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COMMENTARY

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On epidemiology as racial-capitalist (re)colonization and epistemic violence

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ABSTRACT

This commentary reflects upon power-knowledge dynamics and matters of epistemic, procedural, and distributive justice that undergird epidemiological knowledge production related to racial health inequities in the U.S. Grounded in Foucault's power-knowledge concepts—"objects", "ritual", and "the privileged"—and guided by Black feminist philosopher Kristie Dotson's conceptualization of epistemic violence, it critiques the dominant positivist, reductionist, and extractivist paradigm of epidemiology, interrogating the settler-colonial and racial-capitalist nature of the knowledge production/curation enterprise. The commentary challenges epidemiology's affinity for epistemological, procedural, and methodological norms that effectively silence/erase community knowledge(s) and nuance in favor of reductionist empirical representations/re-presentations produced by researchers who, often, have never stepped foot inside the communities they aver to model. It also expressly names the structurally racist reality of a "colorblind" knowledge production/curation system controlled by White scholars working from/for an invisibilized White scientific gaze. In this spirit, this commentary engages the *public health critical race praxis* principle of "disciplinary self-critique", illuminating the inherent contradictions of a racial health equity discourse that fails to interrogate the racialized power dynamics underlying its knowledge production enterprise. In doing so, this commentary seeks to (re)frame and invite discourse regarding matters of epistemic violence and (re)colonization as manifest/legible within epidemiology research, suggesting that the structural racism embedded within – and perpetuated through – our collective work must be addressed to advance antiracist and decolonial public health futures. In this regard, I suggest the value of engaging *poetry as praxis*—as mode of knowledge production/expression to "center the margins" and offer counternarratives to epidemiology's epistemic violence.

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"Find another connection to the rest of the world

Find something else to make you legitimate

Find some other way to be political and hip"

–(Rushin, 2015, p. xxxiii), *The Bridge Poem*

Racial health inequities are the product and (re)production of structural power dynamics – social, economic, and political (Bailey et al., 2017, 2020; Gee & Ford, 2011; Homan & Brown, 2022; Phelan & Link, 2015; Williams & Collins, 2001; Yearby et al., 2022). Yet, considerations of power are

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remarkably absent from most domains of racial health equity discourse. One critical yet perpetually overlooked domain is that of racial health equity *knowledge production* itself – the mechanisms, processes, and procedures for creating, curating, and valuing knowledge(s) about racial health (in) equity, and underlying/motivating epistemologies and norms therein. That is, questions of epistemic, procedural, and distributive justice for racial health equity. Here, I contend that epistemic injustice – and epistemic violence as conceptualized by Dotson (2011)—are defining characteristics of epidemiological research on racial health inequities in the U.S., and that such injustice and violence are in large part necessitated and perpetuated by a research enterprise rooted in logics and practices of settler colonialism and racial capitalism. Below, I outline a brief critique of this epidemiology enterprise as germane to racial health inequities in the U.S., and suggest the potential value of engaging *poetry as praxis* (Petteway, 2021c)—as a mode of knowledge production and expression to "center the margins" and offer counternarratives to the epistemic violence of epidemiology.

Power, knowledge, and epi as epistemic injustice

As articulated by Bhakuni and Abimbola (2021) in their reflection on epistemic injustice as manifest within global health research, "knowledge systems are social systems, with their share of social prejudices and implicit biases that interfere with people's ability to participate fully and equally in knowledge production, use, and circulation" (p.e1465). They note how, "dominant knowledge practices limit the extent to which members of marginalised social or epistemic groups have ownership of knowledge production and sensemaking" (p.e1466), and highlight, for example, how concerns for epistemic injustice can arise from, "aligning research with the priorities of funders or audience from dominant groups, and could give marginalised groups reason to distrust the scientific community" (p.e1468). In my view, such modes/practices of epistemic injustice, as well as mechanisms of epistemic violence, like "testimonial silencing" and "testimonial incompetence" (Dotson, 2011), are *the* defining characteristic of U.S. racial health inequities research under the dominant epidemiology paradigm – which I submit is overwhelmingly positivist, reductionist, and extractivist. Moreover, and perhaps most fundamentally, such research has remained unapologetically blind to power-knowledge relationships in the production of racial health inequities knowledge, particularly in light of Foucault's notions of "objects", "ritual", and "the privileged", and dynamics of repressive/productive power therein (Foucault, 1978, 1980).

Generally, in this context, repressive power pertains to the capacities and mechanisms through which institutions and social structures limit or otherwise regulate people's knowledge production engagements/capabilities through various modalities of exclusion, denial, erasure, and rejection. Productive power, here, can be understood as the ways in which power functions to produce, reproduce, or alter social structures and/as generative of systems of meaning and signification, with both symbolic (e.g. what gets studied and published, who is doing the studying/publishing) and material (e.g. paywalled journals, who gets paid, who gets credentialed) aspects. Importantly, repressive/productive power operate simultaneously and are in many capacities mutually constitutive, such that any one use/expression of power can have both repressive and productive effects. In the dominant mode of epidemiological knowledge production, credentialed elites – Foucault's "the privileged"—produce "objects" of racial health inequities knowledge in a "ritual" of positivist, reductionist, and essentialist data extraction and expropriation. Repressive power is observed, for example, when communities of color can only speak through the credentialed researcher via response to predetermined survey items (followed by never-ending, often decontextualized and ahistoric, secondary data analyses), and when findings are published in pay-for-access journals (productive power, as well) that survey respondents cannot access. Moreover, respondents usually have no knowledge that such work has been published about them, nor do they have knowledge of who published it (e.g. authors, journals).

Repressive power is also observed when only certain topics related to racial health inequities are judged to be worthy of funding and/or publication, i.e. power to set knowledge-producing agendas, decide what 'counts', and how it must be counted (also productive power). It is also observed in the routinized secondary analyses of medical/health records – a prominent mainstay of epidemiology – wherein a limited selection of outcomes and demographic variables (often not theoretically informed or specifically chosen/included/designed for any one specific research question) systematically and artificially shape the contours of what is/can be 'known' about the causes of health/illness within communities of color (again, also productive power). In this case, communities of color have literally no say in how they – their bodies, their samples, their health data, their lives – will be represented/re-presented as "objects" of knowledge.

Productive power is observed, for example, in the manner in which communities of color are produced into existence in the knowledge world as decontextualized, discrete scientific artifacts (i.e. "objects") for the edification of credentialed elites who do not 'know'/recognize them otherwise—that is, communities of color as constructed via the epidemiologic imaginary. It is also observed in the manner in which this "ritual" tends to produce narratives of being 'at-risk' and being 'vulnerable'/'susceptible' that not only obscure the primacy of racialization and role of structural determinism (Ford & Airhihenbuwa, 2010b), but often serve to pathologize racialized 'others' in discourses of health equity (e.g. the biologization of 'race'). Pervading power dynamics and epistemic norms privilege the 'parsimonious' flattening of layered complexity into discretely knowable "objects" (e.g. to constitute evidence), precluding alternative expressions of knowledge and narratives and thereby normalizing the simultaneous exploitation and truncation of community voice:

> I got what I needed, now silence. I wrote this script, just read your lines . . .
>
> actually, no – I'll read your lines for you.

This is perhaps most commonly observed through the uninterrogated use of predetermined survey items (repressive and productive power) and sampling practices that privilege vague and often untheorized notions of 'generalizability'—making no account of the practical actionability of findings within any one specific community's sociopolitical and jurisdictional contexts. Such racial health inequities research thus seemingly presents as 'knowledge for knowledge's sake', and for the express sake of advancing "the privileged's" academic curiosities and personal benefit – as they determined the questions, and they get credited with producing knowledge and advancing the field regardless of whether or not their work tangibly benefitted the specific communities of color who participated as respondents. Bhakuni and Abimbola (2021) reflect on this concern in their analysis of epistemic injustice within global health research, noting that, "there is potential for epistemic injustice if knowledge practices do not prioritise local audiences . . . for the purpose of local learning, or if knowledge production serves the needs of foreign and distant actors or elite epistemic communities" (p. e1467). Under the dominant "ritual", considerations for procedural, epistemic, and distributive justice fail to register at all. Essentially:

> *Tell me only what I want/came here to hear,*
> *and then I will re-tell it*
> *in such a way that it becomes*
> *my knowledge*
> *and benefits me (socially, professionally, economically).*
> *And you?*
> *You will hardly recognize*
> *yourself—*
> *especially in my "fully adjusted models".*
> *Also, you'll need $39.95 and an internet connection.*

Epi as (re)colonization

Critically here, not only is most epidemiological research on racial health inequities blind to power-knowledge relationships, but it is also 'colorblind'. As I have articulated elsewhere, the dominant "ritual" of public health knowledge production is rooted in White supremacist and settler-colonial norms of dispossession and epistemic erasure/silencing (Petteway, 2021a, 2021c, 2022). In this regard, much racial health inequities research reflects what Zuberi and Bonilla-Silva (2008) refer to as "White logic": "a context in which White supremacy has defined the techniques and processes of reasoning about social facts" (p.17). This logic manifests in colorblind, apolitical, positivist methodological practices that center claims of (detached) neutrality and perpetual "objectivity" under the gaze of (mostly[1]) White scholars/scientists—"White methods". Unlike within other fields/traditions of scientific inquiry (more commonly, qualitative traditions), epidemiological research on racial health inequities skirts considerations for/of researcher/author positionality and social locations, thereby centering whiteness and normalizing the invisibilization of the White scientific gaze – thus rendering the dominance of White logic/methods invisible and obscuring their relations of power and ownership as germane to racial(ized) knowledges and consequent narratives. Here, the field would do well to reflect on Abimbola (2019) work, in which he identifies *gaze* as the intended audience of the knowledge being produced. In his analysis, he specifically troubles global health research that prioritizes appeasing the gaze of foreign knowledge audiences. In acknowledging the relevance of researcher positionality (*pose*) within research encounters between local communities and 'foreign' researchers, he suggests that resulting research papers, "should be so labelled by the lead author 'written with a foreign pose for a foreign gaze'" (p.2). Perhaps it is time we ask ourselves why we have not normalized rendering transparent the racialized structure of power-knowledge dynamics within epidemiologic research on racial health inequities – to clearly identify the disparate social and epistemic locations between the "privileged" and the "objects" of their scientific gaze?

These concepts of White logics/methods and gaze in many ways help contextualize Moreton-Robinson (2015) notion of "the White possessive" as germane to racial health equity knowledge production. As she articulates, the White possessive is a, "mode of rationalization . . . that is underpinned by an excessive desire to invest in reproducing and reaffirming the nation-state's ownership, control, and domination" (p.xii). While her focus was more expressly on matters of sovereignty and state acts/actions of material (and symbolic) dispossession, parallels can be readily observed within the racial health inequities research enterprise – which in the U.S. is very much structured by state action, interests, and socio-politically contingent research priorities, e.g. publicly funded discretionary budgets allocated to siloed body-system-specific National Institutes of Health (NIH). Our dominant "ritual" worships 'the NIH grant', which by and large, has historically required engagements with positivist, reductionist, and – critically—apolitical and power-blind logics and methods. For racial health (in)equity research, this translates into settler-colonial, extractivist, and dispossessing research practices that center whiteness and White (in part, read: state) ownership (of data/samples, i.e. bodies) and dominance (e.g. narrative control)—enacting epistemic violence and erasure via myriad social and material significations of power and ownership over knowledge. The most direct benefit is to the state and those participating in furthering its interests/priorities in the (re)production of *certain* racial health inequities knowledges – whom, by and large, are White scholars/researchers producing knowledge for a White gaze.

Epi as racial capitalism

In the U.S. context, this is observed in the fact that, while research on racial health inequities continues to grow, Black, Latinx, and Indigenous scholars make up just 5.7%, 5.9%, and 0.3%, respectively, of tenure-track SPH faculty nationally (Goodman et al., 2019)—all while some of the most highly funded schools of public health are located in historically redlined low-income communities of color. In essence, predominantly-White institutions composed disproportionately of

White faculty are making economic, social, and professional capital gains based on the knowledge they produce about people/communities whose social locations and histories bear very little resemblance to their own. This reality has recently been called out in the context of COVID-19—as most of those benefitting from increased grant funding to 'address racial disparities' are White scholars at predominantly White institutions (McFarling, 2021b). These so-called "health equity tourists" (Lett et al., 2022) are in many ways emblematic of a very fundamental characteristic of racial health equity research – the unspoken of pre-pandemic 'normal' of White scholars being credentialed and empowered (and expected, really) to transform Black, Brown, and Indigenous pain and suffering (because deficits are the focus under the "ritual") into facilities and administrative ('F&A') grant revenue,[2] tenure, silver C-class Mercedes, and conference per diems with not an utterance about epistemic or distributive justice. As Smith (2013) articulates regarding historic processes of the colonization of knowledge(s), "the production of knowledge, new knowledge and transformed 'old' knowledge, ideas about the nature of knowledge and the validity of specific forms of knowledge, became as much commodities of colonial exploitation as other natural resources" (p.37). In the context of racial health inequities research, communities of color are essentially being mined for data that can then be (re)presented by the disproportionately White credentialed researcher (Foucault's "the privileged") as 'new', as 'theirs', and importantly, as legitimate knowledge.

Structural racism, as legible via metrics of (under)representation among faculty bodies, funding review panels (NIH, 2021), academic journal editorial and peer-review boards (McFarling, 2021a; Salazar et al., 2021), creates a context in which, more often than not, White scholars are serving as writer, director, and producer in a third-person production of racial health inequities knowledge wherein they control the full narrative scope – something made robustly clear in reviews of publishing patterns related to 'race' versus 'racism' in top public health and medical journals (Hardeman et al., 2018; Krieger et al., 2021). As I have suggested elsewhere (Petteway, 2021c), such conditions are tantamount to knowledge minstrelsy – productions of knowledge written and performed by researchers who pass-off/repackage community knowledge as their own and as indication of *their* 'expertise'—all while avoiding engagement with matters of structural racism and epistemic, procedural, and distributive justice. Such productions are enabled, and indeed encouraged, by our dominant paradigm of epidemiological racial health inequities knowledge production that, by design, seeks to silence fuller, complementary, and/or alternative expressions of knowledge (e.g. counternarratives, counterstories), to detach presently observed outcomes from historical roots, and to obfuscate the extent to which the research enterprise itself is complicit in the maintenance of racial inequality.

Meanwhile, communities of color remain cast primarily as "objects" to be quantifiably known (±5%) as opposed to 'subjects' (in a Freirean sense) who possess the capacity to *know* and produce themselves into existence (e.g. as resident co-researchers in community-based participatory research, or through modalities outside of epidemiology entirely). In this manner, the dominant ritual of racial health inequities knowledge production can be viewed as a mode of epistemic violence via a "practice of silencing" (Dotson, 2011)—wherein the voices and knowledges of communities of color are diminished, truncated, or outright erased for the ease, comfort, and benefit of mostly White scholars, institutions, and capital interests (social, professional, and financial). Under these conditions, relationships between researchers and community represent not only the re-inscription of social hierarchy, but the reification of racial health inequities research as racial-capitalist (re)colonization.

A non-conclusion and a suggestion

TL;DR➔ racial health inequities research is (surprise) structurally racist, and predominantly White institutions and White scholars quite literally capitalize on racial health inequities via settler-colonial practices of knowledge expropriation. A core question then becomes, how do we reimagine a racial health equity discourse and knowledge production apparatus that is antiracist, and, to borrow from

Black feminist philosopher Kristie Dotson (2018), "on the way to decolonization"? And how do we move away from a historic and present 'normal' of colonizer as curator? Certainly, the events of the last two years – specifically, the depth and insidiousness of structural racism as manifest via continued racialized police (i.e. state) violence, and as amplified by COVID-19 inequities – have spurred some measure of awareness and response to some of the concerns raised here (Collins et al., 2021; NASEM, 2021). However, it remains to be seen how truly committed we are to thoroughly engaging antiracist and decolonizing principles and praxis when it comes to rectifying who gets a seat at the knowledge production table, who sets the menu, who gets to eat, and who simply gets plated. I believe part of the challenge rests in changing the terms (and forms) of engagement within the growing discourse.

A core challenge, as noted by Bhakuni and Abimbola (2021), is that historic and present power-knowledge dynamics continue to render epistemic injustice discernible, "in who is recognised as a credible knowledge producer and in whose interpretive tools are used to make sense of existing or new knowledge" (p.e1466). Here, I suggest that poetry is not only one such *interpretive* tool, but also a knowledge *production* tool—that is, a mode of productive power through which communities of color can counter the epistemic violence of epidemiology. And in this spirit, I have argued for engaging poetry as site of (re)imagination/remedy, source of resistance/healing, mode of reclamation/restoration, and necessary format of scholarly discourse of racial health equity (Petteway, 2020, 2021b, 2021c, 2022). In a companion piece to this commentary – a poem entitled, "RELATIVES//Risk" (Petteway, in press)—I offer a critical reflection on dominant positivist, reductionist, apolitical, power-blind, and extractive paradigms of health equity knowledge production, questioning the settler-colonial and dispossessing proclivities of common practices that usurp narrative space regarding racial health inequities.

Crafted as counternarrative, "RELATIVES//Risks" weaves (social) epidemiology concepts together with antiracist, critical race, and Black feminist theory literatures to (re)frame, extend, and invite discourse regarding matters of epistemic violence, data justice, and decolonization within research practices – a 'call-in' that centers love, resistance, and solidarity. Engaging public health critical race praxis (PHCRP) principles of "disciplinary self-critique" and "voice" (Ford & Airhihenbuwa, 2010b), the broader critical race and PHCRP tenet of "centering the margins" (Ford & Airhihenbuwa, 2010a), and illustrating *poetry as praxis* (Petteway, 2021c), the poem interrogates epidemiological knowledge production norms in light of a history of Black civic, political, and creative resistance as emergent, embodied, and traditionally excluded from racial health equity knowledge expression – explicitly challenging epidemiology's simultaneous exploitation and erasure of our embodied histories, stories, experiences, and knowledges 'at the margins'.

In doing so – in much the same capacity as this more traditional commentary—"RELATIVES/Risks" invites academic scholars and community practitioners to reflect critically on the ways in which traditional health equity knowledge production processes often serve to pathologize and misrepresent communities of color – while simultaneously suppressing/devaluing expressions of knowledge rooted in/arising from those of us at the margins. As such, the piece evokes and enacts core principles of antiracist and decolonizing praxis, while engaging traditional science discourse through a prism of Black creative expression to counter epistemic injustice and violence – with the hope to invigorate productive dialogue regarding who/what our field (mis)represents in efforts to advance racial health equity.

Notes

1. Here, it is important to note that, as Zuberi and Bonilla-Silva (2008) articulate, "White logic and White methods can be – and have been – used by members of all racialized groups" (p.18). This sentiment, of course, finds symmetry in the writings of decolonizing scholars Linda Smith's and Frantz Fanon's writings/concerns regarding how colonized peoples can and do internalize and engage/uphold settler-colonial logics and proclivities (e.g. "brief case carrying Indigenous people", the "colonized intellectual"). The influence/role of whiteness and the reach of

White logic/methods in racial health inequities knowledge production then, of course, is not discretely conterminous with those who are racialized as White. In other words, plenty of scholars of color engage in the same practices.

2. For example, if a scholar at a U.S. university is awarded a $10-million grant to research "racial health inequities" related to, say, maternal and child health, their university will take in "F&A" revenue of usually somewhere between 25% and 50% of the total awarded amount. This money is used for things that have absolutely nothing to do with "racial health inequities" in maternal and child health. Rather, it's a revenue source to support university operations, which can be interpreted broadly (e.g. the funded scholar needs office space, our campus needs new tulips). This positions racial health inequities research as a capitalist revenue stream to advance university interests/operations that have no direct connection to advancing racial health equity, i.e. monetization and commodification of knowledges about inequities experienced by communities of color with no requirement to demonstrate reciprocal benefit.

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