

The COVID Horizon

Introduction to the Special Section

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Abstract

Prompted by long-standing realities that have recently erupted during the pandemic and ongoing protests against racial injustice in the US, this Special Section's essays evolved out of conversations around the theme of the 'COVID Horizon'. Authored by physician-anthropologists at various stages of their training, the Position Pieces describe vital searches for liveability in domains of emergency response. Moving beyond the walls of the clinical, they track medicine as an institution embedded in and shoring up other institutions linked to human rights, carceral detention, reproductive unfreedoms, and/or pandemic biocontainment—all of which define the scope of democratic freedoms and determine who exactly is afforded said freedoms. Within institutions of deferred or dislocated responsibility, the essays probe tensions between action and abstention, distance and proximity, futility and hope, and containment and freedom with the objective of dismantling forms of '*démission*' (Fanon 1952) or abdication and locating an actionable 'otherwise' allowing for accountability and solidarity. The contributors' 'horizoning work' (Petryna 2018) imagines a different ground from which to anticipate the role of medicine in the 21st century.

Keywords

Horizoning, medical anthropology, medicine, physician-scholar, physician-anthropologist, Fanon.

All problems which man faces on the subject of man can be formulated in this one question: Have I not, through my actions or my abstentions, contributed to a devaluation of human reality?¹

—Frantz Fanon, 'Le syndrome nord-africain'.

The scale of COVID-19 pandemic-related deaths and the police killings of George Floyd and Breonna Taylor in the United States illustrate a persistent lack of reckoning with racism and inequality manifesting in overlapping domains including public health, immigration, detention, and human rights. As physician-anthropologist trainees collectively working to intervene critically within these and other problem spaces, we encounter a frustrating disjuncture between the ideals of a humanistic medicine and the actual entanglements of medicine with moral violations at the heart of an expansive prison industrial complex, a militarised anti-immigration regime, and police forces that unleash violence against Black, Brown, and Indigenous communities with impunity. With each of these realities at a breaking point, one must consider for whom practising medicine is ever 'socially distanced' from the perils of dominant institutions that promote an insurmountable disregard for human life and allow racist violence to endure.

Prompted by long-standing realities brought into focus by the pandemic and ongoing protests against racial injustice in the US, these essays grew from conversations around the theme of the 'COVID Horizon' and delve into the meaning of responsive capacity in disrupted worlds. This theme catalysed an intellectual process for us: it added urgency to work already being done and assembled disparate threads from our work in unexpected ways. Contributions to this special section do not converge on the COVID-19 pandemic as an object of analysis *per se*; rather, each essay emanates from acts of reflecting on our divergent projects in and beyond pandemic times. 'The imperative to protect the vulnerable is ultimately part of the imperative to protect us all' (Sandesara 2020)—today we find this ideal of protection imperilled. Inside and outside of hospital walls, racialised and classed distributions leave people in exploitative work circumstances, with housing instability or incarcerated, and with no possibility of finding safe distance from the dangers of this pandemic.

Hospitals are no safe harbour for those who have long been under-compensated for keeping them clean and for caring for and transporting patients. In many cases,

1 Translated from the original French: 'Que tous les problèmes que se pose l'homme au sujet de l'homme peuvent se ramener à cette question : N'ai-je, pas, du fait de mes actes ou de mes abstentions, contribué à une dévalorisation de la réalité humaine ?' (Fanon 1952).

hospitals have become microcosms for, rather than shelters from, the disinvestments patients and providers navigate. Profits have been secured but protections have not come. Encountering constraints on their ability to respond, providers can constrict the radius of care to only those problems that can be managed. This is especially true in settings where the extent of care is determined solely by the fees that can be billed from a medical encounter. Under these circumstances, providers move within hospitals but often cannot deliver relief. When medicine's healing potential cannot meet the scope of damage, care becomes anaemic. That which is most relevant to healing may not be actionable, and what is actionable may not be relevant to the real issues and causes at hand. The paradox is all too familiar. But does this paradox not also do 'work', fostering affective investments and an epistemic isolation that is untenable for medicine? How, then, can scholarly and medical work subvert this myopic tendency, help us to reimagine the stakes of social proximity and care, and realign our practice towards broader solidarities?

Perhaps no other theorist has better traced the ethical and political stakes of medicine's capacity to meet conditions where they are with as much precision as Frantz Fanon. In his critiques of the pervasive illnesses of empire, Fanon exposed the protocol of health workers blaming North African men living and labouring in the French colonial metropole for the coercive conditions these migrant workers (who worked in sugar factories, built cars, and dug tunnels for the metro while barely having enough to eat, sleeping in bunks, and facing discrimination from passers-by and the police) experienced. He asked fellow medical providers to consider the question: 'Have I not, through my actions or my abstentions, contributed to a devaluation of human reality?' (Fanon 1952.) As a decolonial and anti-imperial physician-scholar, Fanon implored his colleagues to see the hospital as a microcosm of a broader social world where a racialised political and economic sanctioning of suffering precluded healing. His emphasis on following pathologies to their causes ('sociogeny') unsettled medical nosology from the dominant forms of dismissal that align medicine with governing political and economic norms. Fanon theorised the ways in which medical practice loses healing potential when it evades the conditions that produce the illnesses for which patients seek relief. The apotheosis of this process, Fanon wrote, is a form of '*démision*' or abdication, such that medical practice loses therapeutic coherence (2018). According to Fanon, only by enlarging the scope of what is relevant to a patient's care can the provider avoid the resignation of their healing role.²

2 For examples of physician-scholars whose practice exemplifies this expansion, see Farmer 2003; Fullilove 2016; Hansen and Metzl 2014; Bourgois et al. 2017; Dewachi 2017; Sufrin 2017, among others. On these dynamics with regards to US immigration policy, see Rendell 2020.

How, then, to inhabit the healing role? The impulse to correct a limited (medical) vantage point with more social science can only go so far in answering the question (Franklin and Munyikwa 2021). Assumptions built into therapeutic approaches—what counts as a valid hospitalisation or medically significant disease, for example, and which outcomes are pertinent—need constant assessment, especially when the conditions necessary for therapeutic reckoning become precarious or disappear. There is also a mismatch between medicine, whose presence is defined by the ‘need to act with what is available now’ (which can lead to accepting inequities and blind spots in practice), and a social science that can observe what is ‘wrong’ without needing to be held responsible to that same standard of immediate response.

The standards are hard to reconcile in the abstract. Rather, these Position Pieces reflect on responsiveness more generally in both clinical and para-clinical domains, where diagnostic and treatment protocols (and the ethical relations they hold) can be scrutinised and reimaged. As they engage in vital searches for liveability within flawed yet malleable medicalised fields, the essays bracket familiar hierarchies between science and social science and question which kinds of knowledge are most relevant, and at what scale, in order to meet conditions where they are. Drawing on Petryna’s work (2015; 2018) on how uncertain climate futures expose the limits of emergency response, our contributing authors are, in different ways, engaged in what she calls ‘horizoning work’. This mode of thinking considers the present against a horizon of expectation in which people and collectives can still act—that is, recovering the circumstances in which futures are available and not denied. In ‘devaluated’ realities and legal and medical limbos, it reimagines responsive capacity and makes alternative circumstances of just action possible. To be sure (and as medical anthropologists have shown), medicine has evolved as an institution embedded in and shoring up other institutions linked to carceral detention, human rights abuses, gendered public health, population control, and pandemic biocontainment. ‘Actions or abstentions’ occur in all of these troubled fields, turning health into a finite good to be doled out through calibrated acts of deferred or dislocated responsibility. Inasmuch as protocol is implicated by responding to or raising a blind eye to the scope of injury, the fantasy of divorcing clinical work from systems of injury is just that: fantasy. Within a combined science and social science framework and from specific standpoints and steadily widened fields of vision, the work of physician-anthropologist trainees can yield different insights into the terms of response to the limits of care.

The Position Pieces dwell in the tensions between action and abstention, distance and proximity, futility and hope, and containment and freedom with an eye toward dismantling forms of ‘*démission*’ while searching for an actionable ‘otherwise’ that allows for accountability and solidarity. One essay describes ongoing domestic

human rights abuses and advocates for a new praxis of human rights advocacy beyond the limits of US empire (Munyikwa, this issue). A second considers the phenomenon of Asian racialisation within American pandemic containment efforts (most notably in the figure of the ‘mask hoarder’) and points to lessons unlearned from other global frontlines (Chen, this issue). Unearthing the grammars of social distancing, a third essay explores the concept of ‘de-densification’ within larger histories of family planning and racialised population management (Hodge, this issue). A fourth essay reads social distance before COVID as a form of non-responsiveness from within the carceral US immigration system (Rendell, this issue); this form of distancing spreads beyond carceral institutions, enrolling medical professionals in a life-threatening form of disregard. Reflecting on a ‘mirage of scientific optimism’ in US transgender health research, the last essay asks what it would mean to build collaborative relationships in the service of research that can respond to rather than reiterate the failures this research unearths (Franklin, this issue). In other words, contributors’ ‘horizoning’ work imagines a different ground from which to see and anticipate the role of medicine in the 21st century.

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