Research Article

Martha Lincoln*

Necrosecurity, Immunosupremacy, and Survivorship in the Political Imagination of COVID-19

https://doi.org/10.1515/opan-2020-0104
received July 6, 2020; accepted February 19, 2021.

Abstract: The neologism 'necrosecurity' describes the cultural idea that mass death among less grievable subjects plays an essential role in maintaining social welfare and public order. In the early months of the novel coronavirus pandemic in the United States, this perspective on the social value of death emerged in diverse contexts, particularly in claims that deaths were a necessary consequence of returning economies to normal. Necrosecurity discourse encourages audiences to perceive coronavirus fatalities as neither preventable nor exceptional, and to perceive themselves as facing little risk of infection or death. Overlooking the realities of infectious disease epidemiology, these accounts portrayed COVID-19 as a mild disease and imagined a population of robust and physically normative individuals who would survive an epidemic unscathed and ready to return to work. These appeals articulate with powerful cultural tropes of survivorship, in which statistical calculations of relative risk and life chances—ostensibly cited to inspire hope for an individual outcome—conceal a zero-sum calculus in which ill or susceptible individuals are pitted against one another. In contrast to the construct of biosecurity—the securing of collective life against risk—necrosecurity paradoxically imagines the deaths of vulnerable others as a means of managing shared existential dangers.

Keywords: COVID-19, death, immunity, medical anthropology, survivorship

1 Introduction

In an extensive interdisciplinary corpus on the cultural significance of death and "the political lives of dead bodies" (Verdery, 1999), there is limited precedent to guide analysis of the cultural framing of death in the United States during the early months of the novel coronavirus pandemic. Official public response to mass casualty events affecting Americans—wars, natural disasters, school shootings, and the events of September 11, 2001—has historically been informed by a cultural imperative to valorize and commemorate the deceased. This is particularly true when deaths are constructed as premature, unusual, or unexpected, and when the departed are imagined to be innocent of responsibility for the circumstances of their passing.

However, as the national death toll from COVID-19 reached 100,000 in the third week of May 2020, an editorial in the *L.A. Times* observed "little sense of shared grief" and noted a surprising absence of public memorialization despite losses on the order of "twelve plane crashes a day for months" (Bierman & Stokols, 2020). Where official discourse in other global settings represented pandemic deaths as tragic misfortunes for families, communities, and nations, a quite different tone was struck at the highest levels of the U.S. state—where public discourse represented the risks and costs of the coronavirus in highly equivocal terms.[1] While the abandonment of ungrievable subjects (Butler, 2010)—in

1 The leadership of the United States was not alone in its willingness to publicly express disregard, skepticism, and indifference towards the effects of the novel coronavirus on the body politic. Comparably, Brazilian President Jair Bolsonaro also advanced a deliberately incompetent, openly anti-scientific response to the pandemic that resulted in catastrophic levels of disease transmission (c.f. Ortega and Orsini, 2020).

Article note: This article is a part of the Special Issue on Pathogenic Politics: Life, Death, and Social Responses to the COVID-19 Pandemic, edited by Theodore Powers & Jeremy Rayner.

***Corresponding author: Martha Lincoln,** Department of Anthropology, San Francisco State University, 1600 Holloway Avenue, San Francisco, CA 94132, United States, E-mail: martha.lincoln@gmail.com

the form of racial health disparities, for example—is a routinized aspect of neoliberal governmentality and typically compels limited attention as such, the COVID-19 pandemic has moved these often occluded dynamics into more public view.[2]

Eschewing the formal tone culturally prescribed for references to the aging and the infirm, President Trump claimed in May that the "only bad survey" finding on the pharmaceutical hydroxychloroquine reported outcomes among individuals who were "very old, almost dead" (White House, 2020j).[3] The same week, a study by Columbia University epidemiologists suggested that 36,000 excess deaths could have been prevented nationally if shelter-in-place orders had been imposed a week earlier (Pei et al., 2020); in response, the President asserted that Columbia was a "liberal, disgraceful institution." In late September 2020, when the evidence of the federal government's failures to contain disease transmission was undeniable, the President continued to insist that the coronavirus "affects virtually nobody." Contravening the findings of nationally respected health authorities, Fox News journalist Tucker Carlson suggested in early April that national counts of coronavirus deaths were overstated (Blake, 2020)—a claim that the President and his supporters would continue to promote through the waning days of his administration (Knight & Appleby, 2020; Weiland et al., 2020).

While positioning pandemic deaths as insignificant, Trump was still at times compelled to acknowledge the norms for a head of state's public utterances about death and mortality rates. When pressed to state how many deaths he found "acceptable" at a briefing in late March, the President insisted "None" (White House, 2020f). But this was already appearing untrue. From the earliest weeks of the pandemic, Trump and others in his administration framed the rising death toll as evidence of policy successes, often by comparing the counts to counterfactual scenarios. For example, on March 14th, he stated in a briefing "As of this moment we have 50 deaths, which is—a lot of good decisions were made, or that number could be many times that" (White House, 2020e). On March 29th, he stated "We don't have 2.2 million deaths.[4] We have a number that's much less—much, much less" (White House, 2020g). On April 4th, as the illusion of a short-lived epidemic was beginning to give way, the President continued to appeal to counterfactuals, stating "There'll be a lot of death, unfortunately, but a lot less death than if this wasn't done" (White House, 2020h).

With Johns Hopkins University recording a US death toll of at least 88,754 (Chavez et al., 2020) on May 17th, the President tweeted "Doing REALLY well, medically, on solving the CoronaVirus situation (Plague!)" (Trump, 2020b). The same day, Dr. Richard Bright, ousted from his position as the director of the Biomedical Advanced Research and Development Authority, testified to Congress that the United States was risking the prospect of "its darkest winter in modern history" (Chavez et al., 2020). Despite this grim prognosis, an attitude of toleration and even nonchalance towards death emerged in American society over the early months of the pandemic, with calls to accept, diminish, or even *encourage* pandemic deaths proliferating through social and broadcast media. These appeals, some of which were expressed by influential politicians, commentators, and government advisors, were dissonant with the sobering situation of continuing mass death—particularly given normative taboos against trivializing death and disparaging the dead—and inspired observations to the effect that the Republican Party had become a "death cult" (Rubin, 2020).

What deeper transformations are disclosed by this apparent public truce with death struck by national leaders? What explains such widespread lack of reverence for those who have died? What work is accomplished by diminishing the significance of death and the risks of a potentially fatal pathogen? In the following discussion, I address these concerns, critically exploring the thematic features of the novel coronavirus as it has been imagined in public discourse. I focus on statements made by right-wing political figures and commentators from February to late May 2020, as the pandemic made inroads into U.S. populations and incurred a first wave of mortality. I suggest how misleading accounts of the virulence of SARS-CoV-2 and the epidemiology, symptomatology, and sequelae of COVID-19 were leveraged in support of a pandemic response program that would ultimately accelerate the transmission of the virus.

---

2 This tendency for abandonment to fall out of view may be particularly likely when exclusion or disparity come in the forms of structural violence (c.f. Farmer 2004), "slow death," (Berlant, 2007), or "slow violence" (Nixon, 2011) that create debility, attrition, or ill health over long periods of time. Because these processes of harm are often challenging to attribute to an individual agent, policy, or other original cause, they may be more difficult to perceive and more readily denied by the systems that perpetrate them.

3 These findings were reported from a large observational study which found that hydroxychloroquine increased mortality in COVID-19 patients (Mehra et al., 2020).

4 A reference to the March 2020 report by epidemiologists at Imperial College London, which projected up to 2.2 million American deaths by October if no mitigation measures were put in place (Ferguson et al., 2020).

While cases and deaths continued to mount in the U.S. over these early months, statements made by the President and his supporters regarding pandemic fatalities advanced a contradictory cultural politics in which the specter of coronavirus death was simultaneously minimized and figured as a form of "essential work": a socially necessary sacrifice by certain fragments of the population, tendered to permit majoritarian subjects and their way of life to survive. I characterize this paradoxical project in terms of *necrosecurity*—an initiative of accepting, fostering, and even promoting death (for some) as a means of securing life (for others). As I will argue, necrosecurity represents a departure from the commitments and techniques of *biosecurity*, in which potential threats are preempted or contained in order for human life and health to flourish. As I will further suggest, this discourse was accompanied by claims that encouraged members of the public to perceive themselves and most others as physically normal, healthy, and unlikely to be harmed by infection—a worldview which I describe as *immunosupremacy*. These claims were further legitimated by appeals to survival, in which statistical calculations of relative risk and life chances—ostensibly cited to inspire hope for individual outcomes—conceal a zero-sum calculus in which ill or susceptible individuals are pitted against one another.

2 Necrosecurity

In an essay written shortly after the beginning of the Global War on Terror, the philosopher Achille Mbembe posed a challenge to Foucault's frequently cited formulation of *biopower,* arguing that this theoretical apparatus for thinking about power over life and death was inadequate. According to Foucault, biopower operates by *making live* and *letting die*—amplifying the vitality of some populations at the expense of other populations, who are neglected or allowed to be exposed to harm. Drawing on Hegel's insight that human subjectivity is established through a confrontation with death, Mbembe situates death as a dynamic and constitutive part of power relations, situating politics as "the work of death" (Mbembe, 2003, p. 16). With this move imagining death, not life, at the center of political power, Mbembe argues that the construct of biopower cannot fully account "for the contemporary ways in which the political, under the guise of war, of resistance, or of the fight against terror, makes the murder of the enemy its primary and absolute objective" (Mbembe, 2003, p. 12). Mbembe coins the concept of *necropower,* a form of power which is, he suggests, deployed in "death-worlds"—sites such as colonial occupations, slave plantations, and refugee camps, where populations are "subjected to conditions of life conferring upon them the status of *living dead*" (Mbembe, 2003, p. 40).

Conceivably, the experience of the pandemic in the United States could be theorized as an expression of biopower, insofar as a vulnerable population was permitted possibly fatal exposures as a hypothesized means of amplifying the vitality of more privileged groups; as Foucault noted, biopower can entail abandonment, exposure to death, and even killing (2003, p. 256). Read differently, these events might also be constructed as exemplifying necropower, insofar as the President and his supporters could be seen to instrumentalize COVID-19 as a means of murdering political enemies. However, I suggest that neither the formulation of biopower nor that of necropower can completely characterize the U.S. federal government's response to the coronavirus pandemic.

A biopolitical logic is certainly evident in discourse designating certain populations as less valuable and grievable—but the construct of biopower fails to fully account for the apparent paradox of the Trump administration's failed pandemic management. The missteps of the state's COVID-19 response go beyond a passive act of "letting die," insofar as they sanctioned, encouraged, and even compelled behaviors that contributed to the transmission of infection.[5] Further, Foucault suggests that "[i]n the biopower system, killing or the imperative to kill is acceptable only if it results not in a victory over political adversaries, but in the elimination of the biological threat to and the improvement of the species or race" (Foucault, 2003, p. 256). The Trump administration's pandemic response fails to satisfy this criterion insofar as it entirely failed to eliminate the biological threat of the novel coronavirus, and indeed did not aim to do so—yet continued to rhetorically promote selective death as acceptable and salutary, with deaths among populations seen as excess or disposable even posited as "a source of value" (Haskaj, 2018, p. 1148).

5 This was visible, for example, in official communications that discouraged the use of face masks, in state and federal shortages of personal protective equipment for front-line medical workers, and more broadly in the Senate's failure to provide financial support to small businesses and families adequate to relieve individuals of the need to risk occupational exposure to COVID-19.

While the triumphalist tone of this pro-death rhetoric certainly contains necropolitical undertones, I suggest that neither such rhetoric nor an incompetent pandemic response—even if deliberate—can be meaningfully compared to the death-worlds that Mbembe describes. Too, neither biopower nor necropower can account for the logic that apparently informed how the pandemic response has attempted to leverage pandemic deaths strategically towards pragmatic ends. I therefore describe these phenomena using the neologism *necrosecurity*—a mode of power that operates between biopower and necropower, between "letting die" and annihilation.

Necrosecurity, as I conceptualize it, is a counterpart to *biosecurity*—a term which critical geographer Bruce Braun describes as "those knowledges, techniques, practices, and institutions whose concern is to secure valued forms of life from biological risks" (Braun, 2013, p. 45). At this point in history, biosecurity is characteristically a high-tech enterprise of securing life against such biological harms—which are typically construed as chemical, bacterial, and viral threats rather than the gross physical injuries inflicted by war. While the term "biosecurity" originally came into use as a descriptor for livestock health and occupational safety among lab workers, it now references a much more capacious, even existential endeavor. A 2013 textbook acknowledges that the term is "difficult to define," but also states "biosecurity is a 'strategic and integrated approach encompass[ing] the policy and regulatory frameworks that analyze and manage risk in the sectors of food safety, animal life and health, and plant life and health, including associated environmental risk'" (Burnette, 2013, p. 3). As this invocation of a "strategic and integrated approach" suggests, biosecurity is closely tied to defense initiatives. Envisioning threats from emerging infectious disease (King, 2002) alongside acts of unconventional warfare such as the release of biological agents (Cooper, 2006), biosecurity discourse blurs distinctions between the priorities of public health and those of the armed forces.

From the perspective of biosecurity, living creatures are an extension of state sovereignty: strategic bio-assets for governments to secure. Bruce Braun therefore describes biosecurity as a form of biopolitics, pointing to how "biosecurity practices bring 'life' into the realm of political calculation" (Braun, 2013, p. 45). However, where biopolitics makes "cuts" in human populations, exposing some groups selectively to injury, debility, or death, biosecurity does *not* characteristically operate in this fashion. Rather, biosecurity typically seeks to preempt or destroy the lives of non-human organisms in the name of security or to contain emerging threats to human biology, as seen, for example, in projects to collect and analyze air samples to detect acts of bioterrorism (c.f. Garza et al., 2014).

In the years following the Cold War, the development of biosecurity initiatives was spurred by "polymorphous new threats" that the United States perceived to be arising beyond an established balance of nuclear terror (Collier et al., 2004, p. 3). These initiatives derived their most compelling *raison d'être* from the events of the weeks following September 11, 2001, when envelopes containing anthrax spores were mailed to news outlets and members of Congress. The anthrax attacks legitimated the establishment of new priorities in national security, much as the attacks on the World Trade Center enabled the arrogation of new state security and police powers. Under the aegis of biosecurity, for twenty years governmental agencies, university programs, and research labs have prepared for a public health crisis or "an attack of epidemic proportions" (Cooper, 2006, p. 113). The construct has accrued the prestigious trappings of a discipline with strategic statecraft value—corporate and public-sector research agendas, dedicated degree programs, national task forces, and multilateral accords. Like other forms of post-9/11 defense strategy in the U.S., biosecurity operates according to a future-oriented logic of anticipation and preemption, seeking not only to control what exists but also to predict and intervene in what might become.

Over the first months of the novel coronavirus pandemic, however, these powers of securing life seemed thwarted. Under the Obama administration, the National Security Council had prepared a "pandemic playbook" whose core premise prescribed that in the event of a "high-consequence" emerging infectious disease threat, "the U.S. government will use all powers at its disposal to prevent, slow or mitigate the spread" (Executive Office of the President of the United States 2016, p. 31). The Trump administration failed to so much as consult the playbook in response to the emergence of SARS-CoV-2 (Diamond & Toosi, 2020). Further compromised by a series of unit closures and resignations that had left "no senior administration official focused on global health security" in the federal government since 2018 (Sun, 2018), the executive branch failed to procure adequate personal protective equipment for health workers, properly manage the rollout of diagnostic testing, or provide meaningful pandemic management guidance to state health authorities. White House interference in the activities, publications, and communications of the Centers for Disease Control and Prevention deliberately stifled timely warnings to the American public regarding the risk of activities like attending

church (Bandler et al., 2020).[6] Though the federal government allocated significant funding to a public-private initiative in vaccine research and development called "Operation Warp Speed" in March, this was effectively a rearguard action; the anticipatory aspect of biosecurity had essentially failed. While the 2019 Global Health Security Index had rated the United States as the nation best prepared to combat a pandemic, over the course of 2020 its leaders delivered one of the worst COVID-19 outcomes in the world (Lincoln, 2020) despite decades of federal investment in "preparedness."

As scholars of biopolitics and biosecurity have pointed out, the project of biosecurity is intrinsically subject to failure given its sweeping, contradictory remit—though perhaps not subject to such abject failure as the U.S. response to COVID-19 delivered. As critical analyses have suggested, efforts to extend increasingly entangling forms of militarized power over life inevitably entail "bioinsecurities" (Ahuja, 2016): "inside jobs," accidental releases, and other forms of blowback. In his discussion of the 2001 anthrax attacks—which the FBI suspected were perpetrated by a US government scientist—anthropologist Joseph Masco affirms "Biosecurity is a *noir* in the United States today because its chief threats, though projected outward, are internal" (2014, p. 191). In yet more practical ways, biosecurity imposes opportunity costs, coming at the expense of traditional sources of life protection such as public health infrastructure, gender equity, labor protections, and food security (c.f. Hsu, 2009). And finally, one might note that the post-9/11 biosecurity-industrial complex in the U.S. was predicated on untruths and misinformation, even by "strategic ignorance" (McGoey, 2019).

Thus, though necrosecurity is deeply informed by anti-scientific and anti-expert sentiments, it is not simply a failed biosecurity, nor is it a form of biosecurity in which the project's intrinsic flaws are made visible. Normatively, biosecurity does not call for human illness or deaths. By contrast, necrosecurity explicitly and centrally instrumentalizes death—imagining a sacrificial population whose exposure to harm will secure against losses to more qualified populations. It is a calculated attempt to leverage the pathogenic and epidemiological properties of disease towards social, political, and economic ends. Lying between passive "letting die" and overt murder of political enemies, necrosecurity entails the promotion of death intended to *preempt other deaths*; instead of seeking to prevent human deaths, as biosecurity would, it attempts to secure life by allowing death to flourish selectively. In the context of the COVID-19 pandemic in the United States, necrosecurity took the form of efforts to use disposable, at-risk populations as a firebreak where illness and possible death would—it was imagined—be concentrated, securing the lives and way of life of a valorized majority.

From a very early moment after the novel coronavirus reached the United States, the Trump administration defaulted to a discourse of necrosecurity, endorsing death as a commonsense means of returning society and the national economy to business as usual. But beyond simply sanctioning death among the weak, right-wing discourse about the novel coronavirus attempted to reassure audiences by presenting the pandemic as relatively unthreatening, particularly to "healthy people." Overlooking the realities of infectious disease epidemiology and the potential effects of the virus, these accounts portrayed COVID-19 as a mild disease and imagined a population of robust and physically normative individuals who would survive an epidemic unscathed and ready to return to work.

3 Immunosupremacy

In Spring 2020, during debates over state policies imposing lockdowns and other disease control measures, right-wing American politicians and cultural commentators opposed attempts to protect public health, made peace with the prospect of potentially widespread mortality, and minimized the risks of the pandemic. Despite longstanding commitments to a "pro-life" politics as well as to concepts of national "preparedness," right-wing actors put forward a discourse that framed COVID-19 mortality as inevitable and of limited public concern. Within weeks after governors issued stay-at-home orders to slow the spread of infection, protests were organized by restive right-wing groups to oppose the mandatory measures. These were accompanied by a burgeoning libertarian movement drawing together calls for civic and economic freedoms, invocations of Constitutional protections, and appeals for bodily autonomy.

6 In April 2018, homeland security adviser Tom Bossert resigned under pressure from national security adviser John Bolton; prior to his departure, he had advocated for "a comprehensive bio-defense strategy" (Landay, 2017). In May 2018, the National Security Council was reorganized; the agency's global health security team was closed, and its head, Rear Admiral Timothy Ziemer, departed the NSC.

Some anti-lockdown discourse also contained claims that death, particularly death among older Americans, should be seen as in some way acceptable.[7] In April 2020 conservative commentator Ben Shapiro stated "If somebody who is 81 dies of COVID-19, that is not the same thing as somebody who is 30 dying of COVID-19" (Moye, 2020), and in a radio interview the former Fox News host Bill O'Reilly asserted that most coronavirus patients "were on their last legs already" (Sullivan, 2020). Right-wing editor Bethany Mandel drew controversy for tweeting "You can call me a Grandma killer. I'm not sacrificing my home, food on the table (…) every form of pleasure (museums, zoos, restaurants), all my kids' teachers in order to make other people comfortable" (Mandel, 2020)—an appeal that hypothetically pitted middle-class family life against the survival of a "grandma."[8] While these comments carefully avoided referencing the racial, socioeconomic, and occupational disparities in COVID-19 epidemiology that were already becoming apparent (c.f. APM Research Lab, 2020; Gold et al., 2020), they effectively relegated all pandemic deaths to insignificance—figuring the average coronavirus death as equivalent to the loss of a fragile grandparent at the end of a full life.

Other comments in support of state re-openings posed philosophical challenges regarding the value of life itself: relativizing the value and meaning of being alive, presenting zero-sum scenarios, and suggesting that the fact of death's inevitability trumped concerns about premature or preventable loss of life. Alexandra DeSanctis of the *National Review* mused "Human life is beautiful and precious and good, but life on earth isn't our ultimate end" (DeSanctis, 2020). Dan Patrick, Republican lieutenant governor of Texas, called for the state's reopening with the unforgettable claim that "There are more important things than living" (Benen, 2020). An investment banker, quoted in a *Vanity Fair* article on Wall Street's response to shelter-in-place orders, endorsed personal responsibility and common sense while giving voice to a superbly overweening fatalism:

> People will die. People do die. People my age die. It happens, right? It can happen with a flu epidemic. People can die. People have to take care of themselves and wash their hands. (…) People have to take responsibility for their own lives. And people do die. That is kind of what happens. (Cohan, 2020)

While many of these assertions did not cite supporting evidence, others attempted to marshal statistics in their estimations of the relative risk posed by coronavirus. The President drew repeated comparisons between coronavirus and influenza, suggesting that a great number of Americans die annually of flu without imposing social costs.[9] These perspectives were echoed by right-wing media figures like Laura Ingraham of Fox News, who characterized the pandemic as "likely to be closer to maybe a really aggressive flu season" (Sollenberger, 2020). In a mid-April interview with Ingraham, television personality Phil ("Dr. Phil") McGraw asserted that "we don't shut the country down" for deaths caused by tobacco, traffic crashes, and "swimming pools," providing incorrect statistics[10] on annual mortality totals caused by the latter two sources (Pesce, 2020). And in May, Republican senator Ron Johnson re-upped this claim, stating "We don't shut down our economy because tens of thousands of people die on the highways; it's a risk we accept so we can move about" (Sullivan, 2020).

In these diverse diminutions of death, faux-scientific rationalizations, calls for trade-offs, and overt derogations of life, some of these comments exemplified what historian David Perry calls "vice signaling"—a performance of partisan

---

7 A similar outlook informed Britain's early efforts to attain "herd immunity," as evidenced by a remark allegedly made by Dominic Cummings, senior adviser to the Prime Minister: "protect the economy, and if that means some pensioners die, too bad" (Shipman & Wheeler, 2020). Mortality at British nursing homes, shaped by decisions to deprioritize "social care" in the response to coronavirus, would later be called "a defining scandal of the pandemic" for the British government (Mueller, 2020).

8 Left-wing and right-wing commentary alike had a tendency to figure the average COVID-19 death in terms of a "grandma." Though COVID-19 affects more men than women, causes more severe illness in men, and is more frequently fatal for male patients, there has been no equivalent discourse of "killing grandpas."

9 These comparisons have been critiqued by Dr. Jeremy Samuel Faust, who in a blog post for *Scientific American* noted that the statistics of annual influenza mortality provided by the CDC are in fact algorithmically generated estimates that are likely to be inflated. Noting that estimated deaths cannot meaningfully be compared to counted deaths, Faust argued "the CDC should immediately change how it reports flu deaths" in view of the likelihood that these figures are "dangerously misleading the public" (Faust 2020).

10 McGraw cited 480,000 annual deaths caused by tobacco, 45,000 deaths caused by traffic crashes, and 360,000 deaths caused by "swimming pools." While the figure for tobacco-related deaths agrees with CDC estimates, McGraw overstated traffic deaths by almost 9,000 deaths per annum and appeared to have added two zeros to the figure for drowning fatalities. The National Highway Traffic Safety Administration reported 36,560 traffic crash deaths in 2019, and the CDC reported annual rates of 3,536 fatal unintentional non-boating-related drownings between 2005 and 2014 (Pesce 2020).

spite "intended to create a community based on cruelty and disregard for others" (Berlatsky, 2020). Along other explanatory lines, journalist Olga Khazan argued that the "empathy deficit" visible in popular attitudes towards the risk of COVID-19 was caused not only by the inevitable onset of "compassion fade" in response to a disaster represented mostly in terms of statistics, but by white animus towards African Americans as well as a widely shared callousness towards the elderly and a desire to limit their consumption of health services (Khazan, 2020).[11]

However, not all calls to rationalize COVID-19 deaths can be written off as armchair epidemiology, perceptual bias, or grandstanding by personalities of the right-wing attention economy. A 2014 essay by Zeke Emanuel, an oncologist, bioethicist, and adviser to the Biden presidential campaign, began recirculating through media channels in conjunction with conversations about the pandemic. Titled "Why I Hope to Die at 75," the piece sparked debate with its disturbingly Malthusian premise that "families—and you—will be better if nature takes its course swiftly." In April, the *New York Times Magazine* ran an editorial titled "Restarting the U.S. Economy Will Cost Lives. So When Do We Do It?" The editors wrote "In the longer run… it's important to acknowledge that a trade-off [between saving lives and saving the economy] will emerge" (NYTM, 2020). While discourse minimizing the risks of COVID-19 was dominated by voices on the right, thinkers of other political stripes also publicized recommendations that policymakers come to terms with death—often using acceptance of lost life as evidence of pragmatism, maturity, and political realism.

The Trump administration did sporadically attempt to dignify death by framing the pandemic as a war against an "invisible enemy"—war being, after all, the health of the state (Bourne, 1918). Yet the administration also continued to insist that US mortality rates were both inevitable and the evidence of a best-case scenario. In early May, Trump commented "So many people have died. That's the one thing we can't do anything about, unfortunately. What I can say is if we did it the different way (…) we would have been talking about numbers that would have been unsustainable and unacceptable" (White House, 2020i)—implying that the COVID-19 case counts and deaths recorded to date were both acceptable and sustainable. Here, the President's framing of the pandemic as a war revealed an unintended underside. The country's pandemic losses were afforded so little official recognition that they could be meaningfully compared to foreign casualties incurred overseas in recent wars, with Trump and other right-wing actors consistently representing American coronavirus deaths as if they were collateral damage: losses at once distant, anonymous, exaggerated, necessary, and insignificant.

On February 29th, reporting the first U.S. death caused by the virus, the President stated[12]:

> Unfortunately, one person passed away overnight. She was a wonderful woman—a medically high-risk patient in her late fifties. Four others are very ill. Thankfully, 15 are either recovered fully or they're well on their way to recovery. And in all cases, they've been let go in their home.
>
> Additional cases in the United States are likely, but healthy individuals should be able to fully recover. And we think that will be a statement that we can make with great surety [*sic*] now that we've gotten familiar with this problem. They should be able to recover should they contract the virus. So, healthy people, if you're healthy, you will probably go through a process and you'll be fine. (White House, 2020a)

This commentary implied that with this one death, the end of the outbreak was in sight. However, within weeks of this statement's issue, the United States would record the highest national totals of coronavirus cases and fatalities in the world. Over the following months the U.S. would remain the world leader in COVID-19 morbidity and mortality, contributing a highly disproportionate share of the global burden of disease. As after his predecessor's premature claim of "mission accomplished," the President's hubris of late February would be punished by nemesis in short order.

Trump's remarks were further noteworthy for manipulating medical and epidemiological facts to advantage a *laissez-faire* response to the pandemic. Here, one might be curious about what it means to "go through a process," "fully recover," or "be fine" relative to an infection that can cause severe pathological changes in lung tissue, inflict a host of as-yet poorly understood damages to multiple body systems (Marks & Pour, 2020), and also, for some survivors, incur long-term symptoms that resemble a chronic disease (Khullar, 2020; Yong, 2020). These were, even at an early moment

11 Khazan cites findings from behavioral science studies in which participants were posed with thought problems regarding the allocation of ventilators in the context of COVID-19 (Huang et al. 2020) and posed with "trolley problems" where they could hypothetically sacrifice an elderly person in order to save a younger person (Awad et al. 2018).

12 At the time, it was not yet known that community-acquired COVID-19 infections had caused fatalities in Santa Clara County, California in early and mid-February; these cases were retrospectively discovered by autopsy in April (Fuller and Baker 2020).

in the COVID-19 pandemic, inconvenient truths—and the President's minimization of these medical facts is consonant with a long history of right-wing scientific denialism, agnotological manipulation (c.f. Proctor & Schiebinger, 2008), and the strategic leveraging of what Donald Rumsfeld once infamously described as "unknown unknowns."

These remarks, showcasing a surprising indifference towards the exceptional and tragic occasion of the nation's first pandemic death, encouraged listeners to identify not with the deceased or their family, but with a group of "healthy individuals" who would survive infection "fine." Such "healthy individuals," the second figure in Trump's remarks, are constructed as a self-evident category and a social majority. This representation glossed over the reality that all individuals are potentially susceptible to infection by a newly emerging virus. Nonetheless, the idea that the coronavirus threatened individually fragile "patients" but not "healthy people" was frequently repeated in the early weeks of the outbreak and endorsed by scientific and medical authorities as senior as White House Coronavirus Response Coordinator Dr. Deborah Birx (White House, 2020c).[13]

In describing disease risk as confined to a select population whose vulnerabilities were presumably both uncommon and readily apparent, the President legitimated a discourse that would have profound consequences for public health in the months that followed. Specific ideological work is accomplished by the idea that individuals are either "high-risk" or "healthy"—and, further, by the belief that health vulnerabilities are a property of individuals, not of populations. Notably, this narrative also inverts the usual format for grievability, making an individual casualty—who would typically be a figure of charisma and identification—seem anonymous and unimportant, while the mass—usually depersonalized and faceless—is made to seem proximate and familiar. This affirmation of a situation in which the strong will presumably survive is at the core of *immunosupremacy*: a worldview in which social worth, physical resilience, and survival are imagined as the same thing.

Through the early months of the coronavirus pandemic, the President's public comments continued to retread an immunosupremacist message—denying the grievable status of fatalities, appealing to the physical resilience of the average person, and understating the danger of the virus. These premises often led to deeply contradictory claims. With at least 67,447 Americans dead of COVID-19 and 1,154,340 infected (Regan et al., 2020), the President tweeted on May 3rd:

> ….And then came a Plague, a great and powerful Plague, and the World was never to be the same again! But America rose from this death and destruction, always remembering its many lost souls, and the lost souls all over the World, and became greater than ever before! (Trump, 2020a)

Though this remark drew mocking commentary for its affected, quasi-Biblical diction, its core premise was not at all a departure from the President's publicly held positions. Subtextually, this statement imagined the novel coronavirus as a kind of cleansing fire whose destruction would redound to the health of the nation—suggesting that specifically *after* the departure of "many lost souls" the nation would become "greater than ever before." Read alongside the President's many assertions implying that losses were confined among "largely old people who are—who were susceptible to what's happening" (White House, 2020b), this tweet expressed a millenarian enthusiasm about the prospect of shedding vulnerable fractions of the US population to achieve new national greatness.

Imagining the body politic as composed of mostly young, healthy, and resilient individuals covered over some unpleasant truths. Owing to age or preexisting health conditions or both, a significant share of Americans is potentially susceptible to more serious illness if infected with COVID-19. Where Trump and the Pandemic Response Team typically described susceptible populations as if they were a negligible cohort, this obscured the reality that four in ten American adults—if not more—are at elevated risk due either to their age or to an underlying medical condition or both (Koma et al., 2020).[14] In some parts of the United States, as much as half of the adult population faces increased risk of more serious illness (Koma et al., 2020). For a very considerable share of the population—90 million of 246 million Americans—there is no guarantee of safety in numbers; no other America to absorb risk on their behalf.

---

13 This discourse reprises the US response to HIV/AIDS pandemic in its early years, in which the new disease was imagined as confined to discrete and socially remote "risk groups" with few implications for the general population.

14 One survey found that 36.5% of Americans were estimated at increased risk for complications on the basis of at least one diagnosis (Koma et al., 2020); another estimated that 45.4% of Americans were at increased risk (Adams et al., 2020). The "underlying conditions" that are understood to contribute to worse clinical outcomes in coronavirus infection include asthma, diabetes, chronic lung disease, serious heart conditions, kidney disease, liver disease, sickle cell disease, obesity, compromised immunity resulting from HIV/AIDS, cancer treatment, tobacco use, organ transplant, and other causes (Centers for Disease Control, 2020a and 2020b).

4 Mild Symptoms

Further diminishing the sense of urgency in prevention, public discourse in the early months of the pandemic characterized the novel coronavirus as causing only a mild infection in most patients. Trump seized on this aspect of the disease as the pandemic progressed, claiming that "a vast majority are going to be fine" (White House, 2020b) and suggesting that "Young and healthy people can expect to recover fully and quickly if they should get the virus" (White House, 2020d). Dismissing the virus as innocuous came to function as a ritual expression of bravado among right-wing populists: before his own brush with disease, British Prime Minister Boris Johnson joked that he "continued to shake hands"; Brazilian President Jair Bolsonaro scoffingly termed the virus "a little flu" (Granada, 2020); and Fox News host Tucker Carlson claimed that COVID-19 "just isn't nearly as deadly as we thought it was" (Baragona, 2020).

The claim that coronavirus caused "mild" symptoms for a majority of those infected is drawn from a February 2020 report that found 80.9% of Chinese patients with confirmed COVID-19 had no pneumonia, or only "mild pneumonia" (The Novel Coronavirus Pneumonia Emergency Response Team 2020)—a datum that was later corroborated by the WHO. However, Professor of Social Research Felicity Callard, writing as she recovered from a suspected COVID-19 infection, critiqued the descriptor "mild" for trivializing the severity of suffering experienced by many patients who do not require hospitalization:

> Accounts by patients (…) who experienced mild Covid-19 without finding it mild also make evident the significant disparity between scientific studies and the everyday, common comparators that people use to understand the experience of illness. (Callard, 2020)

As Callard argues, measurements of "mildness" of COVID-19 understate the experience of the disease insofar as they characterize many non-life-threatening but still potentially painful and frightening symptoms as "mild." Further, as the progression of coronavirus infections is unfamiliar to infected individuals and may vary between cases, the construct of a "mild" illness does not offer clear reassurance; as Callard points out, given the uncertain trajectory of the new disease, "The mild is always potentially (…) severe" (2020).

Though medical literature is still catching up, some published accounts attest to how poorly the term "mild" may describe the experience of coronavirus infection in non-hospitalized patients. For example, in an essay on her husband's experience of COVID-19—which did not require hospitalization, despite his also having asthma—Jessica Lustig wrote:

> [H]e gets more frightened as night comes, dreading the long hours of fever and soaking sweats and shivering and terrible aches. "This thing grinds you like a mortar," he says. (Lustig, 2020)

In a May *New York Times* editorial, 33-year-old journalist Mara Gay, who—despite "being one of the lucky ones," insofar as she did not need a ventilator—described her COVID-19 infection as the feeling of "hot tar buried deep in my chest." Despite her athletic background, she could not walk more than two blocks for weeks after recovering. However, Gay's case of coronavirus might still have been described as "mild" insofar as she "did not develop Acute Respiratory Distress Syndrome (ARDS), or have organ failure, or have an ICU admission" (Callard, 2020). She wrote "I want Americans everywhere to understand that this virus is making people very, very sick. I want them to know this is no flu" (Gay, 2020).

5 Survival

Such evidence about the potential health impacts of the novel coronavirus was coolly received by right-wing audiences. By Summer 2020, opinion studies found that Republicans were significantly less likely to perceive the virus as a "major threat to public health" than Democratic voters, even if they lived in areas that had been highly impacted by the virus (Pew Research Center, 2020). As I have described above, these perceptions were shored up by reassurance about the survivability of infection. In their commentary on the pandemic, right-wing commentators appealed to culturally powerful tropes of survival and survivorship—often by leaning on the deceptively reassuring statistic that COVID-19 infections had a "99% survival rate." In November, as the United States recorded unprecedented levels of COVID-19 incidence, the conservative science journalist Jennifer Margulis tweeted:

> Ask yourself: is an infection with an over 99% survival rate in every age category but those over 70 worth: cutting off your relationship with you [*sic*] best friends, canceling Thanksgiving with your grandparents, flinching away from healthy people because you fear getting sick? (Margulis, 2020)

The constructs of survival and survivorship occupy a similarly fraught position in U.S. cancer culture, where they carry out similar ideological work. In their 2011 article titled *Survival Odds*, medical anthropologist Lochlann Jain cites an essay written by evolutionary biologist Steven Jay Gould after his diagnosis of abdominal mesothelioma. Contemplating the statistical distribution of clinical outcomes among patients who shared his diagnosis, Gould expressed the hope that he would find himself on the "right skew" of the survival curve—past the median point of eight months' survival from time of diagnosis. As Jain points out, gains in statistical knowledge about cancer have given rise to similar narratives of "hope," but these also contain a tacitly adversarial outlook. "Beating the odds" really means outliving other patients:

> Justifying one's own life in the face of the death of the collective makes a dangerous bedrock for hope. But in so doing, Gould translates for us Elias Canetti's (1984) observation about survivors: "It is as though the battle had been fought in order for him to survive it." (Jain, 2011, pp. S48-49)

Elias Canetti's comments on survival are particularly incisive given his status as a Holocaust survivor; in his extensive and highly heterodox body of work, Canetti frequently suggested the morally ambiguous quality of the survivor and pointed to the sadistic and alienated impulses disclosed by the desire to survive. As Canetti wrote in *Crowds and Power*, "The moment of survival is the moment of power. Horror at the sight of death turns into satisfaction that it is someone else who is dead (...) In survival, each man is the enemy of every other" (Canetti, 1973, p. 227).[15]

Other common tropes of cancer culture parallel those found in nascent cultural formations surrounding COVID-19. Notably, both COVID-19 and some forms of cancer offer opportunities for commercialization and commodification. In her analysis of the corporate appropriation of breast cancer as a philanthropic cause, feminist scholar Samantha King (2008) demonstrates that via commodification and mass marketing over recent decades, breast cancer has been systematically rebranded as a "safe disease" (King, 2008, p. xxix)—constructed as both *politically* safe for philanthropic branding as well as imagined to be *medically* insignificant for most individuals with the diagnosis. In this, corporate advertising campaigns, sponsorships, and promotions of breast cancer-related causes have drawn attention away from the role of exposure to environmental contaminants in driving breast cancer incidence, sometimes coopting the efforts of breast cancer activists along the way. They have also misrepresented basic epidemiological and medical aspects of the disease—for example, by conflating breast cancer screening with "prevention" (Jain, 2013). While there is no pink ribbon for coronavirus yet, nor a culture of honoring coronavirus "survivors," nor yet a walk-a-thon or a corporate fundraiser "for the cure," journalist Amanda Hess has pointed out "It's jarring how easily the virus has been fused with branding and processed into the optimistic language of advertising" (Hess, 2020)—suggesting that a corporate defanging of coronavirus risk via the social construction of COVID-19 "heroes" may already be underway.

In sum, as these critiques suggest, appeals to survival should not be constructed as neutrally factual or optimistic, and citations of survival odds do not register a commitment to scientific perspectives on the coronavirus pandemic so much as they underscore a political motive to depict COVID-19 as a "safe" disease. In these ways, discourse regarding the survivability of COVID-19 draws on tropes that have been critiqued elsewhere for their darkness, pessimism, and rhetorical use of scientific ideas to manipulate public opinion.

6 Conclusion

As my discussion has suggested, right-wing discourse on the novel coronavirus has been animated by non-evidence-based yet culturally powerful constructs: necrosecurity, immunosupremacy, and survivorship. Taken together, these accounts of health, disease, risk, and mortality are perhaps usefully framed in terms of a folk theory: a simplifying,

15 The aphoristic, sometimes elliptical essays collected in *Crowds and Power* offer other clues to understanding the cultural response to the coronavirus pandemic. Perhaps most centrally, Canetti understands the crowd as an essential source of psychological and political power—an issue which, partly unconsciously, animated U.S. struggles over state lockdowns and shelter-in-place ordinances.

ideological, and heterodox narrative about cause and effect. Notably, prominent right-wing claims about the risks posed by the novel coronavirus shared an inattention to the physical properties of infectious disease. For example, by drawing a false equivalence between COVID-19 deaths and deaths with non-infectious causes—traffic fatalities, accidents, and non-communicable diseases—arguments for resuming normal social and economic activity neglected the reality that coronavirus cases multiply and spread. This put forward a scenario where a contained amount of death would translate into a return to normal sociality.

By refusing to acknowledge the most basic known realities of contagious disease—centrally, its tendency to spread through populations—these views imagine public health as the sum total of individual healths. In this way, right-wing perspectives figure public health as lacking population ecology dynamics, and indeed without any concept of a public—essentially proposing an *anti*-public health. In overlooking scenarios where a cryptically spreading virus could become uncontainable, these arguments recapitulated Margaret Thatcher's infamous assertion that "there's no such thing as society. There are individual men and women and there are families." In this perversely antisocial iteration of public health, the organizing concept is: *deaths elsewhere mean more health* among groups of socially deserving and physically normative majoritarian subjects.

While the semantic and practical sanctioning of harm to outgroups is not a new phenomenon in American society, its deployment in the context of a pandemic represents a convergence of anti-scientific sentiment with a disturbing new development in "the economization of life" (Murphy, 2017). The federal government's reliance on necrosecurity was materially misinformed, as I have suggested and as epidemiological trends reveal; populations cannot be selectively secured against a highly contagious respiratory virus if disease control measures are not enforced among most of the population. Thus, necrosecurity is shown to be a fantasy—again, one that rested on a deeply contradictory construction of public health.

However, although the Trump administration's response appeared to be informed by an irrational abandonment of both self-interest and scientific principles, it also capitalized on the tendency of pandemics to exacerbate preexisting dynamics of disadvantage and ill health. In parallel, some of the most pronounced social effects of the pandemic have included a significant and rapid redistribution of wealth, with enormous profits realized in particular by employers of the "essential workers" who were disproportionately likely to be exposed to infection in their workplaces. Here, the relationship between death and essential work becomes disconcertingly blurred. In the cultural moment of COVID-19, allowing existing and emerging disparities in life chances to translate into deaths among vulnerable populations has been openly promoted as a means of securing social and economic stability—as if death functioned like an exotic financial instrument, capable of externalizing risks, extracting new value, and promising irresistible future profit.

Acknowledgments: The author thanks Janina Kehr, Ted Powers, Michelange Quay, Jeremy Rayner, Robert Smith, Saiba Varma, and two anonymous reviewers for their comments on this work.

Funding Information: Author states no funding involved.

Conflict of Interest: The author states no conflict of interest.

References

Adams, M. L., Katz, D. L., & Grandpre, J. (2020). Population-based estimates of chronic conditions affecting risk for complications from coronavirus disease, United States. *Emerging Infectious Diseases, 26*(8), 1831–1833. https://doi.org/10.3201/eid2608.200679 PMID:32324118

Ahuja, N. (2016). *Bioinsecurities: Disease interventions, empire, and the government of species*. Durham, NC: Duke University Press. https://doi.org/10.1215/9780822374671

APM Research Lab. (2020, November 12). *The color of coronavirus: COVID-19 deaths by race and ethnicity in the U.S.* https://www.apmresearchlab.org/covid/deaths-by-race

Awad, E., Dsouza, S., Kim, R., Schulz, J., Henrich, J., Shariff, A., . . . Rahwan, I. (2018). The Moral Machine experiment. *Nature, 563*(7729), 59–64. https://doi.org/10.1038/s41586-018-0637-6 PMID:30356211

Bandler, J., Callahan, P., Rotella, S., & Berg, K. (2020, October 15). Inside the fall of the CDC. *ProPublica*. https://www.propublica.org/article/inside-the-fall-of-the-cdc

Baragona, J. (2020, April 27). Tucker Carlson: Coronavirus "isn't nearly as deadly as we thought." *The Daily Beast*. https://www.thedailybeast.com/tucker-carlson-claims-coronavirus-isnt-nearly-as-deadly-as-we-thought

Benen, S. (2020, April 22). Texas' Dan Patrick: "There are more important things than living." *MSNBC*. https://www.msnbc.com/rachel-maddow-show/texas-dan-patrick-there-are-more-important-things-living-n1189811

Bierman, N., & Stokols, E. (2020, May 22). Little sense of shared grief as virus deaths near 100,000. *L.A. Times*. https://www.latimes.com/world-nation/story/2020-05-22/little-sense-of-shared-grief-as-virus-deaths-near-100-000

Berlant, L. (2007). Slow death (Sovereignty, obesity, lateral agency). *Critical Inquiry, 33*(4), 754–780. https://doi.org/10.1086/521568

Berlatsky, N. (2020, May 7). As Bethany Mandel's "grandma killer" tweet proves, vice-signaling is the right's newest and most toxic trend. *Independent*. https://www.independent.co.uk/voices/bethany-mandel-grandma-killer-tweet-coronavirus-lockdown-protest-a9504391.html

Blake, A. (2020, April 8). Birx and Fauci reject Fox News-promoted theory that coronavirus deaths are inflated. *Washington Post*. https://www.washingtonpost.com/politics/2020/04/08/tucker-carlsons-brit-humes-faulty-theories-about-coronavirus-deaths-being-exaggerated/

Bourne, R. (1918). *War is the health of the state*. Retrieved from http://www.bopsecrets.org/CF/bourne.htm, June 9, 2020.

Braun, B. (2013). Power over life: Biosecurity as biopolitics. In A. Dobson, K. Barker, & S. L. Taylor (Eds.), *Biosecurity: The socio-politics of invasive species and infectious diseases* (pp. 45–58). New York: Routledge.

Burnette, R. (2013). *Biosecurity: Understanding, assessing, and preventing the threat*. Hoboken, NJ: Wiley. https://doi.org/10.1002/9781118769119

Butler, J. (2010). *Frames of war: When is life grievable?* New York: Verso.

Callard, F. (2020, May 8). Very, very mild: Covid-19 symptoms and illness classification. *Somatosphere*. http://somatosphere.net/2020/mild-covid.html/

Canetti, E. (1973). *Crowds and power*. New York: The Continuum Publishing Corporation.

Centers for Disease Control and Prevention (2020a, May 14). *People who are at higher risk for severe illness*. https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-at-higher-risk.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Funderlying-conditions.html

Centers for Disease Control and Prevention. (2020b, June 25). *CDC updates, expands list of people at risk of severe COVID-19 illness*. https://www.cdc.gov/media/releases/2020/p0625-update-expands-covid-19.html

Chavez, N, Griffiths, J., Marsh, J., John, T., & Vera, A. (2020, May 17). *May 17 coronavirus news*. CNN. https://www.cnn.com/world/live-news/coronavirus-pandemic-05-17-20-intl/index.html

Cohan, W. D. (2020, May 15). "People will die. People do die": Wall Street has had enough of the lockdown. *Vanity Fair*. https://www.vanityfair.com/news/2020/05/wall-street-has-had-enough-of-the-lockdown?utm_source=twitter&utm_social-type=owned&utm_medium=social&mbid=social_twitter&utm_brand=vf

Collier, S. J., Lakoff, A., & Rabinow, P. (2004). Biosecurity: Towards an anthropology of the contemporary. *Anthropology Today, 20*(5), 3–7. https://doi.org/10.1111/j.0268-540X.2004.00292.x

Cooper, M. (2006). Preempting emergence: The biological turn in the war on terror. *Theory, Culture & Society, 23*(4), 113–135. https://doi.org/10.1177/0263276406065121

DeSanctis, Alexandria [xan_desanctis]. (2020, May 13). It's fascinating to see how the cultural loss of belief in God and eternity so often manifests [Tweet]. Retrieved from https://twitter.com/xan_desanctis/status/1260573101148065794

Diamond, D., & Toosi, N. (2020, March 25). Trump team failed to follow NSC's pandemic playbook. *Politico.* https://www.politico.com/news/2020/03/25/trump-coronavirus-national-security-council-149285

Emanuel, Z. (2014). Why I hope to die at 75. *The Atlantic, 314*(3), 74–81. Retrieved from https://www.theatlantic.com/magazine/archive/2014/10/why-i-hope-to-die-at-75/379329/

Executive Office of the President of the United States. (2016). Playbook for early response to high-consequence emerging infectious disease threats and biological incidents. Retrieved from https://assets.documentcloud.org/documents/6819703/WH-Pandemic-Playbook.pdf. June 5, 2020.

Farmer, P. (2004). An anthropology of structural violence. *Current Anthropology, 45*(3), 305–325. https://doi.org/10.1086/382250

Faust, J. S. (2020, April 28). Comparing COVID-19 deaths to flu deaths is like comparing apples to oranges. *Scientific American*. https://blogs.scientificamerican.com/observations/comparing-covid-19-deaths-to-flu-deaths-is-like-comparing-apples-to-oranges/

Ferguson, N., Laydon, D., Nedjati Gilani, G., Imai, N., Ainslie, K., Baguelin, M. . . . Ghani, A. (2020). *Report 9: Impact of non-pharmaceutical interventions (NPIs) to reduce COVID-19 mortality and healthcare demand*. Imperial College London (16-03-2020), https://doi.org/10.25561/77482

Foucault, M. (2003). *Society must be defended: Lectures at the Collège de France 1976-1977*. New York: Palgrave Macmillan.

Fuller, T., & Baker, M. (2020, April 22). Coronavirus death in California came weeks before first known U.S. death. *New York Times*. https://www.nytimes.com/2020/04/22/us/coronavirus-first-united-states-death.html

Garza, A. G., Van Cuyk, S. M., Brown, M. J., & Omberg, K. M. (2014). Detection of the urban release of a bacillus anthracis simulant by air sampling. *Biosecurity and Bioterrorism: Biodefense Strategy, Practice, and Science, 12*(2), 66–75. https://doi.org/10.1089/bsp.2013.0086 PMID:24697146

Gay, M. (2020, May 14). "I wish I could do something for you," my doctor said. *New York Times.* https://www.nytimes.com/2020/05/14/opinion/coronavirus-young-people.html

Gold, J. A. W., Rossen, L. M., Ahmad, F. B., Sutton, P., Li, Z., Salvatore, P. P., . . . Jackson, B. R. (2020). Race, ethnicity, and age trends in persons who died from COVID-19— United States, May–August 2020. *MMWR. Morbidity and Mortality Weekly Report, 69*(42), 1517–1521. https://doi.org/10.15585/mmwr.mm6942e1 PMID:33090984

Granada, D. (2020, May 20). The management of the coronavirus pandemic in Brazil and necropolitics: An essay on an announced tragedy. *Somatosphere*. http://somatosphere.net/2020/brazil-necropolitics.html/

Haskaj, F. (2018). From biopower to necroeconomies: Neoliberalism, biopower and death economies. *Philosophy & Social Criticism, 44*(10), 1148–1168. https://doi.org/10.1177/0191453718772596

Hsu, H. (2009). *The dangers of biosecurity*: The Host *and the geopolitics of outbreak. Jump Cut*. Reterieved from: https://www.ejumpcut.org/archive/jc51.2009/Host/

Huang, K., Bernhard, R., Barak-Corren, N., Bazerman, M., & Greene, J. D. (2020, April 22). *Veil-of-ignorance reasoning mitigates self-serving bias in resource allocation during the COVID-19 Crisis*. Pre-print https://doi.org/10.31234/osf.io/npm4v

Jain, L. (2011). Survival odds: Mortality in corporate time. *Current Anthropology, 52*(S3), S45–S55. https://doi.org/10.1086/656795

Jain, L. (2013). *Malignant: How cancer becomes us*. Oakland, CA: University of California Press. https://doi.org/10.1525/9780520956827

Khazan, O. (2020, September 22). A failure of empathy led to 200,000 deaths. It has deep roots. *The Atlantic*. https://www.theatlantic.com/politics/archive/2020/09/covid-death-toll-us-empathy-elderly/616379/

Khullar, D. (2020, April 23). The challenges of post-COVID care. *The New Yorker*. https://www.newyorker.com/science/medical-dispatch/the-challenges-of-post-covid-19-care

King, N. B. (2002). Security, disease, commerce: Ideologies of postcolonial global health. *Social Studies of Science, 32*(5-6), 763–789. https://doi.org/10.1177/030631270203200507

King, S. (2008). *Pink ribbons, inc.: Breast cancer and the politics of philanthropy*. Minneapolis: University of Minnesota Press.

Knight, V., & Appleby, J. (2020, November 2). How COVID death counts became the stuff of conspiracy theories. *Kaiser Health News*. https://khn.org/news/how-covid-death-counts-become-the-stuff-of-conspiracy-theories/

Koma, W., Neuman, T., Klaxton, G., Rae, M., Kates, J., & Michaud, J. (2020, April 23). *How many adults are at risk of serious illness if infected with coronavirus? Updated data*. Kaiser Family Foundation. https://www.kff.org/coronavirus-covid-19/issue-brief/how-many-adults-are-at-risk-of-serious-illness-if-infected-with-coronavirus/

Landay, J. (2017, July 20). *White House developing comprehensive biosecurity strategy: official*. Reuters. https://www.reuters.com/article/us-usa-security-biodefense/white-house-developing-comprehensive-biosecurity-strategy-official-idUSKBN1A52HZ

Lincoln, M. (2020). A special self-image is no defence against COVID-19. *Nature, 585*(325). *https://doi.org/10.1038/d41586-020-02596-8*

Lustig, J. (2020, March 24). What I learned when my husband got sick with coronavirus. *New York Times*. https://www.nytimes.com/2020/03/24/magazine/coronavirus-family.html

Mandel, Bethany [bethanyshondark]. (2020, May 6). You can call me a Grandma killer. I'm not sacrificing my home, food on the table, all of our docs [Tweet]. Retrieved from https://twitter.com/bethanyshondark/status/1258074070442217478

Margulis, Jennifer [JenniferMarguli]. (2020, November 8). Ask yourself: is an infection with an over 99% survival rate in every age category but those over 70 worth [Tweet]. Retrieved from https://twitter.com/JenniferMarguli/status/1325471935778598913

Marks, C., & Pour, T. (2020, April 29). What we don't know about the coronavirus. *The New Yorker*. https://www.newyorker.com/science/medical-dispatch/what-we-dont-know-about-covid-19

Masco, J. (2014). *The theater of operations: National security affect from the Cold War to the War on Terror*. Raleigh, NC: Duke University Press. https://doi.org/10.1215/9780822375999

Mbembe, A. (2003). Necropolitics. *Public Culture, 15*(1), 11–40. https://doi.org/10.1215/08992363-15-1-11

McGoey, L. (2019). *The unknowers: How strategic ignorance rules the world*. London: Zed Books.

Mehra, M. R., Desai, S. S., Ruschitzka, F., & Patel, A. N. (2020). Hydroxychloroquine or chloroquine with or without a macrolide for treatment of COVID-19: A multinational registry analysis. *Lancet*. https://doi.org/10.1016/S0140-6736(20)31180-6

Moye, D. (2020, April 29). Ben Shapiro suggests older people dying of COVID-19 is "tragic," but also not so bad. *Huffington Post*. https://www.huffpost.com/entry/ben-shapiro-coronavirus-death-panel_n_5ea9f706c5b6dac085f52a6f

Mueller, B. (2020, May 25). On a Scottish isle, nursing home deaths expose a Covid-19 scandal. *New York Times*. https://www.nytimes.com/2020/05/25/world/europe/coronavirus-uk-nursing-homes.html

Murphy, M. (2017). *The economization of life*. Raleigh, NC: Duke University Press. https://doi.org/10.1215/9780822373216

New York Times Magazine. (2020, April 10). Restarting America means people will die. So when do we do it? *New York Times Magazine*. https://www.nytimes.com/2020/04/10/magazine/coronavirus-economy-debate.html

Nixon, R. (2011). *Slow violence and the environmentalism of the poor*. Cambridge, MA: Harvard University Press. https://doi.org/10.4159/harvard.9780674061194

Ortega, F., & Orsini, M. (2020). Governing COVID-19 without government in Brazil: Ignorance, neoliberal authoritarianism, and the collapse of public health leadership. *Global Public Health: An International Journal for Research, Policy and Practice, 15*(9), 1257–1277. https://doi.org/10.1080/17441692.2020.1795223 PMID:32663117

Pei, S., Kandula, S., Shaman, J. (2020). Differential effects of intervention timing on COVID-19 spread in the United States. *Science Advances, 6*(49), eabd6370 https://doi.org/10.1126/sciadv.abd6370

Pew Research Center. (2020, July 22). *Republicans remain far less likely than Democrats to view COVID-19 as a major threat to public health*. Pew Research Center. https://www.pewresearch.org/fact-tank/2020/07/22/republicans-remain-far-less-likely-than-democrats-to-view-covid-19-as-a-major-threat-to-public-health/

Proctor, R., & Schiebinger, L. (2008). *Agnotology: The making and unmaking of ignorance*. Palo Alto, CA: Stanford University Press.

Regan, H., Marsh, J., Alfonso, F., & Vera, A. (2020, May 3). May 3 coronavirus news. *CNN*. https://www.cnn.com/world/live-news/coronavirus-pandemic-05-03-20-intl/index.html

Rubin, J. (2020, June 23). How the Republican Party became a death cult. *Washington Post*. https://www.washingtonpost.com/opinions/2020/06/23/how-republican-party-became-death-cult/

Shipman, T., & Wheeler, C. (2020, March 22). Coronavirus: ten days that shook Britain – and changed the nation for ever. *The Times*. https://www.thetimes.co.uk/article/coronavirus-ten-days-that-shook-britain-and-changed-the-nation-for-ever-spz6sc9vb

Sollenberger, R. (2020, April 24). *Fox News host Laura Ingraham continues to downplay threat posed by coronavirus with flu comparison*. Salon. https://www.salon.com/2020/04/24/fox-news-host-laura-ingraham-continues-to-downplay-threat-posed-by-coronavirus-with-flu-comparison/

Sullivan, M. (2020, May 10). Trump wants America to "normalize" coronavirus deaths. It's the media's job not to play along. *Washington Post.* https://www.washingtonpost.com/lifestyle/media/trump-wants-america-to-normalize-coronavirus-deaths-its-the-medias-job-not-to-play-along/2020/05/09/72de4c32-9090-11ea-a9c0-73b93422d691_story.html

Sun, L. (2018, May 20). Top White House official in charge of pandemic response exits abruptly. *Washington Post*. https://www.washingtonpost.com/news/to-your-health/wp/2018/05/10/top-white-house-official-in-charge-of-pandemic-response-exits-abruptly/

The Novel Coronavirus Pneumonia Emergency Response Epidemiology Team. (2020). The epidemiological characteristics of an outbreak of 2019 novel coronavirus diseases (COVID-19)—China, 2020. *China CDC Weekly, 2*(8), 113–122. https://doi.org/10.46234/ccdcw2020.032

Trump, Donald [realDonaldTrump]. (2020a, May 3). ....And then came a Plague, a great and powerful Plague, and the World was never to be the same again! [Tweet]. Retrieved from https://twitter.com/realDonaldTrump/status/1256957565562486784

Trump, Donald [realDonaldTrump]. (2020b, May 17). Doing REALLY well, medically, on solving the CoronaVirus situation (Plague!) It will happen! [Tweet]. Retrieved from https://twitter.com/realDonaldTrump/status/1262020427582451717

Verdery, K. (1999). *The political lives of dead bodies: Reburial and postsocialist change*. New York: Columbia University Press.

Weiland, N., Haberman, M., & Goodnough, A. (2020, May 22). Trump suggests virus death count is inflated. Most experts doubt it. *New York Times*. https://nyti.ms/2Xkfwul

White House. (2020a). *Remarks by President Trump, Vice President Pence, and members of the coronavirus task force in press conference*. Feb 29, 2020. https://www.whitehouse.gov/briefings-statements/remarks-president-trump-vice-president-pence-members-coronavirus-task-force-press-conference-2/

White House. (2020b). *Remarks by President Trump after tour of the Centers for Disease Control and Prevention, Atlanta, GA*. March 6, 2020. https://www.whitehouse.gov/briefings-statements/remarks-president-trump-tour-centers-disease-control-prevention-atlanta-ga/

White House. (2020c). *Remarks by President Trump, Vice President Pence, and members of the coronavirus task force in press briefing*. March 9, 2020. https://www.whitehouse.gov/briefings-statements/remarks-president-trump-vice-president-pence-members-white-house-coronavirus-task-force-press-briefing/

White House. (2020d). *Remarks by President Trump in address to the nation*. March 11, 2020. https://www.whitehouse.gov/briefings-statements/remarks-president-trump-address-nation/

White House. (2020e). *Remarks by President Trump, Vice President Pence, and members of the coronavirus task force in press briefing*. March 14, 2020. https://www.whitehouse.gov/briefings-statements/remarks-president-trump-vice-president-pence-members-coronavirus-task-force-press-briefing/

White House. (2020f). *Remarks by President Trump, Vice President Pence, and members of the coronavirus task force in press briefing*. March 25, 2020. https://www.whitehouse.gov/briefings-statements/remarks-president-trump-vice-president-pence-members-coronavirus-task-force-press-briefing-11/

White House. (2020g). *Remarks by President Trump, Vice President Pence, and members of the coronavirus task force in press briefing*. March 29, 2020. https://www.whitehouse.gov/briefings-statements/remarks-president-trump-vice-president-pence-members-coronavirus-task-force-press-briefing-14/

White House. (2020h). *Remarks by President Trump, Vice President Pence, and members of the coronavirus task force in press briefing*. April 4, 2020. https://www.whitehouse.gov/briefings-statements/remarks-president-trump-vice-president-pence-members-coronavirus-task-force-press-briefing-19/

White House. (2020i). *Remarks by President Trump in meeting with Republican members of Congress*. May 8, 2020. https://www.whitehouse.gov/briefings-statements/remarks-president-trump-meeting-republican-members-congress/

White House (2020j). *Remarks by President Trump after Senate GOP policy lunch, U.S. Capitol*. May 19, 2020. https://www.whitehouse.gov/briefings-statements/remarks-president-trump-senate-gop-policy-lunch-u-s-capitol/

Yong, E. (2020, June 4). COVID-19 can last several months. *The Atlantic.* https://www.theatlantic.com/health/archive/2020/06/covid-19-coronavirus-longterm-symptoms-months/612679/