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POSITION PIECES

COVID-19 Diagnoses

A source of immanent value and novelty

Marsha Rosengarten

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Abstract

Although the body is fundamental to observation and feeling, its experience of infection is regarded by the biomedical sciences and, for the most part, the social sciences as relatively obtuse. The body is situated as a mere object *of* inquiry, as if its intricate and highly complex dynamics indicate that it is no more than an imperfect animated machine and, concomitantly, infection simply a change to its normative mechanisms. In this Position Piece, I ask: what might be afforded to the problematic diagnosis of communicable infection and to global health strategies of containment if the body were appreciated as an *active participant* in diagnoses? To do so, I take up the 'pluralist panpsychist' proposition that bodies *think*. Counter to the view that thinking is the preserve of the human mind and that value is an 'after' ascribed to a given fact or situation, I experiment with the idea that the *body*'s sensory awareness can *be thought as a creative source of immanent values.* Drawing on a series of empirical examples primarily focused on the perceived novelty of COVID-19, I offer a preliminary sketch of how revaluing the body as involved in decision-making and novelty might enrich the scope of biomedical and social diagnoses.

Keywords

COVID-19, Infection, Immanent value, Novelty, Diagnosis.

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Introduction

In order to unravel the mystery of novel communicable infection, biomedical diagnoses proceed on the presupposition that they are contending with a first-order reality composed of material substances. Values, meanwhile, make up a second order. They are assumed as a creation only of the mind and thought to contaminate objective knowledge. This arrangement has led to the construction of what are presupposed as 'value-free' technical instruments and to clinical evidence achieved by 'value-free' methods (see, for example, Lacey 2004). Within the social sciences, on the other hand, the presumption that methods or instruments can be free of values (again assumed as if solely a creation the mind) is highly contested. Value-laden cultural concepts and value-inscribed technical instruments invariably participate in the formulation of disease (Haraway 1997; Ong and Chen 2010). Further, treatment and prevention interventions that follow biomedical diagnoses do not necessarily cohere with the priorities and ascribed values of others (Chandler et al. 2015; Kelly, MacGregor, and Montgomery 2017; Fairhead 2016). In sum, despite the contrast that can be drawn between debates on the location of values, there is a shared view that they are the preserve only of subjective perception. Values either obscure factual knowledge or are implicitly inscribed in what is understood as factual.

By consequence, although the body is fundamental to observation and feeling and, no less, at the centre of novel communicable infections, it is regarded as relatively obtuse. It is a mere thing of substance and is thus no more than a passive object in diagnostic decision-making. Its intricate and highly complex dynamics are thought to indicate that it is no more than an imperfect animated machine and, concomitantly, that infection is merely a change to its normative mechanisms (see, e.g., Deeks and Walker 2007; Falasca et al. 2015; Randall and Griffin 2017). In what follows, I ask: what might be afforded to the problematic diagnosis of novel communicable infection and to global health strategies of infection containment if the body was to be appreciated as an active participant *in* the creation of values? Counter to the prevailing view that value is merely an 'after' ascribed to a given fact or situation, I reflect on Martin Savransky's (2019) 'pluralist panpsychist' proposition that the body *thinks.* Its sensory awareness creates values in response to its environment.

The proposition is sourced from the speculative process philosophy of Alfred North Whitehead and the pluralist philosophy of William James. Both Whitehead and James challenge the contemporary scientific claim of reality which, as Whitehead ([1920] 1964, 21) puts this, proceeds on the basis of having 'bifurcated nature', according to which it is 'there for knowledge; although on this theory it is never known. For what is known is the other sort of reality, which is the byplay of the

mind'. If we follow Whitehead, the need for 'value-free' instruments and methods does not arise from a first-order material reality that can be contaminated by a second order (that is, by the conscious perception of the mind), but due to a mode of thought that can be traced to the Kantian distinction between 'phenomena'—that is, appearances, which constitute our experiences—and 'noumena', the things that constitute reality. This dividing of nature, according to which values are conceived as if apart from and transcendental to infection, forecloses on what Whitehead (1979, 222) claims is the universe's 'creative advance into novelty'.[1] In effect, we are left with the implicit notion of 'a static morphological universe': a world composed of isolated stable substances.

Having obfuscated our immanent and creative connectedness, the bifurcation leads us to assume a given separation between consciousness and content, as if perception is apart from what draws it and, thus, reserves the creation of values to the mind. By relinquishing this view, we may arrive at an appreciation for consciousness experienced in many forms (James 1907, 8–9). Taking up the problem of the bifurcation of nature and, more particularly, the proposition that there may be many forms of consciousness, Savransky suggests that bodies may be understood to constitute 'modes of thought in their own right'. Their sensory awareness can be conceived to involve 'the discernment of relevance, problem solving, decision making and feeling' that express 'values and aims'—including those that, while they may 'be characterised as divergent and unruly', are novel—in response to the demands made of them by the environment (Savransky 2019, 122).

I approach Savransky's proposition through the lens of COVID-19. The first two examples focus on what are regarded by biomedicine as COVID-19's baffling novel disease effects. I suggest that the notion of novelty as the mysterious new might be altered by an appreciation of the body that *thinks* and is, by consequence, creative of immanent values and, thus, insistent novelty. The third example focuses on a recent biomedical trial. Despite its inflection with ascribed social values, it reveals how an unwitting appreciation for the body's creativity may be found in the interstices of biomedical research. It leads me to suggest that what gives impetus to the trial and also to modes of securitising against pathogenic infection is not a first order of isolated substances but, on the contrary, the immanent creative and connective work of values. In the conclusion, I draw on the above examples to extend their relevance to what Chandler et al. (2015) suggest

1 Further clarification on what Whitehead means by 'value' can be found in *Science and the Modern World* (1967, 94), where he states:

> 'Value' is the word I use for the intrinsic reality of an event. Value is an element which permeates through and through the poetic view of nature. We have only to transfer to the very texture of realization in itself that which we recognize so readily in terms of human life.

regarding the problem of imposing a scientific reality on lay communities in order to contain communicable infection.

Sensing infection

Arguably, the most dramatic novel bodily consequence of COVID-19 infection is 'happy hypoxia', a term given to people who are able to talk as if without distress but show oxygen levels that should mean they are unconscious or even dead. As a recent scientific news article explained, in most people suffering COVID-19 'the body *senses* the rising levels of carbon dioxide that typically occur simultaneously as the lungs are unable to clear gas as efficiently. But in some […] this response does not appear to be kicking in' (Devlin 2020, my italics). As one clinician cited in a peer-reviewed article describes it: 'There is a mismatch [between] what we see on the monitor and what the patient looks like in front of us.' And, as another clinician says of the 'mismatch': 'The brain is tuned to monitoring the carbon dioxide with various sensors […] We don't *sense* our oxygen levels' (Couzin-Frankel 2020, my italics). Although at first reading, it may seem that what is novel for biomedicine is the mismatch between consciousness and observable measures, 'happy hypoxia' is not new to science. It is a well-known phenomenon among pilots flying at high altitudes, where oxygen pressure is detected as low (Cable 2003). What enables the identification of COVID-19-induced 'happy hypoxia' as novel is the mismatch between what is expected of microbial infection (when thought of as a distinct temporal bodily event apart from the environment) and what is actually observed.

According to the descriptions above, diagnoses of 'happy hypoxia' are made by abstracting oxygen levels from the body (itself attached to a monitor) and comparing them to measures statistically established in a 'normal' body. While the latter measures are crucial diagnostic indicators of difference, they are nonetheless *imposed on* an individual body (Greco 2004, 4). However, as Monica Greco notes, a distinction can be drawn between 'normal' measures devised through knowledge-making practices and what George Canguilhem proposed as the body's 'capacity to institute, or be the source of, norms' (Greco 2004, 3). Careful to acknowledge that there is an intimate relationship between what can be termed 'social' or 'biomedically' derived norms and 'organic' norms in the formulation of a pathological condition, Greco suggests that the distinction is warranted if we are to avoid, as she puts it, reductively confusing 'organic possibilities' with those that are 'intelligible through their codification in knowledge' (Greco 2004, 4). When confused, the body's 'dynamic *adaptability*'—according to its own normative constraints—is elided (2004, 3). Without presupposing the scope of this adaptability, the body may be understood to have its own constraints that involve 'a plurality of vital norms or values—that is, values pertaining to something

like a “vital order”’ (Greco 2004, 9). This does not take away from the interdependency of the body in terms of acquiring and negotiating its constraints in connection with its environment. As Canguilhem (2008, 113) states: ‘The living brings its own proper norms of appreciating situations, both dominating the milieu and accommodating itself to it.’

While measures of low oxygen levels in the body are indicators of potential fatality, for biomedicine the measures are facts that *acquire* value. Thus, the mismatch is ‘baffling’ because it does not conform to the body as merely an obtuse substance. But if we take seriously the repeated reference to the body’s capacity to ‘sense’ and consider oxygen as a value created by the environment in place of the idea that it and the body are isolatable substances to which value is attributed, we can begin to consider how the idea of a *thinking* body alters the conception of what makes ‘happy hypoxia’ novel. If oxygen is itself the achievement of immanent value, its decreasing absence in relation to the divergent values created by microbial infection may be understood to call for multiple decisions to be made by the body ‘all the way down’ (Savransky 2019, 119). These decisions have consequences that are expressed in different spatio-temporal ways, sustaining for a period a site of consciousness that, despite its limited sensory capacity, is privileged by a Cartesian dualism as to the sensory capacities of the body (Descartes 1996) where, accordingly, diagnosis proceeds having already accepted a bifurcated conception of experience.

While the biomedical approach to ‘happy hypoxia’ can be shown to have pragmatic currency for intervening through the administration of oxygen, the ‘normal’ parameters of the body established according to biomedical norms can be said to express, as Savransky suggests, novel aims and values. For the body experiencing ‘happy hypoxia’, a process of revaluation may be said to be taking place. From this point of view, ‘happy hypoxia’ is not an aberration in the ‘state’ of a normal body presupposed as an isolated entity apart from its environment. Rather, it is the achievement of a diagnosis made and acted on by the body as an *interested* participant in response to its milieu (at a minimum, microbial infection and its respiratory relation to air). It is interested to the degree that it discerns values that conflict with it and, in the event of ‘happy hypoxia’, its capacities for discernment do not succeed. Although not different in expression to ‘happy hypoxia’ in a pilot, when created in response to COVID-19, the event of ‘happy hypoxia’ is instructive of the presupposed distinction that biomedicine makes between consciousness and content, but also between bodily infection and the environment.

The bafflement provoked by ‘happy hypoxia’ is also evident in the difficulty that biomedicine has experienced in specifying other COVID-19 disease effects. Of the

many examples that might be considered here, ‘long COVID’ is now acknowledged to have expressly challenged the usual taxonomy used to distinguish the likelihood of long-term disease effects. Initially side-lined by a taxonomy of ‘mild’, ‘moderate’, and ‘severe infection’, the latter involving hospitalisation, patient groups have succeeded in obtaining acknowledgement of an array of felt effects that do not conform to the cessation of ‘mild’ or ‘moderate’ infection (see Callard 2020; Public Health England 2020; Yelin et al. 2020). Again, based on what I have suggested above, we could say that a microbial infection furnishes new values with which the body continues to ‘think’ beyond biomedical determinations of the temporality of infection, itself affixed to a locatable microbial substance. Indeed, in this regard, there are numerous other communicable infections that could be included here. For example, the ‘novel’ emergence of ‘Ebola relapse’ caught biomedicine by surprise and has led to a rethinking of the infection as ‘persisting’ in novel ways, despite situated diagnostic testing that showed it to be gone (Jacobs et al. 2016).

Values in the interstices of biomedical inquiry

I turn now to an area of medical inquiry that is implicitly engaged in an appreciation of the body’s capacity to create immanent values but where attention only to ‘socially’ ascribed values can distract from its potential to ‘self-diagnose’ and intervene. Although antibodies are often portrayed as additional components—‘facts’ acquired by the body as a potential armament against pathogenic infection—they do not come from, as the expression goes, ‘thin air’. That is to say, they are not simply new components to which value should be *attributed* for their capacity to arrest or thwart infection; rather, they are immanent values indicative of a creative response to infection by the body, including with the aid of a vaccine. In an attempt to learn more from the potentiality of antibody protection, numerous laboratory and clinical studies are currently taking place. One such attempt has been a biomedical trial in the United Kingdom seeking to establish whether transfusing antibodies produced by those who have had COVID-19 might facilitate an immune response in those seriously ill with the disease.[2]

What initially drew my attention to the trial was its barring of gay and bisexual men from donating their blood plasma based on the stigmatisation of diverse sexualities, itself affixed to knowledge about the transmission of HIV infection—and *not* on the ‘value-free’ technical instruments of diagnosis that could have demonstrated that these volunteers were no more likely to pass on HIV than others (Keller 2020). Here we might read their barring as an example of how a negative ‘social’ value (in the sense of ‘worth’) is ascribed to a category of persons

2 The trial referred to has since been completed without showing significant overall benefit, although therapeutic plasma has been found efficacious for treating ‘rare diseases’ (NHS n.d.).

challenged by biomedical diagnostics that were, notably, free of this ascribed discriminatory value. But, in doing so, we risk eliding the potential of immanent value created by the body and *sought* by the trial. That is to say, we risk leaving out of a diagnosis the body's capacity for creativity, even though this is evident in the seeking out of novel antibodies. Paradoxically, it could be said that it is the creation of immanent value by the body that enables biomedicine to ascribe value. Without being able to confirm the results of this trial, I also want to suggest that it raises the possible value of a body to another within the concreteness of COVID-19. In this crisis, where 'social distance' has become a crucial strategy to prevent infection transmission, the creation of immanent value by the body complexifies the question of where we might seek connections as well as disconnections from others.

Although those conducting the trial would not claim to be aiming to seek out and put to test values created by bodies in response to their milieu, the trial is nonetheless exploring their potential value to others. The study can be considered a discerning response by biomedicine to the body's capacities to discern in a manner that selects *for,* rather than against, the connectedness achieved by infection. To put this another way, what we see here is a counter to the confusing presupposition that life is composed of stable isolated substances and enacted through securitisation measures of 'quarantining' (frequently put in place in response to other communicable infections), 'self-isolation', 'social distancing', and variable requirements for face masks—measures that would not be necessary if we were merely entities of a first order of isolated substances.

Conclusion

What I have proposed in this brief commentary on diagnosis does not take away the need to examine the values that are imposed as an 'after' to what is presupposed as fact. Rather, it suggests that all values warrant scrutiny for their relevance to the situation in which they are created. I also want to make clear that the examples that I have discussed above are not intended to provide a 'solution' to the experience of COVID-19, as would be expected of a medical or, indeed, a socio-political diagnosis. By populating a diagnosis with values as immanent to the body, my aim has been to cultivate an appreciation for novelty that may enrich the scope of biomedical diagnosis. Contrary to the idea that novelty is merely indicative of a process gone awry, conceiving novelty as an achievement of an immanently creative process—in effect a process of revaluing values—raises new questions that give scope to the body as the centrepiece of infection.

Although it is beyond the focus of this Position Piece to give sufficient attention to what Kelly, McGregor, and Montgomery (2017, 2) describe as the 'lived science

and medicine realities on the ground' that conflict with the lived experiences of those for whom they are intended, I want to finish by drawing a connection between this problem and that I have raised regarding novelty and immanent values. Chandler et al (2015) suggest that there is a mistaken claim that communities who do not readily concede to biomedically informed global health strategies are themselves either mistaken or ignorant in their evaluations of value. On the basis of what I have outlined, we could say that the mistakes arise with the bifurcation of nature that reduces values to mere ascriptions and, in doing so, remains indifferent to the *felt* values of others. While diagnosis premised on a separation between facts and values may succeed in temporally thwarting or assuaging a particular communicable infection, it will not make the creation of novelty disappear.

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About the author

Marsha Rosengarten is a professor of sociology and co-director of the Centre for Invention and Social Process at the Department of Sociology, Goldsmiths, University of London. She is the author of *HIV Interventions: Biomedicine and the Traffic in Information and Flesh*, co-author with Mike Michael of *Innovation and Biomedicine: Ethics, Evidence and Expectation in HIV*, and co-editor with Alex Wilkie and Martin Savransky of *Speculative Research: The Lure of Possible Futures*. Her recent publications focus on biomedical research within the field of HIV, Ebola, and COVID-19.

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