition to participating in the book clubs, you're required to complete three written assignments for each book. The written assignments for *The Death Gap* are due by 3pm on the following Fridays via Blackboard: January 24th, February 7th, and February 21st. The written assignments for *Bandage, Sort, and Hustle* are due by 3pm on the following Fridays via Blackboard: March 13th, March 27th, and April 10th. Please bring copies of your answers to the book clubs.

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 course readings in conversation with one another.

The first exam will be distributed sometime before February 26th and is due March 3rd (Monday) at 3:00pm via Blackboard. The second exam will be distributed sometime before April 15th and is due April 20th (Monday) at 3:00pm via Blackboard. Exams turned in late will be docked one full letter grade for each day they are tardy. *No exam will be accepted beyond 72 hours of its designated submission time.* Additional instructions and requirements will be provided on the exam prompts.

Case Study

The course ends with a final paper that will challenge you to analyze a special case of your choice. For example, you may write about the social determinants of asthma attacks, employment status as a "fundamental cause" of sickness, the emergency department as a social safety net, or the politics of health insurance. The possibilities are seemingly endless, but you must make whatever case you select speak directly to the course's major themes.

All case studies must include the following: 1) an adequately sourced summary of the case, 2) an original examination of the case using two of the course authors, and 3) an assessment of which of the two authors best explains your case. You will submit your case study as a final paper by 4:00pm on May 8th (Friday) via Blackboard. Your final paper grade is also dependent on your performance on three workshop assignments, which are due April 22nd, April 27th, and April 29th via Blackboard (all by 9:00am). Late workshop assignments will not be accepted. Final papers turned in late will be docked one full letter grade for each day they are tardy. *No final will be accepted beyond 72 hours of its designated submission time.* Additional instructions and requirements will be detailed in lecture.

See the end of the syllabus for additional policies and a list of important support services.

Schedule

RR = reading response
BCA = book club assignment
WA = workshop assignment
Gray = important deadlines

Introduction

Date	Topic	Reading	Deliverable
01/13	Syllabus	N/A	N/A

Part I: The Social Roots of Sickness

Date	Topic	Reading	Deliverable
01/15	Durkheim's Legacy	Durkheim	RR by 9am
01/22	Engels's Legacy	Engels	RR by 9am
01/24	*The Death Gap* Assignment 1	Preface, Ch. 1-5	BCA by 3pm
01/27	Du Bois's Legacy	Du Bois	RR by 9am
01/29	Fundamental Causes	Link and Phelan	RR by 9am
02/03	The Status Syndrome	Marmot	RR by 9am
02/05	Racism and Sickness	Williams and M.	RR by 9am
02/07	*The Death Gap* Assignment 2	Ch. 6-10	BCA by 3pm
02/10	Sexism and Sickness	Homan	RR by 9am
02/12	An Intersectional Perspective	López and G.	RR by 9am
02/19	The Violence Continuum	Holmes	RR by 9am
02/21	*The Death Gap* Assignment 3	Ch. 11-13	BCA by 3pm
02/24	Book Club: *The Death Gap*	Ansell	N/A
02/26	Review	N/A	N/A
03/02	Exam I	N/A	Exam I by 3pm
03/02	Movie: *Unnatural Causes*	N/A	N/A

Part II: The Social Relations of Medicine

Date	Topic	Reading	Deliverable
03/04	Medical Roles	Parsons	RR by 9am
03/09	Medical Gaze	Foucault	RR by 9am
03/11	Medical Irony	Waitzkin	RR by 9am
03/13	*Bandage, Sort, and Hustle* Assignment 1	Pref., Intro, Ch. 1-3	BCA by 3pm
03/23	Medicalization	Conrad	RR by 9am
03/25	Capitalist Medicine	Navarro	RR by 9am
03/27	*Bandage, Sort, and Hustle* Assignment 2	Ch. 4-6	BCA by 3pm
03/30	Racist Medicine	Feagin and B.	RR by 9am
04/01	Patriarchal Medicine	Lupton	RR by 9am
04/06	Pathologizing Poverty	Hansen et al.	RR by 9am
04/08	Carceral Medicine	Sufrin	RR by 9am
04/10	*Bandage, Sort, and Hustle* Assignment 3	Ch. 7-9, Conclusion	BCA by 3pm
04/13	Book Club: *Bandage, Sort, and Hustle*	Seim	N/A
04/15	Review	N/A	N/A

04/20	Exam II	N/A	Exam II by 3pm
04/20	Movie: *The Waiting Room*	N/A	N/A

Part III: Case Studies

Date	Topic	Reading	Deliverable
04/22	Case Study Workshop 1	N/A	WA by 9am
04/27	Case Study Workshop 2	N/A	WA by 9am
04/29	Case Study Workshop 3	N/A	WA by 9am
05/08	Case Study	N/A	Final by 4pm

PART I: THE SOCIAL ROOTS OF SICKNESS

WEDNESDAY, JANUARY 15TH
DURKHEIM'S LEGACY

Durkheim. 1897. *Suicide: A Study in Sociology*. (pp. 152-5, 157-60, 171, 173, 202-5, 208-15, 217-21, 241-3, 245-9, 252, 276 [only footnote 25])

In his renowned study of suicide, 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.

In class, we'll see if Durkheim can help us understand the spread of the common cold. We'll also see if he can help us understand recent shifts in white working-class morbidity and mortality.

Reading Response (select one and submit by 9:00am via Blackboard)

1. What explains the differences in suicide rates between Catholics and Protestants?
2. What other health outcomes might be influenced by too much or too little integration?
3. What other health outcomes might be influenced by too much or too little regulation?

WEDNESDAY, JANUARY 22ND
ENGELS'S LEGACY

Engels. 1845. *The Conditions of the Working Class in England*. (pp. 106-30)

Engels, a frequent collaborator with Marx, offers us a radically different perspective than Durkheim on the social roots of sickness. Though, to understand how, we will need to spend some time in class summarizing Marx and Engels's critique of capitalism.

In the text you're assigned, Engels is concerned with describing and explaining working class suffering beyond the point of production (e.g., outside of factories). He essentially writes one of the earliest studies of neighborhood health disparities. Throughout his analysis, Engels introduces us to some useful ideas we'll return to throughout this course. In addition to highlighting education, legal, and medical institutions in working class Manchester, 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 companies.

We'll consider the contemporary relevance of Engels's model by examining some maps published by the Los Angeles County Public Health Department.

Reading Response (select one and submit by 9:00am via Blackboard)
1. What are some current examples of social murder?
2. How might economic insecurity affect health under contemporary capitalism?
3. What might Engels say to Durkheim?

FRIDAY, JANUARY 24th
***THE DEATH GAP* ASSIGNMENT 1**

Answer each question in 150 to 300 words. Quotes from the book are highly discouraged.

1. Write a short summary of the Preface and Chapters 1-5 of *The Death Gap*.
2. What might *one* of our other course authors say about this section of the book? You can highlight moments of agreement or disagreement.
3. How might the book author respond to the other course author cited in the second question?

Due at 3pm via Blackboard.

MONDAY, JANUARY 27TH
DU BOIS'S LEGACY

Du Bois. 1899. *The Philadelphia Negro: A Social Study*. (pp. 147-63)

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 race and sickness.

Du Bois breaks from classical biological explanations of black-white health disparities and points to the interlocking 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 late nineteenth century Philadelphia.

We'll consider the contemporary relevance of Du Bois's writings in class and examine racial disparities in infant mortality, childhood asthma, and other outcomes. Additionally, we'll put Du Bois in conversation with Durkheim and Engels.

Reading Response (select one and submit by 9:00am via Blackboard)
1. How might Du Bois inform our current understandings of racial health disparities?
2. What might Du Bois say to Durkheim?
3. What might Du Bois say to Engels?

WEDNESDAY, JANUARY 29TH
FUNDAMENTAL CAUSES

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

With Durkheim, Engels, and Du Bois by our side, we now turn to one of the most cited publications in the sociology of health: Link and Phelan's "Social Conditions as Fundamental Causes of Disease." This duo opens with a powerful critique of modern epidemiology and Western culture, and they challenge us to think more critically about the "distal" causes of illness and injury.

In other words, Link and Phelan want us to move beyond an individualistic/behavioristic focus on "proximate" forces. Yes, individual risks like smoking and a poor diet are important. But, for a more fundamental understanding of population health patterns, we need to account for the "risk of risks." We need to contextualize individuals risk factors. According to Link and Phelan, social conditions fundamentally structure the risk of risks. For them, social conditions can really be reduced to various resources, which are almost always distributed unequally. These resources include things like money, knowledge, power, and social connections. Reductions in resources correspond to increases in the risk of risks, which of course correspond to increases in morbidity and mortality. This theory encourages us to rethink the boundaries of health policy.

We'll spend some time in class considering how efforts to lift the minimum wage and extend maternity leave might improve population health according to Link and Phelan's model.

Reading Response (select one and submit by 9:00am via Blackboard)

1. What might Link and Phelan say to Durkheim?
2. What might Link and Phelan say to Engels?
3. What might Link and Phelan say to Du Bois?

MONDAY, FEBRUARY 3RD
THE STATUS SYNDROME

Marmot. 2004. *The Status Syndrome: How Social Standing Affects Our Health and Longevity.* (pp. 1-12, 43-5, 78-81, 160-3, 188-9, 240-1)

In many ways, 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.

In class, we'll summarize Marmot's famous "Whitehall Study" and watch a short video clip linking his scholarship to stress research more generally.

Reading Response (select one and submit by 9:00am via Blackboard)

1. How might your future career influence your health according to Marmot?
2. Theorize how the "status syndrome" might influence the health of USC employees.
3. What might Marmot say to Link and Phelan?

WEDNESDAY, FEBRUARY 5TH
RACISM AND SICKNESS

Williams and Mohammed. 2013. "Racism and Health I: Pathways and Scientific Evidence."

More than a hundred years 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, for Williams and Mohammed, the popular focus on "racial disparities" is misguided. We need to understand what causes these disparities.

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 society 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'll divide the class into small groups to make sense of each of these pathways. We'll also think about how Williams and Mohammed's model compliments and challenges our previous readings.

Reading Response (select one and submit by 9:00am via Blackboard)

1. What do you think are some other ways that racism can affect health?
2. What might Williams and Mohammed say to Link and Phelan?
3. What might Williams and Mohammed say to Marmot?

FRIDAY, FEBRUARY 7th
***THE DEATH GAP* ASSIGNMENT 2**

Answer each question in 150 to 300 words. Quotes from the book are highly discouraged.

1. Write a short summary of the Chapters 6-10 of *The Death Gap*.
2. What might *one* of our other course authors say about this section of the book? You can highlight moments of agreement or disagreement.
3. How might the book author respond to the other course author cited in the second question?

Due at 3pm via Blackboard.

MONDAY, FEBRUARY 10TH
SEXISM AND SICKNESS

Homan. 2019. "Structural Sexism and Health in the United States: A New Perspective on Health Inequality and the Gender System."

We've considered how systems of class, race, and status affect health, but what about gender? Homan helps us answer this question. She acknowledges that a number of frameworks have been put forward to help explain gender inequalities in sickness. However, she is unsatisfied with the popular explanations, which tend to focus on individual attributes and interpersonal discrimination. We need a theory that accounts for gender as a multilevel structure.

And that is precisely what Homan advances in this article. She considers how physical health is influenced by multiple levels of structural sexism (systematic gender inequalities in power and resources). Homan executes a unique study to see how health is associated with sexism at macro, meso, and micro levels. She finds that macro-structural sexism is associated with worse health for both women and men. Homan also finds that meso-structural sexism is associated with worse health for women, but better health for men. She does not, however, find that health is associated with internalized sexism at the micro level.

In class, we'll do a small group exercise, unpack Homan's research design, and put her in conversation with our other authors.

Reading Response (select one and submit by 9:00am via Blackboard)

1. What might Homan say to Link and Phelan?
2. What might Homan say to Marmot?
3. What might Homan say to Williams and Mohammed?

WEDNESDAY, FEBRUARY 12TH
AN INTERSECTIONAL PERSPECTIVE

López and Gadsden. 2016. "Health Inequities, Social Determinants, and Intersectionality."

López and 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). López and Gadsden demonstrate that intersecting identities can help predict a number of health outcomes.

That said, they 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 watch a short video in class before digging into López and Gadsden's essay. We'll also review some other relevant articles on intersectionality and health.

Reading Response (select one and submit by 9:00am via Blackboard)

1. What might López and Gadsden say to Link and Phelan?
2. What might López and Gadsden say to Williams and Mohammed?
3. What might López and Gadsden say to Homan?

WEDNESDAY, FEBRUARY 19TH
THE VIOLENCE CONTINUUM

Holmes. 2013. *Fresh Fruit, Broken Bodies: Migrant Farmworkers in the United States*. (pp. 89-110)

Holmes's ethnography of migrant farmworkers ends our first set of primary readings. He analyzes three cases of suffering he discovered during his fieldwork: Abelino's knee injury, Crescencio's headache, and Bernardo's abdominal pain. Although trained as a physician, Holmes finds that social theory can be a particularly useful tool of 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." According to this model, there are 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. We'll spend some time in class considering how the violence continuum might help us understand the suffering of exploited and excluded populations more generally.

Reading Response (select one and submit by 9:00am via Blackboard)

1. What might Holmes say to Engels?
2. What might Holmes say to Williams and Mohammed?
3. What might Holmes say to López and Gadsden?

FRIDAY, FEBRUARY 21ST
***THE DEATH GAP* ASSIGNMENT 3**

Answer each question in 150 to 300 words. Quotes from the book are highly discouraged.

1. Write a short summary of the Chapters 11-13 of *The Death Gap*.
2. What might *one* of our other course authors say about this section of the book? You can highlight moments of agreement or disagreement.
3. How might the book author respond to the other course author cited in the second question?

Due at 3pm via Blackboard.

MONDAY, FEBRUARY 24TH
BOOK CLUB: *THE DEATH GAP*

Ansell. 2017. *The Death Gap: How Inequality Kills*.

You've now read *The Death Gap* in its entirety. Come to class with your book in hand and be prepared to put it conversation with our other course readings. Please also bring your book club assignments. Participation in this meeting will affect your "book club" grade.

WEDNESDAY, FEBRUARY 26TH
REVIEW

This is an open review session. Please come with specific questions about the readings.

MONDAY, MARCH 2nd
EXAM I

Due at 3pm via Blackboard. See prompt for details.

MONDAY, MARCH 2ND
MOVIE: *UNNATURAL CAUSES*

We'll watch an in-class video to conclude Part I.

PART II: THE SOCIAL RELATIONS OF MEDICINE

WEDNESDAY, MARCH 4TH
MEDICAL ROLES

Parsons. 1951. "Illness and the Role of the Physician: A Sociological Perspective."

We begin the second part of the class with Parsons's classic essay on medicine as a functional institution. For him, sickness is but one label we apply to deviant actors (i.e., people who can't perform their normal obligations or those who violate conventional values) and the sick role offers an institutionalized pathway back into normality. When someone can't cope with their personal strains, they may get classified as sick. As Parsons puts it, they enter the "sick role."

This particular role excuses deviant actors from certain obligations. In some ways, this role also exempts them from being held personally responsible for their deviance. However, the sick role 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 patient, a more formalized status that exposes her or him to the rehabilitative work 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 deviance, and an obligation to manipulate sanctions), therapists work to reintegrate the sick back into their normal roles of worker, parent, student, etc.

We'll consider the contemporary relevance of Parsons's framework in class and we'll briefly discuss a follow-up article he wrote.

Reading Response (select one and submit by 9:00am via Blackboard)
1. What does Parsons say about other deviant roles?
2. How does the sick role play out differently today?
3. How does the role of the therapist play out differently today?

MONDAY, MARCH 9TH
MEDICAL GAZE

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

Through a detailed comparison of Pomme (a pre-modern healer) and Bayle (an early modern healer), 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, the question of modern medicine, is joined with the "medical gaze." This gaze 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 auscultation) and instruments (e.g., stethoscopes and x-ray machines). 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. He sees knowledge and power as inseparable. Power is rooted in knowledge, and knowledge is remade through exercises of power. Through the medical gaze, doctors produce a particular knowledge about their patients' bodies. And, as "objects of knowledge," these bodies become objects of power.

Foucault is tough. We'll spend time in class discussing his broader contributions to sociology. A couple of short videos on the modern medical exam will also help us.

Reading Response (select one and submit by 9:00am via Blackboard)

1. What might Foucault say to Parsons?
2. How does the medical gaze operate differently today?
3. How might some contemporary instruments influence the "medicine of the sick organs"?

WEDNESDAY, MARCH 11TH
MEDICAL IRONY

Waitzkin. 1993. *The Politics of Medical Encounters: How Patients and Doctors Deal with Social Problems.* (pp. xiii-iv, 3-10, 75-106)

Like Parsons and Foucault, Waitzkin helps us understand clinical encounters. However, unlike our previous authors, Waitzkin draws on a Marxist perspective. 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 unhealthy forces of oppression. Among other things, this process mystifies and depoliticizes the social roots of sickness.

We'll spend some time in class putting Waitzkin in conversation with Parsons and Foucault.

Reading Response (select one and submit by 9:00am via Blackboard)

1. What might Waitzkin say to Parsons?
2. What might Waitzkin say to Foucault?

3. How does medical irony look different today?

FRIDAY, MARCH 13TH
***BANDAGE, SORT, AND HUSTLE* ASSIGNMENT 1**

Answer each question in 150 to 300 words. Quotes from the book are highly discouraged.

1. Write a short summary of the Preface, Introduction, and Chapters 1-3 of *Bandage, Sort, and Hustle*.
2. What might *one* of our other course authors say about this section of the book? You can highlight moments of agreement or disagreement.
3. How might the book author respond to the other course author cited in the second question?

Due at 3pm via Blackboard.

MONDAY, MARCH 23RD
MEDICALIZATION

Conrad. 2007. *The Medicalization of Society: On the Transformation of Human Conditions into Treatable Disorders*. (pp. 3-19, 146-64)

Conrad turns our attention to a different question. Is American society becoming overmedicalized? In other words, are we too quick to classify and treat human problems as "sickness"? Conrad generally thinks so, but he acknowledges the complexity of medicalization. His task is rather simple. He wants to clarify medicalization and understand its causes and effects.

Conrad sees 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 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. Ultimately, Conrad doesn't see a real end to medicalization.

We'll review a number of cases in class to better understand Conrad's theory: ADHD, homosexuality, mass consumption of prescription drugs, body implants, and WebMD.

Reading Response (select one and submit by 9:00am via Blackboard)
1. What are some other examples of medicalization?
2. What are some other examples of demedicalization?
3. What might Conrad say to Parsons?

WEDNESDAY, MARCH 25TH
CAPITALIST MEDICINE

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

Navarro argues that in order to understand capitalist health care (which can be either "private" or "public") we must situate the practice of medicine within a system of class exploitation. Navarro focuses on a curious space between bourgeoisie and the proletariat: the petit bourgeoisie. This, according to Navarro, is where we find doctors like him. The petit bourgeoisie directly and indirectly participates in the control and coordination of production.

In the case of medicine, doctors care for and control the working class. They reduce proletarian suffering, but in doing so they protect and subsidize the most precious commodity under capitalism: labor power. Control and care, while never independently in operation, 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 organizational/political strength of the working class is strongest.

But, medicine will always be capitalist so long as it exists under capitalism. Such medicine overwhelming preferences the interests of the bourgeoisie over the interests of the proletariat. We'll spend a bit of time in class thinking about some alternatives to capitalism and what medicine might look like under these alternatives.

Reading Response (select one and submit by 9:00am via Blackboard)

1. What is Navarro's critique of Foucault?
2. What might Navarro say to Waitzkin?
3. How might Navarro make sense of the current health insurance debates?

FRIDAY, MARCH 27TH
***BANDAGE, SORT, AND HUSTLE* ASSIGNMENT 2**

Answer each question in 150 to 300 words. Quotes from the book are highly discouraged.

1. Write a short summary of Chapters 4-6 of *Bandage, Sort, and Hustle*.
2. What might *one* of our other course authors say about this section of the book? You can highlight moments of agreement or disagreement.
3. How might the book author respond to the other course author cited in the second question?

Due at 3pm via Blackboard.

MONDAY, MARCH 30TH
RACIST MEDICINE

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

Feagin and Bennefield help us understand medicine as an institution of white supremacy. Systemic racism in the United States is an essential part of medicine and medicine is an essential part of systemic racism. According to Feagin and Bennefield, 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 emphasizes weak concepts for making sense of racial disparities (e.g., bias, prejudice, and cultural competence) and deemphasizes strong concepts (e.g., systemic racism, white discriminators, and white racial framing). Lastly, in terms of differential treatment patterns, medicine is organized by broad white racial frames that structure both implicit and explicit bias.

We'll watch a short video in class about the history of slavery and modern medicine and another video on implicit bias in contemporary health care.

Reading Response (select one and submit by 9:00am via Blackboard)
1. What might Feagin and Bennefield say to Navarro?
2. What might Feagin and Bennefield say to Conrad?
3. What are some other examples of systematic racism in medicine?

WEDNESDAY, APRIL 1ST
PATRIARCHAL MEDICINE

Lupton. 2003. *Medicine as Culture: Illness, Disease, and the Body*. (pp. 142-6, 149, 158-67)

Lupton helps us understand medicine as an institution of patriarchy. 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 fortifies male domination. Three cases demonstrate how health care helps reproduce patriarchy: the history of gynecology, the medicalization of childbirth, and the rise prenatal screening.

For Lupton, the emergence of gynecology as a medical specialty intensified gender distinctions and hierarchies, focused human reproductive concerns on women, and helped solidify a world where male doctors know and control female patients. The case of medicalized childbirth shows how men encroached on a female domain (the decline of the midwife and the rise of the physician), how pregnant women were made into patients (and thus integrated into a new asymmetrical power relation), 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 consider how Lupton's model might compliment or complicate some of our other readings (e.g., Starr, Conrad, Navarro, and Feagin and Bennefield). Time permitting, we'll also watch a short video on the history of midwives in the United States.

Reading Response (select one and submit by 9:00am via Blackboard)

1. What might Lupton say to Navarro?
2. What might Lupton say to Feagin and Bennefield?
3. What might Lupton say to Conrad?

MONDAY, APRIL 6TH
PATHOLOGIZING POVERTY

Hansen, Bourgois, and Drucker. 2014. "Pathologizing Poverty: New Forms of Diagnosis, Disability, and Structural Stigma Under Welfare Reform."

Hansen, Bourgois, and Drucker illustrate a "pathologization of poverty." The poor certainly face significant barriers when accessing care, but it is also true that medical institutions, practices, and logics are essential in the modern regulation of poverty. Hansen et al. 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. Still, according to Hansen and her coauthors, the "era of medicalized poverty" endures.

In class, we'll do a small group exercise and consider some other examples of how the poor are governed through medicine.

Reading Response (select one and submit by 9:00am via Blackboard)

1. What might Hansen, Bourgois, and Drucker say to Parsons?
2. What might Hansen, Bourgois, and Drucker say to Conrad?
3. What might Hansen, Bourgois, and Drucker say to Navarro?

WEDNESDAY, APRIL 8TH
CARCERAL MEDICINE

Sufrin. 2017. *Jailcare: Finding the Safety Net for Women behind Bars*. (pp. 1-14, 21-4)

We conclude our second set of primary readings with Sufrin's study of incarceration and pregnancy. As both a social scientist and a physician, Sufrin introduces us to the concept of "jailcare." Paradoxically, criminal justice institutions like jails and prisons deliver a lot of medicine. She primarily demonstrates this through an examination of prenatal care in a California jail.

Beyond Sufrin's particular case, her concept of jailcare helps us understand a broader "entanglement of carcerality and care" in the United States. As she makes clear, jailcare is a contradiction. It involves the suspension of rights, but it also guarantees the right to medicine. It represses, but it also heals. It's something violent, but it's also something caring. Sufrin insists that we make sense of jailcare in the context of an eroding welfare state and an expanding penal state. Jailcare is catching more and more people harmed by structural violence (which she links to the interlocking orders of class, gender, and race).

We'll put Sufrin in conversation with a number of our other authors like Parsons, Lupton, and Hansen, Bourgois, and Drucker. Indeed, she claims her case study can help us understand "care" more generally.

Reading Response (select one and submit by 9:00am via Blackboard)
1. What might Sufrin say to Parsons?
2. What might Sufrin say to Lupton?
3. What might Sufrin say to Hansen, Bourgois, and Drucker?

FRIDAY, APRIL 10TH
***BANDAGE, SORT, AND HUSTLE* ASSIGNMENT 3**

1. Write a short summary of Chapters 7-9 and the Conclusion of *Bandage, Sort, and Hustle*.
2. What might *one* of our other course authors say about this section of the book? You can highlight moments of agreement or disagreement.
3. How might the book author respond to the other course author cited in the second question?

Due at 3pm via Blackboard.

MONDAY, APRIL 13TH
BOOK CLUB: *BANDAGE, SORT, AND HUSTLE*

Seim. 2020. *Bandage, Sort, and Hustle: Ambulance Crews on the Front Lines of Urban Suffering.*

You've now read *Bandage, Sort, and Hustle* in its entirety. Come to class with your book in hand and be prepared to put it conversation with our other course readings. Please also bring your book club assignments. Participation in this meeting will affect your "book club" grade.

WEDNESDAY, APRIL 15TH
REVIEW

This is an open review session. Please come with specific questions about the readings.

MONDAY, APRIL 20TH
EXAM II

Due at 3pm via Blackboard. See prompt for details.

MONDAY, APRIL 20TH
MOVIE: *THE WAITING ROOM*

We'll watch an in-class video to conclude Part II.

PART III: CASE STUDIES

WEDNESDAY, APRIL 22ND
CASE STUDY WORKSHOP 1: RESEARCHING YOUR CASE

Submit a one-paragraph summary of your case by 9:00am on April 17th via Blackboard. No need to include outside sources at this point. Simply summarize the case for a reader who knows nothing about it. Come to class prepared to discuss your case with others. Be sure to select a case that you can envision yourself analyzing using at least two of the course readings.

MONDAY, APRIL 27TH
CASE STUDY WORKSHOP 2: ANALYZING YOUR CASE

Submit a three-paragraph proposal by 9:00am on April 27th via Blackboard. Be sure to include the following: a) a re-written summary of your case, b) a brief reflection on at least one case-relevant text from outside the course, and c) a loose plan for how you intend to use one or more of the course authors to analyze your case. Come to class prepared to discuss your case and outside text(s) with others.

WEDNESDAY, APRIL 29TH
CASE STUDY WORKSHOP 3: CONCLUDING YOUR CASE

Submit a detailed bullet point outline of your final paper by 9:00am on April 29th via Blackboard. Be sure to clearly indicate how you will address the following portions of the case study: a) an adequately sourced summary of the case, b) an original examination of the case using two of the course readings, and c) a reflection on the limitations of using your selected course readings to explain your case. Come to class with your outline and be prepared to discuss it with others.

FRIDAY, MAY 8TH
FINAL PAPER: CASE STUDY

Due at 4pm via Blackboard. See prompt for details.

Additional Policies

Attendance and Participation

You are expected to attend every class. However, simply showing up will not be enough to succeed. You must also be engaged. Among other things, this means *you must bring a printed or digital copy of the assigned reading to class*.

Technology

Laptops and tablets are permitted in class for notetaking and/or accessing the assigned readings and guides. You will be reminded to turn off your Wi-Fi before every class.

Plagiarism

Presenting someone else's ideas as your own, either verbatim or recast in your own words is a serious academic offense with serious consequences. Please familiarize yourself with the discussion of plagiarism in *SCampus* in Part B, Section 11, "Behavior Violating University Standards" policy.usc.edu/scampus-part-b. Other forms of academic dishonesty are equally unacceptable. See additional information in *SCampus* and university policies on scientific misconduct, http://policy.usc.edu/scientific-misconduct.

Independent Work

This is an extension of the plagiarism policy. You must complete all assignments and exams independently. That said, you are encouraged to discuss course material with your peers outside of class.

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

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

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

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

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

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

The Office of Disability Services and Programs
Provides certification for students with disabilities and helps arrange relevant accommodations. 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

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

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

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