

WHAT ISN'T NEW IN THE NEW NORMAL: A FEMINIST ETHICAL PERSPECTIVE ON COVID-19

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Résumé de l'article

Cet essai soutient que les réponses prédominantes à la pandémie de COVID-19 intensifient les disparités en termes de vulnérabilité aux torts parce que ces réponses tentent simplement de revenir aux conditions antérieures à l'épidémie du virus. Bien que l'impact généralisé du COVID-19 ait rendu l'interdépendance plus vive, la dévaluation socioculturelle sous-jacente de la vulnérabilité, de la relationnalité et de la dépendance a intensifié les inégalités structurelles. Des personnes déjà démunies et défavorisées ont été placées dans des conditions encore plus précaires. Une perspective éthique féministe reconnaît la vulnérabilité, la relationnalité et la dépendance comme des conditions à la fois inévitables et centrales à la vie. Une telle perspective permet ainsi de mieux comprendre pourquoi certaines réponses dominantes au virus sont injustes et à quoi, des réponses à la pandémie plus éthiques et socialement plus justes, favorisant la santé sociale ainsi que la santé physique, pourraient ressembler.



WHAT ISN'T NEW IN THE NEW NORMAL: A FEMINIST ETHICAL PERSPECTIVE ON COVID-19

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ABSTRACT:

This essay argues that dominant responses to the COVID-19 pandemic redouble disparities in vulnerability to harms because these responses simply attempt to return to conditions prior to the outbreak of the virus. Although the widespread impact of COVID-19 has made interdependence more vivid, the underlying sociocultural devaluation of vulnerability, relationality, and dependency has intensified structural inequalities. People who were already disempowered and disadvantaged have been consigned to even more precarious conditions. A feminist ethical perspective avows vulnerability, relationality, and dependency as conditions that are both unavoidable and central to life. Such a perspective thus provides insight into why some dominant responses to the virus are unjust and what more ethical and more socially just responses to the pandemic, which foster social health as well as physical health, might look like.

RÉSUMÉ :

Cet essai soutient que les réponses prédominantes à la pandémie de COVID-19 intensifient les disparités en termes de vulnérabilité aux torts parce que ces réponses tentent simplement de revenir aux conditions antérieures à l'épidémie du virus. Bien que l'impact généralisé du COVID-19 ait rendu l'interdépendance plus vive, la dévaluation socioculturelle sous-jacente de la vulnérabilité, de la relationnalité et de la dépendance a intensifié les inégalités structurelles. Des personnes déjà démunies et défavorisées ont été placées dans des conditions encore plus précaires. Une perspective éthique féministe reconnaît la vulnérabilité, la relationnalité et la dépendance comme des conditions à la fois inévitables et centrales à la vie. Une telle perspective permet ainsi de mieux comprendre pourquoi certaines réponses dominantes au virus sont injustes et à quoi, des réponses à la pandémie plus éthiques et socialement plus justes, favorisant la santé sociale ainsi que la santé physique, pourraient ressembler.

It has become nearly a truism that the COVID-19 pandemic has not only exposed longstanding inequalities but also exacerbated them. Patterns of racial, gender, and socioeconomic inequality have produced disparate rates of infection and mortality. People who were already disempowered and disadvantaged have been consigned to even more precarious conditions by the virus as well as by the attempts to mitigate its impact. The continuing experience of the pandemic straightforwardly reinforces the critiques of structural injustice and differential vulnerabilities offered by feminist and critical race theory: that historical legacies of oppression (both symbolic and structural), present political and economic policies, and persistent interpersonal bias produce disproportionate harmful vulnerability for historically oppressed social groups (women, people of colour, Indigenous people, people with disabilities, and especially those positioned at the intersections of these groups).

Thus, in this case, health is yet another of the many goods that is unequally accessed because of entrenched and interlocking patterns of racial, socioeconomic, and gendered oppression. The injustice is specially pointed with respect to racial disparities in COVID-19 cases and fatalities: in the US, cases are 2.7 times higher for Black people than for white people and 3.2 times higher for Latinx people than for white people (McLaren, 2020).¹ The virus is also twice as likely to be fatal for Black and Latinx people as it is for white people (Selden and Berdhal, 2020, p. 1). These higher mortality rates are linked to increased incidence of exposure to the virus, whether in the workplace, at home, or in transit; people in these communities are more likely to hold jobs that require them to be physically present at work and more likely to live in the same household as a healthcare worker (Selden and Berdhal, 2020, p. 4; McLaren, 2020). Unequal health outcomes are compounded by bias and stereotyping, as in the “racialized characterization of behavior” and conditions such as obesity (Chowkwanyun and Reed, 2020, p. 202). Instead of treating higher infection and mortality rates as the consequence of structural inequalities, biased interpretation of these disparities treats them as a quasi-natural or otherwise inevitable consequence, products of purported individual pathology or innate vulnerability, and so preempts responsibility for preventing or addressing them.

The perspective of feminist ethics calls for both critical and creative reconstructive endeavours (Miller 2017, Gilson 2021). Assessing responses to the pandemic from this perspective, therefore, involves, first, critique of the inequalities accompanying the virus and of the conditions underlying such inequalities and, second, indications as to what is required for more ethical and more socially just responses to the pandemic. The underlying conditions for inequality, as noted above, are the triad of historically entrenched structure, policy, and interpersonal bias. In this context, insofar as dominant responses to the pandemic amount to attempts to return to the state prior to the outbreak of COVID-19, they redouble disparities in vulnerability to harms. Thus, the critiques of structural injustice and precarity offered by feminist and critical race theorists can provide insight into why dominant responses to the virus are flawed and unjust, as well as into what more ethical and more socially just responses to the pandemic might look like.

I. THE CRITICAL PERSPECTIVE OF FEMINIST ETHICS

In this first part of the essay, I highlight three intertwined threads of such a critique. First, feminist ethics offers a conceptual, theoretical critique of how the neglect, disavowal, and, ultimately, division of certain constitutive features of human existence—vulnerability, relationality, and dependence—cause us to mistake ourselves for, or aspire to be, invulnerable, isolated, independent beings and thus lead to ethical error (Kittay, 2011; Butler, 2004). Second, a more recent critique of the hermeneutic dominance of neoliberalism highlights how the disavowal of these features manifests in contemporary politico-economic ideology and policy, reductively economizing value, meaning, and choice as well as generating individualizing, precarity-inducing effects (Lorey 2015). Accordingly, a third practical critique identifies a dearth of provisions for care as a direct effect of the neoliberal policy shifts toward austerity and privatization and thus a direct effect of the neglect of vulnerability, relationality, and dependency that underlies the neoliberal framework. Unravelling public systems of support and privatizing (previously public) services perpetuates injustice, especially because doing so disproportionately affects those who are disempowered and disadvantaged. Yet public institutions and policies have been a vehicle for inequality just as much as (if not more than) a vehicle for equality and for the rectification of past wrongs. At a time when people turn to public health officials and institutions and to federal and state governments for guidance, regulation, and support, critique of the disciplinary and dominating uses of state power is all the more pressing.

Vulnerability, relationality, and dependence are at the core of both the experience of the COVID-19 pandemic and the myriad ways in which individuals, communities, and institutions are responding to it. Definitions of vulnerability range from susceptibility to harm to bodily openness, but the concept may be understood best as an ambiguous condition of being affected.² We are vulnerable because of our corporeal and social nature: we can be affected and in turn affect others in complex ways because we are embodied beings in intersubjective relations with one another. Often vulnerability is equated with susceptibility to harm, but openness to injury is only one (negative) aspect of what it means to be vulnerable. People are also vulnerable in their openness to affection, care, love, and myriad other forms of relation that are both positive and ambivalent. Vulnerability, thus, cannot be reduced to its merely negative manifestations, but is a condition that is both ambivalent (having antipodal effects) and ambiguous; that is, it is a complex, multilayered, and sometimes conflicting condition. One way to understand this complexity is to employ a distinction that is now common in scholarly literature on vulnerability. On the one hand, vulnerability is a fundamental ontological condition pertaining to all; it is an unavoidable condition of being affected that defines our very being. On the other hand, vulnerability is only ever experienced in highly specific ways and, in this sense, it is necessarily variable: it is situational. The complexity of vulnerability can be understood only by analyzing how the shared ontological condition of being vulnerable is realized situationally and is experienced in concrete ways. The fundamental

condition of being affected is the precondition for experiencing specific forms of injury and/or care, which are themselves a product of the ways in which people can and must relate to one another. Thus, a distinction can be made between vulnerability, which names an ambivalent and ambiguous openness to being affected, and precarity, which refers specifically to politically and socially induced forms of vulnerability to harm.

Vulnerability thus also names a condition of relationality. In the context of such vulnerability, *relationality* refers to the formative quality of our relations with others, that is, to the specific ways in which we affect and are affected by one another. To refer to ourselves as relational beings is to afford primacy to the relationships that shape who we are, how we comport ourselves, what we value, and so on, rather than to regard ourselves as primarily individuals defined as free, intentional choosers and free only in our independence from others. Relations of dependency, in which we rely on and need others, are central relations not only at the beginning of our lives but throughout our lives, albeit in ways that often go unacknowledged. The feminist project of challenging gender bias in normative theory initially drew attention to these three dimensions of human life because their association with women and women's stereotypical roles and spheres of activity caused them to be overlooked and devalued. As a project of revaluation, feminist ethical critique held not only that women should not be confined to care work in the private domain, but also that caring for dependents, valuing and sustaining relationships, and being dependent and vulnerable ought to be recognized as unmitigatedly central to all human lives and, thus, valued.

By extending this critique beyond its origins in care ethics, practices and theories that devalue, deny, and/or neglect these features of our existence can be critiqued as enabling ethical error. In particular, devaluations and denials of vulnerability, relationality, and dependence function to splinter these conditions, dividing them between those considered or consigned to occupy them and those who do not (or do not have to). Denying vulnerability, for instance, may most obviously mean ignoring the vulnerability of others, or denying the ethical significance of their vulnerability, or refusing awareness of specific negative kinds of vulnerabilities. Yet denying vulnerability also involves reducing vulnerability's ambiguity and complexity to a merely negative and quasi-inherent condition. Devalued as a condition of being weaker and liable to injury, vulnerability is eschewed in any form and becomes a condition to avoid at all costs and thus a burden to outsource to others to bear. Consequently, denying relationality is not simply denying that one has a relationship to others—although an underappreciation for what counts as a relationship and to whom one is related may be part of denying relationality. Rather, denying relationality means denying the *significance* of that connection and, in particular, its formative quality. To deny relationality means to overlook how who one is and how one lives depend on others. In other words, one's self-definition is intertwined with how one defines others and how others define oneself (Hoagland, 2007; Baldwin, 1998, p. 682). Denying relationality often entails denying dependence—namely, denying that one relies on others and needs them when one in fact does—or

diminishing the significance of that dependence, “backgrounding” those others and their activities (Plumwood, 1993, p. 48).³ Such “backgrounding” is a prime instance of the division of vulnerability, relationality, and dependency that occurs when placing the burden of the (devalued) condition onto those who are marginalized. People may deny dependence in order to maintain the illusion of a valorized independence (and illusions of competence, capability, self-sufficiency, autonomy, and so on) and, thus, often in order to maintain the status quo hierarchy. When people deny dependence and relationality, further stigmatizing those others on whom they are dependent, then it becomes easier to exploit the vulnerability of others—that is, to induce their precarity (Lorey 2015). Neoliberal policies that shift responsibility from public institutions to individuals, emphasizing individual economic maximization and accountability, are the prime mechanism for increasing the precarity of those who are denied the (material and symbolic) resources needed to take such responsibility.

II. VULNERABILITY, RELATIONALITY, AND DEPENDENCE IN THE TIMES OF COVID-19

How has the pandemic brought to the fore experiences of vulnerability, relationality, and dependence, and thus problems linked with devaluing and splintering these conditions? Exposure to a potentially life-threatening virus is a clear instance of vulnerability. It is tempting to regard precautionary measures as efforts to ward off all vulnerability in a misguided display of mastery, but there are more nuanced ways of understanding how vulnerability is at stake in responses to the pandemic. The widespread impact of COVID-19 has made our interdependence—the various ways and the extent to which we all affect one another—much more vivid, drawing attention to the pain of social isolation and to myriad forms of economic interdependence, for instance. Indeed, the basic public-health measures employed to prevent the spread of the virus are premised on recognition of our shared, interdependent existences and of our vulnerability in relation to one another: we have to recognize that we affect one another—for instance, through the very physical medium of the air we breathe in and out—in order to make sense of recommendations that we physically and socially isolate and wear masks.⁴

Yet many of the policies and practices implemented in response to the pandemic deny and divide vulnerability, relationality, and dependence; embrace a neoliberal framework of individual responsibility for risk; and thus amount to a “crisis of care” (The Care Collective, 2020). As much as the measures used to mitigate the spread of the coronavirus are necessary, they exacerbate structural inequalities and distort social relations, thus contributing to inequality in infection and mortality, as well as other adverse effects. Although the pandemic and measures for its mitigation have increased precarity on the whole, they affect people differently in virtue of the preexisting forms of oppression these people experience. People who are exploited and disempowered or who are, in Iris Young’s terminology, “powerless” (Young, 1990, p. 56)—lacking control, authority, and status, especially with respect to their work—are rendered even more powerless, and

their exploitation is deepened. Being unable to control one's working conditions, to maintain autonomy, and to experience a basic level of respect directly affects one's health and life. Denied dependence makes the intensification of exploitation and disempowerment possible. Those who are marginalized—consigned to an “underclass...of social marginality” and “expelled from useful participation in social life” (Young, 1990, p. 53)—are marginalized even more so through isolation and are more likely to experience deprivation (of food and other necessities, of adequate health care, etc.).⁵ Denied relationality further marginalizes those already relegated to the margins of society.

Exploitation and disempowerment have intensified because mitigation measures, which include the social distancing and stay-at-home orders that have led white-collar workers to work from home, rely upon structural economic and social inequality. The ability of middle-class white-collar workers to stay at home depends on the continued labour of low-wage workers (who are disproportionately women and people of colour) who pick produce, slaughter and process animals, deliver food and packages, keep grocery stores open, and maintain public transportation to enable others to get to work, and so on.⁶ In the US, women, Black and Latinx people, and the women of colour at the intersection of those two groups make up the majority of such “essential workers” (Powell, 2020). These workers continue working because they must. Moreover, because their jobs were declared “essential,” they are disqualified for unemployment insurance benefits if they leave their jobs because of safety concerns.⁷ At times they have been required to work, as in the case of workers in slaughterhouses and meat processing facilities, which were ordered to remain open by the Trump administration in April 2020.⁸

Although in the US there has been an effort to acknowledge the work of “essential workers,” it has been minimal and merely symbolic. The phrase “essential workers” refers first and foremost in the popular imagination to medical professionals and occasionally includes grocery workers but few other “essential workers.” The term generally calls to mind hospital doctors and nurses, not the low-paid certified nursing assistants (CNAs) who primarily staff the nursing homes where the coronavirus has run rampant (and who are overwhelmingly women and disproportionately Black women).⁹ The phrase has become the object of shared indignation in response to the disregard that so many workers face from their employers and governments. Sujatha Gidla, a New York City subway conductor, reports that the lack of personal protective equipment (PPE), inadequate facilities for hygiene and social distancing, and failure to provide paid sick and family leave have all led her colleagues to feel that “we are not essential. We are sacrificial” (Gidla, 2020). Food-justice activist Leah Penniman states, “There’s a difference between having our work be declared essential and our lives be declared essential” (Penniman, 2020). By dismissing the label that attributes value to their work, but not to their lives, they reject the structural inequality that allows farm workers, transportation workers, and nursing-home attendants, among so many others, to be taken for granted and backgrounded while being absolutely vital to the persistence of human life in our

society. They call out the denied dependence on which the social and economic status quo depends, and now on which the health and well-being of those who benefit from that status quo (e.g., who can afford to stay at home) depends, and they seek to have their lives valued as much as their work.

Denying dependence is a way of denying relationality and, thus, of enabling the division of vulnerability. In this instance, the vulnerability of most “essential workers” to infection is underestimated or simply neglected. In the early months of the spread of the virus in the US, nonmedical essential workers were regularly denied PPE and told they didn’t need to wear masks. Many teachers now find themselves in a similar position: in many cases, they have been mandated to return to the classroom but with no assurances that they will have PPE or that students will be required to wear masks. Why? Because they—their value and worth—are reduced to their work; their work may be necessary, but as persons they are consigned to the background, devalued. Moreover, their work is valued not because of its inherent value, but because of its instrumental role: it keeps society, reduced in a neoliberal hermeneutic to *the economy*, churning, and so it is the foundation for the continued enrichment of the economic elite. The lives of so-called essential workers are not valued because they are perceived as fungible by policy-makers along with the general public.¹⁰ Denying vulnerability, relationality, and dependence in this way continues the trend of deepening economic inequality.¹¹ Indeed, the US economic recovery has been uneven: economist Raj Chetty has found that the best-paid US workers have “recovered almost all the jobs lost since the start of the pandemic. ‘The recession has essentially ended for high-income individuals’....Meanwhile, the bottom half of American workers represented almost 80% of the jobs still missing” (Steverman 2020).

Whereas denied dependence is at the heart of the increased precarity of disempowered workers, denied relationality is at the core of the increased vulnerability of people who are marginalized. Although they are physically separated from others in society, people confined in prisons,¹² jails, immigration detention centres, nursing homes, and long-term care facilities face high rates of infection. One comprehensive study found that the rate of COVID-19 cases among incarcerated people was 5.5 times higher than among the rest of the population (Saloner, Parish, Ward, 2020). In the US, although only 8 percent of COVID-19 cases have occurred in long-term care facilities, these are responsible for over 40 percent of deaths.¹³ These statistics have also been broken down by race. In testimony before the US Senate Special Committee on Aging, Tamara Konetzka noted that in her study of twelve US states,¹⁴ COVID-19 cases and deaths were twice as likely in “nursing homes with the lowest percent white residents” as they were in “those with the highest percent white residents” (Konetzka, 2020, p. 3).¹⁵ Yet again, vulnerabilities to harm can be attributed to preexisting inequalities. As Konetzka concludes, “the patterns of infections and deaths are not random. Consistent with racial and socioeconomic disparities, ...nursing homes with traditionally underserved populations are bearing the worst outcomes” and reflect the vulnerabilities of neighbourhoods in which they are located (2020, p. 5).

These inequalities are exacerbated and fuelled by a devaluation of dependency in a neoliberal socioeconomic system. The devaluation of dependency includes a devaluation of those who need care *and* of those who perform purportedly unskilled care work (Kittay, 2011, p. 51). Poor pay and working conditions (such as a lack of paid sick leave) for CNAs and nursing-home staff mean that they are compelled come to work, increasing the risk of transmission. Underfunded and understaffed facilities have difficulty maintaining hygienic conditions and adequate care. For instance, staff must often care for both residents who have COVID-19 and those who don't, increasing the risk of transmission. The for-profit status of the majority of such facilities in the US, which is the direct result of neoliberal economic policies, compromises their ability to provide care (Rowan et al., 2020). When residents' needs and care are merely costs to a for-profit institution, the residents are further devalued and marginalized. Even as they are the epicentre of the virus, the cultural devaluation of dependence means that marginalization increases for elderly people and/or people with disabilities in long-term care facilities. The devaluation and stigmatization of dependence licences denied relationality just as it enables the backgrounding of low-income essential care workers. Although these workers may be essential to profit, the lives of workers and residents in these facilities are scarcely recognized as "essential."

Physical separation from others is an obvious mechanism for denying relationality: lacking proximity to others erodes the possibility of relationship, diminishes the significance of existing relationships, and can curtail the responsibilities attached to those relationships. Not having to see or hear others' suffering makes it easier to do nothing to ameliorate it. A conscious denial of relationship occurs most frequently with respect to people who are conceived to be unlike oneself. Distance is not just physical but also psychic, emotional, and intellectual: those incarcerated in prisons and jails and detained in detention centres frequently are already regarded with contempt by others in society. To deny the ethical significance of their vulnerability to the virus is an easy next step: if they are regarded as deserving the punishment of incarceration, as well as the other forms of injury and dehumanization that accompany it, then exposure to the virus may be perceived as yet one more form of appropriate punishment.

Yet people who are marginalized and confined, in whatever form, experience the unique vulnerability that comes from the extremes of both isolation and crowding. In a description of intensive confinement practices, Lisa Guenther notes how "a forced isolation...excludes the possibility of genuine solitude, and...a forced relationality...excludes the possibility of genuine relationships" (2013, p. 147). With respect to the virus, crowded conditions are hotspots for infection, of course, but such "forced relationality" also creates harmful psychological vulnerability; it impedes people's ability to control their movement and contact with others and heightens anxiety about exposure to the virus, especially for those with preexisting respiratory and heart conditions, who are disproportionately represented in prison populations (Hawks, Woolhandler, and McCormick 2020). Social-distancing practices are all but impossible to maintain

within prisons. Social-distancing mandates, however, have meant ceasing any contact with people on the outside, including visitors and educators. Discontinuing educational programs redoubles isolation. Adamu Chan, who is incarcerated at San Quentin State Prison in California, expresses concern about how incarcerated people's attempts to build community and transform themselves have been curtailed: "I worry about people whom society had labeled as violent or wrong and who were actively working to take on new identities and new ways of being. And that's being interrupted now" (2020). So, on the one hand, people are unable to exit crowded conditions, to choose distance, to choose those with whom they come into contact, and, on the other hand, they are forcibly denied the contact and relationships that they have chosen. Although these vulnerabilities are most common in prisons, jails, and detention centres, "forced isolation" and "forced relationality" also characterize the experiences of those in nursing homes, who are deprived of contact with family and friends.

In all these ways and more, the measures taken to prevent the spread of the virus—however reasonable—exacerbate longstanding forms of oppression. Dramatically unequal socioeconomic conditions, inequalities in power and in authority, and vast discrepancies in whose lives are valued by those with power and authority all serve to distribute inequitably the benefits of practices such as social and physical distancing. The practice of maintaining a specified distance from others and the policy of refraining from all but the most necessary in person tasks, for instance, are imposed uniformly. Relatively advantaged people, however, are better positioned to follow them and so to protect their own health and well-being. These kinds of policies also fail to address the underlying inequity: the constraints people face in their choice of contact in the first place. Moreover, the widely enacted practice of working from home entails that white collar workers depend upon the (denied) labour and care work of myriad relatively disadvantaged people for whom social and physical distancing is impossible, impractical, and sometimes even disallowed. Ideas and practices that deny dependence, relationality, and vulnerability facilitate oppression. Such ideas and practices now recur in dominant responses to the coronavirus pandemic. Responsibility for individual and public health, financial stability, and education is assigned to individuals and households while public support is slashed or altogether eliminated.¹⁶ Common responses to the pandemic have sought to maintain the ideology of neoliberal individualism, "center[ing] our attention on individual-level action, culture, or biology and away from the structural causes behind inequality as well as from the need for collective action" (Bonilla-Silva, 2020, p. 7), and to expedite a return to the prepandemic economy. Thus, they continue to sacrifice those upon whom the entire society rests or those whom mainstream society rejects.

III. EQUITY AND SOCIAL HEALTH

None of the foregoing critical analysis is meant to suggest that social and physical distancing and stay-at-home orders are not necessary. Rather, the point is that they are entirely inadequate on their own. They should be rooted in an adequate

ethical framework and accompanied by coordinated policies and practices. An adequate alternative ethical framework—such as that of a feminist ethic—deems dependence, relationality, and vulnerability to be fundamental facets of embodied, social life, facets that are not only unavoidable but also often important and meaningful. Policies and practices that sustain that acknowledgment are ones that support physical health *equitably* but also enable what can be thought of as ethical and social health: the ability to sustain and forge the kind of meaningful, healthy relationships with others that are central to the holistic well-being of individuals and communities. By this definition, ethical and social health would preclude the inequitable protection of physical health.

The coronavirus pandemic has highlighted not only the depths of inequality but also the mutability of habits. It has called for dramatic alterations to people's everyday lives and so reveals the ability to transform habits for the better in intentional ways. Just as people have deliberately formed new habits to protect individual health and the health of the broader public, so we must do so for ethical and social health. Creating habits, practices, and policies that foster ethical and social health amidst the pandemic inevitably involves navigating the ambiguity and ambivalence of vulnerability—namely, the ways in which connecting with others can put people at risk (of physical illness, most obviously) while also being the basis for living well. We cannot eradicate any vulnerability, nor should we aim to do so. Rather, in seeking ethical and social health as concomitants of physical health, we are seeking to eliminate and ameliorate the unjust patterns of vulnerability to harm that follow in the tracks of long-standing forms of oppression.

The domains analyzed above that are sites of injustice—and thus sites demanding justice—are so because of structural practices and institutional policies, which are abetted by personal habits, especially those of relatively advantaged people. The workplace in particular is a site of injustice because people, especially women of colour, are disproportionately affected by the virus because of the work they do, because of the status of that work (as “essential” yet low wage and low status in the social hierarchy), and because of the exploitation and disempowerment they experience through it. Low-wage essential workers are compelled to assume a heightened risk of infection because of the exploitative nature of the labour market, which offers them few alternatives, and because of the disempowering nature of their work, which preclude the kind of autonomy and control over working conditions that could mitigate risk and which may prevent them from taking on the individualized burden of responsibility effectively.

The alternative policies that would remedy these injustices are well known (paid sick time and paid family and medical leave, higher wages, a more equitable healthcare system rather than a multitiered one that benefits those who can pay, etc.). The alternative practices include the effectively anticapitalist practice of valuing both socially and economically the historically devalued, feminized work of caregivers rather than either devaluing it as “producing” nothing or

commodifying it as part of a system that operates for profit at the expense of life and health. That shift in what is valued—from objects and intangible markers of status to actual supportive relations with others—calls for alternative habits. Forming such habits means not allowing social distancing and staying at home to lead to increased isolation, individualism, self-interest, and suspicion. It entails finding meaningful, rather than merely symbolic, ways to enter into supportive relations with others, especially others who are situated differently from oneself and those who seek increased autonomy. The growth of mutual-aid projects, in which people organize in their community to help and support one another in meeting fundamental needs, is evidence of the necessity and meaningfulness of reconfiguring and valuing relationships of support.¹⁷ Finally, it means crafting habits that support low-wage workers, especially care workers and service workers, and people who are marginalized by fighting for the aforementioned changes in practice and policy.

NOTES

- ¹ The subsequent analysis focuses on the situation in the United States because it is the context with which the author is the most familiar, but many aspects of the analysis are just as pertinent to other Western, capitalist societies, as well as to the relationships between these nations and other, less affluent ones.
- ² See Gilson (2021) for an argument to this effect.
- ³ Denial of dependence can, of course, produce actual refusals of assistance, but what I have in mind here is the psychological, cognitive, and affective refusal to recognize that one actually is dependent in various ways and the refusal to recognize the others on whom one is dependent.
- ⁴ Reactionary responses to mitigation and prevention measures thus indicate the opposite—that is, they are other ways in which vulnerability, relationality, and dependence are denied: when people refuse to preserve distance or wear masks, they effectively deny interdependence and relational connection. The chaotic and nearly deranged political context in the US politicized these basic public health measures, with the result that many people refuse to follow them. This choice may seem to be an embrace of risk, but that embrace of risk is actually premised on a denial of vulnerability: those who make this choice claim that the virus isn't that serious and doesn't warrant stay-at-home orders and business closures; they presume the virus isn't that dangerous or presume that they won't contract it or won't fall dangerously ill if they do contract it. In making these presumptions, they deny relationality and dependency (e.g., they deny that they could pass the virus to others), ignoring the myriad factors—health conditions, age, employment contexts and working conditions, etc.—that render others more vulnerable to the virus. This seeming embrace of risk, which is actually a denial of vulnerability and relationality, is made possible by differential precarity and denied dependence (some have to do the work that enables others to continue to shop for groceries, to get needed medical care, etc.). Furthermore, reactionary responses redirect concerns about risk and threat to the public-health measures themselves: masks are interpreted as infringements on constitutional rights; the reopening of businesses and continued economic growth are more important than people's lives and health.
- ⁵ Young's well-known "five faces of oppression" also include cultural imperialism and violence. Although, for reasons of space, I discuss only marginalization, powerlessness, and exploitation here, the other two are equally relevant: exposure to intimate violence in homes, especially for children and women, is exacerbated when people are induced to stay at home, to isolate, or to quarantine. The pernicious stereotyping that is part of cultural imperialism is an easy gambit to scapegoat racialized "others" in a time of fear and risk (in the US, racist rhetoric has involved stereotyping Asian people as carriers of the virus and Latinx people as vectors for transmission).
- ⁶ For empirical evidence indicating that, during the first few weeks of the COVID-19 outbreak in the US, wealthier people were quicker to begin staying at home while poorer people were slower to do so (given pressures to continue working), see Valentino-DeVries, Lu, and Dance 2020.
- ⁷ See <https://www.washingtonpost.com/outlook/2020/05/21/essential-workers-pay-wages-safety-unemployment/>
In what has been termed a "racial justice paradox," Black and Latinx people are also likely to be unemployed (Powell, 2020).
- ⁸ See <https://www.whitehouse.gov/presidential-actions/executive-order-delegating-authority-dpa-respect-food-supply-chain-resources-national-emergency-caused-outbreak-covid-19/>
- ⁹ See https://www.cdc.gov/nchs/data/nnhsd/Estimates/nnas/Estimates_DemoCareer_Tables.pdf#01
Moreover, "of the 5.8 million people working health care jobs that pay less than \$30,000 a year, half are nonwhite and 83 percent are women" (Robertson and Gebeloff, 2020).
- ¹⁰ Tanya Beckford, a CNA at a Connecticut nursing home, states, "the worst thing that I get upset about is hearing the word hero, hero, hero being thrown around for us. And no one is treating us as such. We feel disrespected." Beckford was "on sick leave since April 10 and

[was] still recovering from pneumonia caused by the virus” at the end of May. See <https://time.com/5843893/nursing-homes-workers-coronavirus/>

¹¹ It has become common to speak of “reopening” the economy after stay-at-home orders. This simple phrase highlights the pernicious assumptions that underlie this denial of dependence, relationality, and vulnerability. To “reopen” the economy presumes that it was shuttered, even though many people continued working to enable others to meet their basic needs. The phrase thus devalues the contributions of those who at the same time are deemed “essential,” but so acknowledged (as “essential”) only as background to those whose economic activity is believed to truly matter.

¹² See <https://www.themarshallproject.org/2020/05/01/a-state-by-state-look-at-coronavirus-in-prisons>

¹³ See <https://www.nytimes.com/interactive/2020/us/coronavirus-nursing-homes.html>

¹⁴ Not all US states have collected data that includes race, nor have all states released such data publicly. Konetzka’s research analyzes data from states that have collected and publicly reported it.

¹⁵ *The New York Times* has also reported on these disparities: see <https://www.nytimes.com/article/coronavirus-nursing-homes-racial-disparity.html>

¹⁶ A clear example is the inaction of the US Congress, which allowed the \$600-a-week additional unemployment benefit that was provided through the CARES Act as part of Federal Pandemic Unemployment Compensation program to expire on July 31, 2020. Although many people were excluded from access to the benefit, including immigrants without social security numbers and their citizen spouses and children, it initially enabled over 30 million people to meet their basic needs.

¹⁷ See <https://www.vice.com/en/article/y3mkjv/what-is-mutual-aid-and-how-can-it-help-with-coronavirus> and <https://www.thenation.com/article/society/coronavirus-mutual-aid/> for discussion and examples of mutual-aid projects.

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