

Sociology 475: Medical Sociology

Units: 4.0

Spring 2021 | M | 3:00 to 5:50

Location: Online

Syllabus last updated: January 25, 2021

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Course Description

This is an undergraduate-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.

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. 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, CA: University of California Press. Available Online via the USC Library. [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 texts.

Student Evaluation

Grading Breakdown	
Reading Responses	10%
Book Reviews	15%
Take-Home Exam I	25%
Take-Home Exam II	25%
Final: Case Study or COVID-19 Assignment	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 12:00pm 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 diagrammed/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 too weak. *Late reading responses will not be accepted, but you are allowed to skip two without penalty.*

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 Reviews

We'll read two books, *The Death Gap: How Inequality Kills* (Ansell 2017) and *Bandage, Sort, and Hustle: Ambulance Crews on the Front Lines of Urban Suffering* (Seim 2020). The first book will close Part 1: The Social Roots of Sickness and the second will close Part 2: The Social Relations of Medicine. You must read these books cover to cover and draw on the other course material to evaluate their arguments. See the book review prompts in the syllabus schedule for additional details (March 8th and April 19th).

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. Additional instructions and requirements will be provided on the exam prompts.

Final Paper: Case Study or COVID-19 Assignment

Case Study: You may end the course by analyzing 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. See the "Case Study" prompt for additional information.

COVID-19 Assignment: In lieu of writing a standard "Case Study" final paper, you may complete a special assignment on COVID-19. This assignment tasks you with making sense of the pandemic using the course material. You'll also be required to draw on additional material provided on Blackboard. See the "COVID-19 Assignment" prompt for additional information.

Additional policies and a list of important support services are detailed at the end of this syllabus.

Schedule

RR = reading response

BR = book review

Introduction			
Date	Topic	Reading	Deliverable
01/25	Syllabus	N/A	N/A
Part I: The Social Roots of Sickness			
Date	Topic	Reading	Deliverable
02/01	Social Murder / Fundamental Causes	Engels / Link & Phelan	RR by 12pm
02/08	Status Syndrome / Capitalism & Sickness	Marmot / Muntaner et al.	RR by 12pm
02/22	Racism & Sickness / Sexism & Sickness	Williams & M. / Homan	RR by 12pm
03/01	Intersectionality / Violence Continuum	López & Gadsden / Holmes	RR by 12pm
03/08	The Death Gap	Ansell	BR by 12pm
03/15	Review	N/A	N/A
03/17	Exam I	N/A	Exam by 5pm
Part II: The Social Relations of Medicine			
Date	Topic	Reading	Deliverable
03/22	Medical Roles / Medical Irony	Parsons / Waitzkin	RR by 12pm
03/29	Medicalization / Capitalist Medicine	Conrad / Navarro	RR by 12pm
04/05	Racist Medicine / Sexist Medicine	Feagin & Bennefield / Lupton	RR by 12pm
04/12	Pathologizing Poverty / Jailcare	Hansen et al. / Sufrin	RR by 12pm
04/19	Bandage, Sort, and Hustle	Seim	BR by 12pm
04/26	Review	N/A	N/A
04/28	Exam II	N/A	Exam by 5pm
05/07	Final Paper: Case Study or COVID-19	N/A	Final by 4pm

PART I: THE SOCIAL ROOTS OF SICKNESS

FEBRUARY 1st

A) SOCIAL MURDER

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

Friedrich Engels offers a simple, but powerful, framework for examining 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 educational, 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 consider the contemporary relevance of Engels's model by examining some maps published by the Los Angeles County Public Health Department.

B) FUNDAMENTAL CAUSES

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

Next, we 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 increase the risk of risks, which of course increases morbidity and mortality.

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 12:00pm via Blackboard)

1. How might Engels inform our understandings of health disparities in LA?
2. How might Link and Phelan inform our understandings of health disparities in LA?
3. What might Link and Phelan say to Engels (or vice versa)?

FEBRUARY 8th**A) STATUS SYNDROME**

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

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, 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.

B) CAPITALISM AND SICKNESS

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

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.

In addition to discussing some of the studies that Muntaner et al. cite, we'll briefly review another study on "contradictory class locations" and the prevalence of depression and anxiety.

Reading Response (select one and submit by 12:00pm via Blackboard)

1. What might Marmot say to Engels (or vice versa)?
2. What might Muntaner et al. say to Link and Phelan (or vice versa)?
3. What might Muntaner et al. say to Marmot (or vice versa)?

FEBRUARY 22nd**A) RACISM AND SICKNESS**

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

There remains no shortage of research demonstrating a racial patterning of morbidity and mortality in the United States. However, the popular framing tends to focus on "racial disparities." Less attention is given to racism as a causal force. David Williams and Selina Mohammed help correct this. 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 and status syndrome approaches.

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.

B) SEXISM AND SICKNESS

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

We've considered how systems of class, race, and status affect health, but what about gender? Homan helps us fill the gap. She acknowledges that a number of frameworks have been put forward to help explain gender inequalities in sickness. However, she is unsatisfied with the usual 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 12:00pm via Blackboard)

1. What might Williams and Mohammed say to Marmot (or vice versa)?
2. What might Homan say to Muntaner et al. (or vice versa)?
3. What might Homan say to Williams and Mohammed (or vice versa)?

MARCH 1st**A) AN INTERSECTIONAL PERSPECTIVE**

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

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 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.

B) THE VIOLENCE CONTINUUM

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

Next, we turn to Seth Holmes's ethnography of migrant farmworkers in the United States and his analysis of the "violence continuum." 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 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 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 12:00pm via Blackboard)

1. What might López and Gadsden say to Homan (or vice versa)?
2. What might Holmes say to Williams and Mohammed (or vice versa)?
3. What might Holmes say to López and Gadsden (or vice versa)?

MARCH 8th

THE DEATH GAP

Ansell. 2017. *The Death Gap*.

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 review. Participation in this meeting will affect your "book review" grade.

Book Review (answer three of the following questions and submit by 12:00pm via Blackboard)

1. How might Engels evaluate the book?
2. How might Link and Phelan evaluate the book?
3. How might Marmot evaluate the book?
4. How might Muntaner et al. evaluate the book?
5. How might Williams and Mohammed evaluate the book?
6. How might Homan evaluate the book?
7. How might López and Gadsden evaluate the book?
8. How might Holmes evaluate the book?

Note: 350 words max per question. You must offer page citations. Make sure your answer covers multiple chapters of the book.

MARCH 15th

REVIEW

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

EXAM I IS DUE WEDNESDAY, MARCH 17th AT 5PM VIA BLACKBOARD

PART II: THE SOCIAL RELATIONS OF MEDICINE

MARCH 22nd

A) MEDICAL ROLES

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

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

B) MEDICAL IRONY

Waitzkin. 1993. *The Politics of Medical Encounters*. (pp. xiii-iv, 3-10, 75-106)

Like Parsons, Howard Waitzkin helps us understand clinical encounters. However, unlike Parsons, 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 stage a debate between Waitzkin and Parsons in class.

Reading Response (select one and submit by 12:00pm via Blackboard)

1. How might Parsons's "therapist role" inform our understanding of medicine today?
2. How might Waitzkin's concept of "irony" inform our understanding of medicine today?
3. What might Waitzkin say to Parsons (or vice versa)?

MARCH 29th**A) MEDICALIZATION**

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

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’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.

B) CAPITALIST MEDICINE

Navarro. 1983. “Radicalism, Marxism, and Medicine.”

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. At least for him, this is generally a managerial and regulatory position (rather than a small entrepreneurial one as it is typically defined). According to Navarro, this sort of “middle 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.

We’ll spend a bit of time in class thinking about some alternatives to capitalism and what medicine might look like under such alternatives.

Reading Response (select one and submit by 12:00pm via Blackboard)

1. What might Conrad say to Parsons (or vice versa)?
2. What might Navarro say to Waitzkin (or vice versa)?
3. What might Navarro say to Conrad (or vice versa)?

APRIL 5th**A) RACIST MEDICINE**

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

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

B) SEXIST MEDICINE

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

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.

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 12:00pm via Blackboard)

1. What might Feagin and Bennefield say to Navarro (or vice versa)?
2. What might Lupton say to Conrad (or vice versa)?
3. What might Lupton say to Feagin and Bennefield (or vice versa)?

APRIL 12th**A) PATHOLOGIZING POVERTY**

Hansen, Bourgois, and Drucker. 2014. "Pathologizing Poverty."

The poor certainly face barriers to care, but it is also true that medical institutions, practices, and logics are essential to the contemporary 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.

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

B) JAILCARE

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

Carolyn Sufrin, as both a social scientist and a physician, 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 loosely 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 also spend time in class discussing some other ways that medicine interacts with criminal justice.

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

1. What might Hansen, Bourgois, and Drucker say to Parsons (or vice versa)?
2. What might Sufrin say to Parsons (or vice versa)?
3. What might Sufrin say to Hansen, Bourgois, and Drucker (or vice versa)?

APRIL 19th**BANDAGE, SORT, AND HUSTLE**

Seim. 2020. *Bandage, Sort, and Hustle*.

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 review answers. Participation in this meeting will affect your "book review" grade.

Book Review (answer three of the following questions and submit by 12:00pm via Blackboard)

1. How might Parsons evaluate the book?
2. How might Waitzkin evaluate the book?
3. How might Conrad evaluate the book?
4. How might Navarro evaluate the book?
5. How might Feagin and Bennefield evaluate the book?
6. How might Lupton evaluate the book?
7. How might Hansen et al. evaluate the book?
8. How might Sufrin evaluate the book?

Note: 350 words max per question. You must offer page citations. Make sure your answer covers multiple chapters of the book.

APRIL 26th**REVIEW**

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

EXAM II IS DUE WEDNESDAY, APRIL 28th AT 5PM VIA BLACKBOARD

FINAL PAPER IS DUE FRIDAY, MAY 7th AT 4PM VIA BLACKBOARD

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.*

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