

# Social distance forever?

Or, what is a Horizon for 'being near, together with others'?

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## Abstract

In light of COVID-19 infection control measures, which establish a minimum distance of 6 feet between bodies, many have emphasised the need to maintain social closeness despite physical distance. This Position Piece considers the flip side of this concern: in key spaces that structure social interactions in the US today, physical closeness does not equal social closeness. 'This country is like a prison,' one of my interlocutors told me, pointing to carceral histories of social distancing that predate COVID-19. Moreover, in the co-constituted spaces of criminalisation and justice, punishment and care, distance and proximity, and carceral freedom, the physical closeness of people that *could* have registered as social closeness is precluded, culminating in deadly disregard. Drawing on my medical training and on fieldwork documentation of medical harms in the US Immigration and Customs Enforcement (ICE) detention apparatus, I consider how non-responsiveness spreads within and beyond institutions of immigration enforcement. I suggest that medical providers are implicated in what I call 'contagious containment'—that is, the impulse to distance oneself from harmful realities in which one's clinical practice is complicit. This distancing reinforces the idea of humanity being a scarce resource, especially when the racialised stratification of economic and political resources is preserved in and through institutions like ICE detention. Contagious containment offers the fantasy of separating one's clinical work from the apparatus of harming and, so long as such reservoirs of life-threatening disregard remain, such contagion can (and does) spread.

## Keywords

Immigration, Detention, Carcerality, Clinical practice, Medical-legal advocacy, Contagion, Pandemic.

## **Introduction: Social distance, contagious containment**

In 2020, the term ‘social distance’ came to refer to practices such as keeping a minimum of 6 feet between bodies; not gathering with non-household members; staggering entries to grocery stores, post offices, and banks; no-visit policies for hospitalised people; and shifting gatherings from in-person to on-screen. Many have pushed for the categorisation of such infection-control measures as ‘physical’ rather than ‘social’, arguing that social connectivity and physical separation need not be mutually exclusive.<sup>1</sup> This essay discusses the flip side of that point: physical closeness does not equal social closeness (Jackson 2001). Put differently, I am interested in a form of social distance that often exists despite physical proximity. In this Position Piece, I explore the insidious reality of the kind of social distancing that existed before social and physical distancing as formal policies organised people’s lives under the imperative of containing the COVID-19 pandemic; that is, the ‘contagious containment’ within the US’s carceral immigration system. Drawing on my medical training and fieldwork documentation of medical harms in the US Immigration and Customs Enforcement (ICE) detention apparatus, I trace how medical providers are implicated in contagious containment and attempt to distance themselves from the harmful realities with which their clinical practice is complicit. I argue that this distancing reinforces the idea of humanity being a scarce resource, especially when the racialised stratification of economic and political resources is preserved in and through institutions like ICE detention (Gilmore 2007; Weheliye 2014).

I have been researching this other dimension of social distancing since 2016, at which point the robust immigration detention system was scaling up. I focus specifically on the racialised and relational dimensions of immigration-related policies of distance, which expanded through the late nineties when the Illegal Immigration Reform and Immigrant Responsibility Act of 1996 and the Anti-Terrorism and Effective Death Penalty Act of 1996 fundamentally changed the US response to immigration. These changes included the criminalisation of the undocumented status for migrants, the regimentation of deportation as a form of punishment, the restricting of opportunities for release from detention or relief from deportation, and the widening of the reach of militarised anti-immigration agencies whose purpose was surveillance and enforcement. These policies of distance continue a long history of economically and militarily enforced distances (geographical, physical, and symbolic) that racialise and dispossess people, spread them apart, and increase their vulnerability to harm (De León 2015) within contexts defined by the legacies of global colonialism and imperialism and the

1 See, for example, Aminnejad and Rosa 2020 and Allen et al. 2020.

white supremacist logics that govern those political and economic systems (Lowe 2015).

I first came to consider the long history of social distancing during an encounter with Ahmed<sup>2</sup> in Manhattan. On a break from his food-delivery job, Ahmed detailed the reality of social distancing within the racialised parameters of US freedom. He said he had been sold a false deal in coming to the US but that ‘there is no way to explain this to people who haven’t left Burkina Faso’. Ahmed came to the US from West Africa on a student visa, having scored among the top 5% who took the national college entry exam. He explained that his family spent all their money to get him to the US, expecting that, once he arrived in America, he had make just enough money to thrive and keep studying on the side. In fact, however, he arrived and found that the fees he had to pay to get here were nothing in comparison to what he had to pay to continue studying and living here. This, Ahmed told me, was the common experience of students coming to study in the US from Burkina Faso. Eventually, he said, students drop out of school altogether and focus on working. No longer able to promise a return on his family’s investment in a US education, Ahmed found himself working ‘the jobs Americans won’t touch’. He had to make monthly payments on a loan his family took on to pay his way here, a debt he watched keep growing. Ahmed told me he had not known about the barrier to entry he’d faced before arriving in the US—applying for and securing a visa, paying the cost of a flight, etc.—would then turn around and block him from leaving. Then, he told me something that I heard over and over again during my research: ‘This country is like a prison. [...] This country took more than my fees, labour, hope for degrees, potential; it took my feeling. I have no sentiment of being near, together with others. I look, I see, but I don’t feel.’ Distance is more than a mode of confinement, a barrier to entry, or a systematic economic disenfranchisement. Neither is it purely spatial, even when it is folded into or stretched across physical separations.

Ahmed’s words haunted me. They kept repeating in my mind as I followed the conditions that enable or preclude reciprocity (geographical, financial, affective) in relationships changed by US immigration enforcement and its legacies. For example, Yaba, who had spent 17 years in the US, said that having to separate from loved ones in order to support them caused a ‘categorical transformation’ in his kinship (especially when he could not earn enough in the US to send money home), leading him to feel he has, ‘practically speaking’, lost ‘the family’s love’.

But Ahmed, by contrast, was not only talking about the family members he had left behind. Despite doing a job that required more than 50 human interactions per

2 This and all other names of participants and collaborators that appear in this text are pseudonyms. Names from a public congressional sub-committee hearing in 2007 (pp. 5–6; a video recording and full transcript are also available online) are unchanged.

day, he had ‘no sentiment of being near, together with others’. The sense of being close enough (to be together) had been taken from him. Ahmed’s experience therefore marks a form of distance that becomes affective and relational through the patterning of financial, occupational, emotional, and symbolic investments that occlude human proximities on many scales.<sup>3</sup> His observation that ‘this country is like a prison’ gestures to a dangerous collusion of euphemisms and dismissals that, as I consider next, has the effect of neutralising responsibility across contexts of clinical, legal, and carceral practice. Professional duties held dear can propel one into distancing and sometimes violent relations with others.

When I started this research, I wanted to understand how people forge nearness to one another in spite of impositions of distance beyond their control. Swiftly, however, I began to learn how the condition Ahmed described—‘no sentiment of being near, together with others’—becomes systematic and makes harm routine. The ‘routine’ here refers to dangerous carceral practices that I am calling ‘contagious containment’ within clinical, legal, and prison contexts. ‘Containment’, meanwhile, describes particular strategies of coding, separating, and restricting human relations to make things manageable for those employed within carceral institutions. ‘Contagion’ marks how such strategies have spread across historical moments and continue to spread contemporarily among medical and legal institutions.

### **‘I look, I see, but I don’t feel’**

‘Look, see, but don’t feel’ describes a strategy I observed repeatedly while sitting in on immigration hearings and working with attorney-advocates in prisons and jails where immigrants were incarcerated under the legal designation of ‘administrative detention’. In a public hearing, Hope, an immigration attorney with whom I worked, pleaded with an immigration judge to release her 34-year-old client, Maynor, from a prison in Louisiana so he could get emergency medical care for massive lymph swelling in his left leg, substantial weight loss, and a lump on his left testicle. She told the judge that she feared he would die in detention because his illness was being ignored. The judge insinuated that her appeal was little more than theatrics, advising her to ‘spare the court’. Telling Hope that her client’s medical care in detention would be ‘better than yours or mine’, the judge made it clear that any more appeals to Maynor’s health would not be heard. Physicians outside of the prison/detention system who reviewed Maynor’s case said he was likely suffering from cancer or a life-threatening infection. Like many harms enacted through racist processes of criminalisation and enclosure, the

3 In my work, I theorise these proximities in terms of an ethics of instating human status as a scarce resource through the racialised stratification of economic and political resources in global colonialism and imperialism, following the scholarship of Kamari Clarke (2019), Hidetaka Hirota, Aimé Césaire, Deborah Thomas, Lisa Lowe, Nikhil Pal Singh (2017), and Joseph Masco (2014), among others.

threat to Maynor's life was visible and carefully documented in photographs and written statements. The evidence was clear, but the judge was able to wave it away. After he became sicker in prison over several months, Maynor was deported without care.

Reviewing a 2007 Congressional hearing (US Congress 2007) on medical care in ICE detention, I found a similar story from 11 years before I met Maynor. Mr Francisco Castaneda testified before congress about how he noticed a new, painful lesion in his genitalia, and sought medical care while in ICE detention. He was 35 years old at the time and after some delay, a detention physician saw him and referred him to an oncologist. He was met with more delays. He testified that, after he finally saw an oncologist who ordered a biopsy, 'ICE refused to permit a biopsy and told the oncologist they wanted to try a more cost-effective treatment.' Six weeks later, a urologist said he needed the lesion removed and to determine if he had cancer. ICE and the Division of Immigration Health Services refused, claiming this was an 'elective surgery'.

'Elective' is a dismissive term that can terminate medical responsibility. In his testimony to members of Congress, Mr Castaneda said, 'My pain was getting worse day by day. [...] I tried to get medical help every day. Sometimes I would show the guards my underwear, the blood on it, to get them to take me to medical; but they would say they couldn't help me for nothing.' ICE continued to refuse Mr Castaneda's requests based on the claim that what he needed was elective, not required. After a lymph node in the area became swollen and painful, he contacted an ACLU hotline. Members of the organization advocated on his behalf. By the end of January, ten months after he initially noticed the lesion, ICE agreed to let him get the biopsy and then released him just before the scheduled biopsy, 'due to his medical condition.' But his cancer had spread extensively. Explaining that he'd had an amputation and many rounds of chemotherapy to buy some time, Mr Castaneda said, 'In many ways, it is too late for me; short of a miracle, the most I can hope for are for some good days with Vanessa [his daughter] and some justice.' He concluded his testimony saying that the thought that his pain and his daughter's pain was avoidable 'almost makes this too much to bear.' He explained that he came to testify before Congress because he hoped he could prevent similar things from happening to others in US Immigration and Customs Enforcement (ICE) custody.

During the same hearing, Haitian American and author, Ms Edwidge Danticat, testified about her 81-year-old uncle, Reverend Joseph Nozius Dantica, who died in ICE custody hours after an immigration judge watched him begin to vomit and

seize during his credible fear interview<sup>4</sup> and claimed he was faking his illness. Detention medics claimed the same thing. Reverend Dantica's attorney argued, 'You can't fake vomit.' Hours later, after finally being transferred to a hospital, Reverend Dantica passed away. Following Ms Danticat's testimony, Ms June Everett testified about her sister, Ms Sandra Marina Kenley, who was detained by ICE when returning from Barbados and visibly bled to death from a haemorrhagic fibroid while in ICE custody after her family tried in vain to get her life-saving medication to her.

These stories display the murderous indifference of the American state.<sup>5</sup> The deaths of Reverend Dantica, Ms Kenley, and Mr Castaneda resulted from this indifference. Maynor's deteriorating health in ICE custody resembles the course of Mr Castaneda's neglected illness—11 years after Mr Castaneda testified before Congress in an effort to put an end to this kind of routinised harm. Why was there no response? Institutions with a reflex to contain risk becoming incorporated into a default non-responsiveness. The reservoir<sup>6</sup> for these containment strategies is the racialised stratification of economic and political resources. In this stratification, an 'ascendancy to whiteness' represents an ethics of instating status as human as a scarce resource.<sup>7</sup>

## 'Fatal non-feeling'

The move towards default detention and the criminalisation of immigrants applied a ready-made infrastructure of cruelty to a population whose legal standing is defined as administrative within US law.<sup>8</sup> Ethical disavowals within the system of immigration enforcement, detention, and deportation produce medical harms. Carceral strategies of coding, separating, and restricting bodies precluded moral-ethical witnessing and response (Thomas 2019) in the form of an institutionalised muffling of responsibility that cost people their lives.

4 A 'credible fear interview' is conducted either by an immigration judge, as was the case for Revd Dantica, or by an asylum officer. The interview consists of questioning that is supposed to determine whether there is 'significant possibility' that a person who expresses a fear of persecution or death in their country of origin and attends to apply for asylum could be eligible for asylum. See US Code 8 § 1225 (1940).

5 Readers familiar with related case law will see in my use of the term 'indifference' in the context of medical harms in prisons and detention similarities with *Estelle v. Gamble* 429 US 97 (1976). In this case, the Supreme Court (SCOTUS) established 'deliberate indifference' to 'serious' medical needs as the standard a prisoner's complaint must meet before courts would consider medical and treatment failures to be violations of the Eighth Amendment's prohibition of 'cruel and unusual punishments'. I use the term 'murderous indifference' and detail harmful *outcomes*, including death, because when the law makes the *intent* to harm the legally relevant question (rather than the *effect of harming*) it cocoons institutional perpetrators, making it nearly impossible to hold them responsible for their roles in harming and killing people. 'Inadvertent failures' can have murderous consequences.

6 Here and in my broader work, I use the term 'reservoir' to refer to a source that harbours and enables the continued transmission and propagation of an entity, traditionally thought of as an infectious agent. The reservoirs for and means of transmitting social distance inform my central provocation in terms of how professionals, including medical professionals, get enrolled in carceral realities even if they practise outside the visible perimeters of prisons, jails, and detention centres.

7 See Chow 2002; Weheliye 2014; King 2019; Beliso-De Jesus and Pierre 2019.

8 See Armenta 2017; Gilmore 2007; Gottschalk 2015; Taylor 2016; and Muhammad 2010.

Non-feeling can become fatal. I am provoked into this understanding by Adriana Petryna's theorisation of the 'fatal non-feeling' that results from 'horizon deprivation', or a loss of 'the capacity to meet [rapidly evolving] conditions where they are' (2020). Diminished responsive capacity in the form of 'sensory myopia' can lead to a 'stark surrender to inevitability' (Petryna forthcoming). Crafting alternatives requires the disarming of the euphemisms and dismissals that have long neutralised responsibility across clinical, legal and carceral contexts. It involves understanding how these euphemisms obtain their myopic powers and tracing the endless transfers of responsibility that allow these dismissals to stand.

Strategies of containment certainly spread from mass incarceration to administrative detention, but also from medical practice to carceral operations (and vice versa). Clinical typologies with diagnostic force are taken up in carceral settings, including the 'malingering patient' (someone feigning illness with a specific goal such as obtaining a meal or a safe place to sleep). The category allows clinicians to see even basic requests as causes for distrust and punitive action. Patients considered too 'complicated' can be passed off from service to service or facility to facility until they become nobody's responsibility. The 'complicated patient' becomes an irreducible amalgamation of struggle, embodying the dispossessing structures that make up medical and carceral political economies.<sup>9</sup>

Mr Castaneda, Revd Joseph Nosius Dantica, Ms Sandra Marina Kenley, and Maynor were visibly suffering; their suffering was observed, and at times even acknowledged, but then waved away. Social distancing blunts concern within larger strategies of containment that render concern elective, not mandatory. Today, we must account for the longer histories of social distancing that inform Ahmed's observation that 'this country is like a prison'.<sup>10</sup> Heeding the abolitionist call to render carceral practices of contagious containment obsolete (Shange 2019; Davis 2003; DuBois 1999) requires that we resist the fantasy of separating one's clinical work from the apparatus of harming, as if there were an outside to the moral-ethical contagion of life-threatening disregard. So long as such reservoirs of life-threatening disregard remain, such contagion can (and does) spread.

9 For an unfortunately still apt explication of the category of 'malingering patient' in medicine, see Frantz Fanon's (1952) 'Le Syndrome Nord-Africain'. The essay offers a poignant critique of the clinical diagnostic practice of blaming North African men living and labouring in the French colonial metropole for the suffering these coercive conditions caused them: 'La chose est nette en hiver ; aussi certains services sont-ils littéralement submergés de Nord-Africains au moment des grands froids. Il fait si bon dans une salle d'hôpital' (Fanon 1952, 240).

10 A key historical precedent for the current policies of default immigrant detention was a group of state-specific racial quarantines in the early- to mid-19th century. These required Black sailors arriving by ship (most commonly from Haiti and the British West Indies, where slavery had been formally abolished at the time) to be detained in jail until the ship's departure in order to limit the spread of abolitionist ideas, which were seen as a threatening political contagion (Schoeppner 2013; Hirota 2017; Neuman 1993). I explore this history more fully elsewhere.

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