

Sociology 475: Medical Sociology

Units: 4.0

Spring 2019 | MW | 3:30pm to 4:50pm

Location: Kaprielian Hall (KAP) 113

Professor Josh Seim

Office: Hazel and Stanley Hall Building (HSH) 218

Office Hours: Mondays, 11:00am to 12:00pm, or by appointment

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Course Description

Welcome to Medical Sociology! This course is divided into three parts. First, we'll examine the social roots of sickness. We'll consider how things like class, race, and gender inequalities affect bodily health. Second, we'll study medicine as a social institution. We'll consider how health care is embedded in, and helps reproduce, the social world. The third part of this course will be dedicated to unique case studies on health and medicine. Each student will use 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 medicine as a social institution
2. Learn key theories in the sociology of health and medicine
3. Communicate analysis of course issues through writing and discussion

Course Materials

All readings are available on Blackboard.

Student Evaluation

Grading Breakdown	
Reading Responses	10%
Take-Home Exam I	30%
Take-Home Exam II	30%
Final Paper: Case Study	30%

Reading Responses

Each reading assignment comes with a set of questions, which are posted under the assignments tab on Blackboard. You are expected to submit an answer to *one* question from each set (due 11:00am 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/taled 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 penalty.*

Take-Home Exams

Your performance on two written take-home exams will determine more than 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 bring course readings in conversation with one another. The first exam will be distributed sometime before February 20th and is due February 25th (Monday) at 11:00am via Blackboard. The second exam will be distributed sometime before April 10th (Wednesday) and is due April 15th (Monday) at 11:00am 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.

Final Paper: 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: 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. You will submit your case study as a short paper (five to seven double-spaced pages) by 4:00pm on May 3rd (Friday) via Blackboard. Your final paper grade is also dependent on your performance on three workshop assignments, which are due April 17th, April 22nd, and April 24th via Blackboard (all by 11:00am). Additional instructions and requirements will be detailed in class.

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.

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.

See also: "List of Support Systems" at the end of this syllabus.

Schedule (RR = Reading Response, WA = Workshop Assignment)

Introduction			
Date	Topic	Reading	Deliverable
01/07	Syllabus	N/A	N/A
Part I: Sickness			
Date	Topic	Reading	Deliverable
01/09	Durkheim's Legacy	Durkheim	RR by 11am
01/14	Engels's Legacy	Engels	RR by 11am
01/16	Du Bois's Legacy	Du Bois	RR by 11am
01/23	Fundamental Causes	Link and Phelan	RR by 11am
01/28	Relative Positioning	Marmot	RR by 11am
01/30	Social Ecology	Klinenberg	RR by 11am
02/04	Race and Sickness	Williams and M.	RR by 11am
02/06	Gender and Sickness	Bird and Rieker	RR by 11am
02/11	Embodiment	Krieger	RR by 11am
02/13	The Violence Continuum	Holmes	RR by 11am
02/20	Review / Distribute Exam I	N/A	N/A
02/25	Exam I Due / In-Class Video	N/A	Exam I by 11am
Part II: Medicine			
Date	Topic	Reading	Deliverable
02/27	Medical Roles	Parsons	RR by 11am
03/04	Medical Gaze	Foucault	RR by 11am
03/06	Medical Irony	Waitzkin	RR by 11am
03/18	Medical Authority	Starr	RR by 11am
03/20	Capitalist Medicine	Navarro	RR by 11am
03/25	Medicalization	Conrad	RR by 11am
03/27	Race and Medicine	Feagin and B.	RR by 11am
04/01	Gender and Medicine	Lupton	RR by 11am
04/03	Care Work	Rodriquez	RR by 11am
04/08	Carceral Medicine	Sufrin	RR by 11am
04/10	Review / Distribute Exam II	N/A	N/A
04/15	Exam II Due / In-Class Video	N/A	Exam II by 11am
Part III: Case Studies			
Date	Topic	Reading	Deliverable
04/17	Case Study Workshop 1	N/A	WA by 11am
04/22	Case Study Workshop 2	N/A	WA by 11am
04/24	Case Study Workshop 3	N/A	WA by 11am
05/03	N/A	N/A	Final Paper by 4pm

PART I: THE SOCIAL ROOTS OF SICKNESS

Durkheim's Legacy Wednesday, January 9th

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 seminal 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.

Engels's Legacy Monday, January 14th

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 LA County Public Health Department.

Du Bois's Legacy
Wednesday, January 16th

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.

Fundamental Causes
Wednesday, January 23rd

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.

Relative Positioning Monday, January 28th

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.

Social Ecology Wednesday, January 30th

Klinenberg. 2002. *Heat Wave: A Social Autopsy of Disaster in Chicago*. (pp. 1-13, 79-128)

Klinenberg's "social autopsy" of the 1995 Chicago Heat Wave yields more than just a conclusion on the etiology of a specific disaster. He also gives us a more general model for understanding the relationship between health risks and place-based social ecology. In doing so, Klinenberg indirectly speaks to Durkheim, Engels, Du Bois, Link and Phelan, and Marmot.

Among other things, Klinenberg wants to explain why heat-related mortality was high in North Lawndale but low in Little Village (i.e., South Lawndale), two adjacent neighborhoods with similar age structures and poverty levels. As evident in his detailed comparison, neighborhood conditions like local economy, population density, and crime rates shape public life and systems of social support (the latter of which can be divided into informal networks and formal institutions). In North Lawndale, industrial/commercial abandonment, a thinning population, and elevated crime rates dampen public life and erode social support. This is in stark contrast to Little Village, which contains a busy market, a booming population, and a relatively low crime rate. Such conditions, according to Klinenberg, nourish public life and foster social support. The first ecology promotes elderly isolation and the second does not. And, as evident throughout the text, elderly isolation was a significant predictor of heat wave mortality.

We'll spend time in class watching a short video on the 1995 Chicago heat wave and we'll also consider how Klingenberg's model of place-based social ecology might help us better understand other health disparities in the United States.

Racism and Sickness Monday, February 4th

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.

Gender and Sickness Wednesday, February 6th

Bird and Rieker. 2008. *Gender and Health: The Effects of Constrained Choices and Social Policies*. (pp. 16-45, 57-73)

Bird and 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 physiological differences between males and females 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." Bird and Rieker agree with many scholars that individual choices influence, and are influenced 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 varied ways. Bird and Rieker also claim that gender roles are important for a model of constrained choice.

To better understand their argument, we will review some other articles and watched a short video clip in class.

Embodiment Monday, February 11th

Krieger. 2005. "Embodiment: A Conceptual Glossary for Epidemiology."

Krieger's short essay on "embodiment" introduces a new vocabulary for understanding the social roots of sickness. She extends, but also departs from, many of the theories we've covered so far. Emerging from her so-called ecosocial theory, Krieger's concept of embodiment helps us locate the body in social structure and social structure in the body. In addition to accounting for macro, meso, and micro conditions, she offers a framework that considers the relevance of time (i.e., history and the life course).

For Krieger, these spatial and temporal conditions are shaped by power and inequality in society. Embodiment is a concept that necessitates a consideration of social positioning. We must account for where bodies fall in the intersecting hierarchies of class, gender, sexuality, race, ethnicity, etc. Attempts to isolate these factors are deeply problematic according to Krieger.

Her essay is short, but Krieger gives us a lot to think about. We'll break into small groups and collectively unpack embodiment as 1) a construct, process, and reality, 2) a multilevel phenomenon, 3) a clue to life histories, and 4) a reminder of the entangled consequences of intersecting inequalities.

The Violence Continuum Wednesday, February 13th

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 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.

PART II: MEDICINE AS A SOCIAL INSTITUTION

Medical Roles Wednesday, February 27th

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.

Medical Gaze Monday, March 4th

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.

Medical Irony Wednesday, March 6th

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.

Medical Authority Monday, March 18th

Starr. 1982. *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry*. (pp. 3-29)

Starr wants to understand the rise of medical power in America. He begins with a lengthy conceptualization of authority before telling us how doctors (and professionals more generally) use and protect their authority. Starr insists no one can explain the sovereignty of the American physician and he specifically calls out Marxists for their inability to explain medical power in the United States.

He then provides us with his own explanation. Starr emphasizes the internal conditions (i.e., solidarity and institutionalization) and the external conditions (i.e., division of labor, urbanization, institutional dependence, rise of a progressive viewpoint, and increased regard for science and technology) of a nascent medical profession in the late nineteenth century. From here, Starr shows us how medical authority was converted into monetary power in the early twentieth century by controlling (or at least heavily influencing) the medical market. By the

middle of the twentieth century, medical authority was very strong and doctors were able to defend much of their authority 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 to challenge medical authority. We'll use Starr's analysis to forecast the future of American medicine.

Capitalist Medicine Wednesday, March 20th

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

We should think about Navarro as someone who offers an explicit alternative to Starr's model. He 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 overwhelmingly 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.

Medicalization Monday, March 25th

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.

Race and Medicine **Wednesday, March 27th**

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.

Gender and Medicine **Monday, April 1st**

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.

Care Work Wednesday, April 3rd

Rodriquez. 2014. *Labors of Love: Nursing Homes and the Structures of Care Work*. (pp. 1-19, 115-37)

Most medical work is executed by people other than physicians (e.g., nurses, technicians, aides), yet most of our authors don't seriously address this fact. Rodriquez helps fill the gap through his ethnography of nursing home labor.

Rodriquez examines the "care work" done by certified nursing assistants (CNAs). He sees their work as more than just a collection of instrumental or manual tasks. Their work is also emotional. The emotional aspects of care work, which he frames as largely compassionate, are doubly beneficial for CNAs. On the one hand, emotional work provides an opportunity for these marginalized laborers to claim some dignity at work. On the other hand, care workers' emotional connections with residents help yield more compliant subjects of the nursing home. Rodriquez also notes that such emotional aspects of care work help foster greater wellbeing among residents. Though, to understand any of this, Rodriquez insists that we contextualize care work amidst the regulatory and reimbursement systems that shape nursing homes in the United States. Together, these systems encourage a quantity of care over a quality of care and this influences the way management controls and coordinates floor staff. Facing their own structural pressures, nursing home managers generally want to maximize revenue by increasing the instrumental acts of care work. This motivates them to discourage the "unprofitable" emotions that CNAs use to bond with residents.

In class, we'll consider the generalizability of Rodriquez's findings. We'll also discuss the current state, and anticipated future, of medical labor in the United States.

Carceral Medicine
Monday, April 8th

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

We end the second set of 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, Waitzkin, and Rodriquez. Indeed, she claims her case study can help us understand "care" more generally.

PART III: CASE STUDIES

Case Study Workshop 1: Researching Your Case
Wednesday, April 17th

Submit a one-paragraph summary of your case by 11:00am 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.

Case Study Workshop 2: Analyzing Your Case
Monday, April 22nd

Submit a three-paragraph proposal by 11:00am on April 22nd 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.

Case Study Workshop 3: Concluding Your Case
Wednesday, April 24th

Submit a detailed bullet point outline of your final paper by 11:00am on April 24th 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.

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