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Examining Thanatopolitics: The Socio-Medical Impact of Intergenerational Racialization

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ABSTRACT

This article is a discussion of thanatopolitics — social, political, and economic systems of power that facilitate and perpetuate death — relative to medical inequity and health disparities. The article retraces some of the history of molecularized and biologized racial and racialized dogma as a means of articulating how those ideas have worked to cultivate institutionalized systems of death. This is accomplished by putting Nietzsche's philosophies of "great politics" and "great health" into conversation with Michel Foucault's biopolitics. The interplay between Nietzsche's and Foucault's work (relative to medical inequity and health disparities) evidence a differentiation between the ideals of politics and health that work to sustain life and make live for the betterment of society and the reality of socio-medical systems that make live and let die for the betterment of a few members of society. What follows is thus a discussion of how their work and the rhetoric of race and racialization have informed the epistemologies and praxis of medicine and fortified the legitimization and normalization of medical inequity and health disparities as thanatopolitics.

Keywords: Health Disparities; Medical Inequity; Healthcare; Death; Race

Introduction

Upon looking at the immediate and broader effects of COVID-19 on communities of color, what becomes immediately evident is the extent to which African American people are overrepresented relative to its virulence, mortality rates, and its economic impact. These issues were not caused by COVID-19. They were uncovered and accented by it. More specifically, what COVID-19 revealed are the assemblage of structural violences that produce, propagate, and perpetuate negative health outcomes for minority peoples. Many of these systems are made manifest through the normalized use of race and racialization in science and medicine — an issue which shifts race and racialization out of the framework of socio-historical construction and into the sphere of perceived objectivity and scientific truth. Through this process, racialization becomes the foundation upon which medical inequity and health disparities have been legitimized in Western society. Concomitantly, the interplay of race, health, and inequity becomes evidence of how the politics of health shifts between the desire to sustain life (for the betterment of society) to letting some people die (for the betterment of a few members of society over others) —noting an imbrication of biopolitics and thanatopolitics. With this in mind, this article will examine thanatopolitics relative to medical inequity and health disparities as the outcome of racialization in science and medicine. Thanatopolitics are social, political, and economic systems of power that facilitate and perpetuate a politics of death. E.g. inequitable access to healthy food options, health care, and medicine. They work in contrast to processes that produce and reinforce life. E.g. transplants, prenatal care, and vaccines. The life/death dichotomy

of thanatopolitics does not necessitate the involvement of a social, political, scientific, or medical entity acting directly upon an individual or group — in the way that a biopolitical agent (such as a Dr.'s office giving you a note when you miss work) or apparatus (like a fitbit) may become directly involved in the production of good biological citizens. Instead, thanatopolitics are defined by their disregard of pertinent, life-sustaining mechanisms needed by individuals or groups within larger society — such as what is occurring with immigrant families in camps at the U.S. border. In this way, thanatopolitics are systems and mechanisms of power that allow for the death of an individual or group. Thanatopolitics has been most aptly characterized by Roberto Esposito as agents through which health, medical, and socio-medical institutional violences have been rationalized [1]. Because science and medicine molecularize and biologize the socio-historical ascription of race, they also rationalize and reify race and racialization as valid scientific, medical, genetic, and social categories. Historically and contemporarily, thanatopolitics has been the result of such legitimizations, disparities, and discriminations.

Thanatopolitics and Social Death

Within the context of the COVID-19, what manifested in some areas is the application, normalization and disregard of systemic social, scientific, and medical inequity. This indifference pushes the broader effects of COVID-19 — particularly amongst and within vulnerable populations — beyond the parameters of being a new, virulent disease into being furtive agents of thanatopolitical power. The use of COVID-19 as a means of social and socio-medical discrimination, political demarcation (via the issue of Americans who choose to wear a mask versus those who don't), and the disregard of its virulence work to reconstitute complex notions of fitness and social worth — with "fit" being indicative of one's general health status as well as a nod to natural selection. The prevailing concept of using herd immunity as a national treatment strategy is evidence of this because the process would cause the sick and vulnerable to die-off leaving only those biologically and economically "fit". This is an eugenic notion of perceived value or worth within our society. According to John Hope Franklin Book Prize recipient and associate professor, Lisa Marie Cacho, the relationship between ascribed and denied worth within institutionalized and popularized power differentials prompt an additional kind of death for poor, marginalized, oppressed and/or minority peoples — a social death [2]. Social death is the social devaluation of an individual or peoples based on socioeconomic, racial, and heteropatriarchal conceptions of worth and worthiness. As the scientific and medical communities continue to use race and racialization as molecular and biological concepts within the framework of their research, interpretations of data, and general production of knowledge, those ideas become the foundation for perceived socio-medical hegemony, normalized thanatopolitical power, and the reification of social death. Molecularization, biologization, and racialization within discussions and treatment of COVID-19 will further the application of thanatopolitical power and social death within poor, minority, and/or oppressed communities.

However, this would not be the first time we're seeing this in the United States. Historically, the actualized interplay between thanatopolitical power and social death have specifically occurred within the framework of racialized medicine or at the behest of broader social systems. Think about the recent socio-medical rhetoric surrounding Asian Americans, infected prisoners (many of whom are African American), or detained immigrants (whom are Mexican). According to ethicist and medical writer Harriet A. Washington, the effects of biases are what blur the lines between medical research and public health data by perpetuating race-based ideologies and practices in society, medical research, and public health [3]. For example, from the mid 1800's to the latter part of the 20th century, social medicine and public health were often tied to immigration laws. The 1885 image of a wood carving in Harper's Digest entitled "At the Gates: Our Safety Depends upon Official Vigilance" [4] was an archetypical representation of the cultural and medical ecology of the period as well as its associated propaganda. In the image an angel holding a sword and shield of "cleanliness" stands at the quarantined entrance to the Port of New York City (via Ellis Island) blocking three cloaked, anthropomorphic representations of cholera, smallpox, and yellow fever from entering the United States [5]. Noting Ellis Island in the carving was significant as it was the first Federal Immigration Station in the United States. For more than sixty years it was the point of entry for approximately twelve million immigrants.

Thus, the shrouded, anthropomorphized diseases depicted on the wood carving represented the supposed dangers lurking within the genes of immigrant populations. The image depicted what sociologist Zygmunt Bauman describes as the integration of the stranger, the foreign body, and the diseased in modern society — objects of physical, psychological, social, racial, and genetic fear [6]. The ascribed status of the diseased, foreign, stranger was then articulated as that of a devalued/dehumanized member of society. The product of these ideas was the instigation of thanatopolitical power and social death of racialized peoples. Fear, dehumanization and social death caused by racialization and ideas of social worth have largely influenced the practice of medicine and have had persisting socio-medical affects within Western society. Friedrich Nietzsche's theories of "great health" and "great politics," for example, typify the ways in which normalized theories of fitness and social worth have informed the Western philosophical, ideological, medical, and socio-medical framework and continues to inform people's contemporary engagements with the rhetoric and treatment of COVID-19.

Nietzsche's Great Politics and Great Health

Nietzsche explicitly stated in his theories that health was primarily a psychological state of well-being which one sought out and which was a manifestation of one's ability to overcome, resist,

and order their inherent disharmony [7]. In his texts Philosophy in the Tragic Age of the Greeks and The Birth of Tragedy he stated that "the healthy not only respond to, but also seek out challenges to their worldview; suffering for them, is the midwife of creation, crushing those too passive to overcome its challenges while elevating the strong to new levels" [8]. This idea should sound very similar to the notion of allowing a disease to roll over the American people via the push for herd immunity. Moreover, according to Nietzsche, individuals in great health were considered "dangerously healthy" as they were in perpetual opposition to a state of mind and/or a person perceived as weak, destitute, and in decay — the unhealthy, abnormal individual [9]. Again, if we think to the not so distant past in which the President of the United States mocked his opponent for consistently wearing a mask, we can see that these ideas and ideals are alive and well. In addition, Nietzsche's theories created a dichotomy between individuals he perceived as taking agency in addressing their disease, sickness, or plight against those he believed to be torpid.

His ideas suggested that unhealthy individuals were physically or physiologically sick, and psychologically ill. Otherwise, they too would have worked to alter their state of existence — thus making themselves healthier. This notion is built into the rhetoric of the American progress narrative which states that one is to pull his or herself up by the bootstraps (contrary to whether or not the individual had access to the proverbial "boots"). You must make yourself better and if you didn't, it was because you were unfit (socially, biologically, and economically) to do so. Nietzsche's great politics and great health also blatantly discussed concepts of worth and/or worthiness ascribed to racialized groups. These ideas were echoes of the prevailing medical concepts of the 19th and 20th century which viewed disease and illness in destitute neighborhoods as evidence of intergenerational expressions of genetic inferiority. Thus, Nietzsche's theories were grounded by the normalization of the molecularization and biologization of race and racialization. Social Darwinism and Herbert Spencer's phrase "survival of the fittest" (which mapped evolutionary theory onto social, economic, and political ecologies), evidenced the kinds of thanatopolitical and socio-medical implications of perceived racial and genetic inferiority. Moreover, in Nietzsche's theory of great health, he stated that the condemnation of suffering generated resentment and impeded eminence by blurring the distinction between a "slave morality" (a herd/weak morality characterized as common by way of sympathy and kindness, and which frowned upon strength and independence) and a "master morality" (a noble/strong sensibility characterized as aristocratic by way of self-sufficiency, virtue, and strength) [10].

The terms he used in his analysis were not arbitrary. Instead, they worked to reinforce the Black/White, inhuman/human, and unhealthy/healthy dichotomies already steeped within society. His terminology also created and rationalized a social and socio-medical hierarchy based on one's perceived social, moral, and biological characteristics — further legitimizing the molecularization and biologization of race and racialization. Assessments of the slave morality versus the master morality as well as the aforenoted dichotomies continue to bleed into varying aspects of the practice of medicine and the modern context of health care. For example, in the October 2002 edition of the Journal of Advanced Nursing, John Paley asserted that the ideology of caring and compassion within the nursing profession should have been viewed as a politically unrealistic vice that was evidence of a slave morality [11]. He likened nurses to slaves whom, in a moment of self-deception, convinced themselves that their weaknesses were good thereby debilitating the progress of the profession [12]. Likewise, Francis C. Biley suggested that consumer sovereignty, patient-centered care, and subjectivity inpsychiatry and mental health care were evidence of a shifting landscape of medicine from a noble morality to a slave morality — the latter of which she believed to be detrimental to the practice of medicine and the advancement of society [13]. Paley and Biley championed stoicism, medical paternalism (and thus a reduction in patient autonomy), as well as medical and socio-medical hierarchies existing in the medical endeavor. Paley and Biley's work also evidenced discourses about the idea that one's capabilities and movement away from a perceived slave morality determined the lens through which health, social, and socio-medical worthiness would be assessed and ascribed. Social and socio-medical hierarchy, and ascribed notions of worth/worthiness are the premises through which unequal access to goods and resources have historically been legally systematized — note the use of the QALY and medical access in the history of dialysis treatment.

Medical inequity, health disparities, and the realization of thanatopolitical power are thusly the logical progressions of perceived slave morality and the discrimination inherent in Nietzsche's great health. Similarly, Nietzsche's great politics referred to a process of "taming and breeding" [Zucht and Züchtung]. It was geared toward the identification and exclusion of the "normal" person from the "abnormal" and the healthy person from the pathological [14]. Individuals were deemed abnormal and rejected based on their ability to contribute to the functioning or general betterment of society [15]. However, the term contribution for Nietzsche (and society during the time) had a more complex connotation as it referred to both an individual's physical involvement with the production and stability of society as well as one's genetic input [12]. The categorization and exclusion of individuals based on their perceived normalcy is also indicative of what Bauman referred to as a pole on the moral-immoral axis. The pole is the movement of social ideas and practices along the axis of morality and immorality where diseased or disease prone parts (people) of the social body are drastically and surgically removed from society — resulting in both a social and physical death [16]. Bauman describes the social surgery used to remove individuals perceived as abnormal from those designated as normal in the following:

Stratagems of placing, intentionally or by default, certain acts and/or omitted acts regarding certain categories of humans outside [emphasis his] the moral-immoral axis that is, outside the universe of moral obligations and outside the realm of phenomena subject to moral evaluation declare that such acts or inactions, explicitly or implicitly are morally neutral and prevent the choices between them from being subject to ethical judgement. . . [17].

As such, he contends that normalized health disparities caused by medical inequity and thanatopolitics are not subject to issues of ethics or morality because they exist outside of the moral-immoral axis. This is merely a rationalization of abhorrent behavior — the kind of behavior that mocks mandates for health and wellbeing and ostracizes individuals attempting to increase the health of a nation through education. Yet such behavior situates as a demarcation of perceived normal versus abnormal, healthy versus unhealthy, and master morality versus slave morality, for example, and creates what Roberto Esposito refers to as an "auto-immunitary reaction" [18].

The Auto-Immunitary Reaction

In the auto-immunitary reaction, poor, minority, and/or marginalized members of society are engaged by wealthier society members as if they were an immune system trying to get rid of a virus. Society turns on itself in the same way that an autoimmune disease in the body attacks healthy cells — attacks itself. According to Esposito, anger and fear of infiltration (infection) from individuals who are perceived as being socially, genetically, and physically inferior is what ignites society to turn on itself — thereby causing the social autoimmune reaction. The crux of Esposito's auto-immunitary reaction is the rupture of society's narrative identity and the development, perpetuation, and differentiation of the Self from the Other — a hierarchy which stratifies groups based on ideas of the "higher" Self and the "lower" Other. We see this eruption now as much as during the civil rights movement. Another example of the auto-immunitary reaction can be seen in a quantitative study done by Dr. Thomas Lemke from the University of Frankfurt and his colleagues from the University of Basel and Helmut Schmidt University, respectively, whom examined social Othering as a form of genetic discrimination.

The study was based on presumed genetic disposition for a particular disease or sickness and the ambiguity of genetic information — regardless of whether the individual was symptomatic [19]. Based on their analysis, the authors suggested that the concept of discrimination be broadened such that it not only include formalized, systemic prejudices, but also those that one would endure in his or her everyday engagements. This references an auto-immunitary reaction because the nature of discrimination is the distinction of the Self from the Other, the masked from the unmasked individual, stratification, and fear of infiltration (infection) by the other, for example. In the case of the Lemke study, however, there was simultaneously a fear of physical infiltration (infection) by someone perceived as being lower on the social hierarchy and molecular infiltration (infection) via the introduction of genetic information. In a similar vein, Shirley Sun, author of Socio-economics of Personalized Medicine in Asia, stated that racialization in genetic and genomic research was "demonstrably integral to the social process of "(Self-) Othering" [20]. She further suggested that racialization and the biologization of race in medical and biomedical research fails to acknowledge and problematize the broader effects of using race as a proxy for human variation [12]. The prevalence of medical inequity and health disparities in this country re-asserts the kinds of discrimination and othering discussed by Lemke and Sun through the normalized use of race and racialization as molecular and biological concepts without noting the causality behind many pre-existing conditions or the social determinants of health, for example. The prevalence of health disparities without noting causality or context in the U.S. also indoctrinates clinicians to the idea that the socio-historical construction of race (and its associated ideologies) are legitimate, inherent subscripts to human variation in health and medicine.

The Auto-Immunitary Reaction and Thanatopolitics

The function of auto-immunitary reactions (as noted by Esposito) is to shift juridical power from ensuring the protection of the entire organism (the collective body of society) to the radical movement of select groups into fortified boundaries — protecting some groups over others while also making some groups live and letting others to die (as noted in biopolitics) [21]. Such circumstances lead to the self-designated higher life forms protecting themselves from perceived aggression by putting the lower life forms to death or allowing them to die — actualizing a kind of law-violence-stratification paradigm via thanatopolitical power [22]. Philosopher Jacques Derrida elaborates on this issue in stating that: We are here in a space where all self-protection of the unscathed, of the safe and sound, of the sacred (heilig, holy) must protect itself against its own protection, its own police, its own power of rejection, in short against its own, which is to say, against its own immunity. It is this terrifying but fatal logic of the auto-immunity of the unscathed that will always have associated science and religion [23].

Per Derrida, an auto-immunitary reaction is not only evidence of a politics of selection or thanatopolitics but also an integration of science and religion. The integration of science, religion, selection, and death was also embedded in Nietzsche's "great politics." Great politics sought to cultivate humanity through the development and measurement of racial hierarchies based on an individual's (or a population's) perceived future, promise of life, and physiology — eliminating anything or anyone deemed degenerate, unholy, and parasitic [24]. The infrastructure of Nietzsche's great politics and great health — which highlighted the significance of race and racialization

as molecular and biological concepts — led many contemporary philosophers to believe that the theories were inherently racist [25]. The concept of race within Nietzsche's great politics and great health was not only a reference to the socio-historical construction of race but to humanity as a species (e.g. the race of man/homo sapiens). Over time, the different political and physical characteristics of race, as a homograph, were mapped on to each other and the notion of the weak, "lower" level individual with a slave morality became synonymous with poor and/or minority peoples. These ideas, and the extent to which they are situated within notions of health, work to form one of the many enduring characterizations of poor and minority peoples — the interlaced socio-historical, molecular, and biological conceptualizations of race and racialization and the prevalence of health disparities.

Biopolitics and Thanatopolitics

For Michel Foucault, Nietzsche's great health, great politics and the kinds of stigma and discrimination inherent in those ideas represented a turning point in Western philosophical and political thought in that they articulated the relationship between one's biological existence and political existence [26]. More specifically, Foucault viewed Nietzsche's ideas as a discourse about sovereign control and the regulation of a population [27]. It was a kind of homily about a biological life and belonging to life itself in that life was "regulated, maximized, and harnessed through governmental policy, free-market global capitalism, judicialization, and medicalization" [28]. As with Derrida, Foucault noted that the ideological framework of health is simultaneously a dialogue about selection, science, religion, and sovereignty. Foucault went a step further, however, in stating that life (as a biological, social, and political happening) is affected by the capitalist endeavor. The inability of someone to get an operation, simple medical treatment, or afford the cost of some medications, for example, are all blatant examples of the ways in which one's economic standing is interlaced with the potentiality of a positive health outcome. In New Orleans, for example, there is a twenty-five year difference in life expectancy tied largely to the economic vitality of your neighborhood [29].

Additionally, operations, health care, and medications are considered commodities within the capitalist framework and thus an individual needs a particular amount of money to participate in the consumption of those goods. The managed production and distribution of goods and services are the heart of the capitalist endeavor. As such, unequal access to goods and services (such as health care, pharmaceuticals, and healthcare related services) are reflections of capitalism and thusly facilitate medical inequity with the intention of maintaining economic and socio-medical stratification. So, the actualization of ideas or national concepts that reinforce (intentionally or unintentionally) medical and socio-medical inequity, stratification, or discrimination also fortify and inform income-based health outcomes that assert thanatopolitical power. They are all connected. They are not mutually exclusive from the existence of health disparities or medical inequity. For example, using the Future Elderly Model to assess the social trade-offs created by pharmaceutical innovation, economist and Quintiles Chair in Pharmaceutical Development at the University of California, Darius Lakdawala, stated that the high cost of pharmaceutical innovations incentivizes manufactures to do more research to produce more products for future patients while concomitantly reducing the number of people who can currently access new medical or pharmaceutical technologies [30,31].

The parallax of these kinds of developments is that they hold great promise for people's future access to health while also potentially hindering the contemporary production of positive biological, social, and socio-medical outcomes in communities that need it the most. One's biological and social life are also affected by the capitalist endeavor because there is a stark and direct relationship between the perceived worth of an individual, his or her contribution to society, and the extent to which society is willing to invest back into that person. Access to education and health care, for example, are forms of social investment in individuals that drive health outcomes. If, however, society chooses not to or fails to make those kinds of resources available to its populace, it is facilitating institutionalized stratification — thereby reducing the actual and proximal development of the individual, limiting his or her income potential, and disregarding the relationship between poverty, education, and health — the social determinants of health and the root of health disparities. For example, according to a 2011 study on the Structural Vulnerability and Health of Latino Migrant Laborers in the Unites States, Latino migrant laborers suffer structural violence in the form of economic exploitation, cultural depreciation, political subordination, persisting legal persecution, and increasingly legitimized U.S. governmental discourses of unworthiness — all of which dramatically increases migrant Laborers' potentiality for poor health out-comes [32]. Their health and well-being are highly correlated to and with racialization and perceived social worth. The application of thanatopolitical power and the potentiality of social death in this instance shows how the dynamics of a society's social, political, and economic ecology passively allows for the death of some people while actively working to secure an affluent, healthy life for others. According to French anatomist and physiologist Xavier Bichat, however, society must realize that one's biological existence, political existence, and perceived socio-historical attributes evidence social systems that do not act directly upon an individual (causing him or her harm) but rather ignores the needs of particular groups of people as an indirect means of accelerating their deaths — again noting the overlap of biopolitics and thanatopolitics relative to health disparities. Foucault, however, recognized that although the paradox of making live and letting die could first appear as a logical fallacy, the

molecularization and biologization of race and racialization divides a population into a continuum — re-instigating and legitimizing the distinction between the Self and the Other and allowing the indirect killing (letting die) of the Other for the supposed protection of society (making live) [33].

This racism, as he called it, is different than the kind overtly articulated in Nietzsche's great politics and great health. And yet, it is the existence of racism, medical inequity, and health disparities at the intersection of biopolitics that makes it a thanatopolitics [12]. Foucault stated that "in the economy of biopower, racism has the function of death according to the principle of the death of others. It is the biological reinforcement of oneself as a member of a race or population, as an element in a unitary and living plurality" [34]. For example, in Roxane Richter's book Medical Outcasts she characterizes undocumented Zimbabwean woman in South Africa and undocumented Mexican women in the United States as homo sacers [35] whose medical and socio-medical plights are directly due to the application of thanatopolitical power in the form of structural violence [36]. In elaborating on those women's experiences, Richter stated that: Structural violence — in all of its forms — fabricates pronounced and preventable causes of premature death, suffering, needless disabilities, as well as the exacerbation of lower acuity illnesses/diseases into higher acuity illness/disease phases. As we see from this research, the Zimbabwean and Mexican women fall victim to structural violence in that their access to lifesaving emergency medical care is obstructed, discouraged, and flatly denied by some xenophobic medical personnel, political posture, or institutionalized systemic procedure [12].

Thus, it is not simply their inability to access health care, or pharmaceuticals in South Africa and the United States, respectively, but the relationship between their perceived racialized identities with socio-medical, structural violences that hinders their potentiality for positive health outcomes. Their plight notes an intersection of racialization and biopolitics in which society lets them die rather than providing them the necessary tools and resources to make them live (or better facilitate their ability to live). This is the application of thanatopolitics as noted by medical inequity and health disparity. According to Philosopher Martin Heidegger, however, the causal shift of biopolitics to thanatopolitics occurred because some technologies change the way that one is able to be in the world [37]. Neoteric medical technologies which potentiate medical and socio-medical inequity have historically shown themselves as altering how individuals are able to be in the world and whether people's health outcomes would allow them to be for very long. For example, since the completion of the Human Genome Project, how we (as a species) are able to be in the world has changed. We have a new-found potential to alter aspects of our genetic make-up, diagnose and treat disease on a molecular level, and potentially tailor pharmaceuticals to particular groups of people. What has not changed, however, is the general ideological foundation of Western society and Western medicine. We continue to be victims of — and perhaps victimized by — auto-immunitary reactions instigated by historically situated dichotomies of the Self /Other, black/white, healthy/unhealthy and worthy/unworthy. Thus, the reality of medical inequity and health disparities as thanatopolitics sit at the crossroads of what is often articulated as the progress of science and medicine and the aforenoted dichotomies are embedded into the epistemologies and praxis of medicine. To that end, medical inequity and health disparities are legitimized and normalized through the medical endeavor and we engage with them with a sense of benign routine. And yet, this routine is not benign. It is the malignancy of thanatopolitics.

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