Title

A Violent Operation: Trauma Surgery, Policing, and the Politics of Care in a Los Angeles County Public Hospital

Author

Jones, Emily

Publication Date

2023

Peer reviewed|Thesis/dissertation

UNIVERSITY OF CALIFORNIA

Los Angeles

A Violent Operation:

Trauma Surgery, Policing, and the Politics of Care in a Los Angeles County Public Hospital

A dissertation submitted in partial satisfaction of the requirements for the degree

Doctor of Philosophy in Anthropology

by

Emily Virginia Scholl Jones

2023

ABSTRACT OF THE DISSERTATION

A Violent Operation: Trauma Surgery, Policing, and the Politics of Care in a Los Angeles County Public Hospital

by

Emily Virginia Scholl Jones
Doctor of Philosophy in Anthropology
University of California, Los Angeles, 2023
Professor Laurie K. Hart, Chair

This dissertation research explores the multiple configurations of violence—structural, direct physical, surgical—that form both the targets of practice in trauma surgery and, at times, its instantiation. Medicalization is often used by medical anthropologists to index the individualizing, pathologizing, and depoliticizing effects of medical approaches to social problems. But medicalization is likewise recognized as an important way to facilitate new forms of recognition and distributions of care. Medical care is a crucial and indisputable necessity for remedying the physical effects of violence, structural or otherwise, but institutions and providers of medicine are not morally uncomplicated distributors of healing but rather engender their own forms of violence. These entanglements complicate calls for increased care as solutions to seemingly ever-rising tide of criminalization and motivate the central question of this

research—what is accomplished when public hospitals are deployed as tools to intervene on violence? How do connections between public hospitals and state violence constrain care in this context, and what would it take to meaningfully disentangle them? This dissertation project explores the work of trauma surgery, hospital violence intervention, and police in the management of violently injured patients in a Los Angeles County public hospital. Through extended ethnographic fieldwork, in-depth interviews, and participant observation, I ask how surgeons' experiences of violence shape their embodied understanding of the "conditions of possibility" for how they might intervene in it (Aretxaga 1997, 8). I follow Wendland (2010), who argues that these ideologies of dehumanization and moral categorization are not inevitable features of clinical practice but rather culturally specific and structured by clinicians' broader conceptualizations of the social responsibility of medicine and the state. This project examines the violence embedded in clinical training and practice as a function of broader structural priorities that remain unchallenged as well as the opportunities for change, contestation and transformation that emerge through our embodied participation in them.

The dissertation of Emily Virginia Scholl Jones is approved.

Philippe I. Bourgois

Salih Can Açiksöz

Ji Seon Song

Laurie K. Hart, Committee Chair

University of California, Los Angeles

2023

Table of Contents

List of Figures

Acknowledgements

I am deeply grateful to everyone who participated in this research project. This work would not have been possible without your time and investment. You all invited me into your worlds and trusted that I would write about them honestly and with careful attention. I hope I have done justice to your thinking and experiences in my writing.

The intellectual community that has developed at UCLA has been an exceptional resource. Thank you to my wonderful committee, who have provided me with invaluable mentorship, teaching, and support throughout this process. Laurie, you have been an indispensable help and shoulder to lean on. Thank you for your critical insights, thoughtful reflections, and relentlessly detailed editing eye. Your generosity and support have been so meaningful throughout these past four years, and I simply would not have made it through without you. Philippe, thank you for your inspiration and encouragement. Our conversations have guided me consistently, and your incitements to write gave me the momentum I needed to see this project through. Can, your direction and careful pedagogy have shaped this project and my thinking at a fundamental level, and I am grateful to have had the opportunity to learn from you. Ji Seon, reading your work ignited a real sense of purpose and investment in this project, and our conversations have given me an entirely new perspective and set of questions I hope to carry with me throughout my career.

Vince, I am immensely grateful for your continued investment in this project and endless generosity with your limited time. You have had an immeasurable impact on my trajectory and career, and I hope we are able to continue our work together. Shamsher, thank you for your support and conversation about this work. Your critical thinking and grounded, pragmatic approach have helped me balance my own perspective. Thank you

both for providing the community I needed to grapple with the frustrations and contradictions of clinical medicine and health justice.

Thank you to all of my fellow social science MSTP peers. Your camaraderie and guidance have pulled me through the roughest periods of this long journey. Will, I am tearing up just thinking of the love and friendship and practical guidance you have given me. Thank you for being my earth sign partner in a sea of Geminis! Maxwell and Fabi, your encouragement and critical reading carried me through this year of writing. Jeremy, I likely would not have even started this without your help, and your dedication to an anthropology grounded in antiviolence and abolitionist organizing is a real inspiration. Lauren, thank you for being our trailblazer and offering your support and reassurance at every step of the way. Thank you also to everyone in the clinical ethnography seminar for your thoughtful engagement, community support, and constructive feedback.

To my family—I love you and am grateful for you all. Grandma, thank you for providing the foundation and glue of our family. Erika, you have been the best semi-parent I could have asked for. Thank you for always providing me a safe and welcoming place to call home. Sofia, your strength and resilience inspires me every day. Huxley, Sidney, Paloma, and Seb, thank you for your love and encouragement. Ryan, Remy, Jordan, and Georgia, you are family to me, and I am incredibly grateful for your love and presence in my life. Thank you to my boxing crew for keeping me sane. And, most importantly, thank you to my faithful writing companion, Shishito Pepper Jones, the most wonderful dog on the planet.

Research towards the completion of this dissertation was funded by the David Geffen Medical Scholarship and NIH NIGMS training grant GM008042.

Vita

Emily Jones graduated from the University of Pennsylvania in 2012 with a BA in Biology, *magna cum laude*. From 2013-2014, she was awarded a Fulbright Research Grant in Nepal, which supported her ethnographic fieldwork studying how the nebulous diagnostic criteria of autism were translated and incorporated into the parenting practices and ideologies of Nepali mothers in Kathmandu. She began her dual training in clinical medicine and anthropology as an MD-PhD student at the UCLA-Caltech Medical Scientist Training Program in 2016, funded by the David Geffen Medical Scholarship.

Recent Presentations and Publications:

Jones EV. Introduction to Hospital Violence Intervention Programs. Lecture presented at: Foundations of Practice at the David Geffen School of Medicine at UCLA; January 2023; Los Angeles, CA.

Jones EV. Policing the Safety Net: State and Medical Approaches to Violence in a Los Angeles County Hospital. Paper presented at: American Anthropological Association Annual Conference; November 2022; Seattle, WA.

Jones EV. What Keeps Us Safe? An Ethnographic Exploration of Violence Intervention, Policing, and the Production of Safety in Los Angeles County Hospitals. Paper presented at: National Conference for Physician-Scholars in the Social Sciences and Humanities; May 2022; Los Angeles, CA.

Jones EV, Wertz J, Shen E, Jen H. Prenatal Counseling for Congenital Diaphragmatic Hernia: A Qualitative Study of Provider Perspectives. Poster presented at: Pacific Association of Pediatric Surgeons Conference; November 2021; Virtual.

Jones EV. Introduction to Hospital Violence Intervention Programs. Lecture presented at: Foundations of Practice at the David Geffen School of Medicine at UCLA; January 2022; Los Angeles, CA.

Schlesinger W, Jones EV, Buchbinder L, Kalofonos I. Doing and Seeing: Cultivating a "Fractured Habitus" through Reflexive Clinician Ethnography. *Somatosphere*. 2021.

Introduction

Trauma Call

We get a page for a consult in the emergency department, I call back for the story—a 50-year-old Latino man with diabetes and a foot ulcer. The junior resident is scrubbed in and sends me to go see him, "I want to know if it's necrotic, if he's septic, and if it's tracking up the leg, etc." This is the third diabetic foot I've seen on this call alone, and I walk down without a second thought. I get there and he has just puked into an emesis bag, looks terrible, and the first thing he complains of is chest pain. Of course, I freak out immediately and think he's having an MI[1] (he's not), but the emergency department (ED) hasn't gotten an EKG[2] or even vitals yet. The nurse calls the EKG tech and I run through a cursory history and exam, moving fast because I know the routine at this point but now also because I don't want to be in the room if he starts decompensating. I find out that he has been here before—we have already amputated two of his toes on the same foot. He now has an ulcer with purulent drainage and there are red lines streaking up to his groin. I grab a culture swab and jam it in to see how far it tracks and he doesn't wince.[3] I ask him why he didn't come sooner, he says he works 20 hours a day and can't take time off of work or he'll get fired and won't be able to pay rent. He hasn't seen a doctor since the last surgery and has been taking his cousin's metformin when he can get it. I walk back up to the operating room fuming, and vent to

[1] Myocardial infarction, known colloquially as a heart attack.

[2] An EKG or electrocardiogram measures the electrical activity of the heart and is an important diagnostic tool for assessing chest pain.

[3] One of the complications of uncontrolled diabetes is damage to the peripheral nerves, which is partly why these ulcers can progress so far without treatment—patients cannot feel the pain that would otherwise alert them to the severity of the injury.

the circulating nurse about our abysmal primary care system and the fact that even when people come here for help, any care is temporary.

Later, we all get paged for a trauma, "27yo male suicide attempt multiple stab wounds to bilateral upper extremities, pulsatile bleeding, GCS 10,[4] unable to get BP," who turns out to be a sad dude with a few shallow horizontal razor wounds to his forearms, crying about a girlfriend who cheated on him. The pages are often like this—with so few words and such a rapid assessment it can be easy to distort the picture, and suddenly someone stable sounds like they're on the verge of death. Dr. Tennant ties off a bleeding vein in the patient's forearm in the ED, and we leave. The next page we get is harder to misinterpret, "3yo MVA [motor vehicle accident] with significant PSI [passenger space intrusion], TFA [traumatic full arrest], ETA 15 min." There is a palpable shift in energy. The attending says "Jesus Christ." As we walk towards the ED we get paged again twice, back-to-back, about two drunk guys, one who got hit by a car. The trauma bay quickly becomes chaos—usually it is relatively controlled, but once people hear about the 3-year-old, it somehow feels like there are 20 extra people there. The drunk guys get there first, and we evaluate them quickly, one gets transferred to the surgical intensive care unit (SICU) and one is fine. While we are with them, we get another page—a pregnant woman, also in a car accident, likely the 3-year-old's mother. Once we see that they are stable I walk over to the pediatric side and see at least 15 people in the room, with another 10 watching outside. The trauma bay I just left had four people in it—me, a nurse, an ED attending, and the trauma resident. The trauma surgery attending Dr. Tennant gets up on the bed and screams, "QUIET. There is a 3-

[4] The Glasgow Coma Scale (GCS) is a clinical scale from 3-15 used to assess patients' level of alertness and degree of impairment.

year-old coming in, they have not been able to get vitals for 20 minutes, we need to think about how we're going to do this. I want a cardiac FAST,[5] but if that's negative, I do not think we should be opening his chest." The ED attending agrees. I look around at everyone in the room and am suddenly overwhelmed with anger and disgust. Why the fuck are they all there? What is drawing them there, the sight of a dead baby? There is no way they are all there for a purpose, to be useful. Why am *I* there? I am easily the least useful person in the room. I think briefly about what I would learn from being there, since Dr. Tennant has already run through the plan. I decide I do not need to see the dead baby.

I leave the spectacle, walk over, and check in with one of the interns, who tells me they don't have enough staff and I should go to the next trauma—the mom—and write the note. I am one of the first people in the room, aside from the ED resident and the nurse taking notes. Within 5 minutes I recognize people from the pediatric trauma bay coming in, including my chief resident, looking even more stone faced than usual. I do not ask what happened. As the room fills up the ED resident demands that everyone who does not need to be there leave; I feel emboldened now—I have a designated job, I have to be there—and when he looks at me, I hold eye contact, ready to defend my place in the mêlée. I even begin to respect him for trying to clear the crowd, but promptly let go of that delusion when he says, "What the fuck was she doing driving her kids around at 10:30 at night?" The patient gets wheeled in and I start scribbling notes as the paramedic gives sign out—rear ended at freeway speeds, 7 months pregnant, hypotensive, positive seatbelt sign, no fetal heart tones. She's in the trauma bay for a

[5] A noninvasive, bedside ultrasound examination of the patient to assess for bleeding, but in this case was being used to look for cardiac activity to avoid invasive measures that would ultimately be futile.

total of about 90 seconds before we take her to the OR. As I am helping to move her onto the table she takes her non-rebreather mask off, flops her hand onto my arm weakly and says "*ayúdame*." In that moment I feel both responsible for her and completely helpless and overwhelmed. I say nothing, put her mask back on, and grab her feet as we swing her over. Within two minutes the patient is prepped and draped, the chief resident, attending, and their OB/Gyn counterparts are scrubbed in, gowned, and gloved, and my chief is holding a scalpel and opens her through the fascia with a huge midline incision. Her uterus is completely ruptured, with a small hand thrust through into her abdomen. OB have the baby out in seconds and hand her to the neonatal intensive care unit (NICU) team, the resident screams "I don't have my gown on yet!" and the attending hands the baby to her anyways saying, "Just take her!" She is very small, and eventually they are forced to give up resuscitating her.

At this point the trauma surgeons are working on her bowel, which has a huge hematoma, while the OB team removes her uterus. The physician assistant student on our team, standing just outside the sterile field behind the chief resident squeezing in a bag of blood, makes eye contact with me standing at the foot of the table and motions for me to come join her. "I have a way better view over here," she whispers. It is not a better view, but I stay anyways. "What do you want to do?" she asks. It takes me a second to even register what she is saying. I point downwards to the floor of the OR. "Surgery? Me too! I'm such an OR junkie it's not even funny." I am incensed. I cannot tell which of us has lost our grip on reality. I can barely admit to myself I want to be here, and she is reveling in it. Today was her first day with us, but she had done a trauma rotation before and understood the system well. When she says that, I remember how she was also in the room when the first baby died and begin to hate her.

From that point on I am unable to separate my feelings of anger towards her—which feel justified—from my resentment, which is driven by structures of hierarchy and competition built into the process of medical training. Anger at her callousness, her obscene lack of shame, resentment that her emotional indecency got her in the room. I look at her but do not respond, and after a beat walk back to where I had been standing. I stand there watching in a frozen rage for several minutes when I realize there is a harsh beeping that everyone is ignoring and is not part of the usual OR fray. I look over and realize it is the portable monitor sitting on top of the NICU incubator, announcing the baby's lack of vitals. I turn it off angrily and say something mean, effectively blaming the resident standing guard over the fetus for not doing it earlier. She has patently zero idea what is going on or why she is even there and is probably in her first few weeks as an intern, and thanks me for turning it off.

The junior resident comes in and after a quick conversation with the attending, pulls me out to help him see consults. I am grateful; I had been stewing for too long and there was not much left to see in the surgery. We do not address anything that has happened thus far, and it doesn't even occur to me to try. We walk down into the resident room by the pediatric ED, and one of the residents asks for an update about the mom. She tears up, covering her mouth and shaking her head, as we tell her. She then directs us to the other pediatric trauma bay, where I realize we are seeing the brother of the first kid. It turns out that this child is 3 years old; the first one was even younger. A nurse is sitting with him, and we walk over and see him sleeping in the gurney with a C-collar on. The junior trauma resident wakes him up, asking in terrible Spanish, "*Cuál es su nombre*?" The kid looks back at us, but doesn't say anything, so I repeat, "*Cómo te llamas*?" which he responds to sleepily. Until this point I had felt mostly nothing, a sort

of emptiness that comes when feeling has been crowded out by the immediacy of the chaos, mixed with a simmering and indiscriminate anger. Looking at his small face, peaceful and oblivious, hearing his tiny voice—I nearly lost it. I'm able to stop myself from openly weeping, but just barely, and cannot keep myself from welling up. If the resident sees, he does not say anything. It is only midnight, and I am there for 9 more hours. We do three more operations that night, two of them diabetic foot amputations. The mom survives.

A Los Angeles Safety Net

My time as a medical student on a trauma rotation at this county hospital in Los Angeles, which I will refer to as Rosewood Medical Center for the purposes of anonymization, was a transformative period in my medical education. During my three weeks, I worked for 28 hours on call every three days, with a day off and a 12-hour day in between call shifts. Working 40 hours in two days provides an unusually rapid development of intimacy and knowledge of an institution, its spaces, and the people who make it run. The contrast between the county hospital and the academic hospital where I had worked previously was stark—the sole stairway of this hospital was dark and dingy, dirt not so much lining as ingrained into the concrete steps, paint peeling off of half-hearted phrases of encouragement that appeared on the walls between floors. The cafeteria had a limited menu that relied heavily on the staple configurations of fried potatoes—tater tots and French fries—that recalled my public-school lunches and quickly lost their nostalgic appeal when I ate them several times a day (if I was lucky). Whereas the university hospital patients enjoyed private space in an immaculately clean room, most patients here shared a room with three others, separated only by curtains

that were a mysterious and possibly unintentional shade of brown. The patients, too, were different. A near majority spoke Spanish as a first language, and white patients were a small minority. The kinds of injuries and illnesses they suffered likewise reflected the environments they lived in.

As a public, safety net hospital and Level 1 Trauma Center,[6] Rosewood cared largely for the county's poor, uninsured, and otherwise most vulnerable residents (Gordon 1999). The Los Angeles Department of Health Services is the second-largest safety net system in the United States, serving about 11 million residents across the county (Casillas et al. 2019). Mirroring trends across the state (Gaskin and Hadley 1999), this county hospital serves a predominantly Latine population, with large portion of Spanish-speaking patients and a small minority of white patients. Often, these patients were grappling with advanced stages of illness that had been produced, exacerbated, and neglected by the political and social conditions the patients lived within.

The volume of diabetic limb amputations that this hospital sees is a direct result of the relatively anemic and inaccessible primary care available to the working poor in Los Angeles. In the case of the first patient I saw that night, the inaccessibility of care was heightened by his grueling work schedule that he needed to maintain a relatively bare and frugal existence. The fact that he was also undocumented created additional vulnerabilities and obstacles. His recurrent use of emergency services for care underscores the ways that the emergency department has, through the implementation

[6] This determination is made by the American College of Surgeons and is dependent on a constellation of available resources and patient volume, although the exact criteria differ by state ("Trauma Center Levels Explained - American Trauma Society" n.d.)

of federal requirements to care for all patients[7] and amnesty laws, come to serve not only as a system for intervening in the myriad of acute medical issues that inevitably arise in human life, but also for catching patients whose preventable and manageable illness have progressed to an acute emergency in the absence of medical care (Morganti et al. 2013; Kangovi et al. 2013). Fear is likewise a major obstacle for patients who have been targets of policing, have active warrants, or are undocumented and thus avoid any possible contact with state institutions. Historian Kelly Lytle Hernandez details the intimate and enduring connections between criminalization and immigration that has shaped the politics of police and labor in Los Angeles since the 1700s (Hernandez 2017).

But even beyond the availability of medical care, diabetes is, not uniquely but definitively, a product of the physical and political environment of poverty. The lack of fresh produce and unprocessed foods in low-income areas has been well characterized and described as "food deserts" (Lewis et al. 2005). Unsurprisingly, these same areas are often rife with fast food chains and processed foods sold in convenience stores. Even the built environment works against health—Los Angeles, like many American cities, is sprawled out across over 500 square miles that have been primarily designed for navigation by car, a design with an extensive impact on the city's historic and contemporary racial segregation (Johnson 2013; Davis 2006). These broader contexts have far more of an impact on human health than the practice of clinical medicine, a fact that even doctors themselves are increasingly willing to recognize but struggle to understand their relationship to or role in (Stark 1982).

[7] The Emergency Medical Treatment and Active Labor Act (EMTALA) was a federal law passed in 1986 that required emergency rooms to stabilize any patient who needed emergency medical care regardless of insurance status or ability to pay.

My experiences that night, and throughout my rotation, pushed me to consider the multiple and overlapping forms of violence that the hospital acts as a point of containment and condensation for. The patients I saw that night were not victims of violent injury in the same way as the patient I saw the following call shift—an 18-year-old shot through the abdomen for the second time in 6 months. Unlike him, none of these patients would qualify for violence intervention services, yet their experiences were shaped by violence, nonetheless.

The problem of defining violence, a notoriously "slippery concept," has long motivated anthropologists, social theorists, and legal scholars (Scheper-Hughes and Bourgois 2007, 1). The source of this slipperiness or resistance to simple categorization arises from the coexistence of forms of violence seen as a self-evident and those that are more insidious, yet no less central to the order of the world today. In fact, a central concern of many scholars of violence is understanding precisely how violence becomes categorized as such—what forms of violence are recognized as social harms that demand redress, and how is violence likewise understood as legitimate, necessary, or otherwise normalized to the point of invisibility? Examining the multiple, interrelated forms of violence that are visible in the space of the public safety net hospital provides an understanding of how violence may be intervened on, healed, and repaired, as well as amplified, legitimated and sedimented under the aegis of a politics of care.

Trauma surgery has a uniquely intimate relationship with violence in its myriad forms. It is the specialty of medicine that most directly, although not exclusively, encounters and treats direct physical violence including gunshot wounds, stab wounds, and assaults. In an urban, safety net hospital such as my field site, these forms of violence are disturbingly common. During the course of my field work, I did not spend a

single day on call without seeing at least one patient who had been violently injured, and often there were multiple. The embodied work of trauma surgery itself also demands a level of physical force (in restraining patients) and bodily violation (in surgical operations) that trouble the distinction between violence and care. The practice of trauma surgery thus presents a generative site for observing the construction of the flexible and fragile boundary between legitimate and illegitimate violence. Relatedly, the public hospital is positioned at the crossroads between medical and carceral approaches to violence—through its hospital-based violence intervention program, the hospital aims to equip patients with the resources they need to avoid future vulnerability to violent injury. But it likewise serves as a site of policing and criminalization (Song 2021). The near constant presence of police in the trauma bay and emergency department—omnipresent as a result of their social and legal authority to investigate violent injury—provides an ethnographic window into the entanglements between medical and carceral approaches to community violence and the conflicts and contradictions that emerge between them.

These reflections from a memorable trauma call shift also point to some of the core issues of medical education and hierarchy that have been explored in the anthropology of medicine—dehumanization, cynicism, and a lack of empathy for patients have been documented as a powerful transformation in medical students during their period of clinical training. However, ethnographies of medical training in other, non-U.S. contexts have found that this cynicism is a culturally specific response rather than a universal product of medical training, even in places with few resources (Wendland 2010). The clinical training year of medical school in the United States is rife with the anxiety of knowing painfully little about patient care, even less about how the

institution runs, and the social pressure of navigating a group of people who are too tired and cranky to care about your existence. As soon as you begin to get your feet under you, you are whisked away to the next rotation and invited to start the process anew. The instability (and insecurity) that this process engenders was apparent in my emotional regulation and relationships to the people around me that night.

Drawing on a Foucauldian model of subjectivation, Rhodes (1991) demonstrates how clinicians working in a psychiatric emergency department are both agents of discrimination, criminalization, and abandonment as well as targets of institutional demands and bureaucratic constraints that limit their capacity for care. I follow Wendland (2010), who argues that these ideologies of dehumanization and moral categorization are not inevitable features of clinical practice but rather culturally specific and structured by clinicians' broader conceptualizations of the social responsibility of medicine and the state. This project builds on the work of these ethnographers to examine the violence embedded in clinical training and practice as a function of broader structural priorities that remain unchallenged as well as the opportunities for change, contestation and transformation that emerge through our embodied participation in them (Mahmood 2001). This dissertation project asks how clinicians' experiences of violence shape their embodied understanding of the "conditions of possibility" for how they might intervene in it (Aretxaga 1997, 8).

Being at Rosewood was stressful, mentally and emotionally exhausting, but also changed my understanding of what I was capable of, what I could contribute, and gave me the satisfaction of having a meaningful role that I had not yet experienced elsewhere. The combination of a constant and repetitive flow of patients in need of emergency surgery and minimal staffing meant that even as a medical student I had a substantial

part in patient care, through which I learned more than on my prior rotations combined. My time as a medical student pushed me to confront the contradictions of violence and care embedded in our health system and concentrated in the trauma surgery service of the county hospital. Working there, I began to question the role of the public safety net hospital in the alleviation of social suffering amidst the limitations of clinical medicine.

Violence, biopower, and the legacies of colonialism in medicine

The intersections of violence and politics of protecting and managing life are often central concerns for questions of citizenship, social inclusion, and distribution of welfare. The entanglements between medical practice and institutions and such state projects of differentiation produce important conflicts between a purported politics of medical neutrality and the hierarchical and uneven distribution of social suffering. This tension, between the "universality of a species body" and the "actual politics of that body, [which] appears multiple when examined over the varying grounds of practice" is in some ways the core issue of biopolitics (Redfield 2005, 341). Noting that the relationship between violence and biopolitics is somewhat "undertheorized" by Foucault himself, Akhil Gupta asks "how is the form of violence implicit in biopower different from other types of violence?" (Gupta 2012, 16). This question, explicitly or otherwise, motivates much of the theory and ethnography that I will consider in this paper.

As I will explore in more detail, violence, both physical and structural, ultimately reveals its effects on the body through illness, premature death, and outright maiming and murder, which in turn opens a space for healing, reparation and care. The unique exigencies, limitations, and relationships to broader state services of public health and welfare that characterize the emergency department and trauma services of a public

safety net hospital thus forms an important backdrop for understanding how violence takes shape in this context.

The histories and legacies of colonialism have been a central object of scholarship on violence because of both its brutality and pervasive, global effects. A brilliant ethnographer and theorist, Frantz Fanon has provided both an ethnographic and theoretical picture of colonial violence and its penetration into the psychological and physical lived experience of both colonized and colonizing people. His work expands our understanding of violence by revealing how it fundamentally structures relationships to self, community, and country. Writing of his experience as a black man living in occupied Martinique and studying in France, Fanon describes the embodied, psychological violence of racism as being "sealed into [a] crushing objecthood" in his seminal essay, "The Fact of Blackness" (2002, 109). But it is his work as a psychiatrist in Algeria during the revolution that provided the grounds for his book *The Wretched of the Earth* (Fanon and Philcox 2004 [1961]), which cemented him as a canonical scholar of violence and figure in the decolonization movement. While Fanon's work has proven generative for a broad range of literature on philosophy, colonialism, race, and violence, I turn to his work here because of its utility in unpacking the various registers of colonial violence, understanding of the ways violence comes into view and is intervened on in medicine, as well as his theorizing of violence as a generative, as well as destructive, phenomenon.

His book *A Dying Colonialism* details the forms of complicity between medical institutions and clinicians and the colonial regime, including the mandate to report Algerians with "suspicious" wounds to the colonial authorities and the active collusion with military and police to cover up torture and execution (Fanon 1965, 138). Through

these actions, Fanon argues that colonial doctors exclude themselves from the "protective circle that the principles and the values of the medical profession have woven around [them]" and therefore, if killed, is "always a war criminal" (135). This medico-legal alliance and the kinds of violence produced within it remains a central theme in the provision of healthcare in contexts of colonial and military occupation; for example, Saiba Varma's ethnography of psychiatric clinics in Kashmir uncovers the "distinctively biomedical and therapeutic turn" of the Indian armed forces' interventions and shows how clinics and clinicians become conscripted into military violence despite attempts to remain separate from it (2020, 37). In "Colonial War and Mental Disorders," Fanon describes through case studies how the pervasive racial violence of colonialism in Algeria provoked intense suffering for both the colonized people and those participating in their oppression (Fanon and Philcox, 2004). Citing not only the brutal forms of physical violence that occurred regularly, such as torture and murder, but also the everyday forms of degradation and exclusion, Fanon describes how these forms of violence directly result in the psychiatric illness he treats. Fanon writes that alongside torture and racial terror, "medical science and concern for one's health have always been proposed or imposed by the occupying power" (2007, 145).

Writing a decade after Fanon's death and drawing from a different historical context, Foucault interrogates precisely this alliance between the production of health alongside and within structures of oppression. In *The History of Sexuality, Volume I,* Foucault introduces the concepts of biopolitics and biopower, which describe a shift in governance that occurred in the eighteenth century in the targets and mechanisms of power from the wielding of death to the investment in and management of life (1978). This biopower is not "deductive" in the sense that it does not primarily exert itself

through the removal of life but is rather productive— it "exerts a positive influence on life, that endeavors to administer, optimize, and multiply it, subjecting it to precise controls and comprehensive regulations. Wars are no longer waged in the name of a sovereign who must be defended; they are waged on behalf of the existence of everyone; entire populations are mobilized for the purpose of wholesale slaughter in the name of life necessity: massacres have become vital" (133). He develops biopolitics partly as a means to describe the other "pole" of power over the body—in addition to the "anatomo-politics" of the body as elaborated in discipline and punish, he puts forth biopolitics to account for the attention to the body as a site of reproduction of populations. Bodies are not simply disciplined, they are also administered, and violence is found not simply in the bodily violation of torture or execution, but rather in the prioritization of life that both cemented unequal structures of domination and legitimized open warfare.

The utility of these concepts has been reflected in their widespread usage as well as critique across disciplines; Achille Mbembe, applying Foucault's insights to the operations of colonialism and slavery, argues that biopolitics is "insufficient to account for contemporary forms of subjugation of life to the power of death" and proposes the concept of necropolitics to more accurately describe what he calls the "creation of death-worlds" (Mbembe 2003, 40). Agamben, in his influential book Homo Sacer (1998), offers an extension or "corrective" to biopower in his theory of bare life and its role in legitimating state power. The arguments he lays out turn on several important distinctions—one being the concept of "bare life" as the simple, biological existence that was classically defined as outside the realm of the political, and the other being the structure of sovereign power that is secured through a paradoxical relationship of simultaneous inclusion in and exclusion from the juridical order, formulated through

the logic of the exception. If the sovereign is defined as the one capable of determining the state of exception, when the law no longer applies, then they are both included in the juridical order while remaining outside it: "I, the sovereign, who am outside the law, declare that there is nothing outside the law" (28). This logic is mirrored in the structure of the ban, when a subject is included in the juridical order solely through their exclusion from it.

Agamben uses the concept of homo sacer to bring together the logic of the state of exception with that of bare life—homo sacer is a figure in ancient Roman criminal law who may be killed but not sacrificed, exemplifying "the originary relation of law to life," which "is not application but abandonment" (42). In this moment of abandonment, the homo sacer is included in the juridical order solely through bare life, having been stripped of a political existence. Thus, for Agamben, "the inclusion of bare life in the political realm constitutes the original—if concealed—nucleus of sovereign power" (19). The shift Foucault describes is therefore not the inclusion of bare life into the political, but rather making this connection between power and biological life explicit and primary.

The figure of homo sacer also plays on the tension and duality embedded in the Latin term sacer, which means both sacred and damned. Agamben asks: when did life become seen as universally sacred, and why? He locates the answer precisely in this politicization of bare life itself. While the sacredness of life is now invoked in opposition to or at the limit of sovereign power, Agamben argues that sacredness "originally expresses precisely both life's subjection to a power over death and life's irreparable exposure in the relation of abandonment" (96). This relationship between life's sacred character and vulnerability to violence becomes particularly salient for discussions

around the privileged authority of medicine over the preservation of life at all costs.

A common thread in the theories of violence relied on most heavily by anthropologists is their attempt to unravel the operations of violence that are obscured, normalized and often taken to be part of a given and immutable order. Bourdieu's development of symbolic violence is one example of such a theory; his concept of symbolic violence has proven extremely useful in unveiling the ways that violence is embedded into structures of power (Bourdieu 2007; Nagengast 1994). These oppressive relations of force and domination are all the more insidious because of their invisibility, or what he calls their misrecognition. The process of naturalization that constitutes symbolic violence is, importantly, present not only at the level of consciousness but extends to structures of embodiment and the "social organization of space and time" (Bourdieu 2007, 291).

Much like symbolic violence, the concept of structural violence was an important development for understanding forms of violence that do not stem from individual acts of direct, physical violation by an identifiable actor. Popularized by Paul Farmer, whose work as a physician in Haiti inspired him to think more broadly about the material conditions his patients lived in that produced such devastating effects on their health, structural violence reflects the systematization of violence within a given social order (Farmer 2004, 307). In the context of Haiti, Farmer argued for the term structural violence as a way to account for the ways that Haitians had differential access to resources such as water, housing, food that are fundamental to life. He also noted that much of the poverty that exists in Haiti is not a natural state of affairs but rather the product of a long history of enslavement and colonial plundering, a relationship that persisted long after decolonization in the form of debt to France. This formulation

produces a complex relationship between violence and culpability—understanding some kinds of violence as "ostensibly nobody's fault" demands more than an indictment of individual actors to produce real change or redress (307).

But by the same token, the concept of structural violence has often been misunderstood to provide ethical cover to those actively participating in and benefiting from structures of oppression by eliding the role of individual culpability and complicity in reproducing such structures (Mandavilli 2021). Loïc Wacquant provides a useful critique of the concept: while acknowledging the importance of maintaining a historical and materialist approach to analyzing contemporary patterns of illness and suffering, Wacquant argues that structural violence conceptually conflates categories of violence that are better understood as separate if related processes and cautions that the term "threatens to stop inquiry just where it should begin" (Farmer 2004, 322). What the concept of structural violence highlights best, in the words of Bourgois and Scheper-Hughes, is that "Most violent acts are not deviant. They are defined as moral in the service of conventional norms and material interests" (cited in Farmer 2004, 318). As shown in many ethnographies of care, violence, and the state, unpacking the relationships between structures of power and the distribution of social suffering is a central focus of anthropology.

Bureaucracies and biopolitics of care

The bureaucratic administration of medical care has served as an important site from which to examine the entanglements of state and structural violence, biopolitics, and medicine. Following Arthur Kleinman, Veena Das, and Margaret Lock, who argued that "bureaucratic responses to social violence intensify suffering," the ethnographies I

review here consider how the administration of life participates in the production of a social order in which exposure and vulnerability to death is unequally distributed (Kleinman, Das, and Lock 1997, x).

Nancy Scheper-Hughes' classic work on infant mortality and maternal love in Brazil portrays a world saturated by violence borne of a history of colonialism and exploitative economic relations (2007). The Brazilian people she works with, both ethnographically and as a community organizer, experience daily the assaults of state abandonment, drug and gang related violence, and the grinding, corrosive force of poverty and hunger. She shows in detail how this "everyday violence" manifests in the routinization and normalization of infant mortality— because the death of children in infancy (from hunger and illness) is not only tolerated but expected, mothers are encouraged to see their deaths as an improvement to their lives. This position has affective and material consequences; mothers relate to their children as "temporary visitors" until proven otherwise, neglect those that appear ill or otherwise already likely to die, and do not grieve or mourn their deaths once they pass. Scheper-Hughes positions this social indifference to death as an extension of the broader abandonment and indifference of bureaucratic state responses to the high rates of infant mortality among the urban and rural poor (Herzfeld 1993). Noting that the bureaucratic processing of a child's death lasted only two to three minutes, she analyzes this "rapid dispatch" as directly contributing to child death through its "implacable opacity, its refusal to comprehend, and its consequent inability to act responsibly to the human suffering that presents itself" (Scheper-Hughes and Bourgois 2007, 294).

In *Red Tape*, Akhil Gupta explores similar themes of poverty and the role of bureaucracy in the context of India (2012). His analysis of bureaucratic responses to

poverty and the arbitrary outcomes of state intervention aims to uncover the insidious workings of state violence that obscures and perpetuates poverty and early death for an enormous portion of the population. "What are the juridical and social conditions," he asks, "that make the violence of such exceptional poverty normal…such that it disappears from view and cannot be thematized as violence at all?" (7). His work both relies on and challenges theories of bare life and biopolitics to insist on the recognition of routinized state institutional practices as violent through their direct culpability for the deaths of the poor (7).

An important paradox his work considers is how the routinization of violence against the poor operates not on the basis of exclusion, as Agamben's theories might suggest, but rather through a process of constitutive inclusion. Approaching these questions ethnographically, as he does, reveals biopolitics to be "an internally contradictory, contested project" that is negotiated at different levels of state bureaucracy and administration which are themselves often at odds and contest the notion of a unitary state apparatus or sovereign power that he argues both Agamben and Foucault's theories implicitly rely on (71). This element of his thinking is shared by other scholars of biopolitics such as Nikolas Rose, who draw our attention to the ways that biopolitics operates outside the projects and spaces of nationalist eugenics such as the concentration camp, which Agamben takes as his paradigmatic example (Rose 2007). Reflecting on the massive disparities in life expectancy across nations, Rose calls this inequity, "'letting die' on a massive and global scale," but emphasizes that it is "not grounded in any political rationality that seeks to adjust the qualities of the population as a whole in the name of national political objectives" (2007, 81).

Gupta's use of structural violence as an analytic complements the idea of the state

as “an incoherent agent” of violence that systematically produces arbitrary and indifferent relationships to aiding its constituents (46). If, in line with the concept of governmentality in which state actions are disseminated through institutions such as medicine, we consider the county hospital to be a site where bureaucratic state practices are constituted and implemented, Gupta’s work urges an analysis of systemic violence against particular groups is constitutive of medical care rather than an example of exclusion from it.

This dissertation research explores the multiple configurations of violence—structural, direct physical, surgical—that form both the targets of surgical practice and their instantiation. Medicalization (Conrad 1992) is often used by medical anthropologists to index the individualizing, pathologizing, and depoliticizing effects of medical approaches to social problems (Scheper-Hughes 2009). But medicalization is likewise recognized as an important way to facilitate new forms of recognition and distributions of care. Quesada et al. argue for the development of a “good-enough medicalized recognition of the condition of structural vulnerability” as a tool for the development practical therapeutic resources that contest punitive policies and “discourses of individual unworthiness” (Quesada, Hart, and Bourgois 2011, 341). Medical care is a crucial and indisputable necessity for remedying the physical effects of violence, structural or otherwise, but institutions and providers of medicine are not morally uncomplicated distributors of healing but rather engender their own forms of violence (Feuille 2020). These insights complicate calls for increased care as solutions to seemingly ever-rising tide of criminalization and motivate a central question of this research—what is accomplished when public hospitals are deployed as tools to intervene on violence? How do connections between public hospitals and state violence constrain

care in this context, and what would it take to meaningfully disentangle them?

Dual training and methods

I began developing relationships with the people at my field site as a third- and fourth-year medical student and continued those relationships into my early years of graduate school, when I was also introduced to the hospital violence intervention program (HVIP) team. During my dedicated period of intensive field work, I spent several months with the HVIP team, embedding myself in their daily work routines, following along with them as they interacted with patients and deepening our personal connections through in-depth interviews. After several months, I then turned my focus to the clinical practice of trauma surgery.

Because of the site of my research, my experience and training as a medical student shaped all of my interactions with patients and clinicians alike. I was given access to the most tightly regulated spaces of the hospital like the operating room, but even more importantly I was understood to belong there and be entitled to presence and information. A significant element of my belonging was also rooted in my plan for a career in surgery and my pre-existing commitment to that future through medical school rotations at this hospital. Being a future surgery resident created a relationship of reciprocal investment, where the residents and attendings were more interested in discussing their jobs and their perspectives because of my desire and plan to join them. Initially, I spent time following different teams on call, meeting new residents each day of field work. While this approach gave me an important overview of the differences between team dynamics and a comparative lens for understanding how teams operate, it also presented difficulties for fully immersing myself in their social world when I had to

continually explain my project and my presence and differentiate myself from other medical students they usually had with them.

The social element of adapting to a new group each time was similarly draining, and despite the fact I was not being evaluated or graded based on my performance, I felt an anxiety eerily similar to the anxiety of being a medical student trying to fit in on a new rotation. The uncertainties that are typical of early field work—where should I devote my time and attention? Am I doing this right? —were compounded by the residents' struggle to categorize me in a way that made sense to them. Because I had explained my interest in understanding the relationship between violence and trauma surgery, and was attentive to the dynamics that appeared when patients who were violently injured arrived in the hospital, the residents would often comment that my ethnographic approach, of hanging out with the team and waiting, "did not seem like the most efficient use of my time" since violently injured patients came in unpredictably and only intermittently. Initially, it was hard not to agree with them!

After a few months of this practice, however, I was able to convince the group of trauma attendings, with the support and advocacy of one of them, to let me join a team and follow them daily. I continued this practice for several months, rounding with the team at 6am each morning, going to their daily sign out meeting, called "pass-ons," where the team on call the day prior presented the patients they had seen, and hanging out in the resident work room where they charted and made phone calls to nurses, other services and patient family members. Although nothing had changed about my approach to research—I was still "wasting" as much time as ever, if not more—joining the team in this way allowed me to step into a role of medical student that was familiar and easy for everyone to understand, and I was quickly accepted as part of the team. I

had been worried that my lack of usefulness would make me more of an annoyance in their busy days, but the impression I had was that they were more surprised that anyone would voluntarily spend their time this way. On most days, it took more work to keep myself separate from the team than it did to integrate myself; knowing my interest in surgery, the residents would welcome me to scrub in and participate in the cases, and it took real self-discipline to sit in the operating room and observe, talk to people and take field notes rather than jump into the surgery itself.

My interest in surgery also undoubtedly shaped the investment and interest that the residents and attendings held in my project, and therefore their willingness to engage and participate. Spending time with the attendings in the operating room allowed me to make use of the existing relationship structure of attendings and medical students, which is one of teaching and questioning, and move between technical surgical didactics and the questions motivating my research. This intimate access was invaluable for building relationships with the residents and attendings that produced more trust and ease in formal interviews. Likewise, my own experiences as a medical student gave me both the technical knowledge to understand the nuances of my field site as well as an embodied sense of what the work entails. Yet my proximity to the world of surgery also undoubtedly constrains my ability and willingness to criticize my interlocutors, many of whom may be my colleagues and some of whom have direct influence on the trajectory of my future career.

Outline of chapters

The first section of this dissertation examines how surgical practice and authority is articulated through the body—both surgeons' own and their patients—and its capacity

for violation, transformation and healing. Chapter 1 brings us into the composition and social world of the trauma surgery service, its role in the hospital, and the embodied, physical and intellectual labor that it demands. This chapter highlights the co-constitutive relationship between community violence and trauma surgery and unpacks the effects of this relationship on resident training and patient care. I consider how the embodied suffering and structural deprivation residents work under conditions their relationship to the broader structural violence that figures so prominently in the lives and health of their patients. Lastly, I explore how residents, in providing care for the county's most oppressed residents with too few resources, navigate the tension between practice *on* and care *for* their patients through an ethic of investment and connection.

Chapter 2 probes the interfaces of hospital care, bodily autonomy and surgical violence within the space of the hospital. Drawing on experiences of patients who refuse medical authority and attempt to reclaim autonomy in a context of deep vulnerability, I explore the tangled relationship between bodily violation and injury in surgery as itself an inevitable and constitutive element of care, as well as a mechanism to shore up medical authority. Relatedly, I show how medical bureaucracy is strategically deployed by clinicians to provide care that would otherwise be unavailable, as well as weaponized to punish or control patients who resist medical authority.

The second section situates the institution of the public hospital as part of a local Los Angeles political landscape responsible for the management of violent injury as an object of criminalization and public health intervention. In Chapter 3, I explore the development and institutional formalization of the hospital violence intervention program. Situating this program in the history of public health and medical approaches to conceptualizing and intervening on violence, I ask what this program's history and

contemporary form might tell us about the position of the public hospital in the political landscape of violence and health. I also explore how trauma surgeons work to understand and constitute their own social responsibility through claims about what and who constitute the "community" the hospital serves. The contradictions that emerge in these claims give shape to these surgeons' reckoning with their understandings of the political origins of violence, the limitations of clinical medicine, and what is expected of them in their role as clinicians.

In Chapter 4, I end with an examination of the presence of police in the hospital and the contentious yet collaborative relationships between police, clinicians, and patients that develop as a result. L.A. County hospitals have been a site of recurrent and at times fatal police violence. Because of its institutional role as a place where physical violence is treated and repaired, the hospital serves as a terrain of police presence and investigation, particularly in the emergency department and trauma bay. Although there is a common exchange of information and collegiality between most clinicians and officers in the hospital, tension emerges when clinicians are forced to confront the fundamental "violence work" of the police. This chapter explores how police activity in a hospital context is culturally, institutionally and legally positioned in relationship to clinical models of and mandates to care. By engaging with the legal and historical context around the connections between carceral and medical modes of management and intervention, I consider how care in a public hospital operates as both a valuable and precarious site to understand and combat police violence.

Chapter 1

Bodies as Training Grounds:
Embodiment and the Politics of Surgical Practice

On my first day as a third-year medical student on the trauma surgery service at Rosewood, I was in the resident work room and the intern was giving me a rundown of the service and what my role would be on the team. The interns themselves had just started their year only a week or so before, so they were also fresh and overwhelmed by their new level of responsibility. Eventually the junior resident, a second year, walked in and she introduced me to him. Without saying anything else, he looked at me and asked, "Have you pulled a drain before?" When I said yes, he instructed me to pull one of the patient's drains, gathered his belongings, and left for the day. I later went and pulled the drain myself, feeling a bit nervous walking into the room but relieved and satisfied when everything went smoothly. Almost a full year later, I was rotating as a fourth-year medical student on a surgical service at UCLA. The chief resident asked if I had pulled a drain before, and when I said yes, again dispatched me to pull the drain for one of our patients. This time, however, I only made it a few steps down the hallway before the team's intern came up beside me and followed me into the elevator. As we made our way to the patient's room, he walked me through the steps (of which, if I am being generous, there are three, four if you include putting on the bandage at the end). Pulling a drain is a very basic, very simple, and very safe process that every medical student learns within their first week on a surgical rotation. It is difficult for something to go wrong and is often one of the first things a medical student learns and can do safely on their own.

This example is a very low stakes, micro representation of the broader structures at play in these two sites. At Rosewood, the junior resident instructed me to complete that task on my own because that is how he had been taught, because he believe it was safe for me to do so, but also because he was exhausted from a schedule of being on call for 28 hours every three days. The interns were not available to supervise because they were themselves run ragged from trying to care for and discharge a long list of patients in a hospital system where each individual task requires follow up, sometimes repetitively and in person, to ensure that it actually gets done. By contrast, the intern at UCLA had fewer than 10 patients to cover in a system where everyone can be relied on to complete their work in a timely way without prompting. But was that level of supervision necessary? Or, what effects does that level of supervision have on patient outcomes, patient experience, and the shape of medical training and the production of competency?

I presented this example to one of the trauma surgery attendings and asked his opinion of these conflicts and differences between county and academic hospitals and training programs. “Well,” he reflected, “the reason why I don't go and watch somebody pull a chest tube or pull a drain out…One, I don't want to! Two, we trust them. But three, we don't have the bandwidth to do that. We expect our students… their responsibilities are more because our more senior learners and our attendings are doing other things. And I think that's great and necessary. But the other part of me is like, wouldn't it be nice if we had people to watch? Like, yeah, it's unnecessary, but it makes me I guess think about how poorly resourced our system is.” Avi, a chief resident in general surgery, voiced his own conflicted relationship to the training he was receiving at this hospital:

> As a surgical resident here, it is very difficult to come to terms with the fact that the amount of operating you do and surgical training that happens here is a lot in part due to the fact that this is an underserved population. The attendings are running around doing work, you're running around doing work, and this would not happen at [an academic center], residents doing surgeries, as much as it is here. And it's an excellent training program because of that. But it's also like, is this acceptable care for people?

The county hospital is affiliated with the academic center in a relationship that serves them both, with the county gaining resident labor as well as prestige by association, and an academic appointment for its faculty. The academic center on the other hand, is able to use their relationship to the county as evidence of their commitment to the community, all the while refusing to treat patients with public insurance at their primary site. Similarly, the kinds of illnesses that patients have at the county site are very different from what they typically see at an academic center. While the patients they generally serve are more well off, and the clinical cases they engage with are more complex and are the result of increasingly advanced and at times invasive clinical practice, the county patients present with diseases of poverty. This is due to the availability of medical care, and engagement with primary care and preventative services as well as pharmaceutical management of illness. But even more so it is due to the broader environments of poverty that produce illness--stress, pollution, food deserts, unsafe working conditions, exposure to the elements, and, most relevantly for this chapter, violent injury. The academic center thus relies on the county hospital as an

educational resource, often advertising the relationship with the county as an attraction for potential/prospective residents. One attending described this attitude as "seeing the patients' bodies as a training ground."

This chapter considers the processes of embodiment and training of surgical residents on the trauma service of a county hospital, both of which are structured by the relentless need for resident labor and limited hospital resources. The goals of any residency training program are primarily to create a system in which patients can heal and receive the care they need, and residents can learn to become competent and independent surgeons. On one level, the residents and other staff at this county hospital is under constant strain because of the brutality of the structural conditions they train under—insufficient resources, understaffing, and long hours are physically draining and create conflict within and between services. The same degree of underinvestment in the hospital context is reflected in the broader community it is situated in; a long history of divestment (Johnson 2013), segregation (Avila 2006), and environmental racism (Pulido 2000) has resulted in an overwhelming level of community health needs and disproportionate rates of interpersonal violence (Cousineau and Tranquada 2007). For trauma surgeons, this structural violence is most visible in the volume of violent injury they treat—gunshot wounds, stabbings and assaults—as well as the diabetic limb amputations they perform routinely.

Yet the physical and embodied demands of surgical training create a real demand for hands-on responsibility and labor for the sake of learning and practice. The result is that this county safety net hospital, as emblematic as it is of all the broader forms of structural violence that plague the surrounding community, also produces remarkably well trained, independent, effective surgeons. This tension animates the cyclical trends

in surgical education that oscillate between rigid restrictions on work hours to prevent burnout and medical errors and an emphasis on long periods of consecutive work that are thought to be invaluable for surgical training. This chapter examines how surgical residents learn what their work is and what it means—to themselves and to their patients—through these competing demands.

Structure of the service

The trauma surgery service at Rosewood, like many trauma services, also functions as the acute care surgery team. There are four teams, each with a minimum of four residents, with the occasional med student or PA student who joins them for a few weeks at a time. The chief resident, either a fourth- or fifth-year resident, leads the team, making clinical decisions, leading rounds, and operating throughout most of the time that the team is on call. The junior resident is either a second- or third-year general surgery resident, while the two interns are often one surgical intern and another intern from a completely unrelated service, such as internal medicine or anesthesia. Often there will be a nurse practitioner who works with each team and comes during the weekdays, and their institutional knowledge and understanding of the system can make a radical difference in the efficiency and functioning of the team. Medical students are generally rotating as part of their core clinical training, or as a "sub-intern," which encourages them to take on additional responsibility and function more as an intern than student, within certain limitations.

Each day a new team is on call, which at the most basic level means that they are admitting new patients and operating. A typical day on call begins at different times depending on your role—the interns and medical students might arrive at 5am to

prepare the list of patients for rounds, looking up the lab results from overnight and calling patients' nurses to follow up on tasks that have not yet been completed. On these days, the junior resident will lead rounds, which typically begin at 6am, allowing the chief to sleep in a bit before the long day and night ahead. The whole team meets at 7am at pass-ons, which is a daily meeting of the trauma service. The shift is typically 24-28 hours, with interns and medical students leaving before "pass-ons," where all four trauma teams and all attendings meet together to go over the patients from the night before, and the junior and chief resident leaving after having presented their patients in this meeting and finishing their remaining work.

It is impossible to predict how busy a call period will be, even 12 hours in. At times there can be four back-to-back traumas at 7:30 in the morning, forcing the team to miss breakfast (which is more common than not) and pushing back the start time for the first case. Other days the junior and chief resident will go straight to the operating room while the interns are able to eat a leisurely breakfast before retreating to the resident work room to write notes, call consults, and put in orders for the patients who are already admitted to the team. When trauma patients are en route, the paramedics contact the hospital base and the nurse who receives the call will first call an overhead page that goes throughout the hospital, inconveniently excluding the actual work room where the surgery residents generally are. Following the overhead page, they will then send out a page to all the trauma pagers containing the level of activation, either 1 or 2, which corresponds to the estimated severity of the injury, with 1 being the more severe.[8] The pages also list the mechanism of injury, relevant history or medications, the

[8] The process of determining the TTA level has been agreed upon at a county level.

patient's vitals and level of responsiveness, and an estimated time of arrival.

I have been on call where the team receives only two minor traumas over the first 12 hours, and then is inundated with patients overnight. One day that I spent on call with the team was relatively quiet, only a few pages, a couple of minor scheduled surgeries, and few consults. I went home around 9pm and returned the next morning to chaos. Several trauma patients had come in overnight requiring emergent surgery (called redlines), and the junior resident was scrambling to complete the pass-ons list with the help of both interns. I have been on other calls where the team rarely sits down, between seeing trauma patients, operating, and assessing consults in the emergency department. The complete unpredictability of their work produces a pervasive superstition in the residents to cope with and make some sense of the often-random influxes of sick patients. People are often described as being "white clouds" or "black clouds," depending on the relative level of busyness that they are associated with. This label extends to attendings and is openly discussed, with residents and other attendings agreeing that some attendings often have particularly eventful days on call. "Sometimes I'll come to pass-ons and listen to what happened on her calls and my mouth will be open, like how did she do all of that in one night?"

Pass-ons: a ritual of peer accountability

Each morning, the junior resident from the team on-call the day prior (also referred to as the post-call team) prepares the pass-ons list, which is a complete list of the patients that the team operated on or were consulted for during their call period, and then presents the patients at pass-ons. Pass-ons is itself an incredibly rich and fascinating site for understanding how discipline, hierarchy, and conflict are mediated

in academic surgical practice. The room itself is organized according to seniority and position, with the faculty attending surgeons sitting together at the horseshoe-shaped set of tables on the right-hand side of the room and the junior and chief residents together on the left. Everyone else—interns, medical students, nurse practitioners—sit along the periphery and largely do not participate unless asked to provide ancillary information or clarification.

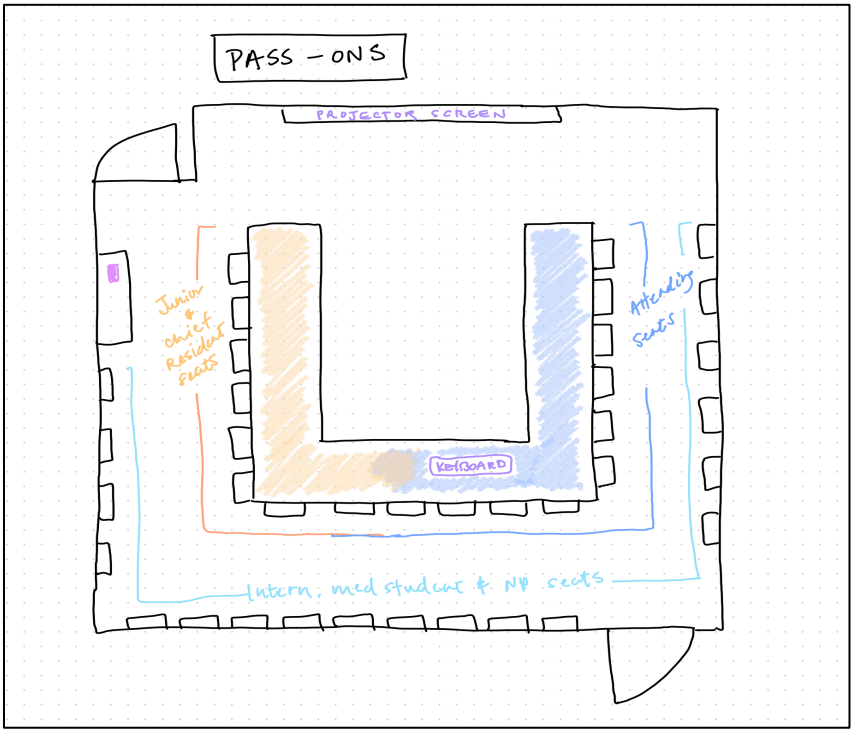

Figure 1: Pass-ons room layout

One of the interns on the team I followed was in internal medicine, and she was indignant and suspicious of this set up; she argued to me that in internal medicine, they all sit together with the faculty, eat lunch together, and generally do not replicate hierarchies of seniority and position in their physical arrangement to one another. While her point is well taken, it pushed me to consider the effect of this seating structure. For one, there is the simple fact that there is limited space at the table and the people sitting there are typically the only ones talking because they are in a position to provide information, ask questions, and discuss treatment plans. The junior resident who was on call the night before makes a list of the patients with the salient information about their presentation, the treatment they received, and their plan for care and then presents this information in a highly routinized way. The attending who is coming on

call that day will typically ask follow up questions about patients they will need to follow up on or operate on, while the attending from the night before will provide clarifying information or discuss the rationale behind specific treatment decisions. Other attendings might chime in with questions about their patients, or with teaching points they think are important. As the junior resident goes down the list, one of the attendings will open pertinent imaging on the projector screen and review it, sometimes pausing the discussion to point out findings or to solicit others' opinions about how the images look. This practice can be very educational if you are paying attention—although often there is not time to stop over every image and explicitly say what they are looking at or what they see, they will sometimes pause over specific images, or let out a quick "yikes," and as a medical student in this room my main focus was determining if I knew what they were looking at and if my reading matched theirs. Much of this learning process is determined affectively; I know I am understanding things when the feeling I have when a certain image pops up matches the general tenor of the room or emotive sounds people make.

One of the benefits of the physical arrangement of the room is that it indicates who is expected to contribute to the meeting and speak, and who is not. In that sense, the clarity of the set up allows the medical students and interns to relax enough to actually learn, which is harder to do when you are anxious about having to publicly answer questions. The implicit message, although there are always exceptions, is that anyone sitting on the periphery should not speak, least of all medical students (see Song 2018). Another important consideration is that a fundamental fact about academic medicine is that the residents who are working on a particular service only do so for a period of 4-8 weeks before moving on to a different service. Each level of resident is also

on a different timeline to transition, which means that the entire team does not rotate off at once and makes it easier to maintain continuity of patient care. But the result is a constant movement of people in and out of the service, with new faces appearing regularly. The set-up of this room communicates through its design who a given person is and what their role is, something that became clear to me when I helped orient a new non-surgical intern who came on to our team.

Pass-ons is thus a space where the boundaries of clinical hierarchies are enacted and performed, where expectations and roles are contested and solidified. Part of this disciplinary process is the constant forms of informal teaching and the semi-public management of dissenting opinions. One of the chief residents described it as a "daily peer review," because the team on call is pushed to defend their decisions and acknowledge errors in a communal setting. This kind of peer accountability was invoked regularly in clinical scenarios. For example, a trauma patient needed a tube placed in their chest to reinflate their damaged lung. The process of performing the procedure was a good example of how academic surgical learning happens—because both emergency department and surgical residents need to learn this procedure, they alternate which service provides the procedure when a patient needs one. This time, it was the emergency department's turn, so the junior resident began prepping the materials for the chest tube. The trauma attending then asked the junior surgical resident whether she had done this procedure before, and when she confirmed she had done it twice, the attending then instructed her to guide the emergency department resident through the process while the attending supervised. Although the procedure went smoothly, when they took a chest x-ray to confirm the proper placement of the tube, they noticed that although the patient's lung had reinflated successfully the tube had not been advanced

far enough and was at risk of reintroducing air into her chest, which would compromise the effectiveness of the tube and potentially lead to the reaccumulation of air around the patient's lung. The surgical resident suggested we just leave the tube as is, since it was doing its job and was just barely out of place. While the attending agreed it would more than likely be ok where it was, he insisted that it needed to be replaced in the correct position, saying "You don't want to show up at pass-ons with a chest x-ray that looks like that."

Often, the discussions center on institutional processes and standards as much as clinical or technical ones—who should be operating on which patients, which service should admit patients, who to call in a given situation. One morning at pass-ons Dr. Lendon, a tall, white man who is one of the more senior trauma surgery attendings, is annoyed because one of the consults has a lot of unclear and contradictory information coming from the MICU team and the chart. He instructs the trauma team to get it together and figure everything out, with the implication that this should have been done prior to presenting the case at pass-ons. Having been with them the whole day and most of the night I wonder when the junior resident was supposed to do that. He had been literally running around the hospital seeing consults in between cholecystectomies[9] without a break. Another element of this daily meeting is the opportunity for the group to assess how much work was done the night before. A bad day will have the list of patients run over on to the back of the page. A really bad day might be visible in the large splatters of blood across the on-call team's scrub pants and shoes.

[9] Gallbladder removal surgeries, one of if not the most common surgeries this team performs.

Emotional training and labor

The experience of listening to pass-ons can be overwhelming for new medical students as they are forced to confront and digest a large volume of illness, death and suffering, presented rapidly in a calm, technical jargon. “As a newcomer, I was like, Whoa, this is not normal, you know?” one medical student described to me. “But that is, for them, really normal. Pass-ons is by definition mundane, it happens every day. We talk about these awful things every day, super fast…people would crack jokes in the middle of [everything], and I was like, none of this is funny! Why are you cracking jokes? But everyone seems cool with it.” In this conversation, I realized how much of my own sense of “normality” had already been shaped by the experiences and cultural expectations of surgery—when listening to the pass-ons presentations, I can recognize and feel empathy for both the patients and the on-call team when there has been a particularly rough stretch, but nothing about pass-ons surprises me anymore, if it ever did. The practice of cracking jokes during a conversation about violence and death is understandably upsetting for some, but I recognize it as a form of coping as well as a form of enculturation to the acceptable forms of emotional expression and regulation in surgery. While some people do at times find themselves overwhelmed by emotion after a horrible sequence of deaths and may even break down in tears, that kind of emotionality is not a sustainable form of expression. Humor, lightness can at times be preconditions or facilitators of a problematic detachment or even cruelty towards patients (Parsons et al. 2001; Wear et al. 2006; Sinclair 1997), but they are also a central way for surgeons and other clinicians to form relationships with each other and maintain access to their own capacity for feeling beyond sadness.

Many ethnographies of surgeons (see Millman 1977) portray surgeons as largely self-centered, egotistical knife-wielding narcissists, violently rending and reconstructing bodies at will. Others, by contrast, tend towards an overly venerating view of surgeons as technical virtuosos with an extremely privileged and almost divine access to the recesses of the body and perilous edges of human life. Both of these narratives offer important windows into the cultural world of surgery, and they are both accurate in their own ways, but ultimately their analytic resonance is circumscribed by their narrow focus. More useful are ethnographers such as Wendland (2010) and Cassell (1991; 1998) who take surgeons to be often well intentioned but deeply fallible, motivated by the pleasures of adulation as much as by an altruistic spirit, and fully imbricated in a social and political world that is as much a factor in their surgical practice as their medical education. "To blame biomedicine exclusively for its ills," Cassell reasons, "is to reproduce its own ideology—that it is independent of society and has an exclusive relationship with nature" (1991, 241).

Claire Wendland's ethnography *A Heart for the Work* argues that the active divestment of the social, economic and emotional world of the patient from their bodies in Western biomedicine is a core cause of medical students' dehumanizing views of the patients they treat (2010). Her experience with medical students in Malawi, who lack both the technological and economic infrastructure to provide basic care but nevertheless maintain a caring and positive relationship to their patients, proposes that both their political engagement with the violence and suffering they encounter, and the primacy of their embodied, caring presence protects against such depersonalization. Wendland's work demonstrates that even in the context of extreme deprivation and limited resources, the perception of patients as dead weights in need of disposition

(Mizrahi 1985) is not a necessary or constitutive feature of medical care. Taken together, these texts encourage us to understand both the incredible durability of particular facets of medical training as a function of broader structural priorities that remain unchallenged as well as the opportunities for change, contestation and transformation through our embodied participation in them. Like all hegemonic practices, the practice of medicine is not a passive or rigidly stable object, but rather needs to be "continually renewed, recreated, defended and modified" (Williams 1977, 112).

Wendland also provides a thorough genealogy of medical anthropology of training and offers new ways out of its dehumanizing practices. Attending to biomedicine as a specific cultural project, she describes biomedicine as containing a "moral order" through which it legitimates its authority over the body and obscures its political operations under the guise of neutrality and rationality. Ethnographic inquiries into medical training in the United States have long shown a pervasive level of depersonalization and dehumanization of patients that occurs through medical school (Becker 1977) that has proved remarkably durable (Good and Good 1993; Kleinman 2009). Some (Hafferty 1988; Young 1997) have argued that the experience of cadaveric dissection operates as a primary site for the emotional socialization of medical cultivation of detachment. The phenomenon of medical student detachment has persisted despite the nearly constant (but ultimately superficial) incitement to curricular reform (Ludmerer 1999) and profound changes in the demographic makeup of medical school classes. Interestingly, gender differences in empathy and humanism present at matriculation are equalized by graduation (Beagan 2000), suggesting that the socializing processes of medical school are influential enough to reshape a lifetime of gendered expectations for social and emotional relationships, at least in regard to

patients. The absence of investigation into the interaction between gender, surgery and structures of feeling in the years since these demographic shifts have occurred invites more ethnographic attention.

One resident described her experiences of overwhelming guilt and panic in moments when she believed she had operated inadequately on patients. “I was just like, completely fucking losing my mind basically, because I was like, I felt so guilty that I somehow made a mistake that caused the patient to be extremely sick. And I remember [the attending surgeon] having to basically say, ‘Pull it together, because you have to take care of this patient right now,’ because I couldn’t operate. I was in a panic…the guilt was overtaking me.” The attending’s response was not one of anger but was a way to refocus and direct her. She described a similar situation where she was pulled into another surgery while on call but left the first case thinking (erroneously, she later learned) that she had caused an injury to an important structure, something she had never done before. This time, she recalled “crying the whole case,” which she said directly to the attending, Dr. Lendon, when asked if she had a cold. “I don’t know if he thought I was joking or what,” she continued, after describing his complete lack of response at this admission. Although this time the attending did not offer or need to help Sophie discipline her emotions, she drew on her prior experience to move through them and keep working. “I was remembering the time from before and I was like…I have to take care of the patient that’s in front of me right now, and the other patient is being taken care of and whatever will be will be. But [the whole time] I just like sobbing into my mask, it was so bad, it was like pooling in my N95, it was so gross, the snot.” As she describes this, we are both laughing at the absurdity of the image, but also as a way of processing and normalizing the intense pressures, expectations and demanding work of

surgery and the sometimes uncontainable emotional overflow they produce.

But at times the errors in judgement or technique are real, and these moments enact a very different emotional weight or toll. While we both laughed as she described herself crying into her mask, Sophie now spoke softly and haltingly, and the pain in her voice was evident. “I had a patient come in who was talking when she came in, she had been shot. She was like a 20-year-old girl…And she was literally saying to me, ‘I need blood. I need blood. I’m dying. I’m dying.” She describes how they tried to resuscitate her in the emergency department and took her to the scanner to get imaging instead of going straight to the operating room. “There was an issue with the tubing [that was delivering blood to the patient] and so we were like sitting there troubleshooting it for like, way too long, we shouldn’t have been in there anyway. And I’m back by the patient’s head and she’s like, ‘I need blood, I need blood, I’m dying.’ And I’m like, ‘We’re working on giving you blood,’ you know, ‘We’re gonna take care of you, we’re gonna take care of you.’ And like, finally she started coughing up blood and the ED attending who was there was looking at me the whole time, like, this is fucking insane.” At this point they bring the patient to the operating room, and once they get to the elevator she continues talking to the patient, “I said, ‘We’re going to take you to the operating room now to stop the bleeding.’ And she said, ‘Why haven’t you been doing that this whole time?’ And yeah, when we opened up her abdomen it was full of blood, and she had a horrible [vascular] injury. And she died. And we were working on her for like, a really long time. And like, both of us were totally panicking because I think we knew that we had done the wrong thing. And she had horrible injuries, I’m not sure she would have lived anyway. But it’s really hard when somebody comes in talking and then they die.”

Perception and attunement of the senses

Another important element of physical learning in surgery is mediated through sensory processing and attention. Initially, the variety of sensory input in the spaces of the operating room, intensive care unit, trauma bay, or patient room can be overwhelming. Each machine and monitor has its own register of sounds, that with experience become easily identifiable—the monitor of the patient's vitals will beep shrilly when the patient's vitals dip below normal, becoming increasingly frantic as the numbers plummet. Often, when observing these numbers and signals, someone might as if the numbers are "real." Prentice (2013) provides an example of how surgeons manage discordance that arises between the patient's clinical status and the technological representation of vital signs like blood pressure, heart rate and oxygenation status. The monitor that measures the patient's vitals stops working, and the attending surgeon uses his hand on the aorta to feel the patient's pulse. She uses this moment to point towards the ways that surgeons incorporate tactile experience of the patient's body in addition to the visual information of the monitor. But the monitor is not just a visual aid, it also produces sound—a beep that mirrors the patient's heartbeat in both timing and frequency. The faster the pulse, the quicker and higher pitched the beep. This output functions as a sort of bodily metronome that sets the pace and mood of the room's activity. When all is well and proceeding smoothly, the sounds fade into the background and are barely perceptible. But an unexpected uptick or slowing can produce an immediate, coordinated response from everyone in the room, an anxious rush to address the problem and stabilize the patient. There is a kind of physical connection and attunement to the patient's body, in this case mediated by technology but not always, that emerges from this practice of sensory attention and enables a bodily

knowledge that coordinates a cognitive analysis.

Different smells bloom and fade throughout a case. The OR itself is somehow imbued with a specific scent of a mix of disinfectants, a smell that clings to your clothes and skin. Before the case begins, the smell of iodine from the sterile preparation fades and is replaced with small wisps of smoke and the smell of burning flesh as the surgeons use electrocautery to open the surgical site. Sometimes the circulating nurse will put a dot of essential oil on your mask if we know that we will be perforating the bowel. Once a nurse did this to me without asking, and I spent the whole case feeling slightly ill from the nauseating artificial scent of bubblegum. When she moved to give some to the attending, he put his hand out to stop her, and said he always wanted to be able to smell what was happening in the case, it was an important source of information for him.

Phenomenology has served as an important theoretical resource for questioning and ultimately undermining dualisms of nature and culture, mind and body. Despite Bourdieu's repudiation of phenomenology as "totally ahistorical and anti-genetic" (Bourdieu 2000, 26), anthropologist Thomas Csordas productively brings Bourdieu's theories in conversation with those of Maurice Merleau-Ponty to argue for embodiment as a the "existential ground of culture"; the body in this formation is thus "not an object to be studied in relation to culture," but rather "the subject of culture" (Csordas 1990, 5). "For Merleau-Ponty in the domain of perception," he writes, "the principal duality is that of subject-object, while for Bourdieu in the domain of practice it is structure-practice" (8). By bringing the two analytics together, Csordas offers embodiment as a non-dualistic methodological figure that invokes a reconsideration of distinctions between subject and object, mind and body, self and other, cognition and emotion, and subjectivity and objectivity (36). Embodiment thus uncovers how perception is always

already shaped by the social. Merleau-Ponty's phenomenological analysis of the operations of bodily perception position the body as sensing mediator of the world that is conditioned through lived experience (Merleau-Ponty and Landes 2012).

Within the operating room, the priorities of attention are taught and learned through implicit modeling as well as explicit instruction. The monitors in the operating room emit a beat that is synchronous with the patient's heart, and the pitch of that beep corresponds to the patient's oxygenation status. These auditory signals enable a rapid and coordinated response from the entire OR team. A heart rate that begins to slow abnormally is quickly and easily identified, as is a dangerous drop in their oxygen levels. Making use of the full range of bodily perception in surgery allows for a more complete attunement to the patient's body. While the conscious perception of the sound of the monitor's beeping might fade into the background, that background then forms the perceptual frame for recognizing changes that demand attention and concern. That does not mean, however, that every sound is attended to, even as a perceptual backdrop.

An example of this distinction arose when I began spending time in the emergency department for field work. While as a medical student I carried a pager, along with the rest of the trauma team, that notified us when a trauma was arriving and gave a brief description of the patient's condition and mechanism of injury, initially I did not have one during my research. I discovered quickly that the pages for the traumas were also announced overhead throughout the hospital. When I had carried the pager, I had no need to hear those overhead messages because I could rely on my pager to give me a more detailed message, and I had not even perceived them. Learning to listen to the overhead announcements took conscious effort at first; I was not accustomed to paying them any attention and missed a few of the pages initially. Once I had trained

myself to hear them, they became an important source of information, as I realized that the overhead pages were announced before the message was sent to the trauma pagers and on rare occasion the page would be broadcast without being sent to the pagers. When this error happened, the trauma team was in the trauma bay seeing another patient, and I realized that I was the only person on the team who knew that another patient had arrived in the next trauma bay over because I had heard the overhead page. Of course, these small lapses are covered in other ways, and they would have found out sooner or later, but it was an interesting moment that clarified the different forms of perceptual attention that are learned through different roles and practices of medicine within the hospital.

Training and the surgeon body

The specific relationship between embodiment and surgery is I think best illustrated through one of my favorite medical jokes, which asks how doctors of different specialties would hold the elevator door—an internal medicine doctor would use their hands, because they don't need them. A general surgeon would use their feet because they don't need those. And an orthopedic surgeon would use their head! I laugh every time I hear or tell this joke, which should tell you something either about the sophistication of my humor or how far gone I am into the social world of medicine. But I am retelling it here to illustrate the relationship between types of medical practice, specifically surgical practice, the phenomenon of embodiment, and the ways that relationship is both cultivated and narrativized through the process of training.

Embedded in this joke is a long history of intellectual and practical division between medical specialties. In his historical analysis of the development of professional

identity for surgeons and physicians in early-modern Britain and America, Christopher Lawrence provides a compelling narrative for how generic modes of embodiment became discursively linked to forms of medical practice (Lawrence 1998). As medicine began to incorporate empirical science into its practice, surgeons were initially categorized alongside barbers and butchers as primarily tasked with physical, rather than intellectual labor; while internists considered themselves the "head" of medical practice, surgeons were labeled the "hands of healing" (82) and characterized the typical surgeon as "a doer not a thinker" (83). These associations brought with them normative standards for emotional regulation, with one surgeon recommending that practitioners develop "the unfeeling brutality of a butcher" (97). The association between carpentry and orthopedic surgery is one that remains to this day and is repackaged in the joke above, which also reveals a great deal about the hierarchical positionings of specialties in relation to their perceived intellectualism *and* physical capacity. While an internal medicine physician might protest the idea that their hands are irrelevant to their job, the general surgeon is positioned as both intellectual in their practice (they need their head) and physically dexterous (they need their hands). Lawrence traces a similar negotiation of positioning by surgeons in the eighteenth and nineteenth centuries who had successfully "plundered the physician's repertoire" with the result of their being considered as "the embodiment of penetrating intellect" (1998, 99). Their emphasis on action likewise allowed them to distinguish themselves from internal medicine physicians through their capacity to access and affect the human body. These characteristics used to demarcate their social position and authority were always expressed in exclusionary gendered terms, for example positioning themselves as the "embodiment of heroism and manliness" (101).

There is a remarkable congruence between the figure of the surgeon that was carved out during this historical period and the self-image of surgeons today. Cassell (1991, 1998). One surgeon demarcates differences in specialties thusly: “A surgeon knows nothing but does everything. An internist knows everything but does nothing. A psychiatrist knows nothing and does nothing. A pathologist knows everything, and does everything, one day too late" (Schwartzbart as cited in Katz 1981, 155). Cassell notes the modes of surgeons’ self-presentation as consistent with these stereotypes, but also goes on to describe the metaphysical or religious aspects of their work. These aspects of surgery are again couched in terms of their unique and rarefied access to the “forbidden geography of the body,” exemplified well by one surgeon who describes “seeking the exact location of the soul in the recesses of the body” and identifies the surgeon as a priest (1991, 75). Cassell also describes the ways that gender was operationalized by both male and female surgeons to negotiate their position in relation to others. Her book *The Woman in the Surgeon’s Body*, while limited in its theoretical approach to analyzing gender relations, provides important ethnographic material of women surgeons navigating a specialty that was structured both physically and ideologically by masculinity (1998). Her work provides evidence of how the historical structuring of surgery as a profession physically and intellectually accessible only to men has endured: “Women possess the wrong body for [expected] rituals of dominance and deference,” she argues (108).

Even more important in my view, however, is the ways that gender exposes the incredibly fractured and precarious nature of social hierarchy in surgery. She describes how male residents would flagrantly disregard instructions from their female “superiors” (in the context of the rigid surgical hierarchy) with impunity and shows how

women were placed in an unwinnable paradox: if they did not adhere to the attributes of surgeons that represent both their professional capacity *and* their masculinity, they were deemed incompetent but maintained an image of respectability in their femininity. If they chose to (or simply did) perform a certain level of masculinity, they would gain a fragile respect that could at any moment be undermined by their status as a woman. While a measure of overt misogyny is inevitably still present in surgical practice today, much of the examples she gives do not resonate with my experience, as much of these gendered expectations have gone underground, in a sense, and are not as visible on the surface. The examples she provides of insubordination and fracture of hierarchy—in both medicine and gender—bring us directly to what Raymond Williams describes as the "specificity of present being, the inalienably physical" (128) experiences that reveal institutions to be "a social experience which is still in process" (132) rather than a fixed or immutable structure (1977).

Rachel Prentice (2013) brings an ethnographic attention to embodiment in her study of surgical training and technological advancement. Through her engagement with a broad range of bodily techniques of learning and practice, she shows how surgical training is rooted in more than the realm of the conceptual and visual, which it is frequently relegated to. Her detailed and attentive phenomenological analysis of how bodies—surgeons and patients alike—interact in dynamic and unexpected ways through the realms of touch and sound alongside vision enrich our understanding of how surgery works.

Trauma surgeons have a particular and varied physicality with patients in their practice. Beyond the act of surgery itself, several attendings noted that learning how to restrain patients is an important teaching point for a medical student's rotation in

trauma. On a purely logistical level, it would be impossible to be a surgeon without direct physical contact with the patient's body, in the operating room as well as before and after surgery. And of course, the kind of physicality that surgery requires cultivates a kind of intimacy and authority to access the patient's body in remarkably invasive ways, which translates to very different expectations for physical contact with the patient generally. The body of the patient exists not only as a physical instantiation of their personhood but also as a manipulable object that requires physical intervention for healing and care. Even within surgical specialties, trauma surgeons tend to encounter bodies at their limits of injury and disfigurement, which at times necessitates a higher level of physical exertion on their part. "People don't always realize I think how physical this job is," Dr. Lendon remarked.

During an elaborate, interdisciplinary, 8-hour surgery on a woman who had been in a car accident, Dr. Lendon briefly held together the woman's chest, which had been cracked open as part of her surgery, in order to ensure that the repair being performed on her arm was done in an anatomically appropriate way and was not distorted by the temporary change in her body's form. A few moments later, the vascular surgeon working on her arm attempted to do the same but lacked the strength (or possibly experience) to do so effectively. Commenting on Dr. Lendon's strength, the vascular surgeon asked for his help, which Dr. Lendon obliged with a laugh. Discussing another patient who he had worked on at length, Dr. Lendon articulated the imbrication of physical and emotional entanglement in patient care. "I think the harder you work to try and save somebody's life, the more you feel invested, I think, in them." He also described how devastating it could be when things went wrong, saying "That feeling of not only intellectually but physically doing everything possible to try and save her life,

whether that's physically doing CPR or physically trying to hold the pelvis together or stop the bleeding…It's really, really difficult."

"Trauma shape": deprivation and exhaustion

The physicality of surgery is amplified by the broader conditions it is practiced. The trauma service is somewhat notorious for its grueling hours and demanding schedule. On the trauma service, having four teams means that each team is on call once every four days. Call days are by far the most exhausting and busy because that is the day in which you are operating and admitting new patients. The day begins with rounds at 6am (unless you are the intern or medical student, who need to come in earlier and prepare for rounds), and these rounds are led by the junior resident while the senior meets the team at pass-ons. The rest of the day is spent operating, either on patients who have been admitted the day prior with urgent surgical issues like appendicitis or gallbladder issues, or on the trauma patients who arrive during the shift. The day ends 28 hours later after the next morning's pass-ons. Much of that time, particularly for the chief and junior resident who operate throughout the day and night, is spent on your feet. The junior resident in particular will often spend a significant chunk of time speed walking the halls between cases to see and assess the consults that are called by the emergency department or other services. As a medical student, our team had a junior resident fill in for ours one day when he was out sick. Having been on her research year, she was not in the habit of performing clinical duties, particularly over such a long stretch. I recall her stopping midway through the day and commenting that she was not "in trauma shape." I related to that sentiment immediately, remembering how my first

call my body was completely unprepared for the experience, and by 3am my back was sore and tight, and my feet swollen and aching. After that first day, simply through repeated exposure (with the help of a few exercises recommended by a physical therapist) my body acclimated, physically getting "in shape" for the long periods of standing.

Along with little sleep and long stretches of standing, the relentless flow of work and new patients often interferes with regular mealtimes. One call day began with a scheduled elective case, which is a bit unusual for this service, and which should have taken only a few hours but was complicated by the patient's anatomy and adhesions from prior surgeries. The chief and junior resident went directly from pass-ons to the surgery, which began at 7:30am, without a pause to eat. The junior resident scrubbed out for a little while to see some of the consults that had been rolling in during the surgery, and immediately after leaving the operating room was speed walking through the halls of the emergency department trying to see everyone as quickly as possible. When he returned, the chief resident immediately asked him to scrub back in because they needed the hands. Finally, around 3pm they made it back to the resident room, where I was sitting with the intern who was working on setting up discharge for one of our patients. When they arrived, I pointed out a cupcake and lemon bar we had picked up for them. The chief thanked us before collapsing in a chair. She then pointed to a bottle of water and asked, "Is this also something I can have?" As soon as I confirmed it was also for her, she picked it up and gulped it down, the thin plastic crumpling under her hands in seconds until all that remained was an empty, shriveled bottle. "I feel like I've never had water before in my life," she said wearily. By 8pm that night, the small lemon bar was still the only thing she had eaten all day. "I used to never eat on these

calls," she said when I asked her to clarify how she was still standing.

More often than not I would eat with the team, even on call days, by hanging out with the interns who were always busy but rarely busy enough to not be able to take a quick break. But I also would regularly skip lunch or dinner if something particularly interesting was happening or if there were multiple traumas coming in back-to-back. And the embodied experience of working without pause for food can be surprising—often the attention that is required of my mind and body to the task and person in front of me eliminates the sensation of hunger entirely, and I will look up and realize 6 hours have passed since I last checked, and it is now 3pm. These are the moments when physiologic need is completely blotted out by physical and intellectual work.

The emotional relationship to physical sensation is likewise conditioned by the necessity and priority of the work in front of you as well as the complete inaccessibility of anything that might ameliorate your discomfort. A primary example of this is the physical constraint of sterility—once you have scrubbed into a surgery, you are coated in a layer of blue fabric that has the unique property of only being able to come in contact (safely) with the patient's body or other sterile objects. In my own experience, my sensation of hunger was fairly intense during my first ever surgeries, but that quickly changed with time and experience. In one surgery, I remember feeling overwhelmed by the gnawing pain of hunger for a brief time while scrubbed in, but of course there is no possible way to address that pain while you are in an operation cocooned in blue fabric and magnetized to the patient's body lest you break sterility. Eventually, almost as if my body realized the futility of this messaging system as a way to meet my physiologic needs, my hunger evaporated. When I brought that experience up with the fellow, she laughed and acknowledged that happened to her often as well. Whether my body has

since reshaped its messaging or my complete resignation to the sensation of hunger has reshaped my experience of it, I no longer feel the pain of hunger in the same way while operating.

This relationship to hunger has likewise been developed in relationship to how others talk about and act on their own need for food. One attending surgeon from my first ever surgical rotation, discussing the topic of food with one of the residents, mentioned that if she just completely abstains from eating in the morning, she does not feel hungry until lunch. While in another context that kind of talk might be interpreted as evidence of a fad diet or eating disorder, in this context it was a helpful tool and remarkably useful tactic for better training our bodies for the physical practice of surgical work (although I did also lose several pounds unintentionally over my 3 months of surgical rotations). In many of the trauma calls I observed, the residents would bring up how hungry they were or say to the rest of the team, "Ok let's figure out dinner," and then promptly begin talking about a patient or start walking to complete a task in another area of the hospital.

The attendings will often make gestures at care and concern for the residents' physical wellbeing, but in practice it feels a bit hollow. One evening the attending asked whether the team had eaten, and after hearing that dinner had just arrived in the work room sent us to go eat and have a break in a rare moment of calm, only to call the chief resident a mere 5 minutes later who then answered the phone mid-bite, and after hanging up immediately stood up, shoveling salad into her mouth as quickly as possible while walking out the door to attend to another patient.

As a third-year medical student on the liver transplant service at another hospital, I had just gotten out of a 12-hour surgery and was sitting in the doctors' lounge

eating a Clif Bar and carefully calibrating how much water to drink to maintain my blood pressure without having to pee during the next 12-hour surgery, which was starting within the hour. While I was eating, the fellow came into the lounge to let me know that the attending wanted to make sure I got a chance to eat. I gave him a thumbs up with a mouth full of Clif bar, and wondered how I was supposed to interpret that—a rare gesture of care and concern from someone who barely acknowledged my existence, but one that felt a bit flimsy as I entered my 85th hour of work that week operating as a glorified and living piece of retracting equipment. The lesson I learned as a medical student was that I could prioritize my physical needs and maintain my health, or I could prioritize the work in front of me and secure social approval and belonging, but I could not have both.

Another evening at Rosewood I tried in vain to convince one of the residents to eat something quickly before going into the next surgery, which was non-emergent. Even though the food we had ordered had arrived and was sitting in front of him in the work room, he said he did not have time. While of course he could have taken 30 seconds to quickly wolf something down, the assessment of not having time was rooted more in the shift of attention and focus that sitting down to eat would require. Stopping to eat does more than add time, which again in this case would have been negligible, it also ends your immersion in the work and turns your focus to your own body in a way that can threaten your momentum and allow the physical manifestations of tiredness and hunger to creep back into your perception.

Later, we had a disagreement over the importance of prioritizing your own physical health in order to be capable of helping others. He argued that he would, of course, put on his hypothetical child's oxygen mask on before his own in the proverbial

airplane mask scenario, only relenting when I described how quickly a person becomes incapacitated from hypoxia at that altitude. This resistance to prioritizing his own bodily needs had been cultivated throughout his residency training, resulting in an internalized understanding of physical suffering as a foundation of excellence in surgery. Since I had been a third-year medical student when he was an intern, we shared the same chief residents during that year, and we reminisced about one of our favorites, an excellent resident who often nodded off while scrolling through CTs in the radiology reading room. “I almost romanticized it,” he said, “Not the part of them working so hardly, necessarily. But the fact that they were so good, and I guess this is what it took.”

The next morning, I returned to find the team panicking to get the list done before pass-ons. Because their night had been so busy, even after pass-ons they had notes to catch up on before they could go home and sleep. I was sitting between the intern and the junior and the chief was behind us at the computer on the other side of the room, and I watched as all three of them intermittently nodded off while trying to work. The chief was the first to fully fall asleep, and we looked over and saw him with his head on his arms in front of the computer. Later he woke up and told us that he had fallen asleep with an energy bar in his mouth and woke up confused and spitting it out. At one point the junior asks, “Is this what strength feels like? Everyone always says this is how you get strong and tough.” The chief responds, “It feels more like it’s killing me. You know, like, dying.” We all laugh. The junior falls asleep next; I watch as he writes one sentence in a note, goes to the imaging to copy the report and put it in the note, and then immediately nods off before he can do anything else. He does this a few times, putting in a few words and nodding off before giving up and completely falling asleep sitting up. The intern looks over and sees him asleep and decides this is a good time for

a nap, too. I think about offering to help them but then think better of it and say nothing. Eventually the chief wakes up and calls the junior's name. I gently put my hand on his back to wake him up and he wakes up slurping the drool that was snaking its way down his face. "No sleeping," the chief says, "We need to work." The intern was there until almost 11am, and the junior and chief were there until 2pm.

"This hospital is full of sabotage": material conditions, hierarchy and emotional regulation

Another day on call: Towards the end of the night, I'm sitting in the work room with the intern and there is another intern on "clean up" for the team who was on call the night before. It's late afternoon, around 5pm, so the only reason he is still there is because he hasn't finished up his work yet. He's loudly and angrily complaining about the amount of shit he has to do, says he's just been fielding pages all day and hasn't written a single note but thank God his PA student wrote some for him. Calls someone to ask for their help identifying and contacting the medicine team for one of his patients who needs multiple X-ray images ordered at specific times to monitor her status, is pretty irate on the phone and just irritable even though the person he's talking to has nothing to do with this patient. He's not directly mean to her but is just complaining and frazzled and it's unpleasant even to overhear. During the conversation he gets another page and says "Oh my *God*" loudly, then has to clarify he's not responding to the person on the phone, who has just told him the name of the patient's medicine attending. He hangs up and starts swearing loudly about the whole situation, says fuck like 5 times in two sentences. Says his patient is being "such a fucking bitch" asking for things that will hurt her. Imitating her, he whines mockingly, "I need ice chips, I need food," even

though she has a small bowel obstruction, meaning she cannot eat or drink. “So fucking stupid,” he says. There is anger and disgust all over his voice, flooding the conversation. Neither my intern nor I is really responding to him at all (we are the only other people in the room), although we do exchange a look with each other at some point during the tirade. He’s not a surgical intern, but an off-service intern on a trauma rotation.

When the team is on call overnight, the following day the intern who was not on call is left to pick up the pieces of whatever needs to get ordered, followed up on, and communicated to other consulted teams alone. This day is referred to as “clean up” and is typically regarded as the worst day of work for the intern, depending on the number of patients who were admitted the previous day. Having a nurse practitioner there to help can mean the difference between a 12 and a 16-hour day, but unfortunately they do not work on weekends and are sometimes not available to help. The stress of this day combined with the isolation of being the only person from the team who is awake and available to answer questions can be grueling, and it was clear that this intern was not able to maintain his emotional composure after 12 hours of solo work.

This intern’s emotional outburst was not the most extreme display of emotion I have seen in a medical context, but it did stand out in the way that the anger was directed, if obliquely, towards the patient as much as the other staff. He is resentful of the intrusion on his clinical authority that the patient’s requests indicate and expresses that resentment in the form of derision towards her lack of understanding of her illness and bodily operations. It is frankly exhausting to listen to, and I feel grateful that I do not have to work with him consistently.

His frustration and anger were in part rooted in the under-resourced and understaffed institutional operation of the hospital, which suffers greatly from a lack of

nurses and a complex county bureaucracy that often impedes rapid and clear communication between specialties. The additional work that these conditions create is often cited by residents as a source of "burnout," the specter of emotional exhaustion that haunts all residency programs and is the primary way that residents and attendings alike permit themselves to discuss the emotional toll of their work. "This hospital is full of sabotage," one intern said to me, while describing the ways that these conditions of understaffing affected them. Nurses would fail to draw labs or forget to send the blood to the lab for analysis. Orders that were placed would not be heeded for hours at a time, requiring multiple phone calls to follow up and communicate their importance. The constant and ubiquitous overwork and understaffing of the hospital leads to real friction and conflict within and across teams. These conflicts inevitably are refracted through the complex and fractured medical hierarchy, which can attach intense emotional content and sweeping judgements to small logistical issues. While the term hierarchy might suggest a linear top-down relationship and strict, unidirectional relationships of power, the contours of these relationships are of course constantly being contested and negotiated. Once, while working in the surgical intensive care unit as a medical student, a nurse from a specialized intervention team approached me to let me know they could not perform a procedure on a patient because the patient did not have the proper consent form in their chart. She said they would go to lunch and come back to do the procedure once we had gotten consent. I knew, however, that this particular consent form was part of our standard "ICU bundle" of forms that every patient has in their chart, so I was surprised to hear it was missing. I brought the nurse over to the patient's chart to double check, found the consent form quickly, and they went ahead with the procedure.

There are several ways to interpret this small encounter—while it very well could have been a simple miscommunication, easily cleared up, the possibility of "sabotage" is ever looming. Why, for example, had the nurse approached me, specifically to discuss this patient's care? Perhaps she saw the color of my scrubs and assumed I was a resident. Or maybe she saw the large font on my badge reading "medical student," and thought I might be her best bet to facilitate a long overdue lunch break for her overworked team. Unfortunately for her I had already learned the lesson, repeatedly, that simply accepting someone's explanation or experience would often lead to overdue tasks and disappointed senior residents. "Do it now, do it yourself, trust no one," were the three rules of surgery that one of my earliest supervising surgery fellows imprinted upon me as a medical student. While not every surgeon would agree with that message (I remember one resident who I recounted these rules to being alarmed and asking, "Where did that fellow go to residency?"), the phrase "trust no one" rears its head regularly, although just as often in relation to other physicians and specialties as the patients. The underlying framework of these "rules" might appear aggressive or hyperbolic, but a more generous interpretation of its message might emphasize the importance of thoroughness and decisive action rather than a paranoid individualism. In this case, the "trust no one" truism was directed not at the patient, but as a form of patient advocacy in a fractured and stressed system. These interactions also highlight the "do it now, do it yourself," part of training—I could easily have accepted the nurse's assertion that there was no consent, or checked the chart after they had already left, but doing so could have added hours of delay.

Nurses, although often stuck implementing physician orders, have their own set of rules that a physician cannot override, and often have their own ways of exerting

independence when frustrated or taken for granted. One intern complained about being awoken at 3am by a page requesting he write an order instructing that the patient was "ok to cut his toenails." This kind of paging practice is often seen as more of a hazing ritual than a real attempt at communication. While the interaction I described was friendly, calm, and without the stress of interpersonal conflict, often real friction emerges between residents, attendings and nursing staff in moments when nursing directives and physician orders or expectations for care collide.

"People here are trying to make things better," Dr. Walker explained, "it doesn't help to be angry at them, even though they do really annoying things." Characterizing calmness, or in his words "not being insane myself," as "the control I can bring to a situation," Dr. Walker described his colleagues' anger as "dramatic," although he acknowledged that he, too, could slip up at times. As an example, Dr. Walker described his frustration once when he repeatedly had to ask a nurse in the intensive care unit to attach a pressure bag to a patient's blood product in order to help it infuse more quickly, since the patient was bleeding and very sick. By the third time he had returned to see the task not done, he recounts saying to the nurse, "You might as well just put their fucking body in a dumpster!" The nurse was, unsurprisingly, not happy with this exchange, and later after having put the bag on himself Dr. Walker returned to apologize for his outburst. But when the nurse responded, "As long as you realize you were wrong," Dr. Walker was quick to hold his ground, saying, "No no no no. I wasn't wrong. You were fucking killing that person, but I'm sorry that I was a dick about it."

Surgical supervision and autonomy

The independence and "do it yourself" mentality that this hospital's training

programs foster is understood by residents to be central to their competence and skill. for some residents the primary reason they hoped to join the residency program at Rosewood, is that, in their view, the long hours and grueling work required of them makes them better surgeons and more equipped to operate and care for patients autonomously. Although I am sure this sentiment would be disputed by academic center residents and faculty, at Rosewood the general consensus is that their residents are more capable, harder working, and have had the opportunity to develop better surgical skills due to early and frequent exposure. “It’s scary,” Sophie confessed, “when the [academic center] residents come here.” In many ways this tension—between supervision and autonomy—is fundamentally rooted in the uneven distribution of resources between hospital systems and the communities they serve.

In light of recurrent studies about the brutality and dehumanizing experience of medical training, residency programs have shifted towards a more humanistic approach to resident training as a means of developing more stable, emotionally connected, and healthy residents. “Wellness” has become a priority, or at least a marketing catchphrase, albeit often limited to the occasional cookie or sometimes a processing group for the residents when they encounter a particularly bad trauma. But these efforts have been complicated by the fact that decreasing work hours does not always improve resident wellbeing and also has a potentially negative impact on resident skills. There is an implicit tradeoff between the residents' overall quality of life and the quality of surgical care they are able to provide (Matulewicz 2017). Body learning and discipline requires hours of training that cannot be bought elsewhere (Hirschl 2015).

The physical demands of surgical training—the necessity of hands-on practice to fuel learning and skill building—means that the surgeons operating in the highest need

areas have the opportunity to build the most skill. This embodied relationship to surgical skill has been argued by some to explain why "flexible" work hours (which is to say, increased work hours beyond the 80 hour limit) for surgical residents does not have the same impact on patient safety outcomes (Bilimoria et al. 2016). The 80 hour work week was initially established nationwide in 2003, a response to the death of a patient, Libby Zion, in 1984 from a medication interaction that was determined to be the result of resident fatigue and insufficient supervision (Halpern and Detsky 2014). Since then, research on fatigue, supervision, and patient safety has circled around the fundamental question of how much work is necessary to learn, and how much is too much to make good decisions. What level of supervision provides sufficient opportunity for residents to learn effective and independent clinical decision-making without compromising patient safety?

Declining surgical autonomy in residency is understood to be a shortcoming of many residency training programs (Doster et al. 2022), and recent research suggests that allowing residents to operate independently does *not* lead to worse patient outcomes (Tonelli et al. 2023). "I think part of becoming a surgeon is getting over the hump of feeling like you can do things," Dr. Walker reflected. "You have to have that self-knowledge that you can be the person to do that." In their view, the only way to develop that self-knowledge is through independent practice. "We won't let people do anything that we think is unsafe, or that they're not capable of doing," he clarifies. "We're not being negligent. We're always thinking about it. We're not just being like, 'Go do some crazy stuff because I don't want to do it, or we don't have anyone else.' We're always thinking about it."

At Rosewood, residents on their trauma surgery rotation perform routine

surgeries with only “indirect” supervision from the attendings. For cases that are done frequently enough that the residents have the necessary experience and skill to move through them independently, attendings will only be present in the room for key parts of the case to confirm that they are clipping the correct structure and that they are not at risk of injuring anything important in the patient's anatomy.

When asked about the practice of indirect supervision, Dr. Lilley weighed in:

> I think it's necessary. It gives me a little pause sometimes, mostly for choles because I get really nervous not seeing what they're doing. But I think it's very necessary for me not to be there, because when I'm there I'm giving them direction, like every step of the way. That doesn't help with their training. You know what I mean? But I think there are other things that like, I'll do indirect supervision because I have total confidence that the chief knows what they're doing…But that standard has changed.

She then recounted a story from her first year as an attending:

> I had a chief do an ex lap[10] and a splenectomy on a trauma patient all by herself. Because I was in the other room [operating on another patient]. And it made me nervous…I had an option of calling my backup in. And I was like, no, I'm not gonna call my backup because I know she can do this. And she did it. I would never do that now. Only four years later, there's not one chief that I would be like,

[10] Short for exploratory laparotomy, a common surgery that involves making a large incision in the patient’s abdomen to assess and treat their injuries.

okay, you can go ahead and start this bleeding spleen trauma ex lap by yourself.

Her thinking points to the constantly shifting standards for how the process of "graduated autonomy" is measured and afforded. Granting independence provides the opportunity for growth, self-reliance, skill, and confidence that is not replicable when residents have someone to rely on or "bail them out," as they often put it. This model of training produces surgical residents who can be trusted to operate independently and do so well, and the erosion of this autonomy is both the product of broader changes in medical education and a source of such change. But too much independence and too little supervision can be frankly dangerous. "That's how I was trained," Dr. Lilley adds, "The first small bowel anastomosis[11] I ever did, I'd seen it before, but I'd never done it before, and I did it unsupervised." Their own experiences of training, which are full of anecdotes such as this that as a medical student I find vaguely terrifying, shape what these attendings see as the boundaries of appropriate supervision. At times, particularly between the hours of 2 and 5am, the attendings at the county hospital will lament the increased responsibilities and demands on their time. Watching as the residents assess and treat a stable, non-surgical patient, they like to point out, with some nostalgia, that when they were a resident their attendings did not even bother to show up to traumas like these.

Dr. Walker was also vocal when discussing this issue. "In order to be good at surgery, you have to do it. And anything you think you can do, you can. Even when you feel scared, like 'Oh I can't do this,' you can. The only way to get better is to do." He

[11] A procedure by which two non-continuous segments of bowel are sewn together to create continuity.

described this attitude towards his own surgical practice, noting that as a resident there were some cases he did not have as much experience with because his program had fellows who would primarily do those surgeries without giving him much of a role. In order to develop those skills he made a point of doing those cases as much as possible as a fellow himself and as an attending here. This attitude towards the importance of practice and also towards trainees' essential capacity for surgery is manifest in the way he teaches. He also mentioned that, as a sign of trust and faith in the residents' skills, that he had allowed the interns to operate on his own father when he needed surgery. In fact, he was the second person to tell me that they had brought a family member to the hospital for surgery—one of the residents, whose father was sick a few years before, removed their father from another hospital because he needed surgery and brought him here, a move that he believes saved his father's life.

Although residents will openly acknowledge that at times, they are alone in situations they might feel underprepared for, but they argue that this autonomy ultimately builds self-confidence and self-reliance, and they note that there is always someone they can call if they need help. For some residents, this independence demands a higher level of responsibility to read and be knowledgeable about surgical care. During one complex operation, initially there were multiple attendings from different services present, but when I returned to the OR after several hours I found only the chief resident, Avi, alone at the table. "This is why I have no patience for people who don't read or pay attention or think certain cases are below them," he says, with an edge of irritation in his voice, as he explained that the vascular surgery attending was running two operating rooms at once and was moving back and forth between them as needed. The resident's sense of responsibility to learning was directly related to the experience of

training in which sometimes you are alone, or you are the first person to arrive, so you cannot rely on other people to tell you what to do. “Inevitably you’re going to end up in these situations,” he says, “and you need to be able to know what you’re doing.”

Later when we sit down to talk, he reflects on how his autonomy has impacted his sense of responsibility and investment in patients’ care, and contrasts his training with those at nearby academic centers:

> The other day, with [our patient], we're like talking to six different services to try and coordinate her care and … I felt very comfortable dealing with that, just because I read, like I learn and I try and push myself. But I think if there was an attending, overseeing all of that, they would probably have said, do this, do this, do this, do this. And you don't think for yourself as much. You don't push yourself to read up on those things. I'm like…should I be worried about that? Should I not be worried about that? What's the usual treatment? Is a recommendation being given by our consultants reasonable or is it crazy? So I think the program like this really pushes you.
>
> I went to other hospital systems where you're just like a glorified intern, even as a chief resident, you're just going in checking on the patient and bringing information to an attending who's making decisions. And they're the real doctor. And also, the patients may like talk about, you know, Dr. Google and why they should have this medication. And here it's not like that, your patients are actually very thankful for you, and they look to you as their doctor. So those are probably the two more surprising things coming here. I think it has pushed me to be

> better, because you can't be in that position and not be at your absolute best. And I wonder if I was in a different residency if I wouldn't have been as compelled to push myself to be as good as I could be?...I think there's definitely a strong culture of you need to be really good here on your own without help. Not that there isn't help available if you need it. Well, there's a strong culture of, you know, you're the doctor here. So what do you want to do? And you need to be able to back it up and make sense with it.

A critical reading of this resident's thinking would emphasize how his sense of purpose, identity, and professional authority is in some way predicated on an unequal relationship of knowledge, power and status between provider and patient. Thus, the patients who are poor, have lower health literacy and are seen as more likely to accept a surgeon's recommendation without demanding a second opinion or questioning their judgement are also more "grateful." Those who have less are positioned as both having more gratitude and posing less of a threat to professional autonomy, which reproduces an idealized form of the doctor-patient relationship predicated on expertise, respect, and deference. Much of this insecurity in the face of patient knowledge and empowerment I think arises when patients' questions force clinicians to confront the fragile boundaries of "scientific knowledge" and the largely cultural and institutional practices that structure clinical decision-making. Having to answer the question of "Why are you doing it this way?" With something along the lines of, "because that is how my attending did it," or "that is how I have always done it," or even "we don't have any evidence one way or the other," disrupts their understanding of themselves and their expertise as not an unimpeachable smooth edifice of expertise but rather a bricolage of

personal experience, cultural mores, and often insurance constraints.

In this resident's view, the autonomy he is granted within the county hospital has not only given him necessary experience but has also greatly shaped his role and identity within the medical system. Here, he is a "real doctor," because he is in the position to make clinical decisions alone, and because the attending faculty maintain a level of trust and independence. But even beyond the clinical hierarchy and culture of decision-making, he cites the relationship between himself and the patients as one that is both gratifying and empowering, yet also burdened with responsibility. All of these relationships are in some way structured or shaped by the fundamental constraints on resources and staffing that the county hospital experiences at all levels of care. Even more broadly, these relationships are structured by the relative poverty and dispossession of the patients who are generally cared for at this public safety net hospital, and the insufficient and uneven distribution of county resources that maintains these gaps.

Many of the residents who work in this hospital were motivated to do so by a commitment to serving the patients who populate it. But the work itself and the conditions it is given under forces them to confront the tensions between their desire to provide excellent care to patients who need it the most, and the reality that their skills are produced by the very same structures of oppression. "I think we do provide still really good care here," Avi emphasizes. "But I don't know, I don't know what the answer is. I don't know what the outcomes are here compared to somewhere else where the attendings are present all the time."

"It just doesn't feel right": working in a two-tiered system

Los Angeles is home to three county hospitals—two of which are trauma centers. At various points in their respective histories, each county hospital became affiliated with an academic medical center that supplied medical students and residents to staff the hospitals in exchange for the educational opportunities such work provided (Cousineau and Tranquada 2007). This relationship serves both the county hospital and the academic center—the county hospital gains legitimacy through its association with a big-name research center that performs high level, quaternary care and also gets staffing support through rotating medical students and residents. As a county hospital, Rosewood Medical Center, although less academically prestigious, has a much higher volume of trauma patients, and academic center residents are sent specifically to cover the trauma service both as a matter of staffing but also as a matter of resident education.

The academic center, meanwhile, benefits from the educational value that a county hospital provides. In fact, this relationship is often an explicitly advertised educational asset to academic centers because of the diversity of "pathology" and presentation that the county center provides. Unlike at an academic center, where patients are, by design, largely white, wealthy, and privately insured, the county patients are more often poor, black and brown, and have gone for long periods of time without adequate medical care due to the overall underinvestment in primary care in the United States (Cousineau and Tranquada 2007). And, of course, due to the exclusionary care practices of highly resourced centers that refuse to treat them. From the perspective of resident education, the county hospital enables exposure to diseases of poverty and stress that are uncommon in the patients the academic center residents typically see, and at advanced stages that should and could have been caught early and treated.

This system is not unique to Los Angeles and is a common feature of many

residency training programs. Recently, NYU's hospital has received scrutiny for its practice of prioritizing VIP patients as well as diverting or "dumping" uninsured patients to Bellevue, the affiliated public safety net hospital down the block (Kliff and Silver-Greenberg 2022). Sophie, a fourth-year resident, cited her experience with this system as a reason she appreciated and enjoyed working at Rosewood:

> In New York, there's a lot of this where there'll be two buildings next to each other, and one of them has really nice amenities and all the private patients go their patients with good insurance. And then literally across the street, sometimes even connected, there is a building where it's for uninsured or underinsured, Medicaid patients who got resident care, under supervised with worse amenities and support. And I always found that pretty fucked up. And one of the things that I do appreciate about Rosewood is that it's just not a thing here. We provide the level of care that we provide, but we provide it to everybody. And it's not like, there's not a two-tiered system here.

This kind of two-tiered relationship between academic medical centers and their public or county run affiliates produces an interesting set of tensions for the residents to grapple with as they move through training. In surgery in particular, there is a particular relationship to action, to doing, to using one's hands and being in the thick of whatever surgical care is being administered. At the academic center, the general reputation (which was largely borne out by what I experienced, although not entirely), is that residents are not as empowered to care for patients themselves or operate with as much autonomy as the county facility. While at the academic center you might walk into an

operating room to see two attending surgeons operating with a chief resident holding the camera.

This difference is well known and plays out in a variety of ways between the two sites. Academic surgery residents enjoy the perks of working at an academic center which involves better staffing, a more plentiful cafeteria, better work hours, more reliable ancillary staff, a high-tech simulation center, the list goes on. The resources available to both residents and patients lead some county residents refer to the academic center training program as "the easy way out."

One academic center surgery attending, referring to the system of indirect supervision at Rosewood for routine cases, described the practice as "abhorrent for people of color who have no other place to go." Although she agreed with the concept of graduated autonomy, she resented the language that academic center residents used to refer to county facilities, for example calling one "surgery camp," and cautioned that "we have to be really careful about what we're doing, where we're letting people practice and the implications of that." Calling this discrepancy "a holdover from total racism," she noted that the trend in resident education has moved more towards supervision but argued that "if we're still saying the county hospital is the place to practice, relative to the university hospital, we still have a fundamental problem." This attending locates the relative autonomy of county residents as the source of racism and implicitly indicts the attendings who permit indirect supervision as a practice.

Dr. Walker reflected on his perception of this phenomenon from his perspective:

> I think there is this thought here that …or maybe this pressure that people come [to the county hospital] to learn how to operate. And it kind of takes over their

> perception of our patients and they want to do things. The biggest example is everyone wants to do an ED thoracotomy. And they lose all sight of what happened to the person and that there is a person in front of them they just want to open the chest and do it. I think that's probably the most contentious procedure that I think people talk about in terms of human dignity versus training.

He continued:

> But I think a lot of the stuff that happens in trauma bay—so, intubating dead patients, doing lines on dead patients, like patients who are clearly dead and that we're going to call, people still continuing to finish their chest tube or finish their line because you know, they want to get it, they want to train—I think that's not negligence anymore, because the patients died, but it's more like, just evil, I guess? I don't know, I've seen a dead patient, after we've called it, the team go behind the head of the bed and have two or three people intubate the patient and it's like, that's not what this is for, you know?

At times, and in certain conditions, surgical and medical training can come at the *expense* of the patient being treated. Medical schools and training programs in the United States have historically exploited the structural vulnerability of certain groups—particularly poor and itinerant white men and enslaved black people—as "clinical material" that was required for purposes of training and education (Savitt 1982, 333). While the practices of experimentation and training without anesthesia that were

concentrated among black patients prior to the Civil War have since been eliminated (at least in theory, see Bourgois and Schonberg (2009) for disturbing contemporary examples), unequal medical treatment divided along lines of race continued in public hospital training programs into the 1960s (Ehrenreich and Ehrenreich 1971; Fernández 2020). Describing the public hospital system in New York, Fernandez (2020) shows how, "lacking a sense of entitlement, poor people of color came to be treated not as consumers of medical services but as exploitable commodities and a captive demographic" due to their need for medical care and inability to afford it elsewhere (139). This dynamic continues today in the form of resident clinics, which serve publicly insured patients as a part of training, and attending clinics, which serve privately insured patients. Segregating clinics in this way is portrayed as valuable to clinical training because of the degree of "advanced pathology" such patient populations carry (Vinekar 2021; McClurg et al. 2022). Affiliations between medical training programs and sites of concentrated poverty and racism like public hospitals and prisons are used as a recruiting tool and publicly advertised by these programs as endlessly renewable resources of education and practice (Theis 2007).

The residents and attendings at the county hospital do not share this view of their hospital as a site of practice. Their objections are two-fold—on the one hand, they largely argue that the level of supervision they provide is adequate and that the independence granted to residents is earned, deserved, and necessary for competent training. On the other hand, county hospital residents resent the attitudes of some academic center residents who come to their hospital intent on operating and without a broader investment in the community they are caring for. Sophie described her experience seeing some academic center residents "come here on trauma, and not give a

single shit about our patients really, and just come here to operate. And then they don't care about anything after that. And it feels, you know, part of it you can attribute in your mind to like, oh, well, they're not familiar with the system here. Or, you know, they're not used to it or whatever. But there's always a part of me, that is just like, doesn't feel right." While much has been written about the practice of objectification in medicine and broader work of positioning biomedicine as "a social authority which legitimates itself by presenting itself as pure technical reason" (Bourdieu 1999, 32), these county residents insist that what happens "after that" is equally important and reflective of overall investment in the patient.

Avi had similar experiences as an intern on specialty services, such as plastic surgery, which are staffed by residents from the academic center:

> As an intern on the plastics service, they would come out of the OR, patients, with like, never having been talked to about what happened in the case. They'd be like sitting in the PACU (post anesthesia care unit), and we'd be getting paged like Okay patient wants to know what happened during surgery can you come talk to them. I'm like an intern, like I have no idea what happened [interns rarely operate, so he was not in the surgery]. Why didn't the surgeon talk to them? You sure as hell know that at [the academic center] they're calling all the families immediately. So to me it was like these [academic center] people coming down here and just taking advantage of this population, which was really infuriating.

For these county residents, the attitude of "practice" was a pattern they saw in some (but not all, they were quick to point out) academic center residents who did not

engage with patients as people deserving the same level of attentiveness and care as their patients at the academic center, but rather as opportunities to improve their technical surgical skills.

Yet this attitude towards the patients of county hospitals as not deserving of the best possible care is not one that I experienced from the residents and attendings of the county hospital itself. “I always impress upon at least the junior residents,” Avi explained, “When you're in the ICU, and you're the only person here, I mean, you better have read, right? Because you're the person that's taking care of them. And just because they're not going to sue you because a bad complication happens, because they're so grateful for any help that you're giving them, doesn't mean that you can get away with being mediocre. There's no room for mediocrity here, just because you're not gonna get in trouble for it legally.”

The experiences and perspectives of these residents illuminates the effects that the uneven landscape of violence, health, and health care in Los Angeles has on the practice of surgery. Through their training, surgical residents develop an understanding of their experiences of embodied suffering under conditions of minimal resources that is both pragmatic and romantic. They come to construct the meaning of that suffering as necessary, as “what it takes.” Grueling work is understood to be the only route to developing surgical skill. But it is also seen as aspirational, and a marker of professional accomplishment and belonging that they witnessed their own chief residents embodying. Their relationship to the suffering of their patients, however, is undoubtedly more fraught. To return to Avi’s insightful framing, the resident autonomy and independence produced by limited resources makes this hospital’s surgery residency “an excellent training program.” But, he asks, “is this acceptable care for people?” The

broader question might be, are the conditions that produce the violence and illness that have made Avi into an exceptional surgeon acceptable? What does it mean to be a "good" surgeon operating in these conditions? The residents lean on an ethic of investment, of caring about the humanity of the patient beyond their educational value as a training ground to help navigate these questions, but their discomfort with the system persists.

Chapter 2

"You Think You Can Trust Someone": Surgery, Violence, and Authority Over the Body

Becoming a trauma patient

I am on call with the trauma team when we get paged for a woman who has been stabbed in the face. She is black, wearing black tights and a tight leopard print shirt with a stripe of mesh down the center. She has a slash extending diagonally across her face from her right eyelid through her right nostril and into her upper lip. She is sobbing. We all awkwardly have to wait outside the room for what feels like ages while housekeeping finishes cleaning the room before we can bring her inside. We begin taking her clothes off; she is very distraught and does not want us to do this. She feels exposed and the emergency medicine attending points to everyone to explain who they are and says that we all need to be here to take care of her. She keeps insisting that she knows her back is fine because she had her back up against the wall, and that she knows there is nothing on her legs. The emergency medicine resident explains that we have to check just to be sure. She does not want us to take her socks off. I get her a blanket to cover up and help her take her tights off, and she allows us to cut off her spandex, saying she doesn't care about them. She is crying and sobs repeatedly, "I don't deserve this."

I hang out as she tells me what happened. Her name is Cynthia, and she says she was hanging out with her friends at their house, and she bought a bunch of food to make brunch and mimosas and cooked for everyone. They were all drinking and hanging out

when friends of her friends came over and started getting a bit belligerent. At some point, a misunderstanding escalates rapidly into a conflict and several of the women start jumping her and hitting her, so she puts her back up against the wall like her mother taught her, puts her head down and starts swinging. She says one of the women went away, returned quickly, and made a downward stabbing motion towards Cynthia's face, and blood started pouring everywhere "like a waterfall." She could not see what was in her hand, it might have been a knife, or maybe a razor because it was clearly very sharp, the wound is clean and deep. At the sight of her bloody face everyone disperses and leaves. The police and ambulance come, and she tells them that she doesn't know who did it and that it happened down the street from where it actually happened, not wanting to get the police involved or implicate her friends. As we are talking, she gets increasingly upset, repeating, "I didn't deserve this" and talking about how she only speaks when spoken to and does not start trouble and is not gang affiliated. She says she does not understand why they would do this after she cooked breakfast for all of them. She cannot believe this keeps happening to her, and recounts how she was recently in what she calls a "domestic altercation" with her boyfriend on the drive here from the South. He threw a phone at her face and hit her in the eye, and she explains that it's still bruised. She is sobbing and bloody snot is running from her nose through the trough of the wound in her lip and about to drip into her mouth, so I wipe it up with some gauze. As she is talking, she says, "I'm going to tell [the police] the truth," because she is so upset at the injustice of it all. Although initially she tried to protect her assailants, she is now coming to terms with how fucked up it all is and decides to talk. At one point she says she wants them all in jail, but she is also afraid. "I need to leave L.A. *tonight*," she says. She is worried because the woman was gang affiliated.

Her phone is dead, and she wants to call people. The conversation is only making her more upset and the more she talks the more she starts sobbing until she is hiccupping and unable to speak. Eventually she starts to calm down a bit and lies down to closes her eyes, and I leave to find her a charger. When I come back, she is talking to police, so I just hang out and listen. The police are very deferent to me as I come in and out. The power of scrubs. As they are talking an anesthesia intern comes in who is on ENT (they are taking face call that day).[12] After the police finish the intern asks if I need to talk to her, I say no, he asks what team I'm on and I explain I'm on trauma but a med student and know nothing. He is here to prep her before the resident comes in to sew her up. He is very gentle and kind, I hold Cynthia's hand because she says, "I don't think I can do it." I tell her the worst part has already happened. She says she wants to go home, and I instinctively make a surprised face and say, "But don't you want to get sewn up?" She asks if her wound is bad and, trying not to freak her out any more than she already is, I gently explain that she should stay and be treated. She doesn't leave.

The intern is very gentle and patient as he injects the lidocaine. He injects slowly and carefully and warns her every time before he puts the needle in, letting her take a break after a while when it gets to be too much. She is crying a lot and squeezing my hand. She says it feels super weird, he explains she might taste metal. After numbing he starts irrigating. There is a funny moment where her false eyelashes get stuck in her wound and I ask him if it would be easier if she took them off, she says she was about to ask the same thing and he stammers, clearly wanting to but having no idea how that

[12] There are typically three teams who alternate taking "face call," which means they see anyone with a complex facial injury for that call shift. The three teams are ENT (ear nose and throat/otorhinolaryngology), plastic surgery, and oral maxillofacial surgery.

works and asks how to do that. I put my gloved hand out and she peels the eyelashes off and hands them to me. I throw them both out, after clarifying that the right one is busted (there is a chunk missing from the blade, which thankfully completely spared her eye) but the left is fine if she wants to keep it. She says hell no.

The intern starts irrigating her face and when he gets to her nose, she ends up swallowing a bunch of water through her nose, which freaks her out and I imagine is pretty uncomfortable and gross. I suggest we sit her up, which helps. Eventually the ENT resident joins us and as soon as she arrives, I slip more into my med student role, not intentionally but because I am there, and she feels much more entitled to my labor because of her seniority and I am happy to help. She asks if I want to help sew and I have to decline, but they then start setting up a sterile field and I become the de facto assistant, opening gauze and tools for them and grabbing suture from a Ziplock bag she keeps in her backpack.

When she starts injecting more lidocaine into the patient's face the difference is striking. She basically jams it in quickly while saying, "Poke and a burn, poke and a burn," not stopping even as Cynthia scrunches up her face and turns away in pain. The resident apologizes but not in a particularly empathetic way and the intern laughs when the patient, very earnest and upset, says she does not want the resident injecting her anymore. I think about how the resident's callous response to pain indexes a kind of competency in medicine and surgery in particular. Being overly ginger and slow is seen as not merely inefficient, but also raises suspicion that empathizing too much with the patient's pain might interfere with your ability to inflict the pain necessary to do the job well. Doing things somewhat quickly and regardless of the patient's response demonstrates a sureness and confidence in your actions that being gentle and slow does

not.

As she starts to sew Cynthia up the resident talks me through some of the musculature that is visible and explains her approach to me, describing the layers that she will sew and telling us it will likely take 3 hours (it ends up taking more like 5 or 6). As she starts to sew the patient is still very upset and uncomfortable, and the resident has me ask the nurse about pain meds. I end up having to go back and talk to them a few times before they actually get the ED resident on the phone who orders some morphine. While she waits for this to happen, she goes upstairs to deal with another patient who is bleeding.

When I go back to check on the patient the ophthalmology resident is there, and she asks if I'm ENT and says she doesn't see any eye involvement and that they can just close it like they would close the face, although she's happy to close the eyelid if ENT wants. I explain that the ENT resident was concerned about the inferior margin of the wound, and she is confused, asks if I'm sure, and says it seems fine to her. I try to find the ENT resident's number so she can call her but have no luck. Thankfully the resident walks in right at that moment and they can talk directly. Communication is in some ways the weakest link in medicine, you have a network of people who know the least about medical decision-making playing a game of telephone with people who know more but are much harder to reach. I have often seen a conversation between two clinicians get repeated to a third person after one of the clinicians leaves, and the instructions and interpretations are completely different!

When the ENT resident returns, she is frustrated to find that the patient is still anxious and not sedated enough to sew up. I leave again to find the nurse and see the ED resident leaving another patient in one of the other trauma bays and explain to him

what's going on. He still seems hesitant to give her more meds and I physically shepherd him into the room so the ENT resident can just talk to him herself. She is frustrated and explains she's been trying to do this for an hour and hasn't been able to and he apologizes and says he will order something else.

While we wait for the patient's pain medication, I start hanging out more with the trauma team. I ask the chief if she is happy in this residency and she says, "Yeah!" brightly, before clarifying, "Well, no one is *happy*." They order dinner and are finishing up loose ends and planning to put a chest tube in one of the patients on their list. The chief is getting antsy (in a good-natured way) because there is not that much time between now and when the dinner arrives. "Ugh," she groans, "by the time we finish the chest tube the food will already be here and it will be cold and then there are going to be traumas and I won't be able to eat for hours!" The intern promises to heat it up for her which placates her, and we set off for the floor.

We get to the patient's room and there is an awkward moment when we go up to his bed and the nurse says, "He's using the bedpan," but the team does not hear it and they start talking to him while he protests and holds up his hand with two fingers raised because he does not speak English. I repeat what the nurse had said, and we leave. There really is so little privacy and dignity in these rooms with four patients and people coming in and out unpredictably, at all hours, poking and prodding and you're in pain and have tubes coming out of you. As they call the translator and get ready, I decide to go down to the ED and check on Cynthia.

As I am walking through the emergency department to check on another patient, I hear the page overhead: "TTA level 1, 15 minutes." A minute later another one, "TTA level 2, 12 minutes." I can't help laughing to myself and later when the chief comes

down, I say, “You really did call it!” The intern gets to the trauma bay first and her pager starts going off, she says hers is super delayed. I never see the page but hear from someone that it’s a stabbing with evisceration. The patient arrives on a stretcher, pushed by paramedics, writhing and swearing from pain. As he wheels by, I catch sight of a small loop of intestine that has managed to push its way out of the wound in his abdominal wall, covered with a large gauze bandage. There is a sizable crowd forming, as there often is for traumas that are expected to be serious. I position myself in the doorway, which allows me to observe both the clinical response and the interactions between the social worker and two LAPD officers, who are talking in the hallway.

The trauma bay is a very porous space, with large sliding glass doors that are permanently open, the only privacy provided by a brown curtain that is quickly pulled closed when the patient, understandably, becomes distressed as he realizes his clothes are being cut from his body in front of a group of strangers. At first, he won’t let them take his shoes off, the junior resident stands at the end of the bed looking at him and finally he relents. But he really doesn’t want us to take his socks off, keeps saying “Come on, dog” so they agree not to. They do the primary review and don’t find anything else. He describes being stabbed to the surgery team, who quickly inform him that he needs surgery, and within two minutes of arriving we wheel him directly to the operating room, the social worker and police officers in tow behind us. I run ahead to get the elevator door.

We arrive at the operating room and the patient is quickly prepped and intubated, and I think to myself that I am glad he has no idea that he is completely naked and visible to a new group of people now. During the operation the junior asks if we ever found out why he would not let us take his socks off, the attending says “Yeah,

his toenails were painted. Metallic blue, it looked like it had been there for a while. I just took them off to check if there were any drugs in them but then we put them back on."

Often, questions of patient autonomy and consent in trauma surgery are systematically and implicitly waylaid in the service of lifesaving. Trauma surgeons are invested with the social and legal authority to claim total control over patients' bodies when deemed necessary. How can we understand the relationship between this form of surgical practice—invasive, characterized by total body control—as a process of care administered through overpowering force and controlled injury? What is the patient's embodied experience through this process? How do surgeons and patients navigate the limits of their bodily control in a context where patient autonomy and medical authority are often in conflict? This chapter probes the interfaces of hospital care, bodily autonomy and forms of surgical control and force within the space of the hospital. Drawing on experiences of patients who refuse medical authority and attempt to reclaim autonomy in a context of deep vulnerability, I explore the tangled relationship between the violation of surgery as itself an inevitable and constitutive element of care, and as a mechanism to shore up medical authority. Relatedly, I show how medical bureaucracy is strategically deployed by clinicians to provide care in the face of patient refusals, as well as weaponized to punish or control patients who resist medical control.

Bodily autonomy and the logic of emergency

Entry into the trauma bay begins a process of transformation of the wounded subject into the subject position of "trauma patient," a specific position characterized by rapid medical intervention and even more rapid loss of autonomy and control. Once the patient is rolled into the trauma bay room, they are moved to the hospital bed by the

paramedics and hospital staff, and the trauma assessment begins. This assessment is highly protocolized and is driven primarily by a need to quickly understand the patient's proximity to death and overall stability. Even gestures that may seem caring often have a secondary motive—the EM resident will typically ask the patient their name, if they are awake, and as soon as they respond the resident will call out— "Airway patent!" because if they can talk, that indicates that the patient is able to breathe. Depending on the severity of injury, the patients will be greeted by either a few people—an EM resident, a trauma intern at least, and a trauma nurse—or a large crowd. Severely injured and unstable patients are quickly and methodically evaluated (by physical assessment and imaging) and stabilized (with IV medications, fluids, and bedside procedures). One of the most critical elements of assessment of trauma patients is exposure, which, in other words, means examining the entire body of the patient. Some patients are unconscious, altered, or otherwise too sick to realize that this is happening, and will regain consciousness later in a hospital gown.

Observing this process, I have always suspected that the experience of entering the trauma bay badly injured, then stripped of clothing and autonomy and worked on simultaneously by a group of strangers you have no choice but to trust, would itself be experienced as invasive and violating. I was surprised, then, when I asked patients how they felt during that time, that many did in fact experience this process as one of care and investment. "When I first came in," one patient recounted, "it was a lot of people, and I realized it was all for me…That made me feel good because I didn't know where I was shot. I didn't know nothing, but really just coming in and seeing all those people felt like a good thing to me just in case maybe one doctor didn't see something that the other doctor did. So that made me feel good." Others, however, at times have found this

process overwhelming and invasive. Whenever possible, the staff in the trauma bay will remove patients' clothing with their cooperation and consent, taking care to cover them with a gown and blanket and keep the curtain to the trauma bay closed to maintain their privacy. But consent is a nebulous term in this space—patients can and do protest, but whether or not the staff respects that can be a complex negotiation of patient autonomy and medical control.

Cynthia, for example, was initially quite upset by the experience of having her clothes removed and protested, before ultimately allowing us to proceed and get her into a gown. The second patient likewise protests as the residents and nurses work to remove his clothing, particularly his shoes and socks. The concession to the patient's strong desire in this case was mediated by the fact that everyone knew, immediately and unequivocally when he came in, that the patient would be taken to surgery and would therefore soon be unconscious. Given the incredibly small likelihood that the patient had a life-threatening foot injury that would kill him on the way to the operating room, the attending knew that he would soon be able to examine his feet regardless and allowed the delay. The gesture of replacing the patient's own socks on his feet rather than giving him clean hospital issued socks granted a small measure of respect to the patient's desires without sacrificing any medical control. What must it have been like to awaken to see that your socks are still on, but your body has clearly been accessed in other, arguably much more intimate ways?

In the moment, I felt sympathetic to Cynthia's refusal to undress, and saw her experience of it as almost an insult added to an injury—first she is assaulted, then she is denied her own experience of it by the people who have been tasked with and trained to heal her but who do not trust her account of what happened enough to leave her clothes

on. I had that experience in mind when another patient came in, this time stabbed in the shoulder and arm. He was a young guy, and it was early in the morning around 9:30am and he was fully awake and sober and communicating calmly and clearly with everyone around him. The trauma junior resident asked him whether he had been stabbed below the belt, and the patient said no, just the shoulder, and they left his underwear on without examining him. Because this patient was so stable and calm, it was probably 20 minutes or so before he was taken to the CT scanner to get imaging of his shoulder to make sure his injuries were not severe enough to require surgery, by which point all the residents had left. As we were getting him ready to move over onto the CT table, he began complaining of some pain in his buttock. When we rolled him over, we saw that he had, in fact, been stabbed there as well. Fortunately, it was relatively shallow and had not caused major injury, but the fact that it had been missed for this long was a real error. As soon as we saw the injury, I hopped into the radiology reading room attached to the scanner and gave the trauma attending a heads up. He was, understandably, quite irritated and asked whether everyone from the team had been there (sometimes the chief and junior are operating and do not make it to the traumas, in which case the intern is the only one there and transcribes what happens but does not participate in the exam), shaking his head in disbelief when I confirmed that the trauma team had, in fact, been present when the patient came in. Later in the resident work room I mentioned this new finding to the junior resident and intern for them to update their notes, and the junior sighed and said, exasperated, “You think you can trust someone!”

I experienced these interactions as a medical student as much as an anthropologist, and noted how quickly I was identifying with and justifying the position of the residents as I resolved mentally to never trust the patient who tells you they know

what happened to them and you do not need to see it for yourself. ("Do it now, do it yourself, trust no one"). Though surgical practice is dependent on a level of group trust and teamwork, an important part of training is determining what information you can accept someone else's word for, and what requires independent verification, particularly when your interlocutor is at a lower level of training. "Convince yourself" has always been one of my favorite phrases that I often heard in surgery, where it was often used by attending surgeons to encourage trainees to take the time to confirm that they understood where and what they were operating on, rather than uncritically accepting the attending's word. While I most often heard this refrain in the operating room, where an attending might instruct the fellow or resident to convince themself that the structure they were looking at was, in fact, the appropriate one, usually by tracing its path and relationships to other anatomic structures, it was similarly applicable in broader clinical contexts where half-answers, deflections, and misunderstandings might have you chasing your tail for hours on end. This practice is important for building confidence and independence within a hierarchical structure of training.

Yet these moments of independent verification are often, and somewhat paradoxically, limited by the need for the senior resident or attending's permission to take the time to orient yourself or confirm the information they have provided you. One night, for example, when I was a medical student, I was helping the trauma team close a patient they had operated on. Whether because it was 4am or because I was not intending to ask the attending for a letter of recommendation for at least four more years, I allowed myself to relax a bit too much. When the chief resident asked me to cut one of the sutures, before I could stop myself, I found myself asking him if it had been tied yet, because I had not seen him do it. This question was interpreted as a challenge

to his authority, and he snapped back at me that yes, of course he had tied it. Although the kinds of responses people generate in these moments are inevitably shaped by personality as much as by seniority, this faux pas of mine provides insight into the ways that the independence cultivated in this training remain sharply constrained by hierarchy.

Embedded bullets, bodily authority

Because their work is directed primarily at urgent and emergent surgery, questions of consent and necessity take a different shape for trauma surgeons than surgeons or physicians whose scope of practice is centered on elective or minor procedures. In general, they do not offer surgery unless someone requires it to survive. This relationship to surgery created conflict with our chronic patient, Mr. Ford, who routinely brought up the bullet fragments left in his leg and asked for them to remove, citing his own bodily autonomy as a justification. "It's my body," he would argue, "I know my body. I should have the final say." This complaint would typically lead to a power struggle between the patient and the residents; once a resident responded, "Oh, so you know where the nerves are in your leg?" The patient's understanding of the role of his surgeon was one of service and obligation—he was asking for a procedure, and therefore the surgeon had a duty to provide it as someone with the skills and knowledge to do so. The resident, on the other hand, saw his own role as much more circumscribed and valued his own professional autonomy over what he understood to be the fundamental misunderstanding that the patient held about the bullets in his body. How is harm constructed and established? Whose perspective determines whether the extent of harm rises to the level of justifying or requiring intervention?

For this patient, who remained in the hospital for such an extended period, the topic was raised repeatedly. Even the supervising attending, Dr. Walker, once suggested that unlike the bullet fragments in his arm, which were deeply embedded and close to important structures, the bullet in his leg was quite superficial and accessible. But when he asked the chief resident Avi whether we should think about removing it, he responded that the patient was perseverating on both the leg *and* arm bullets, and he was concerned that if they removed one, he might then move his focus to the arm, and nothing would be solved. The attending deferred to Avi's judgement and experience with the patient, and they moved on to discuss the next patient. Withholding of surgery from Mr. Ford in this case was mediated by the patient's psychological processing of his injury and contentious relationship with the trauma team, rather than determined based on any immutable physical or medical category of necessity. While insurance concerns are often a significant hurdle for patient placement—and certainly were for Mr. Ford, who remained in the hospital much longer than necessary because they could not reach an agreement with his insurance on where he should be placed—it was never discussed in any of the treatment conversations and did not appear to be a primary concern or guiding factor while he was admitted. Though questions of insurance coverage are often organized around this distinction between elective and necessary, that organization is often a product of medical gatekeeping and not the foundation of it, at least in this case.

When I asked the resident about it later, he reiterated "I feel if taking this bullet out of his leg would make him feel much more at peace with his post-traumatic stress, I would do it. But I think he wants everything removed and so incurring the risk of doing that—bleeding, infection, damage to any of his nerves—without removing all of these, if he then fixates on all the bullets that are in his arm, we will have just incurred risk

without any benefit." Yet he was also understanding of and empathetic to what he imagined the emotional toll of a retained bullet might have:

> Part of it, I think, has to do with society, and the entertainment industry, this whole idea that removing the bullet saves your life. I think part of that has been ingrained in people since they were growing up that this will make me heal, this will make me better. In addition to the fact that nobody wants, like, it's almost like the trauma can never leave you. It's still inside your body. I think that's also part of it…And I think I personally would be more aggressive in removing them than other people. That may also be because I'm a resident, and I haven't had a complication from doing that. But I would also think like, if I was a patient, what would I want done? If I had like a bullet sticking out of my like meat, like my thigh here, and it was sticking out? Even if it doesn't cause me any pain or whatever moved? Right? It's a daily reminder. I'm trying to put my pants on and keeps getting snagged on this bullet. And then I'm like, oh, fuck, I remember I got shot. That's like, I mean, that must be awful. But it's like risk benefit.

Complaints about bullet fragments are common among patients who have been shot, and many patients struggle to accept that this foreign object and constant reminder of the violence they have suffered is now a part of their body. Surgical literature on the subject supports the resident's perspective that fragments embedded in soft tissue such as the muscle of a leg will generally become encased in an inert layer of scar tissue that forms a capsule around the bullet and isolates it from the rest of the

patient's body. Surgical removal is generally only advised in specific situations when the presence of the bullet presents more of a clinical risk to the patient than the process of retrieving it; for example, bullets or fragments embedded in joint spaces are typically removed because they impede the normal function of the joint and can present a source of systemic heavy metal toxicity, specifically lead, although that complication is reportedly very rare (Weiss et al. 2017; Coon et al. 2006; Linden et al. 1982). Other rare complications sometimes occur from the bullet moving in the patient's body, and even eroding into a new space of the body, such as was described in a case report of a man shot in the chest who years later coughed up the fragment that had embedded itself in his chest wall and slowly made its way into his lung (Dienstknecht et al. 2012). Because these kinds of complications are so infrequent—rare enough that individual case reports are enough of interest to be published—they are not described to the patients, who are most often told that by and large, the bullets do not present a significant source of danger or further complications.

Yet the broader toll of the embedded bullets, empathetically hypothesized by the resident and implicit in Mr. Ford's insistence on removal, is presented in surgical literature largely as a marginal consideration. Although there has been increased acknowledgement of the potential psychological harm of having a constant or at least recurrent physical reminder of the violence they suffered, this cost is typically not presented as a meaningful justification for the risks of surgical intervention (Smith et al. 2022). More recently, research has emerged that raises doubts about the standard assumptions around risk and harm of leaving bullets untouched; comparing patients who had been shot but did not have the bullet fragments removed, those who did have them out were less likely to return to the emergency department for pain or other

complications of being shot (Andrade et al. 2022).

What limited social science exists on this topic reveals that, like every patient I saw whose bullets had not been removed, the presence of these reminders of violence was a persistent source of anxiety and confusion. Lee (2012) describes how many of the people he interviewed with retained bullets "desperately want their bullets removed," noting how the presence of the bullets served as a "common source of anxiety and stress" (251). One man described his fears: "What if I'm just chillin' one day and the bullet moves on its own? What if I'm playing football and somebody tackles me? What if I fall real hard and the bullet goes to my spine? Is that gonna get me paralyzed?" (245). Beyond the physical pain and discomfort they caused, the bullets also carried anxiety and the "moral baggage" of the shooting, which people feared, sometimes rightfully, would be seen as embodied evidence of their own criminality (253).

Our patient, Mr. Ford, shared these anxieties, which were inflected by his sense of aging, "Nobody that gets shot wants to go home with bullet fragments in their body," he said. "I'm older I'm not young like I was when [I was shot in] my foot. I was only like 15 or 16 years old so that healed pretty good. But with this I'm well halfway to fifty so…that's going to take a toll on my body with bullets in my body." These fears were compounded by the experiences of other loved ones who had been shot: "Years ago I had a friend, I don't know if that was the cause of death, but she got cancer. She had a bullet in her chest, I don't know if that caused the cancer or what, but she ended up dying over her situation. So that's what really got me kind of like spooked. She got shot years before and they left bullet fragments in her body, and she ended up catching cancer in the breast from where one of bullets where she was shot at." When he tried to communicate these concerns to his surgical team, their reassurances fell flat. "I

mentioned it to them before, but they say well that's not my situation is different and he never heard of no situation like that before. So I'm telling them, I'm telling them from a true-life story. That's what happened, so…" In his experience, the reassurances given by the clinical team seemed more like a denial of the reality that he had experienced rather than a medical assessment that he had nothing to fear. Although he left some room for doubt or uncertainty about the link between his friend's death from cancer and her being shot, it was clear that he saw the clinical decision to leave the bullet in her chest as suspicious at best and negligent at worst.

But it was his own experience in this hospital that undermined his trust in his clinical care. "I don't know if it's just my insurance that they don't want to do this surgery with the arm or the leg, or I understand this is like a nerve thing, but this one doctor was telling me one time that she specializes in doing stuff like that and she had started prepping me for surgery and then the other doctor came back and just stopped the whole surgery. So I'm like dang that's kind of cold. Why would you want to do that? If one doctor say one thing, then he saying another like what do I believe?" Mr. Ford experienced a collision of miscommunication and quickly shifting decision-making that is all too common in medical care, particularly in the context of a teaching hospital in which often the people who are communicating the information are the least informed and most junior.

Constructing harm and legitimacy in surgical intervention

These constructions—of harm, bodily autonomy, necessity, and the purpose of surgery—become more complex when understood in relation to broader surgical practice beyond that of trauma surgery. The question of whether and when to operate is

foundational to all surgical practice, and the boundaries of legitimation for intervention are constantly shifting with developments in technology and guidelines for noninvasive standards of care. This question holds such relevance and importance because of the inherent dangers of and potential for injury from surgical interventions. Yet the approach to evaluating this question, of whether and when to intervene, is less muddied by questions of patient consent, let alone desire, in emergency settings. Other surgical specialties are much less invested in questions of life or death, and are instead oriented more towards patient need, comfort, or desire. In this regard, a plastic surgeon performing elective surgeries on healthy patients presents in interesting and illuminating foil.

These questions of bodily autonomy, desire and surgical intervention have been much more thoroughly explored in the context of gender affirming surgical care. In an opinion piece for the New York Times provocatively titled "My New Vagina Won't Make Me Happy (And it shouldn't have to)," writer and critic Andrea Long Chu notes that "The medical maxim 'First, do no harm' assumes that health care providers possess both the means and the authority to decide what counts as harm" (2018). She argues that expecting or demanding that surgery be proven to treat or alleviate gender dysphoria functions simply as another form of medical gatekeeping. When criteria are placed on surgical intervention beyond "a simple justification of want," it "install[s] the medical professional as a little king of someone else's body." This piece received a surprising degree of backlash from those I least expected to disagree—other trans people, who argued that Chu's admission that surgery had not, in fact, been a complete panacea to her dysphoria was a dangerous and potentially destructive piece of evidence for the broader world to wield against gender affirming care (Thom 2018). But I read it as more

of a commentary on medical constructions of harm and authority over the body that could be applied much more broadly than this specific context, and as an important critique to bring to the fore. Because of course, as many have pointed out, the number of gender-affirming surgeries performed on cis people (breast augmentation being a classic example) far outnumbers those of trans people, yet there are no medical diagnostic criteria, no gender dysphoria disorder, that must be met prior to undergoing surgery. I have likewise not seen any pearl clutching pieces recounting women's deep regret and dissatisfaction after such surgeries and arguing for more stringent psychiatric regulation or structural restriction, as is so often the case for trans people and people who receive abortions. Regret or reversal of gender affirming surgical intervention for cisgender women is common enough to be discussed by the most visible celebrities and models (Kirkpatrick 2022), but because their goals of achieving a perfected or motivational feminine form are both culturally legible and lucrative for an entire industry of surgical body modification, psychiatric gatekeeping does not enter the conversation. Only recently have surgeons begun to suggest that the informed consent process that is standard for all elective surgeries, including gender affirming surgery for cisgender people, may also be sufficient for trans patients seeking surgery (Wu and Keuroghlian 2023).

Surgery is thus undeniably embedded in and productive of such broader structures of power that shape the contours of gender and embodiment. Historically, for example, surgeons' and other clinicians' interventions in the bodies of intersex babies were marshaled towards the production of a gendered body deemed "natural," which paradoxically required surgical intervention to produce (Kessler 1990). Examples such as these reinforce how the construction and constitution of harm is not exclusively or

even primarily a question of the physical toll of surgery—the act of cutting, sawing, and sewing the body—but is rooted in normative understandings of what the acceptable and desirable shapes of the body look like. Eric Plemons (2017) makes a related argument through an ethnographic engagement with facial feminization surgery. Surgical practice in his book is not a merely technical or purely rationalized endeavor, mediated only by biological demands and surgical protocol; although the technical developments in surgical practice and tools do of course constitute what is achievable in the material alteration of facial structure, the relevance or applicability of these techniques only matter or become useful in relation to historically and culturally specific norms of gender presentation.

How can we understand these insights in relation to trauma surgery and the removal of bullets? On one level, these texts reveal a social history of how constructions of harm are not confined to the technical, rational, or expertise-based frame from which most surgeons would argue. In some perhaps surprising ways, given the different aims of the surgeries in question, the conversation between Mr. Ford and the trauma resident mirrors some of these historical debates around the provision of surgical intervention for trans patients. The logic that Avi uses, which is that operating on the one available bullet fragment will not provide meaningful benefit to the patient because the patient's underlying problem is his perseveration, is not dissimilar to logic of withholding surgery from trans patients out of a belief that phalloplasty will not "make" them into a man. Avi argues that removing one bullet will only lead the patient to fixate on the removal of the other, because the true locus of his suffering is his own distorted, even dysphoric, relationship to his body, which he needs to move on from to be healthy. This conflict around bodily autonomy and surgical practice raises questions about how desire

becomes a legitimate conduit for surgical intervention, and, more importantly, how desire and dysphoria are made legible through normative contours of race and gender. Would the threshold of "harm" be more easily met if the presence of a bullet was understood to be unexpected, abnormal, or in conflict with a white, feminine body? How might the constant exposure to gun violence, experienced largely by Black and Latino men, shape what constitutes an acceptable shape of a body for these surgeons?

Race and the body in medicine

Scholars such as Schiebinger (2000) and Fausto-Sterling (1995) have analyzed the rise of scientific racism and sexism as a means of identifying "natural foundations to justify social inequalities between races and sexes" through anatomical drawings and dissections of black women's bodies, including the infamous dissection and display of Sarah Baartman, during the eighteenth century, which performed an important function in producing and maintaining racial hierarchy. (Schiebinger 2000, 9-10). These works along with others in anthropology (see Stoler 2010) unravel the fundamental co-constitution of race and gender as a means of inscribing hierarchies of social authority in colonial projects. Hogarth (2019) likewise connects the history of experimentation on black people, a practice that was disturbingly common and long-lasting, to contemporary racism in medical practice. Analyzing eighteenth century medical practitioners' treatment of black skin as a "problem" in need of rectification, she draws attention to the ways that black people's bodies have been configured as a "peculiarity" in relation to a white norm (845). Comaroff (1993) has also shown the mutually dependent and beneficial relationship that emerged between colonial power and the development of medicine as a scientific practice in the eighteenth century. Biological

difference located in the body became a central project of medicine during this period, a project that was socially opportune and politically very useful to extending and stabilizing colonial rule. She also demonstrates the intimate connections between the economic structuring of race and medical efforts to demarcate and define race as a natural order inhering in the body. "As [black people] became an essential element in the white industrial world, medicine was called on to regulate their challenging physical presence (306). Metaphors of "healing" later developed as central to the justification of a "humane imperialism," which disguised the economic self-interest of colonizers as benevolent interventions in public health (a practice that finds contemporary instantiation in certain neocolonial "global health" projects) (313). The association between blackness and dirt, infestation and disease was also mobilized in relation to fears of interracial sexual relationships and used to justify racial segregation and cordoning (318).

Frantz Fanon, a doctor himself, documented in detail the violent medical pathology induced by colonial war as well as the intimate and inseparable relationship between medicine practiced by the French in colonial Algeria and colonial rule itself (Fanon 1965). He unpacks the various ways in which European doctors "actively [collaborated]" with the colonial state and military forces even in "their most frightful and most degrading practices" (143) including the withholding of medications and vaccines, both the covering up of and active participation in torture of and experimentation on Algerian people. He thus indicts colonial medicine as fundamentally imbricated in the colonial state rule, remarking that "going to see the doctor, the administrator, the constable or the mayor are identical moves" (145). Fanon also shows how this intimacy and complicity between medicine and colonization inevitably

engenders fear, resentment and refusal of care among colonized Algerians, an opposition that is then used as further evidence of the colonized people's "inhuman methods" and need for the "civilizing" (150) practices of the colonizer (see also Pierce and Rao 2006). The contemporary relationships between medical discourse, settler colonialism, gender and the body have been explored by scholars such as Elizabeth Povinelli (2006) and Sherene Razack (2015), whose work demonstrates the ongoing complicity of medicine in the reproduction of neocolonial forms of gendered and racialized corporeal violence.

Anthropology has long been invested in analyzing the relationship between race, class, environment and body formations (Boas 1912), and the question of biological difference and race is one that remains frequently debated in both anthropology and medicine today. Gravlee (2009) outlines in detail the genetic theories of race that undergird commonsense understandings of race that dominate medical practice despite decades of social science research and genetics research demonstrating their conceptual inaccuracy. Outlining the various effects of racism on the body and the measurable, if negligible, presence of genetic difference across racial groups, he argues for a conceptualization of race within anthropology that acknowledges the embodied consequences of racism rather than one that obscures or denies the relationship between race and the body. While ultimately he is arguing for an understanding of the racialized body that demands an engagement with its social and material co-constitution, significant complications emerge when considering the exact relationships between race and embodiment. Racism indisputably has material, embodied impacts, an effect that has been demonstrated repeatedly in public health research and is elegantly summarized by Ruth Wilson Gilmore's resolutely materialist definition of

racism as “the state-sanctioned and/or extralegal production and exploitation of group-differentiated vulnerability to premature death” (Gilmore 2007, 247).

Racism and the practices of segregation, discrimination and violence it entails have corporeal consequences; these practices are registered on the body in observable ways that contribute definitively to ill health and early mortality (Krieger 2004). These observable differences are often taken as pretext to confirm existing understandings of race as a given biological category in medicine (Gravlee 2009). While denial of racism’s bodily effects can perpetuate false narratives of race as a naturalized and corporeal category, recognition of the bodily violence inflicted by racism must be carefully extricated from the pervasive racism in medical perceptions and treatments of black people today. There are intimate connections between the constructions of corporeal race in the eighteenth century and current misconceptions of racial difference in categories of pain tolerance, skin thickness and blood coagulability (Hogarth 2019). Locating race in the body is thus a tricky, if necessary, endeavor, and requires careful attention to combat medical racism rather than reinscribe it.

My hope in outlining these various relations between medicine, colonialism, race and the body is simply to demonstrate medicine’s complicity in the production of racial and gendered difference inscribed on the body, as well as its political partiality and undeniable imbrication in broader state and economic practices, despite persistent narratives to the contrary. Medical training is a primary site for the reproduction of such violence, and nowhere is it more clear than in underfunded, understaffed county hospitals.

Hotel Rosewood, Rosewood Penitentiary

At times, struggles over bodily authority are extended to the question of continued hospitalization—residents and attendings find themselves in conflict with patients whose desire to remain in the hospital is in conflict with their medical needs and the hospital's operational priorities. While it is often presented as a space of concentrated resources where access is tightly controlled and regulated to minimize waste, the reality is that many patients stay long beyond their medical need and remain stuck in the hospital due to the broader unavailability of lower level care facilities, intractable insurance battles to determine where and at what reimbursement rate a patient should go, and also at times the patient's overburdened and fractured social and family structure. One day during lunch while going over the team's list of patients, the discussion turned to a patient who had disposition issues and needed to stay at the hospital to recuperate even though he did not require hospital-level medical care. Hearing this, Sophie refers to the hospital as "Hotel Rosewood," and comments on the ultimate outcome of the extended stay as "spending the taxpayers' money…makes sense."

Some of these disposition issues are the direct result of staffing decisions made by the county in order to cut costs but that paradoxically result in worse outcomes for patients and longer, more expensive hospital stays. For example, Dr. Hastings and I discussed with exasperated disbelief the fact that the hospital employed, at this time, only one speech and language pathologist for the entire hospital. To those without a clinical background this position may not seem to be critical to care, but their role is essential for evaluating whether patients can swallow. Without such evaluations, patients may eat food or drink liquids they cannot tolerate, resulting in choking, or aspiration of the food/liquid into their lungs, which can cause pneumonia. On a purely

logistical level, these evaluations are often important for understanding where the patient can be discharged to. This specific question also drives the need for physical therapists, who are far too limited, leaving trauma patients without much-needed daily rehabilitation services, and extending their stays in the hospital because they are unable to be discharged to a lower level of care without a physical therapy evaluation and recommendation. “Do you know how much costs that incurs to the hospital, how that affects the throughput of patient care, of people that are waiting in the ED, of people that are sick and need the resources?” she asked, rhetorically. “Somebody is literally just sitting there eating, you know, eating a peanut butter and jelly sandwich, taking up a hospital bed because we can't hire one physical therapist for, I don't know $80,000 a year…I feel like there's a huge disconnect between the administrators and the people on the front lines, right? That's always the case. Administrators are looking at the bottom line and the clinicians are seeing the tragedy that like exists every day.”

Being in the hospital over the holidays gave a particularly bleak view of the unfortunate phenomenon of extended stays, with elderly patients remaining in the hospital not due to medical necessity but because their family felt ill equipped to take them in. However, the hospital is not a benign place, and is often referred to as the worst place to heal. One particularly heartbreaking patient on our service was a kind older woman with very complex medical needs. After having spent a week in the hospital, she was a bit more disheveled than usual when we went to see her on morning rounds, and she expressed her concern and frustration about remaining in the hospital. She said she felt that she would go crazy if she stayed here another night, with all of the beeping from machines and the moans of her neighbors keeping her awake at all hours. Delirium is a real threat to the elderly in the hospital, and her warning was tragically prescient, as the

next day she was confused and no longer knew where she was or why she was there. Her hospital course was plagued with the duality of care and iatrogenesis; the work up that she needed in order to make sure she was not bleeding dangerously ultimately stressed her already frail cardiovascular system, and an attempt to correct her overly thin blood allowed a clot to form that cut off circulation to one of her limbs, which was later amputated. Her hospitalization showed the real limits of intervention in this setting. While training emphasizes that every intervention has risks, without firsthand experience it is hard to grasp the extent to which the interventions we do are dependent on the ability of a body to tolerate them and heal. “Discharging a patient,” Sophie explains, “even though we do it seemingly selfishly, is also oftentimes in the patients’ best interest. And in the best interest of all the other patients waiting at the door.”

These tensions—between the need for care and the limited hospital resources—emerged repeatedly in caring for Mr. Ford. His experience of hospitalization, in tandem with the severity and kind of his injuries, his family support system, and his own sense of debility and incapacity led to several forms of refusals by Mr. Ford. For a period of weeks, he would not work with the physical therapists who came to his bedside to help him maintain his strength and mobility. “Man, I'm so depressed,” he told me. “Because I can't do nothing for myself. Like being a one day you've been able to do everything for yourself. And the next day, everything goes by in a flash before your eyes and everything is taken away from you.” Lying in a hospital bed is a terrible way to heal—the body needs to move, within the limits of its injuries, to maintain its conditioning, keep blood flowing, and heal itself. His refusals were motivated by dislike and perceived disrespect from the physical therapist he had seen previously, as well as his severe pain from his injuries. He was reticent, however, to take additional pain medications that made him

drowsy and mentally fuzzy. Eventually, with significant urging by the medical team and social workers, he was convinced to work with a different physical therapist, who he was able to forge a real working relationship with. While initially the trauma team saw this as a turning point in his hospitalization, which at this point had lasted several months longer than expected for his pattern of injuries, unfortunately it was not a panacea for the larger issues at play. The case managers and social workers were working consistently with his insurance to find an appropriate care facility for him where he could recuperate with more intensive and consistent physical therapy than this hospital had the resources to provide, however they struggled to locate a facility that would accept him. Despite the fact that he was taking only oral medications for pain that he could take at home, Mr. Ford was unwilling to go home with his family given his level of pain and need for physical caretaking and support. His resistance to going home was at least partly rooted in his experience of profound physical debility and dependence that he did not want to burden his family with.

Meanwhile, Mr. Ford's resentment at his situation and perceived lack of progress led to repeated friction with the trauma team, who tried to manage both their frustration with his stubborn refusal to leave the hospital and his real ongoing need for care. My own relationship to Mr. Ford was complex, and I have struggled to find a way to articulate his undeniable pain and suffering, the frustrating systemic roadblocks he encountered, and his somewhat mercurial and often prickly demeanor. While I felt empathetic to his suffering and desire for better pain management, it was difficult to forge an enduring, trusting relationship with him as he would alternate between engaged conversations about his medical issues and the plan for care, and outrage at his perceived lack of treatment. These vacillations did not change despite hours of

conversation between him and the trauma team as well as the social workers and case managers.

At one point, frustrated by the patient's lack of cooperation or change in his clinical needs, the chief resident opted to make Mr. Ford's inpatient stay slightly less appealing by restricting his diet to have fewer carbs and not permitting food from home. Food and diet are something the medical team has theoretical control over—they can place an order for a certain diet, which informs what is served to the patients by the hospital cafeteria, but restricting food from home is enforced only by patients' cooperation and the nurses' supervision. Without a meaningful medical reason to prevent him from eating regular food, it is unlikely that the overworked nurses would devote any of their frayed attention to this order. This decision recalled an experience I had while caring for a different patient who had a real medical need for a highly restricted water intake. Writing the order, which although necessary was quite strict, he described the hospital as "Rosewood Penitentiary." In Mr. Ford's case, I am not sure whether the diet order was ever changed, and it did not appear to have the desired effect as he stayed for several weeks following that discussion. These small moments draw attention to the forms of control integrated into practices of hospital care that can easily be deployed punitively. Despite this admittedly troubling decision, every member of the team was independently invested in trying to help Mr. Ford heal and was genuinely happy at every sign of improvement. Though they certainly held frustrations, they were also committed to his care in a way that other services were not— "I don't want to give up on him," the junior resident said after another day of no physical therapy, "I feel like everyone in this hospital is giving up on him."

Refusal and problematic consent

Also problematic for the trauma team were the patients who refused what the team determined to be necessary and lifesaving treatment. Patients who are brought into the trauma bay with severe injuries who require urgent surgery are typically not able to consent to surgery because they are in too much pain, or have received sedating medication, or are in general too ill to participate in a meaningful conversation. Rather, they are informed that they are being taken to surgery, and emergency consent is granted by the physicians. Other patients may be very ill and require surgery but are also stable enough to have a conversation and discuss the risks and benefits for the surgery. Consent is typically granted but rarely a patient will flat out refuse an operation. More often than not, the patients who are most reticent to consent are those who require amputation. One such patient was diabetic and had a sore on his foot that he had noticed and bandaged tightly but continued to walk on without receiving any other care. After a week, he removed the bandage and noticed that it had worsened significantly and was now hot and red and weeping fluid. He was told by another trauma team that he required amputation, but initially he adamantly refused any kind of surgical intervention. Ultimately, they were able to convince him to at least allow the team to debride his wound, to surgically cut away and clear out any dead tissue and irrigate the area with antiseptic to help stall the progression of the infection, at minimum. No one on the team thought that a simple debridement would be a definitive solution. When they took him to the operating room and began clearing out the dead tissue, the infection was as bad as the team had anticipated, and the chief resident was frustrated as they cut away strips of dead tissue and found pockets of pus and grayish, putrid fluid within his foot. Coming across a large pocket of fluid, the chief resident

pointed to it and said “See that? Infection of the mid-foot is not salvageable and requires amputation.” She began exploring the tendon to his big toe, and quickly realized it was also infected. As she went to sever it, she hesitated and asked, “Is this mean? It feels mean,” before cutting it cleanly with a sigh. Maybe if his foot is not functional, he will consent to an amputation, the resident mused. Eventually the attending told them to just stop and irrigate it and move one because they were not doing much of anything. After she said that they immediately found another pocket of pus, cleared that out, and then stopped removing tissue and finished up.

Watching the procedure I felt a bit uneasy and winced when she cut his tendon. Why, I wondered, was this relatively minor procedure harder to watch than an amputation? Why when she cut his tendon did it feel cruel, when sawing off someone’s bone had never bothered me before? I think largely it was the sense of futility and arbitrariness behind the process—of course they were removing dead tissue and helping control the infection, but these were not the definitive steps of an established procedure that would have a much higher chance of success. Ultimately removing the functionality to a toe that would later be completely removed from his foot somehow did feel “mean,” because it was pointless. The patient later had an amputation with another team.

Another patient, who had come in with an abscess overlying a prior orthopedic surgery on his ankle, presented similar difficulties to consent. When the junior resident went to examine him and let him know he needed surgery, the patient categorically refused because his prior surgery had laid him up for three months and was unbearably painful. Afterwards, I went down with Avi, the chief resident, to talk with the patient. He was a middle-aged man, with close cut salt and pepper hair and glasses, and as soon as we walked in began rattling off complaints in rapid fire Spanish and reiterating his

refusal to have a second surgery. It took at least 30 minutes of discussion alongside a nurse who spoke fluent Spanish to convince the patient that without the surgery, he might ultimately lose his foot or possibly die. “Discussion” is perhaps a misleadingly dry description of the actual conversation that took place—the patient was angrily recounting his experience of recovery from his prior surgery and repeatedly refusing any intervention and asking to leave. Meanwhile the resident tried to reason and bargain with him, promising not to make too large of an incision, and the nurse alternately admonished the patient for his stubbornness and skewed priorities (“You’re worried about a cut, but you should be worried about your life!” she said at one point) and begged him to reconsider. By the end, he had begrudgingly signed the consent form but made the resident promise to only make a very small incision to remove the “*feo*” from his foot. Walking away from the room, the chief confessed that it had been the hardest consent he had ever had to do in residency. He was concerned, however, about the attending’s reaction when she found out that he had promised the patient a small incision—he knew she would not approve of him allowing the patient to dictate the intervention, because that impedes our ability to give the best possible care. But in this patient’s case, the chief felt it was better to evacuate as much pus as possible and give the patient a shot at recovery rather than discharge him home where the infection would only worsen, with likely disastrous consequences.

The next morning, I came in to find a sleepy team after a typically busy night. The patient with the ankle abscess was calm, chipper and grateful that his pain and discomfort had been treated. I asked about one patient on the list who came in after being shot. They described how the patient, a large, tattooed Black man, had come into the trauma bay already asking to leave, but needed to be redlined to the operating room.

Even on the OR table, they said the patient was trying to sit up and walk out of the room, and they were forced to push him back down and sedate him. When we went to see the patient that morning on rounds, only a few hours after his extensive abdominal surgery, he had barely come out of anesthesia but was already sitting up in bed, refusing medication and vitals checks, and trying to stand up and leave. The chief resident, Avi, explained to him that he needed to stay and relax to allow his body to heal, describing in detail the abdominal surgery they had performed the night before. After rounds, we went to discuss the patients with Dr. Lilley who had been on call that night, and when we arrived at that patient she remarked, "This is why I love my job. It's the only job where they can say, 'No I don't want you to cut me open!' and I can say 'Too bad.'" She then used the term "therapeutic privilege," which more precisely refers to the practice of physicians withholding information in cases when disclosure would harm the patient but is related in that it entails an act of paternalistic overriding of the patient's autonomy in the name of care, in this case lifesaving, emergent care. While in her office, she checked his chart and noted that he was refusing the nursing care, and the consensus in the room was that he would likely leave AMA (against medical advice) in the next day or so, and that we should try our best to keep him but let him go if he wanted to leave. Fortunately, after further conversations with the team, the patient was convinced to stay in the hospital. The reversal was a surprising one, and when he was asked why he had so badly wanted to leave, the only answer he gave was that he simply did not like lying around. Someone from the trauma team spoke with his father, who confirmed that was just how he was and had always been—on the move. This quality turned out to be an asset for his healing, since he was motivated to move around as much as possible, taking laps around the floor throughout the day. He was a kind and

lovely person, and he developed strong relationships with me, trauma team and his nurse over the course of his admission. One day, the junior resident went to the patient's bedside to sew up his abdominal incision. After he had finished, the resident counted the 26 stitches he had done and joked with the patient that his friends could call him "26 Savage" (a play on the name of popular rapper 21 Savage), earning a good laugh from the patient. When he was nearly healed and ready to go home, he expressed gratitude that we had not allowed him to leave and had explained to him why it was so important for him to rest.

Conclusion

There is a consistent denial, in surgical assessments of "risk benefit," of the legitimacy of the patient's command over their body. I was struck by Avi's ability to so beautifully and empathetically articulate the reasons why a patient might suffer from the ongoing embodied experience of having a retained bullet, coupled with his unwillingness to consider or engage with Mr. Ford's real distress and desire for removal. What these conversations reveal is how the constitution of violence in surgery is produced not only by the patient experience of it—understanding that it will be in service of their health or embodied life experience, consent, desire—but also by the surgeon's. The reason that cutting a patient's toe tendon can feel "mean" when the amputation of their foot does not is the relationship between the necessity of doing so and the understanding of its benefit. Cutting the tendon felt transgressive because there was a real loss of function that resulted from it without a definitive cure, whereas a foot amputation for that patient would have, and did, save the patient's life. Would it not be an act of violence to cut open, amputate, or otherwise operate on a patient's body when

you knew, from experience, expertise and practice, that doing so would harm them more than help?

This question points also to the danger in determining the availability of surgery solely through a "simple demonstration of want" without considering the real physical toll it enacts and its potential for violence. These concerns are most relevant in cases where patient vulnerability (poverty, social exclusion, limited access) meet exploitative and unscrupulous surgeons (who have always existed and will continue to exist). Plemons recounts the case of John Ronald Brown, a surgeon who performed hundreds of "backroom" gender reassignment surgeries in the 1970s and was later convicted of murder for an unnecessary, voluntary, and ultimately lethal leg amputation (73). Surgery demands a literal, physical violation of the body that can result in pain, disfigurement, debility, and even death, and it also requires the embodied expertise and participation of the surgeon themself, who may object to the potential for harm, and is always considering that potential for harm in any decision to operate. I suggest that what opens the possibilities of care within this violence is an amorphous constellation of patient consent, adequate training, and the likelihood of benefit.

Moments where patients expressed a recognition of care in contexts where their bodily autonomy was wrested from them often surprised me; just as when our patient "26 Savage" expressed gratitude that we had pushed him to stay, I had also been surprised by the patient who described feeling cared for and important during his time in the trauma bay, despite being surrounded by strangers cutting off his clothes and putting in IVs. I am not eager to make an argument for increasing physician power over patients and routine violation of their autonomy. Rather these examples of the negotiations and tensions between care, control and coercion further add to our

understanding of the imbrication of violence and care. Care emerges in these moments not as the administration of technical expertise, either accepted or denied by the individual autonomous patient, but instead as a relational practice and product in which power, knowledge, skill and embodied forms of self-determination are constantly in tension and in flux. How might the strength of that patient's relationships with his caregivers have shaped the way he processed and perceived his initial overpowering? McKearney (2020) argues against the anthropological impulse to "fix care's morality" through an examination of the carer's intentions, proposing instead that we understand how "good" care becomes established by the recipient in and through its "relational vicissitudes" (229, 223).

Despite the initial force required to perform his surgery, the absence of meaningful consent in the setting of impending death, this patient's eventual perception of the care he received emphasized gratitude rather than violation. But while the relationships between caregivers and patient may have shaped the meaning, emotional register, and even moral content of that care, attending to the initial force as force remains important. The care itself does not obviate the context in which it is given. McKearney critique's Angela Garcia's meditations on care and violence along these lines, emphasizing her impulse to transform the morality and value of violence through its operation as care (A. Garcia and Anderson 2016). He argues that in her eagerness to find the "redemptive possibilities" of violence (as cited in McKearney 2020, 225), she arrives at an evaluative model that is ill-equipped to characterize the "unsettled and uncertain" contours of "good care" (225).

His thinking resonates with my own reading of Carolyn Sufrin's work, which probes the "disturbing entanglement of carcerality and care" in her ethnography of the

medical care of pregnant women in the San Francisco jail system, which she participates in as an obstetrician herself (Sufrin 2017, 22). In her framing of this "jailcare," she asks the reader to view the practices of care as capable of exceeding its punitive context, rather than asking how the atmospheric violence of the prison corrodes any care administered within it. Given the way she describes her own medical practice, at times her argument reads as an attempt to sanitize the violence she herself is complicit in through her work in the prison by reframing it as care—when a patient steals a bottle of soap from her clinic, she chases her down, threatens to expose her theft to the guards, and ultimately allows her to leave only once the soap is returned. She then goes on to describe her actions as care, which she defines here as emerging in "moments of ambiguity, when disciplinarity involves human connection, intimate concern, and suspicion" (88). I struggle to understand what this definition of care offers us, one that is not merely entangled with punishment but that ostensibly draws strength from it. These arguments serve as examples of how the naturalization of violence within care clouds an analysis of when and in what context forms of harm and force become preconditions of care, and when they might be left behind. Attending to the "relational vicissitudes" makes space for an understanding of care that both acknowledges the sometimes-violent forms it is administered within without accepting them wholesale.

Chapter 3

Community Violence, Institutional Care: Boundaries of Responsibility in Hospital-Based Violence Prevention

"I would be surprised if anyone that you interview doesn't say something to the effect of: in an ideal world, I wouldn't have a job," Dr. Walker speculated, "Right?" "Or," he clarified, "my job would be very different." In fact, while nearly every trauma surgery attending I interviewed reflected on the connections between trauma surgery and community violence, no one else had articulated the inherent conflict in this relationship quite so plainly. "It's always an interesting tension," he explains, "because the parts of my job that I most enjoy from a technical or surgical or medical perspective are often the results of horrific interpersonal violence. And so there's always this weird duality of it's really exciting when someone shoots someone else, but actually, actually, it's not. It's horrible, right? Like what an ultimate systems failure as human beings." These comments recall the troubled politics of practice that make Rosewood both a place of concentrated violence and excellence in surgical training explored in the previous chapter and point to the tensions between the role of hospital medicine, the capacities of its staff, and the cultural expectations around the connections between violence prevention and clinical medicine.

Locating the hospital as a site of violence intervention produces conflict for trauma surgeons who struggle to reconcile their relationship to the broader community and the issues that structure community health far more influentially than clinical

medicine. This chapter explores these tensions— How did the public hospital become constructed as a site of community violence intervention historically, and what do the contemporary forms of that relationship look like today? What implications does this program and its underlying ideology produce for trauma surgeons, and how do they then see their role within the broader community in treating and preventing violence? How do surgeons and hospital violence case managers navigate conflicts between their sense of responsibility for patient health and the complex political landscape that structures violence in the community around them?

Surgery in community

Dr. Walker further laid out his perspective, probing the relationship between trauma surgery, the county hospital, and the community it serves:

> "I think there's a unique perspective that I have, or that we have as a profession, which is, you know, we see people on their worst day, we see horrific, sort of the end stages of societal failures, right? Like, I have a job because there's poor gun control in this country. I have a job because poverty and violence and guns and lack of opportunities and systemic racism and ended in, all have coalesced into this point. Chronic disease that we have that I'm sort of minorly involved with patching up, but not actually getting at the root of making better. And I think, I don't know, like, maybe if I was…not a better person, but if I were a different person, maybe I would be able to quit this gig and go like, do some sort of immersive work in the community. Something, I don't know what that would be. And I'm not actually sure I'm the best person to do that. Like, I didn't grow up

here. I'm not from here. I don't, I don't look like a lot of our patients. I don't have the same life as a lot of our patients. And I think for me, like the thing that I've said to myself is like, I think it's good enough to like, try to be good at the surgery part. And then like, be at least aware enough of the other stuff to sort of, like do the right thing or say the right thing or like point to the person who knows what the right thing is."

His analysis mirrors the contemporary push in medical school curricula that emphasizes the role of the political and structural (but more often labeled as "social") determinants of health. Yet the broader political implications of how he relates his own work to these political conditions of health is less clear. In this framing, Dr. Walker positions himself and other trauma surgeons as a kind of final buttress between health and suffering, life and death in a world where an individual person's trajectory towards one or the other is conditioned by circumstances, forces and events that occur long before they arrive at the hospital. In a way, his framing of his role as a surgeon within this broader system recalls the "minimalist biopolitics" that Peter Redfield describes in his ethnography of Médecins Sans Frontiers doctors in conflict zones, which he defines as "the temporary administration of survival within wider circumstances that do not favor it" (2005, 345). Redfield explores how the logic of medical humanitarianism inadvertently supports a violent status quo through benevolent intervention and reproduces a line between categories of citizen and human. The hidden cost of such a politics, Redfield argues, is the deferral of meaningful change or improvement in the conditions supporting mere survival.

In line with the broader self-conceptualization of biomedicine as a purely

technical and apolitical exercise, Dr. Walker does not identify his work as itself political; he and his colleagues are identified as having a role of treatment or "patching up" that is "not actually getting at the root of making [anything] better." The question of what effect that work has is one that he, along with the other attendings and residents, wrestles with repeatedly. Recounting his experience interviewing applicants for their residency program, he describes how he will commonly be asked, "What are your volunteer opportunities?" Or "What are things that you're doing, the surgical residents are doing to give back to the community?" The response that the program director gives, is "Working 79.5 hours per week[13] in a county hospital as a surgical trainee." Much in the same way that he describes the surgical work as "good enough," Dr. Walker argues that by virtue of being a resident in this place, that residents and attendings *are,* "serving the community." He explains further, that:

> The community has said we need a hospital because we get sick and get hurt and need help. You are serving that need.... But it always makes me laugh because I feel like there's a naïveté about, like, Yeah, I'll be assertive, aggressive, but I will also have to save the world. And the reality is, you are fulfilling a community need, you are serving your community by being a learner and a doer. And so to sort of circle back to something that we were talking about before, like, my conception of my role is, I don't think I'm just an automaton. I do think I serve the community.

[13] The weekly work hour limit is 80, so this is a bit of a wink and a nod to the idea that they work exactly up to the limit and no more, although they often do work longer.

Despite this avowed commitment to working for and within this community, Dr. Walker simultaneously situates himself as outside of if, as he is not from the area and does not "look like" many of the patients he serves. And he is not wrong in this assessment—the majority of attendings live outside the immediate vicinity of the hospital, and many live more than 15 miles away. While the patient population that the hospital serves is majority Latine, with approximately 10% identifying as white [how do I cite this without saying which hospital I'm talking about?], the trauma surgery department faculty are nearly all white, with only one faculty member identifying as a person of color. This racial composition is not abnormal among the broader surgical community (Abelson et al. 2018), a gap that reflects the historical legacies of racism in medical training and education more broadly. Beyond the question of racial justice and equity for the surgeons themselves, some research has pointed to the benefits of Black patients being treated by Black physicians, indicating that patients have better experiences of care and improved outcomes (Jetty et al. 2022).

The issue of how to achieve racial parity within surgical residencies has been a topic of much debate, and one that has not achieved consensus even within this hospital. While residency programs have implemented various strategies to improve racial and economic diversity in their admissions process, pushback has emerged, from various positions, regarding the best approach to achieving this goal and the potential for unintended consequences. Talking with Dr. Tennant, a white woman attending, she explained what might be understood as a "colorblind" or "race neutral" understanding of racial politics that was popularized in the 1990s, mixed with a critique of identity politics. Partly her resistance stemmed from her relationships with patients, which have been longstanding and at times deeply personal, and through which she feels that she

has been “able to transcend this concept [of race].” “It’s totally bothered me that people are like, I only want to have a doctor that looks like me, and that somebody has to look like me to understand me,” she said. “It's been a little hard to consider that all these people that I took care of that I didn't care for them, as well as somebody that was of their own ethnicity.”

In this conversation I sensed that we were discussing several interconnected threads at once—one centering on her own sense of meaning and achievement that she generated through her work, another on her anxieties around the destabilization of metrics (e.g., standardized test scores) of physician aptitude and prestige, which she had relied on historically to evaluate both residency applicants and her own career. It was clear she interpreted discourses around racial equity as implicating her personal faculties as a surgeon and expressed a real defensiveness at the idea (whether it was being argued or not) that as a white woman she was somehow inherently incapable of providing the best possible care to her patients. “That being said,” she conceded, “I have gotten on board.” Through talking with residents, Dr. Tennant had come to support programs for underrepresented medical students to better prepare them for residency and improve their applications and saw the value in having a racially diverse residency class, but it was clear that her shift in perspective was recent and had somewhat of a precarious, uneasy foundation.

By contrast, David, a trauma fellow and person of color, argued that “Racial equity and being responsive to our local community should be the base of everything that we do. It should be the foundation of our department and our training program and the care we deliver.” But in his own attempts throughout medical school, residency and fellowship to integrate racial equity into the infrastructure of academic medicine, he was

met with indifference or minimization. “Nobody cares,” he said.

Locating the boundaries of responsibility of the county hospital

Dr. Lilley expressed some of these tensions in priorities of academic medicine as she grappled with questions of the social and political responsibility of the hospital to the community in our interview. On the one hand, she lamented the limited reach of medical intervention, saying “I think that’s the hardest part for me, knowing that what we do here means so little in the long run.” She cites community activities the trauma department does like Stop the Bleed campaigns as an example of this constricted impact, “That means we’re going to teach kids at high schools how to try to save their friends when they get shout. That’s the outreach. That’s truly awful. But it’s necessary.” On the other, she was not convinced that the hospital in general or trauma surgeons in particular *should* have a broader role in community violence prevention. “I guess, I think that’s kind of a flaw in the overall thinking. Why? Why is the hospital the point of contact? It’d be great if we could be involved just for health care reasons, like here’s your access to care point that’s embedded in the larger societal framework of taking care of people. But I don’t think people should think of us as an intervention for the community because it’s complicated. We should be physicians…we should have nothing to do with trying to change the way your community works at the very basic level because it muddies the water.” When I ask her to expand on this idea, she endorses a view of the hospital as a “nonpartisan entity,” and adds that there is a difference between the role of the city, county and state governments and the role of clinicians, which is that “what we do every day is take care of individuals. You’re not taking care of individuals in the big picture side of things, you’re taking care of an entire community.”

This conceptualization grossly replicates the distinction often made between clinical medicine and public health—one being an individual practice and the other being a population-based practice. What are the implications of this division for a politics of health? What role, then, do doctors have to play? Or, in the case of the hospital violence intervention program, what role does a public, county safety net hospital play in the "larger societal framework of taking care of people"? The existence of the program implicates the hospital in this network of care, which in some ways remains more theoretical than actual, but the scope of responsibility the hospital carries as an institution remains contested.

Part of the tension in this conversation emerges from a conceptualization of community violence that has abandoned biological etiologies of violence, now understood almost universally to be racist, in favor of the public health approach developed in the 1980s that emphasized the role of poverty, historical infrastructures of racism such as redlining and the uneven distribution of environmental toxicity (Prothrow-Stith, Spivak, and Hausman 1987; Sims et al. 1989). This shift in thinking, coupled with a continued commitment to the apolitical discourse of objectivity in science, has produced conflict in the way these surgeons conceptualize their role and the responsibilities of the county hospital in violence prevention—if the origins of violence are structural, political, and economic, then they are outside the scope of clinical responsibility. But trauma surgeons and residents are acutely aware of the true limitations of a clinical practice that is temporally and spatially constrained to the hospitalized patient body, as they routinely see their work undone.

One memorable patient had particularly complex gunshot wounds that required multiple surgeries to address over the course of six weeks, resulting in an abdomen that

chief resident Avi described as a "Frankenstein project," and was unfortunately admitted again only weeks after being discharged. This time, he had been shot in the spine, was paralyzed, and ultimately died. At first, he recalls being almost angry when seeing the patient again, asking with frustration what had happened that landed him back here so quickly. From talking with family, he learned the patient had tried his best to stay out of trouble but "had a mark on him" that he could not escape. "I think it takes more of an emotional toll," Avi explains. "You want to give them a second chance at life, so you picture their life being productive and full of happiness and joy, and maybe this is just the blip you need to get past. I think for a fair amount of people, it's just going to happen again and again. And part of the jaded part of me is just like, oh, you fix them up and then turn them back out again, because I just don't know how to fix it. I don't know how to fix the preventative part."

For some residents and attendings, these encounters are enervating, demoralizing, and contribute to an overall sense of futility in their work. Avi highlighted the racial inequities in care both within the hospital (e.g., time to diagnosis), which he saw as within the purview of clinicians, and what he saw as "the bigger problem"—that "so many people are getting shot and stabbed." "My opinion," he said, is that the violence his patients experience is "because they're in chronically impoverished communities, which were set up 50, 60 years ago when the whole country was redlined, you know? And I don't think, I don't know how to fix that. That's a government policy change. You have to give people land and opportunity that were…taken from them, like 60 years ago. And I don't know if that's fixable, definitely not at a hospital level…I don't know how much we can do as doctors, though, to really fix that. It's mainly just trying to give people another chance at life, saved their acute problem, and then get them back

home so they can have another shot." Despite his overall progressive view of health politics and desire to effect meaningful change through his work, like many surgeons, his political subjectivity began and ended with his clinical practice. As a resident, this understanding is undoubtedly shaped by the relentless physical and intellectual labor required of him—as Dr. Walker pointed to, residency is a time when clinical responsibilities grow so large they blot out even residents' imagination of a life beyond it. A trauma fellow, David, mentioned once that there were entire years of life as a junior resident that he had no memory of; because he had worked so much, that period had become an indistinguishable blur.

Physicians' politics of solidarity

Despite narratives of medical practice as apolitical, doctors have been important participants in addressing political violence (Adams 1998). The political protests of 2013 in Turkey, for example, have shown the ways that discourses of medical neutrality become themselves a space of ideological and political contention. As doctors mobilized to provide clinical care to protestors in the face of what Açiksöz (Açiksöz 2016) calls "atmospheric violence" and state repression, state actors seized on this medical aid as evidence of the physicians' partisanship and pro-protestor stance. Reflecting on the same protests, Can (Can 2016) unpacks how claims to neutrality and an ethics of universal care positions doctors as political actors in relation to state violence. While other scholars of medical humanitarianism have drawn attention to the ways that organizations like Médicins Sans Frontiers come to stand in for an absent state in moments of emergency through their administration of life (Redfield 2013), the medical care provided in the protest infirmaries aligned the doctors more with their patients

than the state as the doctors were themselves caught up in the same structures of state violence as the patients they treated. The sites of care constructed in this moment of protest presented a threat to the state not only in repairing and healing the protestors, but also by serving as a "kernel of utopic visions" for what a non-commercial healthcare could look like and directly challenging the state's power over who is able to receive treatment (Can 2016, 481).

This example provides a useful counterpoint in the conversations around bureaucratic indifference and medical neutrality. In the Turkish protests, doctors practiced a medical neutrality that urged them to care for the protestors regardless of ability to pay, or, even more importantly, whether they agreed with their tactics. In an abstract sense, this relationship to care is not so different from Lisa Stevenson's concept of "anonymous care," in which it does not matter who the person is. Yet the product of this care could not be more different—whereas the Turkish doctors have been produced as the targets of state violence, the medical apparatus of control over indigenous Inuit communities conscripts medical knowledge and practice into violent colonial projects of domination. In the case of the United States in general, and Rosewood-UCLA in particular, clinicians are more often than not legally positioned as state actors, sometimes in conflict with medical ethics (Song 2021). Given the bureaucratic and legal constraints (e.g., mandated reporting), what would it take for an American doctor to operate in solidarity with their patients, rather than the state?

Some surgeons, when encountering patients with recurrent violent injury, understand this issue to be clearly within the scope of medical care just as prevention for any other health issue, such as diabetes or influenza. "We've been doing it with other things forever," argued one surgeon, Dr. Hastings, who had been influential in

developing the HVIP at Rosewood. “Like if someone has an MI,[14] do we just put a stent in them and send them back out? No. We give them rehab, you know, all these things to address the root causes of heart disease.” In her assessment, a similar approach to violence prevention had not been taken up in trauma surgery prior to the 1980s because it was understood to be outside the scope of political and technical responsibility of surgeons. “I don’t mean to belittle surgery, it’s really amazing, and I think you should do it,” Dr. Hastings explained, before saying that the work of surgery, of “[learning] how to take out people’s spleens and fix their bowels,” was, in her experience, “not enough.” She then recounted a story of a patient she encountered during her intern year who pushed her to see both the limitations of surgery and what it would take to move beyond them. “I met a guy who was 16 years old, and he had been shot. And at that time, there were no work hour restrictions. I was there all the time, and I got to know him really well. He was my patient. You know, all I could do is write, at that point, Aspirin orders or whatever.” When he had recovered enough and was preparing for discharge, she asked him “So, what are you going to do? You know, you’re getting better, what’s your goal?” His response, was “Goal? I’m not going to live past 25.” She continued, “It struck me in such a profound way. And then he came back two weeks shot again, and he lived through the experience, but this time he was in the ICU, he was on a ventilator, he had a torso gunshot wound…I started recognizing that there are things we can do about it and that we should be involved in it, because it’s not enough. And we’re on the front lines and have a really unique vantage point to understand next steps.” This framing of violence as squarely within the purview of surgery and public health is important, in her

[14] Myocardial infarction, known colloquially as a heart attack.

view, in understanding violence not merely as "a criminal justice problem," but as the result of community need, vulnerability, and divestment.

David invoked an element of moral responsibility in assessing his commitment to violence prevention and racial equity. "I like being a surgeon," he explains, "I like seeing patients, I like operating. But I think I would be, I would consider myself sort of selling out…. I've always felt like, and this is before I even decided to go to medical school, I've always felt like I have a responsibility to do more work for community causes, for social justice causes. And so having gone from basically high school till now, 20 plus years of trying to figure out how to live that world view, then to just be like, 'Well, I'm gonna have a nice job and a nice life,' is selling out."

But when direct involvement in and advocacy for the community is a central goal, separation from the work can serve as a self-protective measure against burnout and disillusionment. "Sometimes I feel like it'd be nice to just come and take a call, and then go home and realize that my world and life is completely separate from this," David reflected. "But that makes me feel like almost dead inside…like, what happened that my world view on that changed? But I think it's sort of like a reflex to wanting to take care of myself, and not really a reflection of what I think is possible with these programs. More just like, I can't keep letting my work environment bleed into my personal life and make me miserable." Having struggled repeatedly throughout every institution he had worked in to effect institutional change and create more accountability between public hospitals and the people they served, David lamented the isolation he felt when confronting the culture and politics of the department more broadly:

The priorities of an academic surgery department don't align with what I think is

important work…I always tell myself, that's not the audience I need support from anyways, and keep working on what I want to do and keep trying to push it forward. But it's just isolating.

I've been trying to engage some people in the department about doing even like social determinants of health screening for our clients, figuring out ways to dig a little deeper into their social history ask about their life to figure out how to connect them to resources that would help them with that. But yeah, I can't even find a person or the time to do that type of interview, you know? And I personally don't have time to do it myself for even the patients that I see on call. It does seem really daunting in that aspect that like the way clinical surgery is just structured is that we are just providers within the system. And we're asked to see patients, fix patients see patients, fix patients see patients, fix patients, you know, it's like there's nothing, there's no, there's nothing built into our institution or how we practice surgery to be able to fit anything else.

He also recounted the anxieties he felt about pursuing what he describes as a "traditional" medical path, one that left little room for involvement with the community work that he had found meaning and purpose in. These doubts were most present in the first two years of medical school, in which students are primarily dedicating their time to studying and book learning, as opposed to clinical practice. It was during his first exposure to clinical medicine that he "fell in love with trauma [surgery]" and the "pure clinical aspects of taking care of patients." But it is also this period, notably, where the brutality and dehumanization of medicine makes its presence known. One of the most

consistent findings in medical anthropology and sociology is the pervasive and enduring cynicism and detachment that previously idealistic and well-meaning students develop during third year of medical school clinical rotations (Feldman and Newcomb 1994; Perry 1999; Self et al. 1991; Helkama et al. 2003). As discussed in the previous chapter, medical training operates as a locus of profound transformation—of ethical commitments, desires and self-conception.

What is remarkable to me about his phrasing is how it makes recourse to emotion, to the embodied experience of "[falling] in love," to suture the conflicting structures of meaning that were operating in his life—on the one hand, community work that he found to be more impactful in the lives of the people he worked with, and on the other, academic medicine, which brings with it the social value, financial security, and social authority. Falling in love is conceptualized, at least in our particular cultural and historical moment, as an experience that is in some way out of our control, that exceeds or displaces rational thought and reasoning and affords a great deal of emotional cover or protection from questioning. What is it, exactly, that we are falling in love with? David phrases it as the "pure clinical aspects," which I take to mean the embodied, immediate act of providing surgical care to patients. The "purity" of this practice lies, I think, in its seemingly unambiguous moral character—the institution of medicine may have its flaws, but the act of repairing someone's wounds, sewing them back together, is a relationship of skill and service that one can safely take pride and find satisfaction in. It is also an experience and practice that produces an overwhelming sense of immediacy and immersion; there is no space to think about the world outside of the injured body in trauma surgery. Ultimately, however, rooting a commitment to surgery in an individual feeling of love does not resolve the conflict between the institutional failures of medicine

and a desire to effect meaningful change in the world, but rather displaces that conflict onto the individual—the "pure clinical aspects" can never fully be separated from the "revolving door" in which they are administered.

A partial history of the construction of violence as a medico-carceral object

How and why has the public hospital come to serve as a site for the management of violence at all? The history of medicine in Los Angeles shows the multiple, at times competing forms of medical and hospital-based approaches to intervening in community violence. Biological models of violence, which approached the question of violence as a representation of organic (and racial) dysfunction, saw the body and brain as the main site of intervention. While neurosurgeons and psychiatrists acknowledged the relevance of social conditions in producing these forms of brain disease, they ultimately saw violence as stemming from an intractable physical and racialized instantiation of the social ills of poverty and disenfranchisement and asserted the role of physicians and surgeons as body technicians working to cure the physical roots of violent behavior. Against this biological model of violence were conceptualizations of violence that emphasized its political and social origins; while community activists such as the Black Panther Party named the structural, racial violence of redlining, community divestment, and policing as the main sources of violence within their communities (Nelson 2011).

The early 1970s saw medical research and theory being developed to conceptualize the roots of crime and violence. In 1973, California's then-Governor Ronald Reagan proposed the establishment of a Center for the Reduction of Life-

Threatening Behavior, later renamed the Center for the Study and Reduction of Violence. to study the biological and medical roots of violent crime. The political impetus for the development of this center came on the heels of the relatively nascent and undeveloped but growing practice of "psychosurgery," which described the surgical practice of modifying, altering, or destroying parts of an individual's brain with the goal of reducing violent or otherwise disruptive behavior. This practice had gained footing after three doctors, two neurosurgeons and a psychiatrist, received a large NIMH grant to study the "organic" etiologies of violence, following the publication of their letter published in the Journal of the American Medical Association extolling the scientific need for and merit of such a project (Casey 2015). "The urgent needs of underprivileged urban centers for jobs, education and better housing should not be minimized," the doctors wrote, "but to believe that these factors are solely responsible for the present urban riots is to overlook some of the newer medical evidence about the personal aspects of violent behavior" (V. H. Mark, Sweet, and Ervin 1967). "There is evidence," they continued, "that brain dysfunction related to a focal lesion plays a significant role in the violent and assaultive behavior of thoroughly studied patients." Their conclusion was thus that beyond the study of the "social fabric that creates the riot atmosphere," that what was needed was "intensive research and clinical studies of the *individuals* committing the violence" (emphasis in original). This letter, published two years after the Watts Rebellion in Los Angeles and immediately following riots in Detroit, Michigan, provided insight into the medical logic of violence and behavioral control that these doctors had developed through their surgical and psychiatric research into the brain-based etiologies of violence at a Boston center for the study of violence, summarized in their book, Violence and the Brain (V. Mark and Ervin 1970).

Multiple critics pointed to one particularly psychosurgery patient, who had a history of depression and was operated on three times, resulting in periods of confusion, memory loss, and "mood changes ranging from near euphoria to severe depression" (Mark and Southgate 1971, 269). Following the third operation, which destroyed part of her thalamus, a central area of connection and interface for sensory input of the body and important structure for learning and memory consolidation, the patient refused further intervention and was reported to display paranoia, "overt anger and irritability" and disorientation (270). Over the course of weeks, her mood stabilized, and her mother is quoted as remarking that the patient "is her old self again" (270). The patient was then discharged to her home with in-home care support, and after a few days committed suicide using a toxin she had acquired and hidden with her months before her admission to the hospital. In the physicians' assessment, they note that "the aim of [psychosurgery] was not only to elevate mood but also to prevent suicide," and concluded that the procedure was therefore "ineffective" (272). However they were also encouraged by the fact that her memory and cognitive function appeared to have recovered, as evidenced by the fact that she was able to recall and implement the suicide plan she had made months before. In fact, they even went so far as to suggest that it was the very successes of the procedure that made the patient able to complete her suicide, noting that it is "during the state of initial improvement that the greatest danger [of suicide] exists," an argument still used to explain the established increased risk of suicide following the prescription of antidepressants (272). This patient's case report became an important resource for opponents of psychosurgery in general and the development of the UCLA Center for the Study of Violence in particular, as it highlighted both the dangers of such interventions and the kinds of perverse medical

metrics of success being used to evaluate them.

Given the rapid increase in the homicide rate during the 1960s and 1970s, violence prevention and reduction took a prominent role in political discourse. While much of the policy developed and enacted in this period took a hardline law and order approach to violence and crime, setting the foundation for the future decades of a massive expansion in the carceral ideologies and infrastructure of the United States, a concurrent approach emerged that promoted the role of medicine and public health as both preventive and curative models for addressing violence. But rather than serving as a corrective or challenge to policing and incarceration as solutions for violence, often the medical models were either explicitly designed to supplement and integrate with the prison, or were conscripted to do so after the fact. Prison administrators in this era were intrigued by psychosurgery as a possible tool of control for prisoners, and surgeries were planned in both California and Michigan on prisoners in both states (Casey 2015). Historian Brian Casey outlines the two distinct, and in many ways contradictory, forms of opposition that emerged in response to the growing popularity of psychosurgery—the response of the broader medical community, spearheaded by the National Institute of Mental Health (NIMH), and the response by activists. On the one hand, the NIMH critiqued the practice of psychosurgery from a position of rational, evidence-based medicine, arguing that the primary issue with psychosurgery was its poor research design and lack of clear evidence demonstrating safety and efficacy. The NIMH director at the time, Dr. Bertram Brown, argued for increased levels of funding for improving basic science research at the time, pointing to a need for expanded and well-executed research in understanding the etiologies of violence (Brown 1973)b. He approached psychosurgery as a neutral technology that could either be wielded for the political

purposes of control, or, if operated under the "dominant ethic [of] cure and control of disease," could become a useful tool of medical science (Brown 1973, 65). Brown understood this call as part of the broader goal of the NIMH at the time to unpack "the mental health aspects of law and order" by developing medical approaches to violence and improving the therapeutic efficacy of prisons, and explicitly advocated for the allocation of money within the Law Enforcement Assistance Act to medical research as a way to "help the law enforcement system achieve its goals" (Brown 1973, 66).

On the other hand, community activists and civil rights groups, notably the Black Panther Party, protested the use of psychosurgery generally and the development of the UCLA Center for the Study of Violence specifically. Their critiques had several important dimensions; for one, they saw psychosurgery as a tool of control that threatened the physical integrity and mental capacity of anyone deemed to challenge the social order. For another, they argued that the very model of violence underlying the logic of psychosurgery denied the political causes of violence that they had long been working to draw attention to and change. Alondra Nelson details the activism by the Black Panther Party to oppose the construction of this center, which they feared would lead to the further medicalization of violence and ultimately to the "further criminalization of social groups…and in turn justify calls for increased surveillance and social control" (2011, 155).

Historian Nic John Ramos further argues that the "epidemiology of violence theory" developed by the proposed violence center's main advocate, the Chair of Psychiatry at UCLA Dr. Louis Jolyon West, joined other movements in psychiatry in the 1960s that "upheld the belief that race and medicine held intrinsic explanatory power to locate and eradicate the origins of violence" (Ramos 2019, 59). Through an investigation

of these theories in relation to the community psychiatry movement and deinstitutionalization of California's state hospitals in the 1970s, Ramos shows how competing theories of the etiology of violence and race in psychiatry were mobilized to both "obscure the processes of racial capitalism that produced ill health" and to legitimize the further surveillance and control of black Angelenos in the era of broken windows policing. Ramos' work is critical to understanding how "the logics of a carceral society work to structure more than just the activities within prisons," and showing "society's difficulty with conceiving of individual wellness and safety without police" and medical authority, which are understood as intersecting systems of power (84).

In opposition to a "biological solution to a social problem" (Valenstein 1991, 550), activists highlighted how psychosurgery would serve as a tool of racial and gender oppression, connecting it to the diagnosis of "drapetomania," which was created as a way to pathologize slaves who ran away and was cured, per physicians at the time, by amputating toes (Students for a Democratic Society 1973). They also noted how surgeons advocating for psychosurgery's benefits in treating women patients, specifically, citing physicians' case notes that highlighted how women patients were "helpful on the ward, running errands" as successes of treatment (Students for a Democratic Society 1973, 3). Activists opposed to the violence center thus understood it as a political tool of racial and gender oppression, and saw psychosurgery as a dangerous tool in the hands of surgeons and researchers who, in the wake of the Watts Rebellions, maligned the largely black communities where the uprising had taken place as inherently, biologically violent.

Violence, public health, and King-Drew hospital

Although ultimately the construction of the UCLA violence center was successfully halted by the opposition of community organizers and activists, the question of violence as a public health concern continued apace in other arenas. Despite the narratives of hospitals being politically neutral spaces, the history of Los Angeles holds plentiful examples of how county hospitals become configured as both the solutions to the question of community violence and at other times as obstacles to the safety and wellbeing of the community. Following the Watts uprisings of 1965, the county proposed and developed a plan for the opening of a new county hospital in the largely black neighborhood of Watts, which existed in a no man's land of healthcare, adrift between the two county trauma facilities, LAC-USC Downtown and Rosewood-UCLA Medical Center in the South Bay. Sociologists Darnell Hunt and Ana-Christina Ramón examine how the hospital, which was named Martin Luther King Jr. Hospital and eventually affiliated with the only black medical school west of the Mississippi, Charles R. Drew University, was created explicitly with the intention of reducing the social strain that was thought to have provoked some of the violent uprisings (Hunt and Ramón 2010). The idea at the time was that in building this facility, the county would be providing much needed healthcare to the area as well as an avenue for professional and paraprofessional training and social mobility, and improving the overall wellbeing of the community in the process.

The hospital contained a trauma center, and was seen at the time as an essential part of the county's trauma infrastructure. In 1988, the Los Angeles Times reported that King-Drew hospital treated 3500 trauma patients, 40% of the county's total, and described how the hospital served as a training program for Army surgeons to get hands on experience in a hospital that staff had dubbed a "combat zone" because of the volume

of violently injured patients they treated (K. J. Garcia 1989).

But as the county grappled with budgetary crises in the 1980s and 1990s, the hospital came under increased scrutiny by both the media and local government. Hunt and Ramon unravel the media discourse at the time through a detailed review of the shifting narratives in the Los Angeles Times reporting on King-Drew hospital. While initially articles suggested that any issues with the hospital's operations were due to overwhelming demand and insufficient funding, the narrative soon shifted to the incompetence of medical staff and administrators despite ample funding. Following a Pulitzer-winning exposé series in the L.A. Times in 2005 that popularized the hospital's moniker "Killer King" and outlined the failures of the hospital to provide adequate treatment and suggested that both fraud and incompetence on the part of the largely black staff and administrators was the root of its issues, the hospital failed its regulatory review. Hunt and Ramón demonstrate how racialized narratives of medical and administrative failure were used to fuel the image of the hospital as a danger to the community's wellbeing, despite its origins as an institutional redress to community violence.

Despite the fact that the hospital's struggles were shared by the other county hospitals, and administrators' efforts to improve the hospital's operations were hamstrung by the county budget, the hospital was ultimately shuttered and privatized in stages, beginning with the trauma center, over the significant objections of the community (Lara-Millán 2021).

Sociologist Armando Lara-Millán provides a complementary analysis to this history of King-Drew by examining the intersecting forces of funding deficiencies and legal demand in shaping the county's approach to public hospitals in this period. In

2003, following significant community opposition to the privatization of the county medical facility Rancho Los Amigos, a federal judge ruled that the county could not make its planned healthcare cuts as a cost savings measure. Lara-Millán argues that this ruling shaped the future of King-Drew hospital by closing off budgetary concerns around the hospital's resource-intensive trauma unit as an avenue to closure. Instead, he suggests, the county was pushed to craft a narrative of King-Drew's closure as "a victory for progressive efforts" and patient safety (Lara-Millán 2021, 131). Doing so required a reliance on intense regulatory scrutiny coupled with media portrayal of the hospital as a dangerous facility for patients. The inception of King-Drew Hospital reflects how county hospitals can be targeted as themselves sites of community investment and violence intervention; the closure of King-Drew Hospital likewise shows how such investments can be set up to fail through insufficient county funding and politicized narratives of public safety now redirected and applied to the institution itself. In many ways, the hospital's trajectory provides a small microcosm of the shifting political narratives of violence and interplay between the role of medicine, public health, and the carceral state in addressing community violence.

The hospital as a site of violence intervention

This historical legacy of the hospital as a site of medical and carceral approaches to violence prevention is visible in the formal institutionalization of a hospital-based violence intervention program (HVIP), which was developed in 2017 and has grown significantly since. Designed with the intention of providing much needed services and longitudinal care to patients who have experienced intentional violent injury—defined somewhat narrowly as gunshot wounds, stabbings, and assaults—the program employs

case managers who are from the community and are trained to guide patients through the resources that are available to them and the bureaucratic processes required to receive them. The simple goal of such programs, which have become increasingly common and now number in the 30s nationwide (Dicker and Juillard 2020), is to prevent the somewhat tellingly named "recidivism," meaning reinjury or death by violence. This section examines the development of the Rosewood hospital violence intervention program within the historical context of Los Angeles, medical understandings of violence and its origins, and traces the implications this program holds for the responsibilities of trauma surgeons individually and the county hospital institutionally.

The design, funding structure, and implementation of these programs raise important questions about how medical and public health models of community violence and its origins conflict and overlap with other models of violence. While the broader systems of governance at the city, county, state and even federal levels lean predominantly on the carceral system as a tool of violence mitigation, local antiviolence activists, both today and historically, have identified health and medicine as a site of political struggle to improve community health and push back against the regimes of policing and incarceration that they see as sources of racist, state violence.

Models of the etiology of violence in medicine have a troubled history that has moved from overtly racist surgical interventions in purported brain pathology to a now more widely accepted liberal politics of public health intervention. Those engaged in the HVIP, both from a position of liberal public health-based advocacy and more radical, progressive desire for racial equity and community justice, must confront the complex, historically laden and politically vexing problem of violence and the embedded

positioning of the HVIP within that landscape.

The safety net hospital operates as a node in the institutional management of violence in the county that relates to other care centers as well as carceral institutions. Despite political pressure towards care-based alternatives to incarceration, sustainable funding and true county investment remains inaccessible. While the HVIP might have value in shifting discourse around violence and violence prevention away from punitive carceral models, such changes are limited by sustained imbrication in carceral state at the level of funding and services provided.

In many ways, the creation of the hospital violence intervention program was intended as a buffer against this kind of bureaucratic disposition of patients both within and from the hospital without meaningful care or attention to their broader existence. Championed by some of the hospital's most progressive doctors, those most committed to creating a public hospital that is invested in and addresses the real needs of the community it is situated in, the HVIP was envisioned as a way to extend the hospital's support both temporally and spatially beyond the confines of a hospital admission, with the goal of giving patients much-needed material and emotional support to heal from their injuries and hopefully avoid further victimization. The institutional work of creating and sustaining such a program, however, has proven to be exceptionally difficult with the limited and contingent resources available to the program and the hospital staff dedicated to sustaining it.

The office of the hospital violence intervention program is in a small building about a ten-minute walk from the main hospital building. Originally built as wooden Army barracks and designed only to last seven years, this office building, along with many others, has stood since the early 1940s when the hospital was initially built. The

case managers all work together in a single, small room, with a large center desk partitioned into six work spaces with two other small desks along one of the walls. There is a sliding glass door leading to a neglected courtyard, empty save for a layer of dead leaves. For some reason, they prefer to keep the shades drawn and the door closed, so the room is lit only by the bright fluorescent overhead lighting and smells strongly of Glade air freshener. The case managers all have different schedules and minimal oversight, so when I open the door, it is always a surprise how many people will be there—at times the room is full and bustling, with case managers on the phone calling clients or arguing over the weekend's baseball game. Other times, the room will be empty when people have gone to lunch or are on their day off.

In the evenings, usually the only person there is Aaron, a middle-aged Latino man who was the original case manager for this program and has been involved in community gang intervention and violence intervention for over a decade. Formerly a gang member himself, Aaron speaks charismatically and passionately about his personal transformation away from the gang lifestyle and into the community figure and mentor that he is now, a transformation that in his story was sparked by a moment of religious awakening. Affiliated with a gang since he was 11 years old, Aaron had gone to prison in the early 1990s as a teenager and was there for several years before being released early on parole. He will often describe how getting shot and injured himself and being in the hospital initially forced him to pause and reassess his life choices, but says he was always sucked straight back into his old thinking and way of being after just a day or two. It was not until later in his life, when he was around 30, that he was able to fully remove himself from the gang lifestyle and thinking. That shift came, as he tells it, from a true deus ex machina moment—walking in an alley with his gun, he fell to his knees

and had a direct conversation with Jesus. After that moment, he was saved, and eventually converted from the Catholicism he had grown up with to an Evangelical denomination that allowed for a personal relationship with God. Two weeks from then, he was sent to prison, which he felt was a gift from God that helped to remove him from his life and start anew. Since then he has been an active gang and violence intervention worker in the community, and has dedicated his time, both at the hospital and outside of it, to the work.

Every morning, the case managers receive a list of the patients who qualify for their services, which is created from a combination of the trauma surgery pass-ons patient list and referrals from social workers and doctors. The list is then reviewed by the case manager who is seeing patients that day, based on the schedule they have established for the week, and that case manager will then go to the hospital in person to introduce themselves to the patients and explain what they do.

One day, I go with Aaron and another case manager, Daniel, who has just started and is still training, and who I am meeting for the first time. He and Aaron are not strangers to each other, though—Daniel credits Aaron with helping him get out of the gang life and onto a better path. We go to see the first patient, a young Latino man who has been stabbed. After introducing himself, as always careful to point out that he is not a police officer or a doctor, Aaron asks where the man lives, and then mentions that he goes to church nearby there. As soon as Aaron says this the patient's demeanor changes, and he begins to open up and actually engage in the conversation. "I see you got the HA tatted so I know you need some type of support," Aaron says, and they both laugh. "We can be real now, I used to be in the lifestyle." He gives him a brochure and a card with his contact information, and lets the patient know he will be in touch.

When we leave the room, Aaron and Daniel give me a little lesson on gang geography and tattoos. “RA” refers to Rosewood Area, and even though some people might get the letters tattooed even if they are not gang affiliated, Aaron claims that if they “look like us” (referring to himself and Daniel) and have that tattoo, they are most likely in the lifestyle. During this conversation we are standing in the elevator lobby on the 6th floor, and after making this point Aaron turns to the security guard sitting behind us, a young Latina woman, and says “Right?” She nods, and he laughs and turns back, “See? I knew she was listening.” Aaron is always interacting with the people around us, whether he knows them or not, saying hi and cracking jokes. Walking to the stairwell, he makes a bid for someone’s pizza as he holds the door for them. Later he apologizes to one of the nurses sitting at the emergency department nursing station because he neglected to say hi the first time we walked past. Most of the time we walk through the halls he sees someone he knows personally, whether a patient or hospital employee. When I tell him that he is the friendliest person in the hospital he responds that it is part of the job, building that rapport with people.

Daniel has a similar personality—easy going, always smiling, often curious and inquisitive about my background and upbringing and thoughts on the world. He tells me about one of the patients who is currently in the surgical intensive care unit (SICU) but is improving and might be downgraded after months of care. He recalls seeing him for the first time and having an uncanny sense that he knew him, but attributing that feeling initially just to the fact that they looked similar—black, tattooed. But, unable to shake the feeling, he looks him up on Facebook and sees they have many mutual friends. He then calls around and talks to someone he grew up with, who reminds him that they used to live next to this patient when they were kids. He’s eager to talk with him,

because he is “high risk,” meaning he is likely to retaliate against whoever shot him if he ever recovers enough to leave the hospital. After we have seen all the patients, we talk about why they do the work. Daniel says that part of why the work he does is important because it has a direct effect on his life—if he can help someone then his kids might not get shot, or they might see him on the street and say oh he’s cool leave him alone. The stakes are personal for him.

Talking to Daniel a few months later, after he was settled into the work and had more experience, he reflected on the struggle he experienced between his desire to help people and help the community, and the frustration of realizing that he could not do so on his own. Beyond the other people and services needed to give people support and material resources, it was the person’s desire to change, willingness to engage with him, and ability to get their side of the work done. Some patients he enrolled were reticent to sign up for services, and completely dropped off contact once they realized that certain programs, like Victims of Crime (VOC) Compensation Fund run through the state of California, required participation in criminal proceedings against the person’s assailant. As the intermediary between these state-run services and the gang lifestyle he was familiar with, he did his best to walk a fine line between the two worlds—he had, for example, the best line of any case manager when discussing the VOC requirements: “You have to cooperate, but you don’t need to say anything.” Other patients were initially enthusiastic and invested in getting services but were unable to deal with the administrative requirements those services carried, even with the support of the case managers.

When Daniel first started, he expected that when he got someone to enroll that it would be “off to the races,” but the truth is that the patients have to meet them

somewhere and do their part as well—he cannot make a change in their lives without their investment and participation. Producing meaningful life change is a mutual, collective effort, rather than a unidirectional donation of aid. While some patients are available for and interested in forming longitudinal relationships with the case managers, who are then able to invest time and resources into supporting them as they recover, many others are not. The reasons for this lack of engagement were varied, and often outside the case managers' control. Some patients simply refused to participate out of hand, others would lose the brochures moving from one hospital room to another and become unreachable after discharge. Almost always, patients who were still in the hospital were deeply confused about the many different people helping them and what their respective roles were, since they met so many new and often rotating faces throughout their stay. A few who I spoke with felt a bit defensive even just at the name of the program, perceiving an attribution of responsibility or blame for their victimization. "People don't ask for things like this to happen to them," Mr. Brown said to me once. "It's sometimes like, at the wrong place at the wrong time. So sometimes there's just no way to avoid it."

Bridging public health and public safety

One of the implicit goals of the program is to reduce patients' arrest and imprisonment, but the HVIP has a somewhat fraught relationship to prisons and police at the level of interpersonal relationships and interactions as well as ideologies and broader structural entanglements. Aaron's perspective on police has been shaped by a lifetime of interaction with police and the prison system. Incarcerated at a young age, he spent a few years in prison for what he describes only as "one of the worst things a

person can do" before being freed on parole as a teenager. The sequence of events—crime, incarceration, early freedom, followed by a return to crime—informs his [understanding] of a fundamental relationship between punishment, order and life change. "Should they have done that?" he asks rhetorically, reflecting on the parole board's decision, "Absolutely not. That basically tells me that I can get away with anything." Without an extended sentence, he reasons, his return to the gang lifestyle was inevitable. That understanding of the corrective potential of incarceration led him to even suggest to the mother of a teenaged girl, who had been consistently in trouble over the past year, not going to school, spending time "in the streets," that her daughter might benefit from spending time in the juvenile justice system. Although he thought he might have offended her with the suggestion, he believed that sending her daughter there for a few months would give the mom a break from having to search for her when she runs away. Since she would be able to get her high school degree while there, he thought that "no question" she would be better off that she went there than continue on the path she was on, even if she may "get in a few scuffles" while inside. When the other case managers in the room—all women—push back on this idea, pointing to the emotional trauma of prison, as well as the potential for physical and sexual violence, he is dismissive, and says that we have been watching too many movies. [15]

When the topic of police presence in the community arises, several years after this initial conversation took place, Aaron takes an interesting structural vantage point in describing his understanding of the role of police— "They're like a gang," he argues,

[15] Currently, nearly 300 formerly detained people have filed a lawsuit against the county for decades of sexual and physical abuse at a wide range of juvenile detention facilities, only the most recent in a long string of abuse allegations, largely perpetrated by guards at the facilities (Winton 2022).

"because they're organized. What are gangs? Groups of people that are organized, whether good or bad." He continues, "They're able to use whatever allies, whatever power they have behind that badge to be able to do what they want, when they want, how they want to do it. And that's just the way it is. That's how gangs work." He then recounted a story of a 19-year-old he was working with through a city-funded community program, who, with the kind of critical thinking only a teenage boy could employ, decided to throw up gang signs while taking a photo with several LAPD officers working the same event. When the officers saw what he had done, they were incensed, and decided to follow through on a warrant the boy had issued to him months before that they had been turning a blind eye to for the sake of the program. Rather than wait for him to finish working with the children he was with, the LAPD officers opted to arrest him in the middle of a game, in front of everyone. The officers "did that out of spite, anger…bottom line," he concludes. "That's what gangs are good for—revenge. That was a vengeful move." This framing of the police has led him to develop what he calls a "professional understanding" with them—he accepts that their work is fundamentally opposed to them, and having any kind of relationship with them would compromise his standing and safety within his own community. Understanding of the undercurrent of investigation that lies beneath every conversation with police, he treats them with a pragmatic distance, understanding that if he were perceived by the community as working directly with police, he would have to "get up and move." "You have to keep in mind," he explains, "that no matter what question it is, it's for a reason…They don't waste words, everything, every conversation with a police officer is leading to something. And the minute you forget that the minute you start jibber jabbering…" So while Daniel, who was also present when that teenager was arrested, was angry at how it

went down and tried to argue with the officers, Aaron saw the futility in trying to push back. “They’re not gonna get it.”

This disagreement was part of a broader tension between how Aaron prioritized acceptance of police—violence and all—and social harmony, and Daniel’s frustration with the continued dehumanization and disrespect he has experienced and continues to experience in interactions with police. Recently, for example, he was playing in a park with his children at a park playground when several officers came over to him and, in front of his children, made him pull up his shirt while they photographed his tattoos. While this was happening, he turned to the senior officer, who he knew from the community events they had worked at together, and tried to reason with him, unsuccessfully, by explaining that he was happy to cooperate, but he did not want this to happen in front of his children. He describes how, as a black man, he has worked very hard not to react in the way that he is expected to react to such moments of humiliation and disrespect—with anger. But he cannot come to terms with how retaliatory the police are, and the level of violence they use, and still see them as the “peacekeepers” they claim to be. In his view, the police are incentivized to create conflict and discord within the community because it improves their job security, and ultimately constrains their ability to create meaningful relationships with people in the community. At bottom, Daniel is wrestling with the tension between a desire to create a mutually beneficial relationship that establishes peace and reduces violence in the community, and the reality of his interactions with police, which reflect how their respect for him, their understanding of his humanity, is conditional. At any moment, regardless of the work he has done, his standing in the community, his personal history with a given officer, at any moment he can be reduced back to a black ex-gang member, and any respect he had

eared will be snatched away.

Dr. Hastings, a trauma surgeon who was instrumental in establishing the HVIP at Rosewood, explained how there was "some crossover," between preventing violent reinjury and preventing incarceration, and described the "very careful balance" of working with police and maintaining patient privacy and trust. Although she saw the overall intention of the program as "diving into the root causes" of violent crime, which inevitably would help to prevent "[filling] back up our prisons in a revolving door sort of way," she was reticent to make that a primary metric of success. Describing a patient who had been shot and received services through another violence intervention program in California, Dr. Hastings highlighted how the program was able to make significant change in his "life course"; he went through a job training program and began working for the city department of public works, and worked there for years. But one day, while walking back to his home in the same neighborhood he had lived in for many years, he was shot again. After being treated for his injury, he called his case manager at the violence intervention program and apologized, reassuring his case manager that it "was not the program's fault" that he had been reinjured. "Is that a failure of [the HVIP]?" Dr. Hastings asked. Noting that this patient "still lived in a community that was vulnerable to violence," she argued that these programs "cannot change the ecology [of a community] overnight," and that this patient's reinjury should be understood not as a failure of the program but rather as the result of the "structural racism of the United States."

Dr. Hastings' comments reflect the conflict between the achievable goals of an individual service-based program like the HVIP, and the political origins of violence that continue to shape people's life chances and vulnerability to violence, whether they

participate in the program or not. Although HVIP advocates and public health researchers of violence often discuss how such interventions address the "root causes" of violence, stories like the one above expose the limitations of intervention that addresses the individual in isolation from their broader environment and "ecology," as Dr. Hastings put it. Without discounting the very meaningful change that the program was able to produce in the life of the patient whose story she recounted, the framing of the HVIP's intervention as "not a failure" when the patient was ultimately injured again appears to prioritize the operational achievements of the program over the patient's actual lived experience of violence. Positioning reinjury, once the gold standard assessment for these programs, as external to the failure or success of the HVIP facilitates recognition of the meaningful, tangible ways that case managers are able to connect to patients, improve their lives, and potentially change the course of their lives. But it likewise divorces the goals and aspirations of such programs from the broader political conditions of violence in the community.

Circuits of funding

The logic of this framing, which in many ways replicates the scientific structures of knowledge production by artificially isolating variables from their context in order to produce definitive results, becomes even more clear when understood in the context of the funding structure and institutional stability of the HVIP. Although the so-called public health approach to violence has grown in popularity and HVIPs themselves have grown steadily in number, their position, at least in Los Angeles County, is less stable than it would appear on outside glance. While other, more established HVIPs have found stability through direct integration into the city's budget, this HVIP has secured

its funding through a grant from the California Board of State and Community Corrections. Funding for and attention to violence prevention has increased significantly in recent years (Summers 2021). The availability of government grants has allowed the program to grow significantly from its inception, with only two case managers and a program coordinator, to now having seven full time case managers as well as a program director. But the contingent nature of grant funding produces its own administrative burdens—the physician directors find themselves working frequently to re-apply for funding and ensure that the grant-required monitoring and reporting is done correctly, and the program coordinators and case managers are forced to enter data across several, completely separate and unintegrated systems.

Dr. Hastings spoke on these difficulties in detail and their implications for the relationship between the program and the community it serves. "Why couldn't they be county funded?" she asks. "Could we just guarantee that this was going to be part of our comprehensive trauma center? …Part of it is, you know, having a good relationship with the community is proving to them that you're not going away, you're not going to disappear, you're not going to abandon them. And I think that's been a big fear for us, because grants come and go, and…being at risk of losing that and then abandoning the community I think would send a really bad message. How do we ever establish that we're a safe place for them, and that we're here to help them if we're not even secure enough to be a presence longitudinally?" An emergency medicine attending who was also very involved in the creation and development of the HVIP, Dr. Horner, described his own sense of exhaustion with the funding structure and administrative burden required to produce a stable program. This administrative work may be, as he puts it, "mundane," but it is far from meaningless—the program he created would not exist

without this funding. “It’s just been a little disillusioning,” he noted, “to feel like from the administrative side this program is just chasing grant after grant rather than developing a model of a good and useful program in our institution that would change things, rather than something that just works in the institution enrolling clients.”

What contributes to or perhaps structures this sense of disillusionment is not the meaninglessness of the work, but its apparent futility or endlessly circular nature, and the time investment that takes him away from programmatic involvement that might improve or develop the impact of the program. With minimal resources and insufficient staffing to create a program that not only operates smoothly but also successfully achieves its goals, his primary focus is forcibly wedded to making the program financially solvent, leaving him with no time to be “a part of” the program itself. This sense of futility or circularity of work is mirrored in his descriptions of his clinical practice:

> The hospital-based violence intervention programs really came about because, you know, people talk about the revolving door of patients, meaning they would come in and we would take them and they would be discharged out into the world, but come back again because nothing really changed for them. And it's always been thought of like, well, it's an external problem that nothing really changed in the world. So we created these programs to help them navigate that world into a new role. But I wonder also if like the, the reason for the revolving door, because it seems like it feels like a revolving door to *me*. Like when I'm on call, I just see a patient, help them, discharge them and it just, just cycles over and over like that. And I wonder if the problem is with us actually, it's our institution that needs to be changed to be

able to break that cycle, rather than just having a program like this say they're going to provide social services to patients.

The analysis he is presenting here is at odds with the hegemonic narrative that biomedicine is a neutral technology for which the only problem is that there is not enough to go around (Wendland 2010). By reframing public health discourse that localizes social pathology to a world *external* to the medical system as, in fact, describing an *internal* issue at the level of the institution, the object of intervention shifts away from the patients and onto the medical system itself. His use of the phrase "revolving door" is evocative here as both a public health term of analysis and description of his own place in the medical institution and recalls the endless loop of "chasing grant after grant" that he resents. Here again the indictment is of the institutional demands and constraints that keep clinicians treading water to stay afloat at the expense of higher-level institutional change that could improve care for everyone. These constraints are in large part tied to the political economy of public health care in the United States and in Los Angeles in particular—funding is minimal, and budgets at the level of the state, county and city largely prioritize funneling public money into law enforcement and carceral institutions rather than organizations of community care such as hospitals and other community health facilities (Chandler 2020), a topic Dr. Horner brings up himself. Unpacking the relationship to county and medical bureaucracy that hospital staff encounter reveals how "bureaucratic responses to social violence" work to "intensify suffering" not only for the objects of bureaucracy, in this case, the patients, but also for the subjects of bureaucracy—the workers responsible for the reproduction of institutional approaches to care that remove them from their human connection to the

people they hope to serve (Kleinman et al 1997, x).

Care, bureaucracy and disposition of violence in the emergency department

One night while in the emergency department, a patient arrived who had been placed on an involuntary hold for "danger to others" by her long-term care facility, where she had been yelling at staff members and throwing objects within arm's reach. She was sent to the medical emergency department because she was unable to walk and needed assistance with basic life activities, and was found to have a minor leg infection (cellulitis) likely caused by the medication she took for her blood pressure, a common side effect that was likely exacerbated by her bed-bound state. Because of psychiatry's complete inability or unwillingness to cope with even the most basic of medical issues, the patient was sent to the medical ED for treatment of her leg infection. Once there, she became an immediate problem, not because of her medical care, but in regards to her "disposition," [the preferred medical terminology for where the patient is sent (e.g., home, the appropriate inpatient service, or another care facility)]. Because she was effectively banned from her care facility due to the psychiatric hold, which they speculated was driven largely by the long-term care facility staff's exhaustion with the patient's agitation and "violence" towards them, she could not return there until the hold either expired or was cleared. The psych ED would not take her with her cellulitis, despite the fact that it is an issue routinely treated on an outpatient basis with an oral antibiotic. The medical ED is not designed to keep patients for any longer than necessary to stabilize them and send them to the appropriate place, so she could not languish there for the remainder of the 72 hours. The solution they improvised was to

effectively over-treat the patient's infection to force an inpatient stay by prescribing her an intravenous antibiotic. The conversation on rounds went something like:

Attending: Ok well what do you want to give her

Resident: I was thinking Bactrim [an oral antibiotic]

A: But if we do that there's no reason to admit her [oral antibiotics can be given outpatient]

R: Ok then what about ceftriaxone [an intravenous antibiotic that would necessitate inpatient admission]

A: Well she has an allergy to Keflex [another antibiotic structurally related to ceftriaxone, which would risk provoking a similar allergy]

R: Well we can't do anything like clinda that has oral equivalence [clindamycin is bioequivalent in its oral form compared to IV, meaning there is no justification to administer it intravenously if the patient can take it orally.]

A: Let's just do vanc [vancomycin is an intravenous antibiotic that is often used to treat more serious skin infections, particularly those that are likely to have methicillin resistant staph aureus (MRSA) bacteria (although both Bactrim and clindamycin also provide MRSA coverage). It is an effective drug but also carries a higher risk of side effects and toxicity.]

At this point the residents turned to me and the other fourth-year medical student and laughingly told us to cover our ears because this was not real medicine. Of course this is exactly what the *real,* daily work of medicine in a county hospital consists of. In the moment, I understood these decisions to be less than ideal, medically dubious, but strategically expert in navigating the hospital's bureaucratic requirements. But talking about the situation later with the attending, Dr. Horner, he was more critical—he

pointed out that he could have done things differently, by, for example, letting the patient hang out for a few hours before calling the facility and trying to talk them into dropping the hold and letting her return. That approach was not a sure bet, and also required an additional level of follow up that admitting her would not. On a broader level, even thinking about those additional dimensions of her care required a kind of mental load and attention that is not always available in high acuity, busy clinical spaces like the emergency department. "It's weird, it's almost like I turn my brain off," the attending explained. "There's almost not enough space to be able to reconcile all the problems and structural things and get really good at what you're doing." The "doing," in this case, is both the clinical work and the navigation of bureaucracies that structure both this hospital's operations and its relationship to other care facilities in the county. Without the time or "space" to situate the patient within her broader context and think about how he might intervene on a different, non-medical level, he opted to follow the path that addressed her disposition issue and allowed him to move forward and on to the next patient.

The operations of the ED with respect to the rest of the hospital and broader medical system are interesting and a bit more complex than the classical metaphor of a funnel, selecting and sorting who is deserving of a bed in the hospital and who is not. The relationships between the ED and the hospital are much more reciprocal, in that the patients seen in the ED are sometimes sent by medical and surgical services specifically for a workup. Likewise, and much more commonly, the patients seen in the ED who do not require an inpatient stay are often supplied with imaging and labs that are not necessary for their immediate evaluation but that facilitate and expedite their outpatient work up and care. In this way the ED functions cooperatively and reciprocally with the

broader network of services. The hospital operates not as a standalone center but as a point of concentration for rapid and resource intensive administration of care, and resources in this case take the form of technical and technological capacity as well as the specialization and availability of staff. These relationships complicate a heuristic understanding of the emergency department as a space largely animated by concerns around determination of "real" or "deserving" need for care. This critique of hospital care, although often appropriate, does not capture the entire apparatus of the ED. While the primary goals of the ED are to distinguish between, crudely, patients who are actively dying or not, and patients who require inpatient care or not, those determinations are not exclusively ruled by a cynical or pecuniary obsession with preserving hospital resources over care.

While on a shift in the emergency department, I noted how some patients who were seen were unable to receive diagnostic imaging, (e.g., a shoulder MRI to evaluate for a tendon injury), because their injury was not severe or dangerous enough to warrant the attendant time and resources, several other patients seen that evening did receive care that would not materially impact the course of treatment in the emergency department, yet was ordered nonetheless as a means of speeding up diagnosis in a county medical system in which it may take months to schedule care and obtain an official diagnosis. For a patient with a colovesicular fistula [a hole between the patient's colon and bladder], as well as another patient with a likely new lung cancer diagnosis, imaging and labs were ordered explicitly with their future work up and care in mind. In these moments, the emergency department clinicians are wielding the resources at their disposal to help patients receive timely care that will potentially impact the course of their illness in a system where delays are the norm rather than the exception.

These connections are forged through the temporal and spatial relationships of care. Because every patient's stay in the emergency department is by definition temporary, and in fact the operation of an ED is often measured based on the amount of time the average patient spends in it. I am reminded again of the MSF doctor interviewed by Peter Redfield who argued that "for a doctor, there is no emergency that lasts." It is this structuring limit on the time a patient spends here that produces a constant outward—towards outpatient care—and inward—towards hospital admission—orientation in ED clinicians. This orientation is driven by a caring pragmatism towards the patients.

Spending time in the emergency department, I was struck by the largely empathetic stance most residents took towards patients and their recognition of the layers of poverty, addiction and violence that produced many manifestations of illness, seemingly without judgement. One resident even said it felt "wrong" to forcibly sedate and medicate a young schizophrenic girl who had threatened other patients in the waiting room and was repeatedly trying to leave her room. Certainly this expression of empathy was a low bar to clear, as the practice of forcibly medicating and restraining patients is one of the clearest examples of direct medical violence, yet it remains a routine practice for controlling and caring for patients deemed violent or disruptive.

This patient's hospitalization is also important to contextualize within broader practices of deploying psychiatric holds and the constant availability of the emergency department as a strategy of violence intervention and management deployed by other caring and carceral facilities throughout the county. Historian Nic John Ramos tracks the massive increase in public funding for state of the art emergency departments and away from preventative health that began in the 1980s, a move that was deemed by

public health experts as "irrational and unnecessarily costly," to argue that funding for emergency departments would be best understood not as investments in the infrastructure of public health, but rather as part of a "security archipelago of police, fire, 9-1-1 operators, ambulance services, prisons, and state hospitals that helped citizens maintain a sense of safety and security" (Ramos 2017, 253–54). This shift in funding priorities was fueled by the "social, political, and sexual panic around racialized violence" mobilized by politicians in the wake of the Watts uprisings (253). Emergency rooms fulfilled a role in the production of public safety through the fear of being caught in the wrong place at the wrong time and not having access to adequate medical care, and thus appealed to both white suburban voters as a means of securing "white collective safety and mobility," as well as black and brown voters who feared being caught in violence within their neighborhoods (255). These policies were further entrenched by the passage of amnesty laws for undocumented immigrants, an estimated 32% of which resided in Los Angeles County, as well as the Emergency Medical Treatment and Labor Act (EMTALA) in 1986, which guaranteed emergency medical stabilization at any ER.

The status of safety net hospitals as continuously available, public institutions that cannot turn people away provides a mechanism for managing the incompetence of other state agencies. Klein details how the constant availability of services and mandate of universal acceptance without eligibility requirements means that emergency rooms "'solve' both individual and systemic problems…families, the police, and social agencies use the emergency room for treatment as well as detention. These two functions are inextricably intertwined" (Klein 2010, 218).

Conclusion

How can we situate and understand the responsibilities and relationships that the county hospital carries with respect to the community it is embedded within? Ethnographies of institutions have explored how medical care is transformed across institutional contexts and spaces. "Hospital ethnography" (van der Geest and Finkler 2004) has emerged as an important aspect of medical anthropology that considers the hospital as "an intensive space where critical moral, political, and social questions arise regularly and with great urgency," and likewise a space where "broader political, social, and moral forces in society" converge (Livingston 2012, 42). Goffman's canonical work on what he calls "total institutions" delves into the particular forms of control and confinement at work in institutional spaces and its effects on the people within them (Goffman 2007). He connects both sites of medical care provision and punishment in aligning the asylum with spaces of punishment and genocide—the prison and the concentration camp—by outlining a shared set of logics and methods of enforcing obedience, conformity and separation from the outside world. Although his work has been widely used to expose violent institutional logics and the "constant conflict between humane standards on the one hand and institutional efficiency on the other," more recent anthropology (Hannig 2017) has worked to uncover how such institutions operate not as silos from but in constant communication with their environments (Goffman 1978, 78).

Lorna Rhodes' *Emptying Beds* uses a Foucauldian analysis to untangle the institutional binds, conflicts and ambiguous relationships that emerge between doctors and patients in a psychiatric emergency department (Rhodes 1991). Although written 30 years ago, her ethnography could easily, and somewhat depressingly, describe the inner

workings of contemporary public hospital. The space of the emergency department emerges in her ethnography as both chaotic and regimented, with clinicians struggling against the irreconcilable demands of the institution, the needs of their patients, the resources available and their own waning emotional investment in their patients' health. The staff themselves describe the unit as "an enclosed and prison-like space," but one that operates with the ultimate goal of disposition rather than confinement, with one physician stating, "Here, *everyone* is an inappropriate admission. I don't admit patients, I discharge them" (40,41). Rhodes shows this logic to be rooted in an approach to medical care in which the (seemingly) futile goals of treatment have been supplanted by a desire for competency; the needs of their patients appear so vast, and the resources to treat them so limited, that the staff reshape their sense of competence and fulfillment around the goal of rapid patient management and discharge. This goal is aided by the logic of emergency care, which by definition is temporally constrained (recalling the comments of a former head of MSF-France— "as a doctor, there is no emergency that lasts"), as well as the constant demand for rapid action as new patients arrive, itself undoubtedly the product of the limited and underfunded health care for the severely mentally ill (Redfield 2005, 347).

The logic of disposition here is an echo of the "rapid dispatch" that Scheper-Hughes (2009) documents in the bureaucratic response to child death in Brazil—the staff at this psychiatric unit treat the human suffering they encounter as irrelevant to the substance of their jobs. Repeated visits to the emergency department are not evidence of a systemic failure to treat the underlying illness, but rather become an expected outcome of their patients' deplorable inability to manage their own illness on their own (Mizrahi 1985). This "revolving door" phenomenon, as it is often referred to in medical

literature, highlights another aspect of how this unit, punitive and disciplinary as it may be, differs from Goffman's conception of a total institution in that the primary work is not focused on the "management of a relatively stable population of chronic patients," but rather "the management of movement" as the public hospitals' commitment to serving all those in need exceeds the available resources (Rhodes 1991, 43).

Thinking about the clinicians that Rhodes writes about in these terms reflects how, in some ways, the clinician's investments in their professional roles as bureaucrats more than caregivers functions as an acceptance and reproduction of the broader state commitments to the patients they treat—or, more accurately in the case of the United States, the neglect and lack of value, resources and investments in health. The political economy of healthcare in the United States reflects the broader indifference to the health of the poor, racialized, and otherwise oppressed groups that the public institutions are tasked with treating. Assuming the role of bureaucrat, simply administering suffering and managing the movement of bodies, becomes a form of alignment between clinicians' expectations for their patients' health and their role in intervening on it and the acceptance of ill health and suffering for the poor reflected in the politics and policies of health care funding at the county, state and federal level.

Despite the incommensurability between the needs of patients and hospital resources, ethnographers of care in environments where medical and material resources are scarce have highlighted the ways that care can in fact exceed its material circumstances—Wendland (2010), for example, shows how political commitments to their patients protect medical students in Malawi from the same patterns of dehumanization, indifference and pathologizing blame that characterizes medical socialization in the United States, despite a profound lack of both staffing and supplies.

Likewise, Livingston's (2012) study of an oncology ward in Botswana reveals caregiving to be a "moral endeavor…at once deeply personal and deeply social" (113). She makes the argument that the care provided on the oncology ward, as part of a system of universal care, operates as "an extension of the state's commitment to care for its people" (113). The residents at Rosewood, too, often find themselves working against the bureaucratic exigencies of the hospital in order to fulfill their duty to care for patients and address their health needs beyond what the system has to offer. Learning to manipulate the system's insufficient resources to their patients' benefit is thus a central element of training. Sophie, one of the chief residents in general surgery, discussed how "a lot of what we learn in this residency is how to maximize the system." She then gave an example of a patient she had admitted while on the trauma service who, based on his clinical status did not require admission, but who was suffering greatly and who she did not want to have to go through the long process of waiting for a clinic visit and scheduling a surgery outpatient. "I know if I admit that patient, that patient has to be staffed with an attending today or tomorrow or whatever, and I also know that we'll talk about that patient at pass-ons and Dr. Lendon will know that the patient is here and is having a chronic problem and needs surgery. And it kind of pushes the whole system towards getting that patient what they actually need to make their life better. A guy who's saying, I have no life I can't live like this anymore."

Dealing with the social elements of their patients' lives plays an outsize role in residency training, and having few resources, relying on their own grit and inventiveness to get things done in settings where nothing is easy, provides a source of meaning and pride in their work. Avi, for example, told me a story of having a patient who had no phone, and did not know the number for any of his family members. The

only information he could provide was that his brother worked at a burger restaurant somewhere in the area. To find him someone who could help care for him at home, Avi opened up Google maps on the computer, searched for burger restaurants, and went one by one, calling each restaurant and finally finding him. Or the story of a resident who was awarded employee of the month (with a special parking spot, of course) for driving to a patient's home to find her dog, who she had been perseverating on and deeply worried about since getting admitted. Apparently, when he arrived at the patient's house, he learned that her son had kicked the dog out. The resident found the dog wandering the streets and brought it back for another resident to adopt since the patient could no longer care for the dog herself.

These stories were often told to me to underscore the residents' commitment to their patients, as well as the lengths they often went to in order to provide care. Yet as much as these anecdotes worked as signposts of their work ethic and caring relationships, they were just as often given as evidence of how much of their labor was, to their deep frustration, "non-medical" and the result of the facility's dearth of resources. How then might we understand the ways these surgeons construct their relationship to the idea of the "community" that the hospital serves? What can we learn from the differences between this relationship and the commitments and investments in community that the HVIP case managers share? And how does violence—the politics of it, the embodied experience of it, our uneven vulnerability to it—shape these relationships and structure their differences? Steven Gregory writes that "The notion of a community 'bounded' by a common history, social identity, or sense of attachment to place not only elides [its] heterogeneity but also obscures the central role that efforts to define the meaning and limits of community play in the political lives of urban residents

and in the construction of their collective identities and commitments" (1998, 11). For many of these surgeons, the community the hospital serves and the violence it experiences is imagined both as a source of training, of learning, as well as the recipient and beneficiary of this learning. But they worked to maintain a distinct separation from it—physically, economically, and in terms of their sense of social responsibility to it. Unlike the HVIP case managers, many of whom have experienced violent injury, some of whom have been treated in this hospital, unlike the Turkish doctors, who found themselves as targets of state violence, the trauma surgeons do not share the same intimacy with violence as their patients. Those who do hope to foster more meaningful relationships to their patients and create systems of accountability and public power in the hospital through community-based programs like the HVIP find themselves up against the demoralizing forces of county bureaucracy and tightly rationed resources.

Chapter 4

Policing the Safety Net: Medical and Carceral Management of Violence

"Incapacitation"

One patient on the trauma surgery service had been shot and was just starting to heal from surgery when he decided it was time to leave. The only issue was that his abdomen, swollen from the trauma of his injury and the surgery he needed to repair it, could not be closed fully and was being held together with a small strip of sponge attached to a vacuum, a setup known as vacuum-assisted closure or a wound VAC. Without monitoring, and without the vacuum portion of this setup, his wound would be left open to the elements—he would likely develop an infection and potentially compromise the healing of his abdominal fascia, which would be catastrophic and potentially lethal. Multiple layers of hospital staff met with him to try to convince him to stay, including nurses, interns, trauma surgery residents, and psychiatry residents, without success. One surgery resident decided, after talking with the patient, that his desire to leave despite the threat to his health and safety constituted a "lack of insight" into the consequences of his decision. "Insight" is one of the criteria used in determining whether a patient has the capacity to consent, thus labeling the patient as lacking insight was effectively a way to corral the patient's autonomy and not allow him to leave. "I incapacitated him," the surgery resident explained to me later, which I found to be a very telling formulation.

Although the typical usage of the term "incapacitate" implies a physical maneuver that renders a person unable to move or exert agency, in this case the resident used it to

describe a medical determination that described a medico-legal process with deeply physical implications. The residents then consulted psychiatry in order to place the patient on a 5150 hold for grave disability, but before they could see him the patient decided to leave. Because of his label of impaired insight, the patient was unable to leave against medical advice (AMA), as that process requires the patient to sign a form indicating that they understand the risks of their decision. When the patient left, or "eloped," he was first stopped by several of the hospital's Sheriff's deputies, who after talking with him determined he was lucid and therefore they could not attempt to hold him in the hospital against his will. Ultimately, the HVIP social worker was the person who was able to convince the patient to return to the hospital, after calling him, his sister, and his wife repeatedly. In those conversations, she learned that the patient's ex-wife had left their young child at the hospital, which compelled him to leave in order to care for the child. The patient's encounter with the Sheriffs, in conjunction with his child being left at the hospital, resulted in a Department of Child and Family Services (DCFS) case being opened.

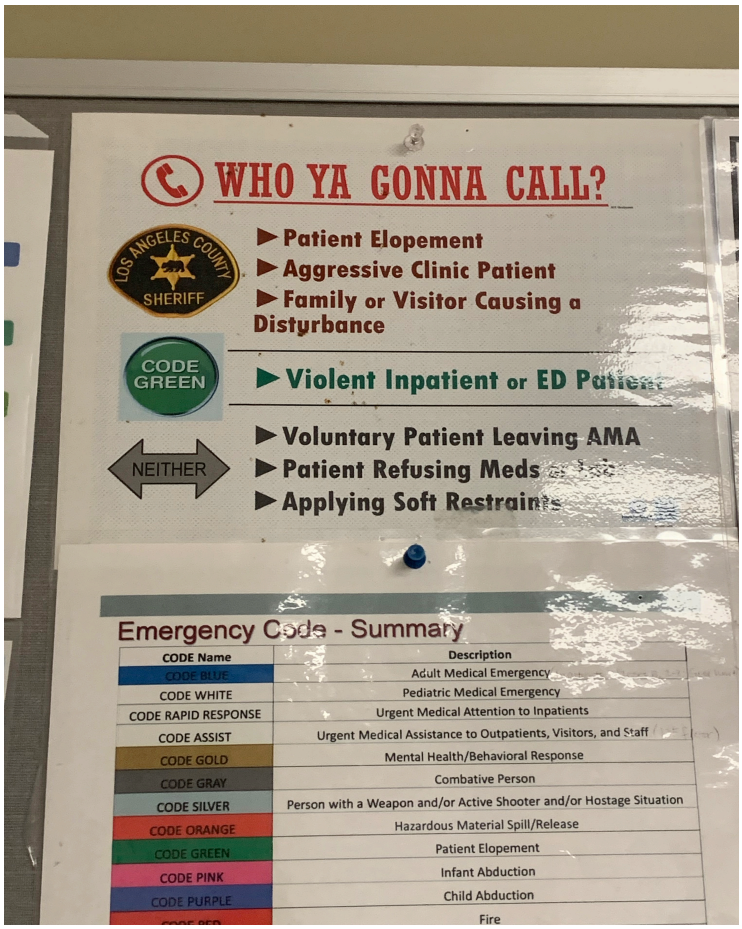

Figure 2: Institutional management of patient behavior

This patient's story is not remarkable, and talking to the residents I heard a seemingly endless stream of stories about patients who had left with life threatening injuries who they had never seen again and had possibly died. Other patients have a different experience of hospitalization, and are involuntarily kept in the hospital in order to receive care. This detention is accomplished through chemical and physical restraints and the presence of the sheriffs, and is justified legally through a combination of psychiatric holds, emergency exemptions, and the determinations of the patient's incapacity to make decisions for themselves. This patient's interaction with the hospital

institution—the trauma service, the sheriffs, the HVIP, social work—show how the collision of care and violence is lived by the patient who, in their need for lifesaving medical care, becomes the subject of multiple forms of control, state surveillance, and criminalization.

Understanding the criminalization of this patient requires attending to the multiple, intersecting forms of medical and police interventions he experienced. Once being labeled as lacking capacity to leave against medical advice, the patient's departure was considered an "elopement." Seen in the image above, clinical staff are instructed to call the on-campus Sheriff's substation when patients elope, inviting direct contact between the deputies and the patient. In this case, the patient's "lucidity," as determined by the deputies, secured his freedom—what might have happened differently if the patient had been (understandably) angry, upset, or interpreted by the deputies to be "unstable"? The racialized interpretation of patient affect and psychiatric illness becomes a central way that police and medical control over the patient's body is organized (Ramos-Zayas 2011).

The involvement of DCFS is an example of what Dorothy Roberts (2022) calls "family policing," the system of child separation that often begins in clinical spaces as the result of California's far-reaching and strict reporting laws. Her work demonstrates how this arm of the state operates with minimal legal protection or oversight, with agents entering homes without warrants and proceeding with cases that leave little room for parents to advocate for themselves and their children. This process is also deeply racialized; a 2021 study estimates that nearly 60% of black children in Los Angeles will experience a DCFS investigation at some point in their childhood (Edwards et al. 2021). Through this structure of mandated reporting, which demand that

clinicians and social workers report any instance of suspected child abuse or endangerment to the state, the hospital becomes another interface between the carceral and welfare operations of the state. Not unlike the examples of refusal of care discussed in the prior chapter, the patient's claim to autonomy and freedom butted up against the medical infrastructure that prioritized the administration of (potentially lifesaving) medical care over the patient's own desires. In this case the surgery team attempted to deploy the custodial functions of psychiatric care, by labeling the patient as unable to understand the consequences of his refusal.

The imbrication of the custodial and treatment functions of the emergency department shown in the previous chapter likewise extend into the hospital more broadly. For every patient who is grateful to have been cared for over their own protestations, there is another who demands to be free no matter the cost. But for every patient who is able to walk away, there are several who are detained, incapacitated, or otherwise held against their will. In these cases, the hospital's duty and ability to care for patients who refuse it is directly dependent on its function as a custodial institution. Without the power and capacity for detention, the hospital would not serve these patients. This chapter probes the mutual construction of surgical, psychiatric, and carceral power over the patient body that is routinely on display in the public hospital. What space is there for clinicians to meaningfully protest, counteract, intervene in police violence in the hospital? What legal, moral, professional claims can be made against these forms of violence? How do our own practices of physical restraint, bodily control/violation enable our complicity in these forms of state violence, and how might they provide an alternate path?

While hospitalized, at times against their will, patients are subject to multiple

forms of criminalization from police, who are a frequent component of hospital care, and clinicians, who are often conscripted into carceral projects, alike. Considering the historical context of these collaborations illuminates their character and the foundation upon which these relationships are built. Bringing this history into conversation with ethnographic data from the public hospital today, I argue that the county hospital should be understood as both a point in the "carceral archipelago" (Foucault 1995) that forms the broader system of policing and incarceration in the county, as well as a site from which to combat and contest these forms of state violence. I explore this conflict through ethnographic and interview data with trauma surgeons, who grapple with the competing demands of their responsibility to care and their complicity in patient criminalization. The county hospital operates as a site of violence management and intervention even beyond the formal program considered in the prior chapter—patients deemed violent, aggressive, or disruptive are brought to the hospital for both treatment and detention—and is thus a productive site from which to examine the ways that the "violence work" (Seigel 2018) of police is obscured, legitimated, and normalized.

Code Gold: therapeutic and custodial logics combine

Nowhere are these historical connections between surgery, psychiatry, and the carceral state more visible than in the hospital's practices of intervention in patients labeled disruptive, agitated, or violent. The trauma bay serves as a site where physical violence is treated and behavior labeled disruptive, aggressive, or violent is corralled and controlled. Patients are often upset and angry, often for good reason, and can present a physical danger to the hospital staff. Behavioral response teams, of which the Code Gold team is a core example, have been developed in many hospitals as a specialized and

experienced clinical response to violence that minimizes harm to the patients and staff. They are not, however, benign interventions—whether or not the Code Gold team is involved, the response to patients who lash out at staff, either due to drug use, medical distress, or psychiatric illness, is typically one of physical and chemical restraint. The clinical and institutional response to the "combative patient" is also a place where medical care and control often confronts police authority, and is thus a moment of vulnerability for patients to police violence and carceral control. Dr. Walker described a relevant experience from his own time as a resident:

> What I saw happen was a patient would get agitated, potentially for a medical reason, right? Like they're hypoxic or hypoglycemic. Whatever the response was, we're going to show up in force and talk about this idea of keeping everybody safe. But what we're actually going to do is put hard leather restraints on people and chemically sedate them. And the example I'm thinking of is, fairly early on in my intern year here, there was a man who was accused of some sexual crimes against children who also happened to be like a very physically large intimidating guy. And he had a Code Gold, which actually I don't even think we called a Code Gold at that time, like a psychiatric alert code overnight. I was the on-call overnight intern and I got called to the bedside and basically as I'm rushing up there, this guy is freaking out like he'd ripped off one of the whole arms of the bed and was swinging it around. And the sheriffs were there with like, maybe not, they didn't have guns drawn, but they were armed and they were showing up with force and the nurses were screaming, and everybody was like, give him all these, we used to call it 'triple ripple,' which was like IV Ativan IV Benadryl, and I think

> IV Haldol maybe, all together, some sort of combination of sedatives. And I felt so intimidated and these guys have guns and this guy's crazy and everything. He's a child molester, and he's gonna beat me up and all this stuff. And I ended up sedating him and the reason that he was freaking out is because he was hypoxic, he couldn't breathe. And my chief resident totally chewed me out the next morning and was like, 'What the hell were you doing? You have to be a doctor first.'

Dr. Walker's experience as an intern reflects how ideas of what constitutes "safety" become significantly transformed by the intersecting processes of criminalization experienced by this patient. How did the patient's emotional response to his medical issue escalate to the point of forcible sedation and restraint? The patient's status as an alleged criminal undoubtedly shaped the form that the medical response took to his agitation and frustration. Dr. Walker reflects on how his perception of the patient as a threat, in conjunction with the embodied presence of sheriffs with guns, produced a sense of intimidation and fear that led him to sedate and overpower the patient before evaluating him medically. The presence of the sheriffs, which formed part of the ambient criminalization of this patient, ultimately facilitated more violence by clouding his nascent, limited medical judgement as an intern in this high acuity context, with harmful effects on the patient's health. His recollection of this incident also points to an important ideological mechanism of policing generally, which is its construction as an arbiter of "safety," an appellation that obscures the significant "violence work" police are tasked with. By juxtaposing the "idea of keeping everyone safe" with the mechanism used to do so, "put hard leather restraints on people and chemically sedate them," Dr.

Walker highlights the violence embedded in the psychiatric/behavioral response, which itself might be understood as a form of medical policing, and the potential for this procedure to act in conjunction with broader carceral systems of control. While in the opening vignette of this chapter I described a case where the systems of medical control in the hospital functioned as a substrate for contact with the sheriffs and criminalization through family policing, Dr. Walker's experience reveals the inverse process, where police presence and criminalization produce medical violence. These examples show ethnographically how systems of medical and carceral control operate synergistically in the space of the county hospital.

His reflections on the relevance of this moment to his clinical training also emphasized how his role and responsibility as a doctor was shaped in opposition to this moment of violence—his chief resident criticized him for his response and told him to be a "doctor first," implicitly counterposing the role of police—to detain and overpower—with his role as a clinician, which is to assess and treat. What is more, learning to attend to the medical care of the patient even in the face of chaos and disruption becomes a central feature of training. While this attention is often learned on a background of machine noises, other clinician's voices, and patients' demands, this example makes clear that the police are taken as another element of the hospital infrastructure that Dr. Walker must learn to regulate his own reactions to in order to competently perform his job. These kinds of interactions with police in patient care are relatively common in this hospital, and produce conflict and tension for surgeons who are made complicit, either willingly or unwillingly, in police action.

Police violence and psychiatric illness

Patients having psychiatric crises are particularly vulnerable violence not only outside the hospital, but within it. While the Code Gold response carries its own forms of harm, it is a response primarily made up of clinicians as well as unarmed security guards who are trained to restrain patients. Two Sheriff's deputies, although present, are not permitted to interact with or lay hands on the patient unless they are actively instructed to by clinical staff. There have been, however, notable and tragic moments where police were directly involved with patients in such moments—at Rosewood-UCLA, one of the three county hospitals and a Level 1 trauma center, there have been two fatal police shootings within the hospital itself.

In 2015, LAPD officers shot and killed Ruben Herrera in the Emergency department at Harbor-UCLA Medical Center in Torrance (Staff 2015). He was 26 years old, bipolar, and according to his family had been fixing his bike in the front yard when the police approached him, looking for someone who had been throwing bottles in the area. LAPD officers brought him to the emergency department after physically assaulting, pepper spraying, and tasering him before arresting him in front of his home. His parents, who witnessed the beating and his arrest, contest the police account that he had "viscously attacked" the police and report instead that it was the police who initiated the physical contact, and that Mr. Herrera had never hit the officers. After being medically cleared in the emergency department at Harbor-UCLA, the officers removed Mr. Herrera's handcuffs from the gurney he was attached to in order to transport him. The LAPD officers alleged that at this point, he assaulted them and reached for their gun, and they then shot him. In a lawsuit brought by the family after his death, the medical examiner testified that he was shot in the back, while lying on the ground. The jury granted the family a $3.5 million dollar settlement (Knoll 2017).

In 2020, another psychiatric patient was shot and killed at Harbor-UCLA, this time by a Sheriff's deputy who was there guarding an injured colleague in a nearby room. The patient, a 38-year-old man named Nicholas Burgos, was admitted to the hospital when he became upset and began acting out. Rather than wait for the Code Gold team, which responds to many such incidents on a routine, daily basis throughout the hospital, the Deputy ultimately shot Mr. Burgos seven times. He died a month later, after receiving care in the surgical intensive care unit and undergoing multiple operations (Winton 2020). The timing of Mr. Burgos' death, in the fall of 2020, coincided with a moment of national (and international) uprising and activism following the murder of George Floyd. Several months into the covid pandemic, the uprisings provided a channel for communal expressions of grief, anger and solidarity. They likewise brought renewed attention to the issue of police violence against Black Americans that has been a target of sustained organizing and activism, most recently in the form of the Black Lives Matter movement that emerged in 2014 after the police murder of Michael Brown.

In the immediate aftermath of the second shooting, hospital staff gathered together to protest the act of violence and call for the removal of the sheriffs from the hospital space. Local governmental bodies, such as the Board of Supervisors and the Civilian Oversight Commission, which investigates sheriff misconduct, responded by inviting testimony on experiences with the sheriffs in the hospital from community members and clinicians. A task force of community members convened by the Board of Supervisors recommended removing the Sheriff substations from the county hospitals completely, and minimizing or eliminating police interaction with patients in medical settings (Nagami and Nakano 2021).

The hospital itself responded by creating an internal committee to review the incident, which led to minor institutional reforms, like mandating that all outside police check in with the hospital's own LASD sub-station on entry. Many of the clinicians, however, took a more radical oppositional approach, calling into question the very presence and legitimacy of having armed police in the hospital. A statement issued by the Department of Family Medicine at Harbor labeled the incident as an example of unacceptable "gun violence," and called for the removal of police from behavioral code response teams (Harbor-UCLA Department of Family Medicine 2020). Protests were held by clinicians and community organizers in front of the hospital, both of which called for the removal of police from care spaces such as the hospital (Tchekmedyian 2020). These calls were echoed the following year by the Los Angeles County Community Prevention and Population Health Task Force, which described police violence as "a public health issue," pointing to the physical violence as well as psychological stress experienced by patients—particularly black patients—during encounters with police. The report drew on this platform of care to advocate for the removal of the LASD substations in all DHS facilities and reallocation of those funds directly to healthcare providers, which they describe as a "care first" model (Nagami and Nakano 2021). This language was directly connected to the broader movement in Los Angeles towards a politics of "Care First, Jails Last," codified through a voter-approved ballot measure, Measure J, in 2020, which allocated 10% of the county's funds to "address the disproportionate impact of racial injustice through direct community investment and alternatives to incarceration" ("Care First Community Investment (CFCI) | LAC -JCOD" n.d.). This local movement joined a shift in mainstream medical attention to and framing of the issue of policing and incarceration. In 2018, for example,

the American Public Health Association issued a statement, "Addressing Law Enforcement Violence as a Public Health Issue," which highlighted the structural racism mediating police violence and called for a "public health strategy that centers community safety and prevents law enforcement violence" (American Public Health Association 2018).

Recent research in medicine and public health has underscored the harms of policing in the hospital, including increased mistrust in medical institutions (Alang, McAlpine, and Hardeman 2020), patient privacy violations (Harada, Lara-Millán, and Chalwell 2021), police shootings (Rosenthal 2016), racial discrimination in security requests (Green, McCullough, and Hawley 2018), trauma patients' withholding information from clinicians who they fear may collaborate with police (Liebschutz et al. 2010), and delayed care (Jacoby 2018). Despite this evidence, the securitization of hospitals has only increased in recent years (Lara-Millán 2014; Gallen et al. 2022), and police have become culturally and institutionally integrated into hospitals with minimal policies to regulate these interactions (Janeway, Samra, and Song 2021).

History of police in Los Angeles hospitals

The formal relationship between the county's police force—the Sheriff's Department—and the hospital system emerged only in the 1990s. The Los Angeles Sheriff's Department (LASD) was contracted to work in substations within each county hospital beginning in 1993 as a direct response to a moment of highly publicized violence in one of the county's emergency departments (Lara-Millán 2021). In 1993, a

man named Damascio Torres, entered the emergency department at LAC-USC,[16] shooting four doctors and holding two staff members hostage for several hours before surrendering. This moment of hospital violence ignited a debate around its cause and potential avenues for future prevention, giving a window into the process by which police become installed as solutions to violence even in spaces of care. The L.A. Times published articles at the time that emphasized the understaffed, under-resourced nature of the hospital, and connected the often long wait times to the patient's violent outburst (Mitchell and Hubler 1993). The news narrative suggests that the anti-doctor violence that emerged in this instance was borne out of the patients' negative experiences with doctors and systems that did not have the resources to adequately help him in a timely manner due to the recent billions of dollars that had been cut from their budget (Cros 1993). Armando Lara Millán develops this line of thought in his book, showing the political process by which the resources allocated to the hospital's construction were knowingly insufficient for the scale of patient demand. One of the driving arguments of his book shows how the USC hospital, which was in disrepair and needed to be rebuilt, was built to be much smaller than necessary. The county's own commissioned report argued that the hospital would require a minimum of 750 beds in conjunction with increased outpatient resources to support the health needs of its residents, yet the hospital was built for 600 beds only as a way of obtaining federal funding. This infrastructure decision, Lara Millán argues, came as an attempt to recategorize the patient population as largely homeless, indigent, and outpatient, and therefore the responsibility of the federal government, who then stepped in to bail out an increasingly

[16] Los Angeles County-University of Southern California Hospital, recently renamed Los Angeles General Hospital, the largest public hospital in the county.

insolvent county health system that was flailing in the wake of conservative tax reform in the county during the 1980s.

After this shooting occurred, the county had a choice in how it would proceed in order to address the issue of emergency department violence. In order to establish the structural conditions of the county's emergency departments as the implicit cause of Torres' attack, Lara-Millán provides a somewhat incomplete portrayal of Torres as having a political agenda. It is clear from court records and L.A. Times reporting that Torres was floridly psychotic at the time and convinced, despite negative tests, that he was infected with HIV. Allowing the quote "They made me wait, now I'm going to make them wait" stand in for a coherent "motive" when the quote itself and broader narrative were both provided by police is a bit irresponsible (Mitchell and Hubler 1993). In fact, the reliance on that specific police narrative around the shooting being a premeditated, retaliatory attack on the doctors at the hospital aligns itself with the state's argument that Torres was not insane, knew what he was doing, and therefore could not plead out of prison time. This argument was made successfully in court despite the fact of Torres' obvious psychosis. That being said, reporting at the time does speak to an attempt by other patients to connect the inhumane conditions of the ER waiting room and disrespect patients felt at the hands of doctors to the legitimacy of the violence as a means of drawing attention to their experience and frustration—a nurses' union official said, "People get mad when they wait 16 hours and are still not seen," and one patient who was present during the shooting was quoted as saying, "They treated him with no respect. They should have addressed him a little bit better. Everybody's human, and he was sick."

The theory of violence and its etiologies that underlies the county's decision-

making process centered on two primary causes: the general criminal character of the patients who sought care in the county emergency departments, and the conditions of overcrowding that precipitated violent behavior. These patients, who we know to be largely black and brown, under and uninsured, poor and disabled patients, were characterized as unhoused and relying on the emergency department for shelter and drug distribution. The other element of their alleged criminality was the "gang-infested" community surroundings. The overcrowding was taken as a precondition of violence, but, Lara-Millán argues, was abandoned as a target of primary intervention. Lara-Millán lays out three possible solutions that the county entertained as responses to this crisis moment—increasing the number of hospital beds to admit patients more quickly, installing temporary trailers to decompress the overcrowded waiting room, and security-based measures like the creation of a sheriff substation and the hiring of additional police officers and a specific gang prevention unit. The fact that the county dismissed the possibility of the temporary trailers, which would have been by far the cheapest available option, because of regulatory concerns that patients would not be within supervision of medical staff in case of emergency, is taken by Lara-Millán as indication that regulatory demand complicates a facile notion of welfare retrenchment as a process of steady defunding and shapes the institutional forms of the welfare state during this period of budgetary crisis.

As convincing as this point may be, it does not shed additional light on the decision to fund the security-based measures over care-based or staffing solutions. While he recounts that the idea of adding beds was dismissed out of hand because of the budgetary crisis at that time, he does not linger long enough on this idea to explain why that same budgetary crisis mysteriously vanishes when it comes to funding police

presence in the hospital. This question, of how and why the notion of public safety has been secured through increased resources for police, prisons, and other carceral infrastructure of punishment over structures of care, welfare, and health, is precisely what abolitionist scholars who outline the "retrenchment-criminalization thesis" engage in. The narrative of county negligence producing violent agitation was effectively demobilized and suppressed by constructing the population of the ER as criminal and in need of policing. Rather than focus on the issue of extremely delayed waiting times due to insufficient staffing and beds, they opted for a police-based response—installing a substation of the sheriff within all county hospitals in Los Angeles. Lara Millán understands this decision to be one of legislative need, or "legal demand," rather than outright criminalization.

Yet, in my reading, his analysis is constrained by his narrow focus on contesting the now well-established argument that the carceral state of the 1980s was built on the back of welfare retrenchment (an argument he dubs the "retrenchment-criminalization thesis"). Perhaps caught in the reactive pendulum of academic knowledge production, he appears intent on demonstrating the shortcomings of retrenchment and criminalization as explanatory models rather than thinking about how the role of legal demand interacted with those forces at this particular moment in history. Instead of arguing that the retrenchment-criminalization thesis "fails" at anything, I wish Lara-Millán had used his rich, detailed, and extensive archival research to point to the ways that criminalization is mobilized to meet legal demand in order to address the social fracturing and stress that austerity produces, albeit in a violent, counterproductive way. These political economic conflicts around resource allocation are what put county hospitals at the center of ongoing ideological and material struggles between carceral

logics of safety, which posit safety as a product of police violence and incarceration, and abolitionist models of safety that emphasize the need for community connection, support and care.

Welfare state, security state

Understanding the logic and process behind the securitization of the public hospital demands an engagement with a critical analysis of the cooperative, linked evolution of the welfare state and security state. While the 1980s Reagan-era War on Drugs has been marked as a critical period for the expansion of the carceral state, often secured on the back of welfare retrenchment and cuts to public services, some scholars have pointed to the continuities and political foundations that this period shared with the earlier 1960s War on Poverty. Rather than understanding the pro-policing and incarceration policies that emerged from the War on Drugs as a radical shift from the prior more liberal and service-oriented policies of the 1960s, historian Elizabeth Hinton shows how the disruption brought by the Civil Rights movement and urban uprising in the face of wanton police brutality, most notably the Watts Riots of 1965, was viewed by even the liberal contingent of politicians at the time as a cause for increased policing of specifically black urban youth (Hinton 2016). Thus even the services funded by President Lyndon B. Johnson's War on Poverty were targeted as crime intervention policies—"federal policymakers treated antipoverty policies less as moral imperatives in their own right and more as a means to suppress future rioting and crime," which was manifest in the yoking of "education, health, housing and welfare programs aimed at eliminating crime's root causes" to "police training, research programs, and criminal justice and penal reforms intended to suppress criminal activity" (23, 24).

Political scientist Naomi Murakawa argues that liberal racial paternalism was a significant if often overlooked political thrust towards the establishment and growth of the U.S. carceral state (Murakawa 2014). While the explicitly racist conservative rhetoric that emerged around "crime" (a wholly unstable and incoherent category) often bears the blame for the massive increase incarceration that began in the 1980s and continues today, Murakawa notes that liberal conceptualizations of the roots of crime and violence also rested on an assumption of black criminality and urban violence rooted in white racism. She describes these two perspectives as "'competing' constructions of black criminality, one callous, another with a tenor of sympathy and cowering paternalism" (2014, 10). Embedded in this view of black criminality was an understanding of racism as a psychological problem rather than set of structural relations or the result of a biological racial hierarchy, which had a direct impact on the set of solutions that were pursued to address it: "liberal law-and-order agendas flowed from an underlying assumption of racism: racism was an individual whim, an irrationality, and therefore racism could be corrected with 'state-building' in the Weberian sense—that is, the replacement of the personalized power of government officials with codified, standardized, and formalized authority" (11).

Ruth Wilson Gilmore develops the related concept of the "antistate state" to describe this paradox by which the state "grows on the promise of shrinking" (Gilmore and Gilmore 2008, 152). Citing Peter Evans, Gilmore notes that the state moves to secure its legitimacy by eliminating "'services that the affluent can supply privately for themselves,'" and reshifts its purpose: "What the state promises to deliver is protection," an analysis that recalls Foucault's conceptualization of the biopolitical state as one that is produced through apparatuses of security (13). In her analysis, prisons and policing

have come increasingly to function as "catch-all solutions to social and political problems," a move that is deeply connected to the evisceration of welfare benefits. Gilmore suggests that the expanded funding of prisons and policing operates as a means of consolidating state legitimacy through both "a claim to provide social 'protection'" and, echoing Weber, a "monopoly on the delegation of violence" (151).

Ruth Wilson Gilmore highlights how during the economic downturn of the 1970s, it was the welfare programs initiated through the War on Poverty that bore the blame for public overspending and were thus subject to massive cuts in the name of austerity. Yet this responsibility was clearly due to ideological rather than fiscal priorities. In building a case for the failures of the welfare state, politicians relied on gendered and racialized constructions of its use, most notably in the figure of the "welfare queen," which portrayed a black mother as the paragon of welfare abuse. For example, anthropologists such as Bourgois (2009) and Garcia (2014) have shown how budgetary cuts to health care institutions and clinics often continued even as the economy flourished, leaving the most vulnerable without access to the public health and safety net resources they relied on for care. Aumoithe (Aumoithe 2021) details this process in his archival investigation into the shifting landscape of public safety net hospitals in New York City in the 1970s. He outlines how economic pressure to cut costs at the federal level led to the closure of several public hospitals, which "harbingered public hospital retrenchment elsewhere" and illustrated the ways in which "privatization consumed public space in American cities" (2). Gilmore describes this process as the "privatization of resources that the affluent can supply themselves," and shows how it has historically been coupled with an increase in the security functions of the state, such as policing and incarceration. Ruth Wilson Gilmore's framing of the state's repressive

and reformist "fixes" of racial difference, the entanglements between the welfare and security state emerge as mutually constitutive poles of state power. As she puts it, "the oscillation between reformist and repressive 'fixes' is not a simple binary movement but rather overdetermined at the source" (Gilmore 2002, 21).

Police in the hospital

During one trauma call shift, around five pm, the trauma team is paged for a patient coming in with a gunshot wound to the head. From the information in the page, it sounds very bad, likely not a survivable injury. He apparently had been found in the street by police, and there were several Sheriff's deputies accompanying him when he was rolled in by paramedics. He is a small, young black man. His head is wrapped in white gauze with pink blood and spinal fluid leaking through. He has an ankle monitor on. Someone comments that it looks like an execution, since he was shot at such close range. He is not responsive, and is intubated immediately. As they are doing the initial assessment and intubating him, one of the nurses is handling his belongings and charting all of his information. At one point she moves to hand one of the deputies the patient's wallet, which is covered in dried, dark red blood, stopping short only when she realizes the deputy is not wearing any gloves. She puts the wallet in a small plastic biohazard bag. The deputy then retreats to wait in the hallway, watching everything through the glass doors and listening in to the general conversation around us. A different nurse asks him what had happened, and he says he's not sure since another unit had gotten there before him, and he had found them there doing compressions, but they said they had just found the patient in the street. I notice that he is wearing a temporary visitor sticker with his name and the date; I doubt anyone would have

stopped him from entering even without it.

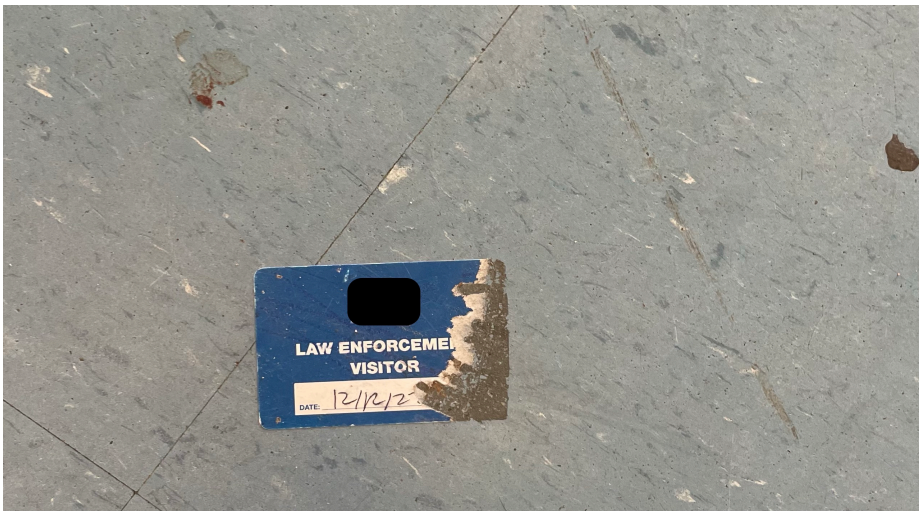

Figure 3: Police visitor badge

The team then goes with the patient to the CT scanner to get imaging of his injury. The sheriff's deputies remain outside in the hallway. Once the imaging is done, the team goes outside to run the list,[17] huddling together only a foot or two away from the deputies who do not appear to be paying real attention. But then the physician assistant from the neurosurgery team appears, having seen the patient and discussed the imaging with his attending, and says to the trauma chief resident that they will not be operating on this patient who has been shot in the head because it is not a survivable injury. Now the deputy is very obviously listening, and does not have to struggle to hear anything since we are standing right next to him. With this information, the trauma team heads out of the emergency department and goes upstairs to tend to their other

[17] "Running the list" is the process of going through the patients one by one, discussing what needs to be done to make sure everyone is on the same page.

patients.

Police are a constant presence in this emergency department. Waiting in the trauma bay hallway, standing over patients in custody who are sitting, cuffed, waiting to be seen. The emergency department presents a particularly fraught space for patients, who are often brought either involuntarily or emergently, frequently sedated with pain medication, and then interviewed by police officers investigating. While police typically allow the medical team to evaluate and resuscitate the patient when they initially arrive, after the flurry of activity subsides and the patient is stable—and alone—the police will enter the patient's room to question them about the sequence of events that led to their hospitalization. At times these conversations are welcomed by patients, who are grateful for the police presence, which they see as their only or primary means of justice and restitution after being injured. But more often, these conversations are at the very least questionable in terms of the patient's capacity to consent, their physical, emotional and legal vulnerability, and often their racial vulnerability to police violence.

Within the trauma bay, police often appear in the background of the early resuscitations. For surgeons and emergency medicine providers, their understanding and awareness of police presence is often limited to this initial moment of patient contact, and their level of attention to police is directly related to the level of interference they present to patient care. Typically, this interference is minimal—the police wait in the hallway to the trauma bay, observing without interrupting, only asking for information from the providers once the patient is stabilized. But once the medical teams complete their initial assessment, they leave, and the patients are alone in their rooms, medically stable but still injured, emotionally overwhelmed, and sedated from pain medication. This is the period of time when police enter the patient rooms to

interview the patients.

Legal scholars (Patel 2022; Song 2021) have recently begun to unravel the confluence of medical vulnerability, constitutional privacy protections, and policing to argue that police are granted inordinate leeway in conducting investigations in hospital contexts. Song (2021) explores the relationships between violence, medical care and policing in hospital emergency rooms from the perspective of the law and its implementation. She notes how the emergency room operates as a "portal" for police because of the kinds of patients and care it provides—on the one hand, urgent medical sequelae of stabbings, gunshot wounds and assaults (which constitute the working hospital definition of violence) are always seen first in the emergency room and are often transported by police or at their behest. On the other hand, waning investment in primary healthcare and a growing population of uninsured and underinsured patients has led to the emergency room becoming the primary location of medical care provision for poor and racialized groups (86). Complicating matters, the courts have ruled that the emergency room is, for the purposes of Fourth Amendment protection, contiguous with the public street and therefore is an acceptable place for police to conduct investigations.

Her work shows convincingly how the public and universally accessible nature of emergency departments has led to a significant reduction in the scope of patients' constitutionally protected right to privacy, as the courts have determined that the emergency room is an acceptable terrain of police inquiry and investigation. This determination has also been justified by patients' lack of autonomy with respect to medical staff's access to and authority over their bodies, as the Fourth Amendment right to privacy is a *descriptive* standard, rather than a *normative* standard; therefore, the

less privacy you have, the less privacy you are entitled to. The emergency room thus operates as an important site for understanding the negotiation between medical and legal approaches to violence (Mulla 2014). Following other scholars of race, state violence and legal privacy rights such as Khiara Bridges (Bridges 2017), Song shows how legal doctrine in this case serves to multiply and concentrate vulnerability to violence in the space of the emergency room by effectively ruling that "the cost of obtaining medical care is police access" (105). Beyond spatial access, the relationship between medical providers and police has a direct bearing on the information police are able to garner from patients as well as its very legality. Medical providers thus occupy dual roles with respect to the state and their patients—as agents of the state and as clinicians—the ethics and responsibilities of which are often in conflict in regard to patient privacy and protection from harm.

Trauma surgery and the police: conflict and complicity

From a legal perspective, the relationship between hospital staff, medical providers and police thus has a direct and critical bearing on the information police are able to garner from patients. Courts have ruled that police investigations in the hospital are an inevitable result of clinician's responsibilities as mandated reporters. Medical providers thus occupy dual roles—as agents of the state and as clinicians—the ethics and responsibilities of which are often in conflict in regard to patient privacy and protection from harm. Yet, interviews with trauma surgeons reveal how the presence of police in the emergency department is not only legitimated through legal doctrine but also through professional allegiances between clinicians and police and a cultural acceptance of police as affiliated with or otherwise belonging to the hospital.

Dr. Lendon acknowledged the trauma bay as a site of significant overlap between police action and surgical care. “The point of the spear is right there, in the trauma bay, where violent injury meets law enforcement, mental health care.” This intersection places trauma surgeons at the center of competing interests between clinical care and police investigation and detention of patients. “At what point does the does a person become less of a suspect and more of a patient?” Dr. Lendon asked, “And when do patient rights trump being a suspect in custody? And what are the priorities that we should have?” These tensions between the criminal and medical control over a patient who has been violently injured shape the interactions between police and surgeons in the trauma bay. “The trauma surgeon is the team leader, is the one that’s pushing back,” he continued, “to make sure that we provide the best possible care for our patients.”

Multiple trauma attendings have described how managing police presence in the trauma bay becomes integrated into their responsibilities once the patient arrives. While part of their impulse to remove police from the room is simply “crowd control,” to reduce the chaos and make space for the clinicians to work, another driving force is to establish boundaries of responsibility and authority through enforcing spatial divisions. “I ask our patients to be uncuffed when they come into the trauma bay one because I need to take care of them,” Dr. Walker explained. “But two, that’s not…I don’t feel like that’s the police officers’ domain. They can stand at the door.” The issue of patients being handcuffed also speaks to the overlapping but distinct medical and police approaches to patient detention, and the distinction between their roles more broadly: “Even if the patient’s violent, we’ll do our own restraints…I don’t, we don’t want the police officers to have a role.” What distinguishes medical restraint and police restraint is the intention and goal, as well as the perception of the patient and why they need it.

While police restraint is used to secure safety *from* the allegedly criminal, dangerous patient, medical restraint is (at least idealistically) deployed as a way to ensure safety *of* the patient. "We restrain people without handcuffs to keep them safe, and that's really the concern…They're dying of hemorrhagic shock, I don't think they need handcuffs." Other descriptions of medical restraint illustrate how those procedures also contain significant violence, yet this distinction in approach and intent is, I think, important. "I always sort of operate on the principle of—maybe I'm naïve—I don't think that our patients are going to hurt us," Dr. Walker explained. "Could it happen? Absolutely. And certainly people get kicked and punched, and that stuff happens. But I think…I don't think the handcuffs are going to make that better or worse, and so, I think [keeping handcuffs on] is horrible patient care." Dr. Walker highlights how approaching people as patients rather than suspects requires removing the lens of threat, even while he acknowledges the very real potential for physical harm that exists for staff. Being a tall, white man, Dr. Walker notes that his decisions around patient restraint are often understood as "cavalier" by some of the other clinical staff. While he does not specifically mention who has, implicitly or explicitly, labeled him as such, it is worth noting that nurses, who remain overwhelmingly women, are the most vulnerable to workplace violence in the emergency department (Kansagra et al. 2008).

Beyond the desire for unfettered provision of medical care, this drawing of boundary lines by surgeons is also aimed at securing medical authority over the patient in that space. "I feel like once you come into the hospital," Dr. Hastings argued, "you're ours. I feel like the police jurisdiction sort of ends. When [the police] are in my space, it really bothers me, it really makes me mad. And it really bothers me that I have to ask them to step out, because I'll be honest, I'm intimidated. And it's a really uncomfortable

feeling to be like, I need you to step out or closing the curtain. I don't think I should have to do that as a doctor, I think that line is kind of sacred. And I need to do my job to get this patient better." Drawing attention again to the burden of controlling police presence in the hospital space, Dr. Hastings emphasizes her discontent with that responsibility, which she positions as fundamentally outside of her role as a surgeon. "It's very intimidating," she explains, "I don't like it at all. It's uncomfortable. I don't want to ask people to step out, I want to just be in the zone."

Conflict over territories of authority were most pronounced when police were present to provide security for other officers who were ill or injured. [The Sheriff's deputy who killed Nicholas Burgos was there guarding another injured deputy in a nearby room.] "Honestly, of all the things I hate treating at this hospital, number one I hate treating police officers," Dr. Walker declares. "I remember a police officer got shot once and it was like tangential hip, didn't hit the bone just went into the muscle, and like all of [the local division of LAPD] showed up [at the hospital]. The Chief of Police came in. He tried to barge into the CT room, I had to grab him by the shoulder and pull him out…And I swear to God, he looked at me like, 'I could have you killed if you don't get your hands off me.' There's like an arrogance." At about 6'4," Dr. Walker was able to rely on his own physicality to control the situation, but it is easy to imagine how that interaction could have gone differently had another attending been on call that night. "The mass of people that show up, it's overwhelming. It makes it really difficult to treat people. And there's just no…they don't feel any restrictions on their movement."

While on the whole descriptions of police becoming confrontational or aggressive when denied access to patients were rare, conflict did occur. Dr. Walker reported that early in his career, LASD deputies who arrived with a patient to the trauma bay were

being “super aggressive,” and at one point the emergency department attending, a woman, was being “shouted down.” “I think at one point I had sort of been focused on the patient and she was kind of getting threatened by the sheriff in a way where I almost wanted to apologize to her. I was like, I’m really sorry I left you in that position.” In my own experience, officers and deputies were typically deferent to clinicians in the trauma bay space, whether during emergent situations or after the patient was stabilized. Often they would even ask me if they were in my way or if they should step out of the room, simply because I was wearing scrubs and a badge. But when they wanted or needed information, they might badger every clinician in sight, asking for information or for blood samples to confirm whether the patient had been driving while intoxicated.

When one patient came in—stabbed in the abdomen—two LAPD officers were with him as he was wheeled in to the trauma bay. Once he was safely on the operating table and in the process of being prepped, I went to the elevator to go back to the ED and check on the officers, only to find them already in the elevator when the doors open. The social worker deposited them in front of the reception desk, directly across from the window into the operating room and several large monitors displaying the medical information of every patient on that floor, and promptly left. After a minute or two, the charge nurse came down the hallway and upon seeing the officers, immediately asked them to leave. One of the officers bristled, asking “Why do we need to leave? I thought it was fine as long as we don’t cross the red line.” She asked whether the patient was in custody, and the officer responded “No, but we need to know his status.” She remained firm, calling someone to escort them to a break room, and informed them that the doctor will update them when the patient is out of surgery. After a few minutes of back and forth, the officers relented and were taken to another room.

Talking about this night with the residents and attendings, I learned this was not an uncommon phenomenon. The police often would follow the patients and surgery team into the elevators that lead directly to the operating room, sometimes even holding the door so they could ride with the patient. When patients who have been violently injured are being operated on, the police can often be found standing in the operating room hallway or sitting in the staff break room. But as in the example above, the procedure for where police should and should not be is not a universally agreed upon and consistently applied set of rules; rather, the level of access police have—to restricted hospital spaces, to private patient health information, to patients' bodies—is determined through a contested conjunction of institutional and personal histories, conflicting forms of knowledge and expertise, and the general temperament of the people who are interacting. While that charge nurse was adamant that the police were not entitled to occupy space within the OR hallway, within full view of private health information of other patients as well as with a small, windowed view into the operation itself, others are more permissive. Another day, I found two sheriff's deputies parked in the hallway, one standing facing the operating room, the other sitting and scrolling on his phone. When I asked what they were up to, the seated deputy informed me that someone had been shot and they were waiting to see whether he had died.

When talking about the confusion around and uneven implementation of hospital policy in this context, Dr. Hastings mentioned that there was some procedure established for police to check in with the OR charge nurse, but she questioned whether that was an appropriate solution. "I'm not sure it's their responsibility to enforce that. That puts them in a very…like they're here to be a nurse, right? They're here to help the patient. It's not their job to oversee whether law enforcement is crossing the line. It's not

a fair responsibility to give them. It's not a fair responsibility to give to the physicians either." Underlying her sense of frustration is, in my view, an unwillingness to be brought into the work of policing, either in the sense of collaborating *with* police investigation and detention by providing information and allowing patients to remain handcuffed in the hospital, or in the broader sense of securing the spatial and informational boundaries around her patients' care *from* the officers and deputies looking to encroach on them. "They cross lines all the time," Dr. Hastings asserts. "They cross treatment lines, they cross in the ICU, getting information lines, they don't respect HIPAA." When I ask about specific moments of boundary crossing, she reiterates what I had observed: "They'll come into the elevator with us," she confirmed. "When the patient is literally dying, they come into the elevator with us and go up to the OR. Multiple times we have to say, 'Don't cross this line because you're not sterile.'" In moments where police are invited into the OR environment, Dr. Hastings discussed how that invitation created an implicit alignment between police and surgeons: "Sometimes the charge nurse will be like, 'Oh, the officers are in the break room waiting to talk to you.' I'm like, I don't want to fucking go talk…Why are they in our break room? It's almost like an assumption that we have to be on the same side."

But this perspective on the routine violations of police was not shared by every attending. Some, like Dr. Walker, approached their presence with an indifferent acceptance: "Having police officers upstairs near the OR, I don't really have a problem with that. I feel like I've been indoctrinated into the way things are, I don't necessarily think about them objectively. I've always been places where…trauma is inherently associated with police because it's inherently associated with crime." Despite his own interactions with police interfering with care, he accepts their presence and action

within the hospital because of their role in responding to violent crime, which is likewise a routine element of his own responsibilities as a trauma surgeon. But his acceptance was tempered by an understanding of the fundamentally incompatible goals of police and surgeons. “The missions are not aligned,” he commented, “I think my role, and I think the nurses sort of feel the same way, is that we are here to advocate for our patients. I'm not… I'm not a law enforcement officer. And I think we're very uneasy doing anything at the behest of law enforcement because it's not necessarily in the interest of our patients.”

Custody and blackout

Conflict and confusion around authority over violently injured patients while hospitalized continues after the initial period of resuscitation and operation. One issue that arose were the attempts made by police to restrict communication between the clinical team and the patients’ family. This pattern occurred largely when patients were either in custody or on “blackout” status, where their presence in the hospital is hidden. There are specific criteria for who can make this determination and under what circumstances, but police are permitted to do so if they suspect a patient might be the target of further violence or retaliation while hospitalized. Although restrictions on visitors or direct communication between patients and their family are legally appropriate for police to make when patients are in custody, the same restrictions do not apply to clinician communication with family. Understanding of this differentiation varied widely, however, between trauma surgery attendings. Dr. Hastings, for example, was under the impression that when patients are in custody, that clinicians are “not allowed to communicate with the family,” although she recognized that her

understanding might not be accurate. “This is my understanding. Do I know if it's true? Could I swear by it? No. But …I defer a lot to social work to sort of tease that out for me.” Dr. Walker, although also unsure of the exact policy, took a different approach: “I choose to remain a little ignorant of the actual policy on it, because, again, I’m not here for the police. And so I think people should be able to talk to their family members.” When he has been instructed not to communicate with the patient’s family, his response was one of suspicion “Can you actually stop me from doing that? I don’t actually know.”

Others, like Dr. Lilley, rejected the idea that police could forbid communication with patient family: “That’s not true,” she asserted. However, she does make a habit of calling the detective in charge of the relevant case and confirming. “The beat cops say things. When you call [the detective] and say, ‘I need to talk to this patient’s family to give them a medical update, they almost universally say, ‘Okay.’” She explains that she makes these calls because “it just saves me a bunch of trouble later” to have that explicit permission if she receives pushback from nurses or other officers. I interpreted this habit in two ways—on the most simple level, it reflects a level of deference to the authority of police. On the other hand, having trained at this hospital as a resident, Dr. Lilley was intimately familiar with the various opaque and internecine bureaucratic webs that structure the hospital’s operations, and was well trained on learning the most efficient ways of navigating them. Receiving direct permission from a supervising officer allowed her to proceed with her intended plan while bypassing any future dissent that might otherwise derail or delay her. Dr. Lendon took a similar tact, even further streamlined by his years of experience, “It usually doesn't come up in the first little while after the patient comes in because I just ignore the police. I just ignore them. And I say [to the patient], ‘I’m going to call your family, what number do you call them on,’ before

[the police] can tell me 'Oh, you're not allowed to have contact with the family.'" If the police do attempt to restrict his communication with family, he reports that he will, "push back pretty hard on those, because I think that becomes inhumane and you're violating patient rights."

Patient vulnerability

Multiple attendings also spoke to the role of police in helping patients and saw the information that they provided as clinicians as a form of patient advocacy. But the question of patient vulnerability while hospitalized was likewise a recurrent theme when discussing interactions between patients, clinicians and police. The conjunction of physical vulnerability due to injury and the effects of sedation makes leaves patients open to police interrogation and investigation while in the hospital, with little legal or clinical protection. Some clinicians, like Dr. Hastings, commented on the "protective role" they felt was necessary to have in order to act as a buffer between police and patients. "This person doesn't have any legal representation. They have a health problem. And so [the police] can't come in right now. And you're violating their rights, because also, by the way, we just gave them fentanyl." Institutionally and logistically, this layer of protection that a given trauma attending might provide is, unfortunately, patchy at best. Following the initial assessment and resuscitation of patients, if they are not taken to the operating room then they typically remain in the trauma bay for some time, but the trauma team will be quickly off to see the next patient or begin operating. Likewise with the emergency department physicians, who are busy with a constant influx of patients.

This setup leaves patients alone in the room, with nurses attending to their

immediate needs, along with those of the multiple other patients they are responsible for. Dr. Walker summarized the patients' position concisely, "They are sort of like sitting ducks in the room." "There's a lot of times where the presence of a police officer, you're not, you're not inherently detained. And people feel like they can't leave, but they can leave…But in the hospital. You're sort of stuck. Especially if you want to get your medical care, but again, you're not detained." Song (2021) emphasizes how the legal vulnerability of patients compounds their medical vulnerability—in one case she reviews, the patient was physically immobilized and incapable of leaving the room, however the court ruled that she had not been formally detained by the officers because "[her] confinement was unrelated to police conduct' (State v. Pritchard, as quoted in Song 2021, 2672). Reflecting on the patients' injuries and likely sedation with pain medication, Dr. Walker adds that "We wouldn't let them necessarily consent for an operation, but we provide the environment where they can speak to law enforcement."

One patient, who received an operation and spent nearly a week on the trauma service, complained to me that he had not been contacted by police at all and had not had the opportunity to provide his story to them. I had to remind him that in fact, he had spoken with an officer almost immediately after arriving. Whether from the adrenaline, sedatives, or anesthesia he received afterwards, the patient had no memory of that conversation.

Beyond the privacy violations, which are numerous and often include sensitive health information, the constant physical presence of police in the emergency department has a meaningful impact on the quality of both patient care and relationships between clinicians and patients. "Simply having a law enforcement person present staring at them the whole time," Dr. Hastings commented, "can be alarming…It

changes the interactions that everyone is having with that patient. Like that person's not going to be, I think, as open or honest with the care team and everybody because it's sort of like now we're affiliated or associated with that." In fact, multiple studies have demonstrated a correlation between increased police presence in hospitals and a diminished level of patient trust in their care providers, with some patients even opting to delay or forgo care out of fear of police interaction (Jacoby 2018, Tahouni 2015). The reputation of public hospitals as "police strongholds" in the community is a longstanding source of mistrust in medical institutions (Ehrenreich 1970, 15).

Building professional reciprocity

Despite widespread recognition of the discrepancy in goals and approach between police and clinicians, an attitude of collegiality with police often pervaded my conversations with attending surgeons. Song (2021) suggests that the relative lack of attention paid to policing in hospital contexts compared to other public institutions may stem from hospital staff and clinicians' view that police presence is "fully justified, even desirable" (2649). "I don't know how to explain it," David, a trauma surgery fellow commented. "It's like law enforcement is almost an extension of what we do, naturally…police officers and Sheriff's deputies have free rein to come in and out of our emergency rooms and hospitals and the nurses and the medical staff treat them as if they're our coworkers." His comments reflect how the presence of police in the emergency department is not only legitimated through legal doctrine but also through a cultural acceptance of police as affiliated with or otherwise belonging to the hospital (Janeway 2021). Dr. Lilley voiced her perspective on the professional allegiance that she felt with police:

> Sometimes the information that we give or get from one another can become super important. There's certainly things that I've learned about how, what was the violence of the scene, or what was the circumstance, that become relevant to me making decisions. The only place I would have gotten [that information] from was from [the police]. Just like how us providing information about the injuries that we encountered, or other things now becomes relevant to what they're trying to identify or find. So I think that there is certainly an overlap, where we really need to work together and help one another."

It is important to contextualize the extent of police presence and involvement in this county, safety net hospital. Although their presence has been normalized, it is not typical of every hospital. "This is the only place I've worked that has had this degree of law enforcement presence in the way that it has," Dr. Walker confirmed. This increased presence is not accidental—the patients who rely on this hospital are themselves targets of policing. Or, as Dr. Lendon puts it, "Our clientele is a little rougher sometimes." After I connected the hospital to the other various county institutions, Dr. Walker agreed, "I think you're right, it's actually an interesting way to think about it like, this is a county facility just like Twin Towers is a county facility just like County Jail is a county facility." This sense of connection to other county workers emerged in relation to the relatively good opinion most attendings held of the LASD deputies who worked within the hospital, at least in comparison to "outside" law enforcement. Their improved standing was gained on the grounds that they served as intermediaries between clinicians and other police departments, and were themselves unlikely to intervene unless specifically

asked. The difference between these deputies' behavior was attributed to their hospital specific "training," an idea that has gained traction and political ground in many states (Rayasam 2023). The investment in the concept of police training as a method of making police less lethal and less violent has done little to achieve that goal—in fact, 2022 was the deadliest year on record for police shootings (Levin 2023)—and has done a great deal to shore up the budgets and authority of police departments. Nowhere has this phenomenon been more evident than in the history of the Los Angeles Police Department, which historian Max Felker-Kantor analyzes in detail during the period of 1965-1992 (Felker-Kantor 2018). His work charts how the unifying political goal of police reform, which gained strength and popularity following the Watts uprisings of 1965, served only to cement the power and inflate the budget of the LAPD, ultimately *increasing*, rather than mitigating, police violence in Los Angeles.

It was during these conversations that I felt the limitations of my intimate positionality most acutely. While undoubtedly all elements of my interactions with the trauma surgery attendings were shaped by our relative positions within the medical hierarchy, during these interviews I felt the most hesitation to probe too far into their comments. Much of my attention was focused on reserving judgement in order to create an environment in which they could respond honestly and I could hear them on their terms. While I did on some level fear that dissent might jeopardize my relationships with these attendings, that fear extended in both directions—not only was I mindful of the power discrepancy in our respective positions, but I also found that I felt protective over my perception of them and wanted to find moments of alignment even in contexts where we disagreed. Overall, however, I was surprised by the clear level of thoughtfulness and consideration that these surgeons gave to the question of police in

the hospital, given how naturalized the presence of police felt ethnographically. That openness may be a recent shift, I learned while talking with Dr. Hastings, who described her attempts to confront these issues earlier in her career, "I can tell you that I personally went to my superiors multiple times and was basically told to just get along with [the police]." "Maybe my superiors have started to see, or at least appear that they understand the power struggle or dynamics. Now it's ok to say these things out loud, but I would say 10 years ago, when I was complaining about it, it was not well received." Her comments speak to the meaningful changes in the local political context of Los Angeles and the effect of the last decade of community activism and organizing around police violence, which have extended into the space of the public hospital.

Conclusion

This chapter has traced the conflicts that emerge through police presence and action in the county hospital. On the one hand, public health and medical scholars have pointed to the now well-established, incontrovertible evidence that prisons and police have wide-ranging negative health effects on those most targeted by these systems of state power. On the other, one of the paradigmatic institutions of biomedicine—the hospital—are only increasing their practices of securitization and continue to play host to tragic and avoidable scenes of police violence against their most vulnerable patients.

In 2014, a man name Marquette Cummings was stabbed in the eye by another prisoner while they were being held in an Alabama prison. He was then transferred to a nearby hospital where his mother, Angela Gaines, was able to see and interact with him. Although Mr. Cummings' mother insisted that her son was responsive to her commands, the prison warden instructed the hospital staff to remove Mr. Cummings

from life support and change his code status to "do not resuscitate." When faced with the strenuous objections of Ms. Gaines, the clinicians responsible for Mr. Cummings' care responded that, "because the State had legal custody over Cummings" at the time, it was "not her call," since "the decision to let her son die was the Warden's decision" (Estate of Cummings v. Davenport 2018, 4). Without having conducted a brain death exam, the hospital staff acted on the Warden's instruction and removed Mr. Cummings from life support. He then died. Although Ms. Gaines successfully sued the prison warden following her son's death, I could find no evidence that the hospital or its staff faced any repercussions for their role.

I highlight this tragic case here to draw attention to the forms of deference to police instruction that are manifest in the hospital—and their stakes. Even in a space where medical authority over the patient's body is so profound, clinicians can and do act as facilitators of police violence, often in spite of ethical, legal and social responsibilities to care that might compel resistance or dissent. This facilitation can happen in more mundane ways, such as the routine practice of mandated reporting, but can also happen in ways that contravene basic medical ethics and standards of care and result in the death of a patient, as in the case of Mr. Cummings. The ethnographic and interview data from this chapter give shape to the ways in which the hegemony of police is secured and reproduced within the hospital and in relation to clinicians themselves. Police authority is largely accepted, even in moments when their instructions directly contravene attendings' own knowledge about their scope of authority and responsibilities. This construction of police authority recalls Veena Das' insights into the ways in which police act and speak "as if they directly embodied the law" (Das 2007, 169).

More recently in Virginia, a man named Irvo Otieno was taken from his home

during a psychiatric crisis, placed on a 5150 involuntary hold, and transported to a nearby community hospital by police. While there, police claimed that Mr. Otieno assaulted them and took him to jail immediately, without allowing him to spend even the 72 hours of his hold in the hospital. When Mr. Otieno's mother asked to see him, she describes the physician she spoke with throwing up his hands "in desperation" and saying, "It's the police!" After spending days in jail, where he was held naked in a small cell, he was brought shackled to a state hospital. Although his lawyers contend that Mr. Otieno appeared "nearly lifeless" on hospital surveillance tapes when he is initially brought in, he was inexplicably held on the ground under the weight of ten people, seven of whom were sheriff's deputies and three of whom were hospital staff. After 11 minutes, they had asphyxiated Mr. Otieno (Treisman 2023; Robertson and Bohra 2023).

Although initially reported as the result of only sheriff's deputies' actions, the role of hospital staff in Mr. Otieno's death should not be overlooked. While the attendings I have interviewed may have expressed their frustrations with police activity in the emergency department and their desire to separate police from the process of patient restraint, others undoubtedly defer to police presence and authority without reservation. Unlike the HVIP case managers, whose daily saturation with police presence has led to a critical understanding of distance and recognition of their racism and dehumanizing practices, physicians' class and racial backgrounds often facilitate a blind indifference to this violence as violence at all. Allowing individual personality and political commitments of healthcare workers to stand as the sole buffer between police in the hospital and patient safety will thus inevitably end in further violence.

In his lectures, Foucault describes what he calls a "protective continuum" that connects the medical and carceral management of "danger" (Foucault et al. 2003, 33).

"There is the notion of 'danger,'" he writes, "of the 'dangerous individual,' which will make possible the justification and theoretical foundation of an uninterrupted chain of medico-judicial institutions" (34). This framing attends to the ways that the "rougher clientele" of the public hospital, as Dr. Lendon put it, are forced to occupy a position in between illness and criminality—as dangerous—that legitimates the entanglements of medical and carceral practice.

References

Abelson, Jonathan S., Matthew M. Symer, Heather L. Yeo, Paris D. Butler, Patrick T. Dolan, Tracy A. Moo, and Anthony C. Watkins. 2018. "Surgical Time out: Our Counts Are Still Short on Racial Diversity in Academic Surgery." *American Journal of Surgery* 215 (4): 542–48. https://doi.org/10.1016/j.amjsurg.2017.06.028.

Açiksöz, Salih Can. 2016. "Medical Humanitarianism Under Atmospheric Violence: Health Professionals in the 2013 Gezi Protests in Turkey." *Culture, Medicine, and Psychiatry* 40 (2): 198–222. https://doi.org/10.1007/s11013-015-9467-2.

Adams, Vincanne. 1998. *Doctors for Democracy: Health Professionals in the Nepal Revolution*. Cambridge Studies in Medical Anthropology 6. Cambridge, UK ; New York, N.Y., U.S.A: Cambridge University Press.

Agamben, Giorgio. 1998. *Homo Sacer: Sovereign Power and Bare Life*. Homo Sacer 1. Stanford, Calif: Stanford University Press.

Alang, Sirry, Donna D. McAlpine, and Rachel Hardeman. 2020. "Police Brutality and Mistrust in Medical Institutions." *Journal of Racial and Ethnic Health Disparities* 7 (4): 760–68. https://doi.org/10.1007/s40615-020-00706-w.

American Public Health Association. 2018. "Addressing Law Enforcement Violence as a Public Health Issue."

Andrade, Erin G., Megha Uberoi, Jane M. Hayes, Melissa Thornton, Jessica Kramer, and L. J. Punch. 2022. "The Impact of Retained Bullet Fragments on Outcomes in Patients with Gunshot Wounds." *The American Journal of Surgery* 223 (4): 787–91. https://doi.org/10.1016/j.amjsurg.2021.05.022.

Aretxaga, Begoña. 1997. *Shattering Silence: Women, Nationalism, and Political Subjectivity in Northern Ireland*. Princeton, NJ: Princeton University Press.

Aumoithe, George. 2021. "Dismantling the Safety-Net Hospital: The Construction of 'Underutilization' and Scarce Public Hospital Care." *Journal of Urban History*, November, 1–30. https://doi.org/10.1177/00961442211056971.

Avila, Eric. 2006. *Popular Culture in the Age of White Flight: Fear and Fantasy in Suburban Los Angeles*. American Crossroads 13. Berkeley Los Angeles London: University of California Press.

Beagan, Brenda L. 2000. "Neutralizing Differences: Producing Neutral Doctors for (Almost) Neutral Patients." *Social Science*, 13.

Becker, Howard Saul. 1977. *Boys in White: Student Culture in Medical School*. New Brunswick, N.J: Transaction Books.

Bilimoria, Karl Y., Jeanette W. Chung, Larry V. Hedges, Allison R. Dahlke, Remi Love, Mark E. Cohen, John Tarpley, et al. 2016. "Development of the Flexibility in Duty Hour Requirements for Surgical Trainees (FIRST) Trial Protocol: A National Cluster-Randomized Trial of Resident Duty Hour Policies." *JAMA Surgery* 151 (3): 273–81. https://doi.org/10.1001/jamasurg.2015.4990.

Boas, Franz. 1912. "Changes in the Bodily Form of Descendants of Immigrants." *American Anthropologist* 14 (3): 530–62. https://doi.org/10.1525/aa.1912.14.3.02a00080.

Bourdieu, Pierre. 1999. "The Specificity of the Scientific Field and the Social Conditions of the Progress of Reason." In *The Science Studies Reader*, edited by Mario Biagioli, 31–50. New York: Routledge.

———. 2000. *Pascalian Meditations*. Stanford, Calif: Stanford University Press.

———. 2007. "Gender and Symbolic Violence." In *Violence in War and Peace: An Anthology*, edited by Nancy Scheper-Hughes and Philippe Bourgois, Nachdr. Blackwell Readers in Anthropology 5. Malden, Mass.: Blackwell Publ.

Bourgois, Philippe I., and Jeff Schonberg. 2009. *Righteous Dopefiend*. California Series in Public Anthropology 21. Berkeley: University of California Press.

Bridges, Khiara M. 2017. *The Poverty of Privacy Rights*. Stanford, California: Stanford Law Books, an imprint of Stanford University Press.

Brown, Bertram S. 1973. "Mental Health in the Future: Politics, Science, Ethics and Values." *The ANNALS of the American Academy of Political and Social Science* 408 (1): 62–69. https://doi.org/10.1177/000271627340800106.

Can, Başak. 2016. "The Criminalization of Physicians and the Delegitimization of Violence in Turkey." *Medical Anthropology* 35 (6): 477–88. https://doi.org/10.1080/01459740.2016.1207641.

"Care First Community Investment (CFCI) | LAC -JCOD." n.d. Accessed May 26, 2023. https://jcod.lacounty.gov/cfci/.

Casey, Brian P. 2015. "The Surgical Elimination of Violence? Conflicting Attitudes towards Technology and Science during the Psychosurgery Controversy of the 1970s." *Science in Context* 28 (1): 99–129. https://doi.org/10.1017/S0269889714000349.

Casillas, Alejandra, Giselle Perez-Aguilar, Anshu Abhat, Griselda Gutierrez, Tanya T Olmos-Ochoa, Carmen Mendez, Anish Mahajan, Arleen Brown, and Gerardo Moreno. 2019. "Su Salud a La Mano (Your Health at Hand): Patient Perceptions about a Bilingual Patient Portal in the Los Angeles Safety Net." *Journal of the American Medical Informatics Association* 26 (12): 1525–35. https://doi.org/10.1093/jamia/ocz115.

Cassell, Joan. 1991. *Expected Miracles: Surgeons at Work*. Philadelphia: Temple University Press.

———. 1998. *The Woman in the Surgeon's Body*. Cambridge, Mass: Harvard University Press.

Chandler, Jenna. 2020. "What L.A. Could Do with Its $1.8 Billion Police Budget." Curbed LA. June 2, 2020. https://la.curbed.com/2020/6/2/21277088/defund-police-los-angeles-lapd-budget.

Chu, Andrea Long. 2018. "Opinion | My New Vagina Won't Make Me Happy." *The New York Times*, November 24, 2018, sec. Opinion. https://www.nytimes.com/2018/11/24/opinion/sunday/vaginoplasty-transgender-medicine.html.

Comaroff, Jean. 1993. "The Diseased Heart of Africa: Medicine, Colonialism, and the Black Body." In *Knowledge, Power, Practice: The Anthropology of Medicine and Everyday Life*, edited by Shirley Lindenbaum and Margaret M. Lock, 1st ed., 215–33. Routledge. https://doi.org/10.4324/9780429033872-8.

Conrad, Peter. 1992. "Medicalization and Social Control." *Annual Review of Sociology* 18 (1): 209–32. https://doi.org/10.1146/annurev.so.18.080192.001233.

Coon, Troy, Michael Miller, Farshad Shirazi, and John Sullivan. 2006. "Lead Toxicity in a 14-Year-Old Female With Retained Bullet Fragments." *Pediatrics* 117 (1): 227–30. https://doi.org/10.1542/peds.2005-1098.

Cousineau, Michael R., and Robert E. Tranquada. 2007. "Crisis & Commitment: 150 Years of Service by Los Angeles County Public Hospitals." *American Journal of Public Health* 97 (4): 606–15. https://doi.org/10.2105/AJPH.2006.091637.

Cros, Jessica. 1993. "PATIENT'S FRUSTRATION APPARENTLY LED TO L.A. HOSPITAL SHOOTINGS." *Washington Post*, February 10, 1993. https://www.washingtonpost.com/archive/politics/1993/02/10/patients-frustration-apparently-led-to-la-hospital-shootings/31f38986-a2ad-4996-aefc-206f9fdf66e1/.

Csordas, Thomas J. 1990. "Embodiment as a Paradigm for Anthropology." *Ethos* 18 (1): 43.

Das, Veena. 2007. *Life and Words: Violence and the Descent into the Ordinary*. Berkeley: University of California Press.

Davis, Mike. 2006. *City of Quartz: Excavating the Future in Los Angeles*. New ed. London ; New York: Verso.

Dicker, Rochelle, and Catherine Juillard. 2020. "Hospital-Based Interventions to Reduce Violence and Recidivism: Wraparound Programs." In *Violence, Trauma,*

and Trauma Surgery: Ethical Issues, Interventions, and Innovations, edited by Mark Siegler and Selwyn O. Rogers Jr. Springer Nature.

Dienstknecht, T., K. Horst, R. M. Sellei, A. Berner, M. Nerlich, and T. C. Hardcastle. 2012. "Indications for Bullet Removal: Overview of the Literature, and Clinical Practice Guidelines for European Trauma Surgeons." *European Journal of Trauma and Emergency Surgery* 38 (2): 89–93. https://doi.org/10.1007/s00068-011-0170-x.

Doster, Dominique L., Amelia T. Collings, Christopher Thomas, Laura Torbeck, E. Matthew Ritter, Jennifer Choi, and Dimitrios Stefanidis. 2022. "Balancing Autonomy of Thought and Action in the Context of Patient Safety: Resident Perspectives on Intraoperative Autonomy." *Global Surgical Education - Journal of the Association for Surgical Education* 1 (1): 62. https://doi.org/10.1007/s44186-022-00039-8.

Edwards, Frank, Sara Wakefield, Kieran Healy, and Christopher Wildeman. 2021. "Contact with Child Protective Services Is Pervasive but Unequally Distributed by Race and Ethnicity in Large US Counties." *Proceedings of the National Academy of Sciences* 118 (30): e2106272118. https://doi.org/10.1073/pnas.2106272118.

Ehrenreich, Barbara, and John Ehrenreich. 1971. *The American Health Empire*. Random House Inc.

Estate of Cummings v. Davenport. 2018. United States Court of Appeals for the Eleventh Circuit.

Fanon, Frantz. 1965. *A Dying Colonialism*. New York: Grove Press.

———. 2002. *Black Skin, White Masks*. Repr. Pluto Classics. London: Pluto Press.

Fanon, Frantz, and Richard Philcox. 2004. *The Wretched of the Earth: Frantz Fanon ; Translated from the French by Richard Philcox ; Introductions by Jean-Paul Sartre and Homi K. Bhabha*. New York: Grove Press.

Farmer, Paul. 2004. "An Anthropology of Structural Violence." *Current Anthropology* 45 (3): 21.

Fausto-Sterling, Anne. 1995. "Gender, Race, and Nation." In *Deviant Bodies: Critical Perspectives on Difference in Science and Popular Culture*, edited by Jennifer Terry and Jacqueline Urla.

Feldman, Kenneth A., and Theodore M. Newcomb. 1994. *The Impact of College on Students*. New Brunswick, N.J., U.S.A: Transaction Publishers.

Felker-Kantor, Max. 2018. *Policing Los Angeles: Race, Resistance, and the Rise of the LAPD*. Justice, Power, and Politics. Chapel Hill: The University of North Carolina Press.

Fernández, Johanna. 2020. *The Young Lords: A Radical History*. Chapel Hill: The University of North Carolina Press.

Feuille, Catherine. 2020. "Rethinking the Medicalization of Violence: The Risks of a Behavioral Addiction Model." *The Journal of Law, Medicine & Ethics* 48 (S4): 179–82. https://doi.org/10.1177/1073110520979420.

Foucault, Michel. 1978. *The History of Sexuality Volume I*. 1st American ed. New York: Pantheon Books.

———. 1995. *Discipline and Punish: The Birth of the Prison*. 2nd Vintage Books ed. New York: Vintage Books.

Foucault, Michel, Valerio Marchetti, Graham Burchell, and Michel Foucault. 2003. *Abnormal: Lectures at the Collège de France 1974 - 1975*. Lectures at the Collège de France. London: Verso.

Gallen, Kate, Jake Sonnenberg, Carly Loughran, Michael J. Smith, Mildred Sheppard, Kirsten Schuster, Elinore Kaufman, Ji Seon Song, and Erin C. Hall. 2022. "Health Effects of Policing in Hospitals: A Narrative Review." *Journal of Racial and Ethnic Health Disparities*, March. https://doi.org/10.1007/s40615-022-01275-w.

Garcia, Angela, and Brian Anderson. 2016. "Violence, Addiction, Recovery: An Anthropological Study of Mexico's Anexos." *Transcultural Psychiatry* 53 (4): 445–64. https://doi.org/10.1177/1363461516662539.

Garcia, Kenneth J. 1989. "Army Surgeons Training for War-at King Hospital: [Home Edition]." *Los Angeles Times (Pre-1997 Fulltext)*, November 7, 1989, sec. PART-A; Metro Desk.

Gaskin, Darrell J., and Jack Hadley. 1999. "Population Characteristics of Markets of Safety-Net and Non-Safety-Net Hospitals." *Journal of Urban Health : Bulletin of the New York Academy of Medicine* 76 (3): 351–70. https://doi.org/10.1007/BF02345673.

Geest, Sjaak van der, and Kaja Finkler. 2004. "Hospital Ethnography: Introduction." *Social Science & Medicine* 59 (10): 1995–2001. https://doi.org/10.1016/j.socscimed.2004.03.004.

Gilmore, Ruth Wilson. 2002. "Fatal Couplings of Power and Difference: Notes on Racism and Geography." *The Professional Geographer* 54 (1): 15–24. https://doi.org/10.1111/0033-0124.00310.

———. 2007. *Golden Gulag: Prisons, Surplus, Crisis, and Opposition in Globalizing California*. American Crossroads 21. Berkeley: University of California Press.

Gilmore, Ruth Wilson, and Craig Gilmore. 2008. “Restating the Obvious.” In *Indefensible Space: The Architecture of the National Insecurity State*, edited by Michael Sorkin. New York: Routledge.

Goffman, Erving. 2007. “On the Characteristics of Total Institutions.” In *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates*. New Brunswick, NJ: Aldine Transaction.

Good, Byron, and Mary-Jo DelVecchio Good. 1993. “‘Learning Medicine’: The constructing of medical knowledge at Harvard Medical School.” In *Knowledge, Power and Practice: The anthropology of medicine and everyday life*, edited by Shirley Lindenbaum and Margaret M. Lock. University of California Press.

Gordon, James A. 1999. “The Hospital Emergency Department as a Social Welfare Institution.” *Annals of Emergency Medicine* 33 (3): 321–25. https://doi.org/10.1016/S0196-0644(99)70369-0.

Gravlee, Clarence C. 2009. “How Race Becomes Biology: Embodiment of Social Inequality.” *American Journal of Physical Anthropology* 139 (1): 47–57. https://doi.org/10.1002/ajpa.20983.

Green, Carmen R., Wayne R. McCullough, and Jamie D. Hawley. 2018. “Visiting Black Patients: Racial Disparities in Security Standby Requests.” *Journal of the National Medical Association* 110 (1): 37–43. https://doi.org/10.1016/j.jnma.2017.10.009.

Gupta, Akhil. 2012. *Red Tape: Bureaucracy, Structural Violence, and Poverty in India*. A John Hope Franklin Center Book. Durham: Duke University Press.

Hafferty, Frederic W. 1988. “Cadaver Stories and the Emotional Socialization of Medical Students.” *Journal of Health and Social Behavior* 29 (4): 344. https://doi.org/10.2307/2136868.

Halpern, Scott D., and Allan S. Detsky. 2014. “Graded Autonomy in Medical Education — Managing Things That Go Bump in the Night.” *New England Journal of Medicine* 370 (12): 1086–89. https://doi.org/10.1056/NEJMp1315408.

Hannig, Anita. 2017. *Beyond Surgery: Injury, Healing, and Religion at an Ethiopian Hospital*. University of Chicago Press. https://doi.org/10.7208/chicago/9780226457321.001.0001.

Harada, Megan Y., Armando Lara-Millán, and Lauren E. Chalwell. 2021. “Policed Patients: How the Presence of Law Enforcement in the Emergency Department Impacts Medical Care.” *Annals of Emergency Medicine* 78 (6): 738–48. https://doi.org/10.1016/j.annemergmed.2021.04.039.

Harbor-UCLA Department of Family Medicine. 2020. “A Statement from the Harbor-UCLA Department of Family Medicine on Police Violence in Our Hospital and Community,” October 14, 2020.

Helkama, Klaus, Antti Uutela, Esa Pohjanheimo, Simo Salminen, Anne Koponen, and Leena Rantanen-VA¨NTSI. 2003. “Moral Reasoning and Values in Medical School: A Longitudinal Study in Finland.” *Scandinavian Journal of Educational Research* 47 (4): 399–411. https://doi.org/10.1080/00313830308589.

Hernandez, Kelly Lytle. 2017. *City of Inmates: Conquest, Rebellion, and the Rise of Human Caging in Los Angeles, 1771-1965*. Justice, Power, and Politics. Chapel Hill: The University of North Carolina Press.

Herzfeld, Michael. 1993. *The Social Production of Indifference: Exploring the Symbolic Roots of Western Bureaucracy*. Chicago: University of Chicago Press.

Hinton, Elizabeth Kai. 2016. *From the War on Poverty to the War on Crime: The Making of Mass Incarceration in America*. Cambridge, Massachusetts: Harvard University Press.

Hogarth, Rana. 2019. “Of Black Skin and Biopower: Lessons from the Eighteenth Century.” *American Quarterly* 71 (3): 837–47. https://doi.org/10.1353/aq.2019.0057.

Hunt, Darnell M., and Ana-Christina Ramón, eds. 2010. *Black Los Angeles: American Dreams and Racial Realities*. New York: New York University Press.

Jacoby, Sara. 2018. “When Health Care And Law Enforcement Intersect In Trauma Care, What Rules Apply?” https://doi.org/10.1377/forefront.20180926.69826.

Janeway, Hannah H., Shamsher Samra, and Ji Seon Song. 2021. “An Ethical, Legal, and Structural Framework for Law Enforcement in the Emergency Department.” *Annals of Emergency Medicine* 78 (6): 749–51. https://doi.org/10.1016/j.annemergmed.2021.08.009.

Jetty, Anuradha, Yalda Jabbarpour, Jack Pollack, Ryan Huerto, Stephanie Woo, and Stephen Petterson. 2022. “Patient-Physician Racial Concordance Associated with Improved Healthcare Use and Lower Healthcare Expenditures in Minority Populations.” *Journal of Racial and Ethnic Health Disparities* 9 (1): 68–81. https://doi.org/10.1007/s40615-020-00930-4.

Johnson, Gaye Theresa. 2013. *Spaces of Conflict, Sounds of Solidarity: Music, Race, and Spatial Entitlement in Los Angeles*. Berkeley: University of California Press.

Kangovi, Shreya, Frances K. Barg, Tamala Carter, Judith A. Long, Richard Shannon, and David Grande. 2013. “Understanding Why Patients Of Low Socioeconomic Status Prefer Hospitals Over Ambulatory Care.” *Health Affairs* 32 (7): 1196–1203. https://doi.org/10.1377/hlthaff.2012.0825.

Kansagra, Susan M., Sowmya R. Rao, Ashley F. Sullivan, James A. Gordon, David J. Magid, Rainu Kaushal, Carlos A. Camargo, and David Blumenthal. 2008. "A Survey of Workplace Violence across 65 U.S. Emergency Departments." *Academic Emergency Medicine: Official Journal of the Society for Academic Emergency Medicine* 15 (12): 1268–74. https://doi.org/10.1111/j.1553-2712.2008.00282.x.

Katz, Pearl. 1981. "Ritual in the Operating Room." *Ethnology* 20 (4): 335. https://doi.org/10.2307/3773355.

Kessler, Suzanne J. 1990. "The Medical Construction of Gender: Case Management of Intersexed Infants." *Signs* 16 (1): 24.

Kirkpatrick, Emily. 2022. "Bella Hadid Says She Regrets Getting a Nose Job at 14." *Vanity Fair*, March 15, 2022. https://www.vanityfair.com/style/2022/03/bella-hadid-nose-job-14-regrets-plastic-surgery-rumors-therapy-depression.

Klein, George C. 2010. "Negotiating the Fate of People with Mental Illness: The Police and the Hospital Emergency Room." *Journal of Police Crisis Negotiations* 10 (1–2): 205–19. https://doi.org/10.1080/15332581003800121.

Kleinman, Arthur. 2009. "Care-Giving and the Moral Impoverishment of Medicine." *Project Syndicate*. (blog). May 28, 2009. http://www.project-syndicate.org/commentary/kleinman1.

Kleinman, Arthur, Veena Das, and Margaret M. Lock, eds. 1997. *Social Suffering*. Berkeley: University of California Press.

Kliff, Sarah, and Jessica Silver-Greenberg. 2022. "'Major Trustee, Please Prioritize': How NYU's E.R. Favors the Rich." *The New York Times*, December 22, 2022, sec. Health. https://www.nytimes.com/2022/12/22/health/nyu-langone-emergency-room-vip.html.

Knoll, Corina. 2017. "Parents of Mentally Ill Man Fatally Shot by LAPD Awarded $3.5 Million." *Los Angeles Times*, October 7, 2017, sec. California. https://www.latimes.com/local/california/la-me-ln-jury-award-ruben-herrera-20171006-story.html.

Krieger, N. 2004. "'Bodies Count,' and Body Counts: Social Epidemiology and Embodying Inequality." *Epidemiologic Reviews* 26 (1): 92–103. https://doi.org/10.1093/epirev/mxh009.

Lara-Millán, Armando. 2014. "Public Emergency Room Overcrowding in the Era of Mass Imprisonment." *American Sociological Review* 79 (5): 866–87. https://doi.org/10.1177/0003122414549552.

———. 2021. *Redistributing the Poor: Jails, Hospitals, and the Crisis of Law and Fiscal Austerity*. New York: Oxford University Press.

Lawrence, Christopher. 1998. “Medical Minds, Surgical Bodies: Corporeality and the Doctors.” In *Science Incarnate: Historical Embodiments of Natural Knowledge*, edited by Christopher Lawrence and Steven Shapin. Chicago, Ill: The University of Chicago Press.

Lee, Jooyoung. 2012. “Wounded: Life after the Shooting.” *The ANNALS of the American Academy of Political and Social Science* 642 (1): 244–57. https://doi.org/10.1177/0002716212438208.

Levin, Sam. 2023. “‘It Never Stops’: Killings by US Police Reach Record High in 2022.” *The Guardian*, January 6, 2023, sec. US news. https://www.theguardian.com/us-news/2023/jan/06/us-police-killings-record-number-2022.

Lewis, LaVonna Blair, David C. Sloane, Lori Miller Nascimento, Allison L. Diamant, Joyce Jones Guinyard, Antronette K. Yancey, and Gwendolyn Flynn. 2005. “African Americans’ Access to Healthy Food Options in South Los Angeles Restaurants.” *American Journal of Public Health* 95 (4): 668–73. https://doi.org/10.2105/AJPH.2004.050260.

Liebschutz, Jane, Sonia Schwartz, Joel Hoyte, Lauren Conoscenti, Anthony B. Christian, Leroy Muhammad, Derrick Harper, and Thea James. 2010. “A Chasm Between Injury and Care: Experiences of Black Male Victims of Violence.” *Journal of Trauma: Injury, Infection & Critical Care* 69 (6): 1372–78. https://doi.org/10.1097/TA.0b013e3181e74fcf.

Linden, M A, W I Manton, R M Stewart, E R Thal, and H Feit. 1982. “Lead Poisoning from Retained Bullets. Pathogenesis, Diagnosis, and Management.” *Annals of Surgery* 195 (3): 305–13.

Livingston, Julie. 2012. *Improvising Medicine: An African Oncology Ward in an Emerging Cancer Epidemic*. Durham: Duke University Press.

Ludmerer, Kenneth M. 1999. “Instilling Professionalism in Medical Education.” *JAMA* 282 (9): 881. https://doi.org/10.1001/jama.282.9.881.

Mahmood, Saba. 2001. “Feminist Theory, Embodiment, and the Docile Agent: Some Reflections on the Egyptian Islamic Revival.” *Cultural Anthropology* 16 (2): 202–36. https://doi.org/10.1525/can.2001.16.2.202.

Mandavilli, Apoorva. 2021. “Editor of JAMA Leaves After Outcry Over Colleague’s Remarks on Racism.” *The New York Times*, June 1, 2021, sec. Health. https://www.nytimes.com/2021/06/01/health/jama-bauchner-racism.html.

Mark, V. H., W. H. Sweet, and F. R. Ervin. 1967. “Role of Brain Disease in Riots and Urban Violence.” *JAMA* 201 (11): 895. https://doi.org/10.1001/jama.1967.03130110121050.

Mark, Vernon, and Frank Ervin. 1970. *Violence and the Brain*. Violence and the Brain. Oxford, England: Harper & Row.

Mark, Vernon H., and M. Therese Southgate. 1971. "Violence and Brain Disease." *JAMA* 216 (6): 1025–34. https://doi.org/10.1001/jama.1971.03180320067018.

Mbembe, Achille. 2003. "Necropolitics." Translated by Libby Meintjes. *Public Culture* 15 (1): 11–40.

McClurg, Asha Belle, Kavita Shah Arora, Lauren D. Schiff, Erin T. Carey, and Genevieve Scott Neal-Perry. 2022. "Dismantling Structural Barriers: Resident Clinics Refocused on Equity." *Obstetrics & Gynecology* 140 (5): 739. https://doi.org/10.1097/AOG.0000000000004920.

McKearney, Patrick. 2020. "Challenging Care: Professionally Not Knowing What Good Care Is." *Anthropology and Humanism* 45 (2): 223–32. https://doi.org/10.1111/anhu.12302.

Merleau-Ponty, Maurice, and Donald A. Landes. 2012. *Phenomenology of Perception*. Abingdon, Oxon ; New York: Routledge.

Millman, Marcia. 1977. *The Unkindest Cut: Life in the Backrooms of Medicine*. New York: Morrow.

Mitchell, John L., and Shawn Hubler. 1993. "Patient at County-USC Shoots 3 Doctors, Gives Up in Standoff : Violence: One Victim Is Reported near Death and Two Are Listed as Critical. The Gunman, Who Said He Wanted Pain Medicine, Held Two Staff Members Hostage before Surrendering." Los Angeles Times. February 9, 1993. https://www.latimes.com/archives/la-xpm-1993-02-09-mn-1286-story.html.

Mizrahi, Terry. 1985. *Getting Rid of Patients: Contradictions in the Socialisation of Internists to the Doctor-Patient Relationship*. Vol. 7. https://onlinelibrary.wiley.com/doi/abs/10.1111/1467-9566.ep10949079.

Morganti, Kristy Gonzalez, Sebastian Bauhoff, Janice C. Blanchard, Mahshid Abir, Neema Iyer, Alexandria Smith, Joseph V. Vesely, Edward N. Okeke, and Arthur L. Kellermann. 2013. "The Evolving Role of Emergency Departments in the United States." *Rand Health Quarterly* 3 (2): 3.

Mulla, Sameena. 2014. *The Violence of Care: Rape Victims, Forensic Nurses, and Sexual Assault Intervention*. New York ; London: New York University Press.

Murakawa, Naomi. 2014. *The First Civil Right: How Liberals Built Prison America*. Oxford ; New York: Oxford University Press.

Nagami, Damon, and Lauren Nakano. County of Los Angeles Community Prevention and Population Health Task Force Letter. 2021. "LAW ENFORCEMENT IN HEALTH CARE SETTINGS," June 15, 2021.

Nagengast, Carole. 1994. "Violence, Terror, and The Crisis of The State." *Annual Review of Anthropology* 23 (1): 109–36. https://doi.org/10.1146/annurev.an.23.100194.000545.

Nelson, Alondra. 2011. *Body and Soul: The Black Panther Party and the Fight against Medical Discrimination*. Minneapolis ; London: University of Minnesota Press.

Parsons, Genevieve Noone, Sara B Kinsman, Charles L Bosk, Pamela Sankar, and Peter A Ubel. 2001. "Between Two Worlds." *Journal of General Internal Medicine* 16 (8): 544–49. https://doi.org/10.1046/j.1525-1497.2001.016008544.x.

Patel, Sunita. 2022. "Embedded Healthcare Policing." *UCLA Law Review* 69 (3): 808–76.

Perry, William G. 1999. *Forms of Intellectual and Ethical Development in the College Years: A Scheme*. 1st ed. Jossey-Bass Higher and Adult Education Series. San Francisco, Calif: Jossey-Bass Publishers.

Pierce, Steven, and Anupama Rao, eds. 2006. *Discipline and the Other Body: Correction, Corporeality, Colonialism*. Durham: Duke University Press.

Plemons, Eric. 2017. *The Look of a Woman: Facial Feminization Surgery and the Aims of Trans-Medicine*. Durham: Duke University Press.

Povinelli, Elizabeth A. 2006. *The Empire of Love: Toward a Theory of Intimacy, Genealogy, and Carnality*. Public Planet Books. Durham: Duke University Press.

Prentice, Rachel. 2013. *Bodies in Formation: An Ethnography of Anatomy and Surgery Education*. Experimental Futures. Durham, NC: Duke University Press.

Prothrow-Stith, Deborah, Howard Spivak, and Alice J. Hausman. 1987. "The Violence Prevention Project: A Public Health Approach." *Science, Technology, & Human Values* 12 (3/4): 67–69.

Quesada, James, Laurie Kain Hart, and Philippe Bourgois. 2011. "Structural Vulnerability and Health: Latino Migrant Laborers in the United States." *Medical Anthropology* 30 (4): 339–62. https://doi.org/10.1080/01459740.2011.576725.

Ramos, Nic John. 2017. "Worthy of Care?: Medical Inclusion from the Watts Riots to the Building of King-Drew, Prisons, and Skid Row, 1965-1986." Los Angeles, CA: University of Southern California.

———. 2019. "Pathologizing the Crisis: Psychiatry, Policing, and Racial Liberalism in the Long Community Mental Health Movement." *Journal of the History of Medicine and Allied Sciences* 74 (1): 57–84. https://doi.org/10.1093/jhmas/jry043.

Ramos-Zayas, Ana Y. 2011. “Learning Affect, Embodying Race: Youth, Blackness, and Neoliberal Emotions in Latino Newark.” *Transforming Anthropology* 19 (2): 86–104. https://doi.org/10.1111/j.1548-7466.2011.01134.x.

Razack, Sherene. 2015. *Dying from Improvement: Inquests and Inquiries into Indigenous Deaths in Custody*. Toronto: University of Toronto Press.

Redfield, Peter. 2005. “Doctors, Borders, and Life in Crisis.” *Cultural Anthropology* 20 (3): 328–61.

———. 2013. *Life in Crisis: The Ethical Journey of Doctors without Borders*. Berkeley: University of California Press.

Rhodes, Lorna A. 1991. *Emptying Beds: The Work of an Emergency Psychiatric Unit*. Comparative Studies of Health Systems and Medical Care, v. 27. Berkeley: University of California Press.

Robertson, Campbell, and Neelam Bohra. 2023. “Another Mental Illness Tragedy Spurs Questions About Virginia’s Health System.” *The New York Times*, March 23, 2023, sec. U.S. https://www.nytimes.com/2023/03/23/us/irvo-otieno-virginia-mental-health.html.

Rose, Nikolas S. 2007. *Politics of Life Itself: Biomedicine, Power, and Subjectivity in the Twenty-First Century*. Information Series. Princeton: Princeton University Press.

Rosenthal, Elizabeth. 2016. “When the Hospital Fires the Bullet - The New York Times.” February 12, 2016. https://www.nytimes.com/2016/02/14/us/hospital-guns-mental-health.html.

Savitt, Todd L. 1982. “The Use of Blacks for Medical Experimentation and Demonstration in the Old South.” *The Journal of Southern History* 48 (3): 331. https://doi.org/10.2307/2207450.

Scheper-Hughes, Nancy. 2009. *Death without Weeping: The Violence of Everyday Life in Brazil*. Nachdr. Berkeley: Univ. of California Press.

Scheper-Hughes, Nancy, and Philippe Bourgois, eds. 2007. *Violence in War and Peace: An Anthology*. Nachdr. Blackwell Readers in Anthropology 5. Malden, Mass.: Blackwell Publ.

Schiebinger, Londa L. 2000. “Skeletons in the Closet: The First Illustrations of the Female Skeleton in Eighteenth-Century Anatomy.” In *Feminism and the Body*, edited by Londa L. Schiebinger, 25–57. Oxford Readings in Feminism. Oxford ; New York: Oxford University Press.

Seigel, Micol. 2018. *Violence Work: State Power and the Limits of Police*. Durham: Duke University Press.

Self, D. J., D. E. Schrader, D. C. Jr Baldwin, and F. D. Wolinsky. 1991. “A Pilot Study of the Relationship of Medical Education and Moral Development.” *Academic Medicine* 66 (10): 629.

Sims, D. W., B. A. Bivins, F. N. Obeid, H. M. Horst, V. J. Sorensen, and J. J. Fath. 1989. “Urban Trauma: A Chronic Recurrent Disease.” *The Journal of Trauma* 29 (7): 940–46; discussion 946-947.

Sinclair, Simon. 1997. *Making Doctors: An Institutional Apprenticeship*. 1. publ. Explorations in Anthropology. Oxford: Berg.

Smith, Randi N., Brett M. Tracy, Stephanie Smith, Sean Johnson, Niels D. Martin, and Mark J. Seamon. 2022. “Retained Bullets After Firearm Injury: A Survey on Surgeon Practice Patterns.” *Journal of Interpersonal Violence* 37 (1–2): NP306–26. https://doi.org/10.1177/0886260520914557.

Song, Ji Seon. 2021. “Policing the Emergency Room.” *Harvard Law Review* 134 (8): 75.

Staff. 2015. “Police Shoot, Kill Man in Harbor-UCLA Emergency Room.” December 21, 2015. https://www.beckershospitalreview.com/news-and-analysis/police-shoot-kill-man-in-harbor-ucla-emergency-room.html.

Stark, Evan. 1982. “Doctors in Spite of Themselves: The Limits of Radical Health Criticism.” *International Journal of Health Services* 12 (3): 419–57. https://doi.org/10.2190/4UA4-PLVK-46JY-677G.

Stoler, Ann Laura. 2010. *Carnal Knowledge and Imperial Power: Race and the Intimate in Colonial Rule ; with a New Preface*. Berkeley, Calif.: Univ. of California Press.

Students for a Democratic Society. 1973. “A UCLA Center for Violence? Unless We Stop It.”

Sufrin, Carolyn. 2017. *Jailcare: Finding the Safety Net for Women behind Bars*. Oakland, California: University of California Press.

Summers, Juana. 2021. “$5 Billion For Violence Prevention Is Tucked Into Biden Infrastructure Plan.” *NPR*, April 1, 2021, sec. Politics. https://www.npr.org/2021/04/01/983103198/-5-billion-for-violence-prevention-is-tucked-into-biden-infrastructure-plan.

Tchekmedyian, Alene. 2020. “Questions Remain Following Deputy Shooting at Harbor-UCLA That Wounded Patient.” *Los Angeles Times*, October 14, 2020, sec. California. https://www.latimes.com/california/story/2020-10-13/hosptial-workers-protest-sheriff-violence.

Theis, David. 2007. “Big House Health Care.” *University of Texas Medical Branch Magazine*, 2007.

Thom, Kai Cheng. 2018. “The Pain—and Joy—of Transition.” *Slate*, November 29, 2018. https://slate.com/human-interest/2018/11/andrea-long-chu-new-york-times-criticism-response-transgender.html.

Tonelli, Celsa M., Tyler Cohn, Zaid Abdelsattar, Frederick A. Luchette, and Marshall S. Baker. 2023. “Association of Resident Independence With Short-Term Clinical Outcome in Core General Surgery Procedures.” *JAMA Surgery* 158 (3): 302–9. https://doi.org/10.1001/jamasurg.2022.6971.

“Trauma Center Levels Explained - American Trauma Society.” n.d. Accessed June 2, 2023. https://www.amtrauma.org/page/traumalevels.

Treisman, Rachel. 2023. “7 Deputies and 3 Others Face Murder Charges in a Black Man’s Death at Mental Hospital.” *NPR*, March 17, 2023, sec. National. https://www.npr.org/2023/03/16/1163933779/irvo-otieno-police-killing-virginia-hospital.

Valenstein, Elliot S. 1991. “The Prefrontal Area and Psychosurgery.” In *The Prefrontal Its Structure, Function and Cortex Pathology*, edited by H. B. M. Uylings, C. G. Van Eden, J. P. C. De Bruin, M. A. Corner, and M. G. P. Feenstra, 85:539–54. Progress in Brain Research. Elsevier. https://doi.org/10.1016/S0079-6123(08)62699-0.

Varma, Saiba. 2020. *The Occupied Clinic: Militarism and Care in Kashmir*. Durham: Duke University Press.

Vinekar, Kavita. 2021. “Pathology of Racism — A Call to Desegregate Teaching Hospitals.” *New England Journal of Medicine* 385 (13): e40. https://doi.org/10.1056/NEJMpv2113508.

Wear, Delese, Julie M. Aultman, Joseph D. Varley, and Joseph Zarconi. 2006. “Making Fun of Patients: Medical Students’ Perceptions and Use of Derogatory and Cynical Humor in Clinical Settings.” *Academic Medicine* 81 (5): 454. https://doi.org/10.1097/01.ACM.0000222277.21200.a1.

Weiss, Debora, Don Lee, Ryan Feldman, and Kate E Smith. 2017. “Severe Lead Toxicity Attributed to Bullet Fragments Retained in Soft Tissue.” *BMJ Case Reports* 2017 (March): bcr2016217351. https://doi.org/10.1136/bcr-2016-217351.

Wendland, Claire L. 2010. *A Heart for the Work: Journeys through an African Medical School*. Chicago ; London: The University of Chicago Press.

Williams, Raymond. 1977. *Marxism and Literature*. Marxist Introductions. Oxford [Eng.]: Oxford University Press.

Winton, Richard. 2020. “Patient Shot by Sheriff’s Deputy inside Harbor UCLA Hospital Dies.” *Los Angeles Times*, November 18, 2020, sec. California.

https://www.latimes.com/california/story/2020-11-17/patient-shot-by-sheriffs-deputy-as-he-wield-heavy-medical-device-inside-harbor-ucla-hospital-dies.

———. 2022. “Nearly 300 Sue over Alleged Sexual Abuse at L.A. County Juvenile Halls and Camps.” *Los Angeles Times*, December 27, 2022, sec. California. https://www.latimes.com/california/story/2022-12-27/hundreds-sue-alleging-sexual-abuse-at-l-a-juvenile-halls.

Wu, Catherine A., and Alex S. Keuroghlian. 2023. “Moving Beyond Psychiatric Gatekeeping for Gender-Affirming Surgery.” *JAMA Surgery* 158 (3): 231–32. https://doi.org/10.1001/jamasurg.2022.5828.

Young, Katharine Galloway. 1997. *Presence in the Flesh: The Body in Medicine*. Cambridge, Mass: Harvard University Press.