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ARTICLE

Pushing through the pandemic portal with care ethics: Possibilities for change

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Abstract
This paper begins with specific articulations of 'care' by three prominent care theorists - Eva Kittay (1999), Joan Tronto (2013), and Maria Puig de la Bellacasa (2017) - to analyze aspects of the Covid-19 reality in the US and in India. The central concern is to explore whether a care analysis of the pandemic can initiate radically different imaginings of 'living with' in a post-Covid world. After examining some roadblocks to adopting the deeply relational nature of life that Covid-19 foregrounded, I explore whether our response to the crises contains an implicit self-refutation of entrenched neoliberal frameworks based on atomized selfhood, individualized responsibility, and the values of market fundamentalism.

Keywords: Care ethics; covid-19; US; India; post-covid world

The threshold

In her April 3, 2020 report on Covid-times, Indian novelist and activist, Arundhati Roy, thinks of pandemics as a portal or 'gateway between one world and the next'. She goes on to explain:

> '(W)e can choose to walk through it, dragging the carcasses of our prejudices and hatred, our avarice, our data banks and dead ideas, our dead rivers and smoky skies behind us. Or we can walk through lightly, with little luggage, ready to imagine another world. And ready to fight for it'. (Roy 2020)

Feminist moral psychologist, Ami Habrin (2016), also sees crises in general as 'tenderizing moments' that help loosen the stranglehold of old conceptual habits. Both Roy and Habrin claim that re-orientation towards the radically new is possible after the disorientation of trauma. But we can choose *different modes* of walking through the portal. So even if a new normal emerges after the pandemic, can we ensure that it is not a 'new barbarism' (Zizek 2020)? Why do we hope that the changes post-pandemic will

not line up with 'disaster capitalism' (Klein 2007) or deeply inequitable policies that could have been forestalled in normal times?

I explore whether feminist care ethical analyses can nudge us towards leaving behind the 'dead rivers and smoky skies' of neo-liberalism and step towards a genuinely different post-Covid-19 world. Joan Tronto (2017) and other care ethicists have long argued for *homines curans* as a replacement to *homo economicus.* But given that the latter structures meaning-making itself, how can a shift away from market fundamentalism be motivated or even be *thinkable* when reacting to a pandemic? So, even if 'there is an alternative' in the care perspective, what resources persuade us to pursue that option?

As iconic of Covid-19 lockdowns, let us begin with two sets of images from two different parts of the globe. The first hit the headlines in US media: the tired faces of nurses and first responders in overcrowded hospitals, the pot banging and horn tooting to celebrate them as 'heroes on the frontlines', the outpouring of donations from the public providing them with food and PPE, and stories of them sleeping in cars and garages to keep their own families safe. The second are scenes from India – not of its overpopulated cities turned into ghost towns, but of hordes of migrant labor either waiting endlessly at train/bus stations in the searing heat or walking back to their villages (sometimes hundreds of kilometers away) after the shutdown.

> (W)ith railway and bus services suspended amid the lockdown, there were few options other than simply packing up and trying to walk the vast distance back home. Many were being sent back from the borders by stick-wielding cops for violating social distancing norms amid the lockdown. Many died during this 'long march'. … Along the way, going without meals and water, some have faced police brutality … In Uttar Pradesh, the police sprayed returning workers with bleach purportedly to disinfect them'. (Basu and Basu 2020: 84)

Juxtaposing these scenarios highlights the tangling of a health disaster with a social and humanitarian crisis. Both are about vulnerability, but of very different kinds. The first reminds us of biological fragility where anyone can be attacked by the virus. The second is a politically induced precarity where some shelter and work from home, even reveling in it as an opportunity for self-enrichment, while others are pushed to the brink of starvation and rendered house-less and open to violence. A care ethical analysis of the entanglement of these corporeal and social vulnerabilities experienced during the pandemic is our starting point.

To build its moral vision, the perspective of care starts with relationships and dependencies that are associated with being human. Our bodies can be 'attacked' by the virus and need care. The 'Covid patient-care worker' nexus is just a specific instance of interdependency required by humans to survive infancy, old age, and sickness. This *relationality* becomes the baseline for rethinking moral and political life in an ethics of care. But what has care taking by hospital workers got to do with the moral horror of migrant workers left helpless in a State shutdown? The latter predicament is not human susceptibility to pathogens but a political oversight in a bid to protect a few. Can 'caring for' as a practice of responding to universal health-needs (the first image) track and neutralize imbalances of power underlying the misery of the walking migrants, instead of simply triggering charitable responses to their suffering? This is

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a question of moral psychology, of political will, and of an epistemology that thinks power and knowledge together. My attempt is to show how the different emphases in articulations of 'care' by Eva Kittay (1999), Joan Tronto (2013), and Maria Puig de la Bellacase (2017) begin to address all three. As a technical notion in the work of feminist theorists, care is not 'a species of sentimental tosh' but becomes a new 'language of justice', asking 'hard questions about rights, institutional obligations, processes and accountability' (Mehta 2020). Sections II, III, and IV highlight different aspects of the pandemic refracted through the care lens used by Kittay, Tronto, and Puig de la Bellacasa. Sections V, VI discuss the systemic transformations these suggest and the blocks to their implementation. Section VII points out a pragmatic self-contradiction in existing neoliberal conceptual structures, foregrounded by our experience of the pandemic. Making this incoherence visible could be a 'tenderizing moment' to bootstrap us into a different liberatory future post-pandemic. But first, let us look at pandemic reality through the slightly different, but complementary, prisms of care used by our theorists.

The lie of 'we are in it together'

A focus on human embodiment undergirding the claim that we are all (equally) dependent on others could well suggest that we are in the same boat regarding susceptibility to the virus. However, care ethics complicates matters. In her early work, Eva Kittay (1999) distinguishes between 'primary/inevitable dependency' of the infant whose very survival depends on a caregiver, and 'secondary dependency' of the caregiver whose attention to the infant *renders* her dependent on (and thereby vulnerable to) others for *her own* wellbeing. Focused on taking care of the infant, the caregiver often is unable to take care of herself. The whole point of feminist care theory is to make institutional interventions addressing these acquired 'secondary dependencies' (of mostly women and other minorities who do care work). We recognize a moral responsibility to respond to dependency needs. But if so, the caregivers' obligation to the young and the sick (that respond to this responsibility) must be extended *analogically* (Kittay 1999: 69) to a responsibility for the caregivers' vulnerability 'which is itself a consequence of her…concern for her charge' (1999: 66). Kittay's justice as *doulia* makes the latter a social responsibility. Reciprocity and equality are filtered through *nested dependencies*: primary (biological) needs are addressed by interpersonal caregiving. But in a just society, those engaged in the latter must be embedded in welfare networks robust enough to address *their* needs arising because of them taking care of primary vulnerabilities of others.

From this point of view, nurses and frontline responders working in hazardous conditions without protective gear is a clear failure of justice. Ethico-political intuitions demanding that the State provide hospital beds for Covid-19 patients *also* require that those giving the care in medical facilities be looked after. The principle of *doulia* establishes that a government's response to safeguard citizens against a virus entails an obligation to also address the precarity of its medical staff taking care of the infected populations. The responsibility to keep citizens safe translated into State policies of social distancing and lockdowns. But *survival* under lockdown further reinforced the networked interdependencies of care. Life while sheltering at home expands Kittay's category of 'dependency workers' to 'essential' workers and includes transit workers,

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sanitation workers, food packaging workers, grocery workers, and postal workers. It became clear that for some to stay at home depended on many others not doing so. And it was also evident that such work though necessary for life, is classed, raced, and low paid. In fact, the uproar to instate testing and safety measures in meat packing companies in the US parallels the outrage of seeing healthcare staff working in make-shift PPE.

In other words, starting from primary vulnerability of all bodies, Kittay's theory moves to dependencies of all 'essential (care) workers' on infrastructure and of their need for social support. *Doulia*-based justice speaks to these secondary vulnerabilities that tend to fall off the radar in the clamor around meeting imminent, primary vulnerabilities. But 'nested-equalities' and 'nested-reciprocity' invoked by *doulia* ensure that attending to biological frailties of all translates into a demand for protective social relationships for all. Inequities in supporting caregivers exacerbate the experience of inevitable human vulnerability itself further disrupting the innocence of primary dependency.

The experience of primary corporeal vulnerabilities therefore, is politically tainted. The pandemic makes it glaringly clear that racism in the US is a health issue. The *New York Times* reported how even a five-star nursing home with a Black clientele is hit harder by deaths than even a one-star White facility (Gebeloff et al. 2020). Since populations with co-morbidities are more susceptible, Black and Latino communities in the US are hit harder by the Corona virus. Systemic poverty does not simply block access to healthcare (a secondary dependency), but the lack of nutrition and long- term neglect of diseases due to lack of insurance make minority bodies more vulnerable to death from the virus. Thus, we enter the portal of Covid-19 with bodies marked by social inequities.

This connection became abundantly clear by mass protests that broke out in American cities after the police murder of a black man, George Floyd, on March 25, 2020. That protestors felt the need to violate life-preserving measures of social distancing to demand better living conditions for Black Americans is telling. Note that on March 13, 2020, Breonna Taylor, an African American medical worker was killed, not by the virus that she was professionally involved in controlling in the hospital, but by a police 'no-knock' raid gone awry: she was gunned down while sleeping (sheltered?) at home in her predominantly Black neighborhood (Michaels 2020). The possibility of death is iconic of primary vulnerability – the starting point for care ethics. For Taylor, this possibility tangled with meanings carried by the color of her skin. What Kimberlé Crenshaw calls the 'unmattering' (2020) of Black *deaths* pits the risk of dying from racist state violence while sheltering at home or the 'stealth victimization of (our) bodies through radical disparities of health and wealth' as higher than or on the same level as exposure to the virus. The different modalities of Black death due to social inequity explains the rationality of public protests in spite of and during social distancing aimed at saving lives. It shows how structural conditions infect the purity of primary dependency at the foundation of care ethics.

'Maybe he did not know about us'

In India, the relation between Covid-19 and political resistance went the other way. The peaceful Shaheen Bagh protests starting in late 2019 and organized primarily by

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women against the State's controversial Citizenship Amendment Act (CAA) were disbanded (India Today 2020). The Corona virus became a convenient excuse to distract from repressive State practices against Muslim minorities. However, defiance of stay-at-home orders as a calculated risk for survival also emerged in India dramatically and differently.

Domestic migrants from rural India come to work in the informal and unorganized sector in the cities, as street vendors, construction workers, security guards, rickshaw pullers, delivery boys, domestic help, and the like. These jobs mostly pay in cash and without formal contracts, leave no paper trail. A large percentage designated 'footloose' move from city to city and site to site without a permanent 'home' in the urban space even though the cheap labor they provide keep Indian cities afloat. When Prime Minister, Narendra Modi, clamped a sudden lockdown on the midnight of March 24, these workers became stranded. Their jobs dried up instantaneously. Without savings they were no longer able to pay rent and had no recourse but to return to their villages. Hundreds congregated in train and bus stations only to realize that public transportation had been halted. In desperation, many began walking back in the scorching heat to their villages that were sometimes hundreds of miles away. Since this was in violation of social distancing orders, they were easy targets for brutal treatment by police enforcing the shutdown. States panicked at the possibility of the disease spreading to rural areas hitherto unaffected and authorities rushed to seal internal borders. Not allowed to go forward, the migrants were housed in cramped, unsanitary facilities that undercut the very point of the lockdown. Even fifty days into the lockdown, local authorities were caught up in partisan bickering without a plan to send the people home safely. Meanwhile the migrants kept walking with many dying of exhaustion. The gendered misery of the exodus was stupefying with pregnant women giving birth unattended on the streets. Ironically, this was in a context where some evacuation flights had been arranged by the Indian government to bring back its citizens stranded abroad.

What is interesting is that this consequence of the lockdown seemed to have taken the State completely by surprise. That something so obvious had not been planned for led one of the migrants interviewed by Arundhati Roy to muse, 'Maybe… he (the Prime Minister) did not know about us. Maybe nobody told him about us'. Such a forgetting stunningly echoes Crenshaw's 'unmattering' of certain deaths in systemic racism. It is true that the constant mobility of these Indian workers makes them hard to track and renders them statistically invisible. Yet, the Economic Survey of India 2017 had estimated interstate migration to be close to 9 million annually between 2011-2016. (Ghosh and Basu Ray Chowdhury 2020: 97). Their presence was certainly not unknown. But when planning the response to the virus, they were simply overlooked in a blatant act of willful ignorance and a staggering systemic amnesia.

Joan Tronto's version of care ethics (2013) articulates this oversight as a direct link between what she terms 'care deficits' and 'democracy deficits'. The neglect of migrants – a not-caring about them – connects to their being excluded from the democratic process and dropping out as *citizens*. Because of being on the move, these groups are not around to vote in their home states and the usual motivation for governments to seek them out is absent. For the same reason, migrants who, by definition, are not at home cannot avail of institutional assistance usually indexed to residency requirements in India. Tronto's 'political notion' of care reads the predicament

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of Indian migrant workers during Covid-19 in terms of their having a relation to the State different from its elite citizenry. This signals failure of the Indian 'caring democracy.'

Addressing the 'democracy deficit' here requires *structural changes* giving migrants access to state power. 'Once a democratic society makes a commitment to the equality of all its members' Tronto says, 'then the ways in which the inequalities of care affect different citizen's capacities to be equal has to be a central part of the society's *political* tasks' (2013: 10). Thus, through the lens of care, needs of migrants move to the heart of democratic discussion alongside its usual concerns with liberty and equality. The migrants' surprise at being 'forgotten' can now signal a political entitlement gesturing to the unacceptability of being within the coercive power of the state but not its care-taking functions. Note that had the government announced clear plans to accommodate their situation (i.e. provided them with immediate cash, shelter, and food), they would not have been driven to aggravate their precarity by fleeing. Ambar Kumar Ghosh and Anusua Basu Ray Chowdhury (2020) rightly worry that the States' care for economic migrants when based on generosity or discretion or even calculations of 'acceptable deaths' is bound to be unreliable. However, Tronto's ethics of care is none of these. It formulates the demand for care 'in terms of the indispensability of the *right* (emphasis mine) to basic requisites for survival' (Ghosh and Basu Ray Chowdhury 2020: 93). The care responses of civil society and various NGOs that stepped in to provide not just food but even hygiene products like sanitary pads for women is recast as a responsibility of the State.

It is interesting that Western care ethics has discussed migrancy in the context of either immigration or 'global care chains' (Weir 2005) where people from poorer countries move across national borders to fill the shortage of care workers in the global North. The unique harms associated with low paid care work done by non-citizens under harsh immigration policies complicate the vulnerabilities or secondary dependencies of care-workers in an international context. Claims that transnational movement of care labor is by 'choice' and comes with some benefits for the migrants themselves only makes the ethical issue more tangled (Kittay 2009). The 'problem' of migrant labor highlighted by the Covid-19 lockdown in India, however, is the different issue of *internal* migration within a nation that must also be addressed by care ethics. The pandemic highlights their thin citizenship status that calls for a political redressal and not charity or sympathy.

The 'war' discourse

Discourses of waging war on the Corona virus as an 'invisible enemy' is problematic on multiple levels. Enemy combatants are killed to win a battle – an odd response to a virus that is not even technically 'alive'. Moreover, the aftermath of wars is often a troubled peace. There is the worry that post Covid-war conditions would absorb digital, online exchanges as the way of life just as past warfare normalized technologies of surveilleance like barbed wire. Social distancing as a strategy to conquer the virus can be weaponized in favor of caste systems, segregations, and pernicious social silos that read contact as contagion. A return to independent individualism as a defense against the virus would make the status of *interpersonal* care in a post-Covid world suspect. However, going against the combat model, recent care ethicist Maria Puig de la

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Bellacasa (2010, 2017) appeals to Donna Haraway's posthumanist relational imaginary of 'staying with the trouble' (of the virus) without getting annihilated by it.

Inspired by the permaculture movement, Puig de la Bellacasa re-articulates this alternative relational ontology. Re-reading the classic Fisher-Tronto definition of care as 'maintaining, continuing and repairing our world' as presupposing entanglement of technoscience, human agency, and naturecultures, Puig de la Bellacasa's care ethics is based on awareness of our connections with more-than-human entities – with plants, animals, air, water, and objects. Nonhuman agencies in the web are there for us to 'live with' and when we 'don't listen to what they are saying, experiencing, needing, the consequences are consequential – as mass extinctions and animal related epidemics testify' (Puig de la Bellacasa 2010: 161). Ethics is now not enacting of specific normative obligations but an open-ended *attentiveness* to our co-becoming with others in the tissue of *bios.* Our 'doings' are always material interventions having consequences for more than ourselves and our kin; but these wider connections, in turn, also transform us. Thus, caring for humans is co-implicated with paying attention to other-than-human agencies, including viruses. From this point of view, human life-styles that have destroyed habitats and forced species into close contact with one another are part of the causal chain of the breakout of zoonotic diseases like Covid-19. 'Living with' various non-human others also introduces 'ecological time' and shifts focus from the short episodic, temporal connections of everyday causality.

Actualization of care is consequently much more than interpersonal childcare or healthcare practices; it points rather to an 'ethos change' that motivates attention to hitherto ignored human-non-human relations. Neglect (non-attentiveness, not-mattering) is the opposite of care, and Puig de la Bellacasa adds 'thinking with' – the epistemic dimension of inter-relationality undergirding a 'living with'. Tied to such an 'obligation of curiosity' (Haraway 2008), Maria Puig de la Bellacasa's 'care' is essentially 'speculative' – an exploration of new ways of co-existence without the certainty of pregiven principles.

This twist to the care perspective casts a unique light on Covid reality. The binary of virus or entities more-than-human, on the one hand, and humans on the other, are rethought as co-implications. The expanded relational framework makes it nonsensical to call the virus a 'Chinese virus' coming from *outside*, just as much as it becomes ridiculous to blame the onset of the disease in India exclusively to a religious gathering of Muslims (Basu and Basu 2020: 87–89). In a networked world, changes in one corner reverberate in another and 'we' are situated in and co-constituted by the 'world' we inhabit. Pandemics urge exploring and experimenting with different configurations of such entanglements with various others. Specifically, attention to a microbial other shifts to our *relations* with both social others and the environment in what is called the One Health approach (Shah 2020).

However, any articulation of a complex network will always ignore some other possibilities and options. Consequently, exploring changes to the relational framework must be accompanied by an epistemic humility or an awareness that what we are working with is not the final say. From the very beginning, the pandemic was shrouded in not-knowing. We were not sure of where it came from, how it travelled, how long it would be active, how and who it would affect. Certain consequences were predicted, but the best way forward to 'live with' it was not known. Yet ethical responses were needed. For Puig de la Bellacasa, care agency must embrace such ignorance;

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our relations change unexpectedly because of the behavior of 'other agencies' which we cannot predict, and require us to be open to continual adaptation. This given-overness to the other in fact now becomes the scientific attitude towards the virus. It is significant that Dr. Anthony Fauci of the US Corona Task Force pushed back on the Government's predetermined resolves to open the economy by insisting that 'you've got to understand that you don't make the timeline, the virus makes the timeline. So you've got to respond, in what you see happen' (LeBlanc 2020).

The relational framing of vulnerabilities

It should be clear from the above three accounts that care theories illuminate different aspects of Covid-reality in different relational terms. But they all expand our circle of responsibilities in various ways, Eva Kittay's *Love's Labor* situates instances of dyadic care (mother-child, nurse-patient nexus) in nested dependencies, thereby including response to needs of 'essential workers' or caregivers who meet primary needs as an ethical imperative. Subsequently, Joan Tronto's *Caring Democracy* positions the democratic state as the outer circle in this network, and articulates democratic citizenship and political responsibility in terms fulfilling the basic care needs that Kittay begins with. The subject matter of political life now changes 'from an abstract set of concerns about 'the economy' (2013: xiii) to discussing why needs of all citizens are not met and asking questions like: Why was expenditure on healthcare essentials (like PPE) a low governmental priority? Why are social services for minorities underfunded? Why is violent policing of Black communities still the norm in the US? Why does a section of workers live hand to mouth in India so that they are sent over the brink by missing a single pay check? Why is government relief administered so as to be inaccessible of this population? Why is the 'work' done by this population overlooked when contract labor abroad was given the means to return home? And why is the state of agricultural economy such that it necessitates internal migrations in the first place? Finally, Puig de la Bellacasa's *Matters of Care* expands the relational web to an ontological scale including other-than-human agencies in naturecultures. This ushers in the relevance of the environment and climate change to our living together and also our epistemic agency of attending to other agencies that could always undercut what we think we know. Questions that now arise are: have human lifestyles that ignore nature made pandemic outbreaks likely? Are there different ways of thinking our connections to non-human agencies in our relational world that avoid this (Shah 2020)? What happens when think of care for humans and for nature as co-constituted?

Thus, we see that 'care' beginning as the interpersonal framework required to survive infancy, sickness, and old age in Kittay moves to democratic deliberations on assigning care responsibilities in Tronto, but ends up being framed ecologically as a manner of situated thinking/knowing/doing in Puig de la Bellacasa. In each of these avatars, it is implicated in a strong sense of social responsibility that go beyond anemic connotations of independent and private choice. Equality of citizenship lies in receiving care, in being able to give care, and having a voice in democratic deliberations determining who gets to care for what and how. These concerns include exploring different configurations of 'living with' and within naturecultures.

However, is hypervisibility of relationality and of different kinds of dependency in the pandemic foregrounded above an automatic step to a 'new world' of care,

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post-Covid? After all, exposure to hitherto ignored needs can be accompanied by knee-jerk treading of old paths in response. In fact, strategies of containment like social distancing and sealing borders that went hand in hand with the spread of the virus reinforced frameworks of individualism and personal responsibility rather than of relationality. The rush to open economies without a clear plan, leaving hospitals to bargain in the marketplace for PPE, calling to civil society to provide food to the migrants, and the government charging them fares for the sporadic transport ultimately made available, all point to the 'normalcy' of some populations being left to their own resources. Stories of people in India demanding that their neighbors who worked in hospitals not come home (for fear of them bringing the virus into their buildings) harks back to the independent atomic subject responding to danger by walling herself from the 'outside' instead of going the way of Puig de la Bellacasa. It should be remembered that *all* societies – including liberal ones – have strategies to deal with human dependency. So the point is to motivate *rejection* of liberal methods instead of simply finetuning them while walking through the pandemic portal. The next section VI, discusses reasons why this does not happen and why we tend to stay with market-solutions to pandemic vulnerabilities. The final Section VII, however, attempts to disrupt that paradigm from within the pandemic experience.

From visibility to denying dependency: shame and 'privileged irresponsibility'

Feminist scholarship helps identify strategies whereby old habits valorizing independence, individualism, and privatization are carried with us as 'luggage' as we move through the pandemic portal.

Tronto's analyses of 'privileged irresponsibility' is one such mechanism. She calls conceptual constructs to shrug off social involvement 'responsibility passes' – two of which were particularly relevant during the pandemic. The first is the *bootstrapping pass* according to which citizens are considered free to negotiate for their needs in the marketplace. The second is the *charity pass* where benevolence and good will of others is presumed to step in and help out when we fail to take care of ourselves. In either case, governments are let off the hook. *Their* irresponsibility morphs into a fault of others: the Indian migrants and Black Americans for not managing their lives better, and of civil institutions and even individuals for not being 'giving' enough.

Another strategy is linked to epistemologies of ignorance (Sullivan and Tuana 2012). An effective way of not doing anything is to *not know* that anything needs to be done exemplified in the impulse of not testing for the virus to avoid confronting its spike. In more specific terms, instincts to preserve status quo are natural for the privileged, leading them to not 'see' needs that call for systemic change and hence, loss of their privilege. Such willful maintaining of ignorance fuels Tronto's 'privileged irresponsibility'. Interestingly, when race protests took over the US in April, middle class and celebrity Indians started posting #BlackLivesMatter on Facebook. The apparent solidarity of Indian elites with Black lives in America, coupled with the former's lack of outrage for home-grown discriminations during the pandemic within India, nuances the phenomenon of privileged/willful ignorance leading to inaction. Disrupting social hierarchy abroad does not endanger privileged *Indians* in the way that speaking for the disenfranchised migrant labor at home would. Similarly, critiquing casteism and communalism in India is simpler for white Americans because it does little to threaten

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their own status within supremacist frameworks. Thus, while the pandemic does 'make visible' different kinds of needs, their 'uptake' is blocked in privileged social locations because of their desire to maintain status quo. Merely bringing vulnerabilities to the forefront as the pandemic does, is therefore, inadequate for change. We need parallel engagements to deconstruct the illusions associated with power.

One could argue that affective forces unleashed by the pandemic can result in political transformation. Retired civil servant, Avay Shukla, mentions deep shame in a series of hard-hitting commentaries on the Indian situation which could well be a stepping stone to mobilizing change. 'I am ashamed of the thought processes of my class', he says,

> …of Whatsapp forwards that oppose any more 'doles' to the hungry millions… . I am ashamed that people like me can encourage the police to beat up the returning hordes for violating the lockdown, which in the ultimate analysis, was meant to protect 'us' from 'them.'… How can one not be ashamed when I hear my peers decrying the expense of trains/buses for returning migrants, the costs of putting them up in quarantine when they approve of their likes being flown back by Air India? This is not double standards, this is bankrupt standards'. (Shukla 2020)

Similarly, when asked by the *Los Angeles Times* for their reasons for protesting racial injustice, some said, 'I am white and I am ashamed and outraged every time a black citizen is killed by a white officer….' and 'I, for one, have never been less proud to be an American than I am today…' (*Los Angeles Times* 2020). One wonders whether the current upsurge of diverse voices against racism can be traced to mainstream America finally feeling some shame about how Black lives have *not* mattered so far.

Now, I have argued (Dalmiya 2016) that shame registers both *commitment* to a normative ideal and the *failure* to have realized it. Shame at elite reactions to the Indian migrant situation or at police brutality of African Americans acknowledges that we find the situations to be *wrong* – which presupposes an implicit commitment that they *ought not to be.* This normative realization can then propel action to fix things and 'right' the wrong. But that said, there is controversy about 'white shame' being a catalyst for institutional justice (Newton 2020; Sullivan 2019). It is said to incline towards self-indulgent paralysis rather than be action-inducing. Besides in the pandemic, *only a few* felt shame. This shows the riskiness of basing necessary social transformation on a wildly contingent base. Thus, in the next section we look at another, more pervasive, emotion – admiration. Referencing Zagzebski's (2017) analysis of it (albeit, in a different context) could help identify a more reliable instigator for transformation in post-Covid times.

The safety net of unsafe caring: failures in the 'old way'

The pandemic did more than make vulnerabilities visible. It also highlighted certain ironies in the way we lived through it. The first image we began the paper with – of stressed out health-care workers – is the disconcerting fact of those valued as 'essential' being left without basic protections. The second scenario of vulnerable Indian migrant workers encapsulated how the very strategy designed to keep citizens safe (the lockdown) led to unsafety – the absurdity of requiring citizens to shelter at home

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without either giving them a safe home or allowing them to reach it. However, the pandemic revealed not only these contradictions, but also a more or less pervasive *admiration* for first responders. Could one build on this admiration to leverage change in a post-Covid world?

My argument is that Corona-times brought out a unique self-refutation in life organized around self-interest, autonomy, and profit-seeking. To spell this out: being silent or 'not talking' is not an incoherent state – it can well be *true.* But to *say* 'I am not talking' presupposes *talking* that does contradict what it attempts to present (that I am not talking). In other words, the states of 'not talking' and '*saying* "I am not talking"' cannot both be true. A similar kind of indirect incoherence became visible in the pandemic. By all counts, first responders were the 'super heroes' of the times. Hospital staff cared for Covid patients under overwhelmingly dire circumstances. And we *admired* them. But such admiration is implicated in extolling a relational selfhood at odds with privatization and its foundational notions of individualism, choice and personal responsibility structuring the neoliberal ethos. Afterall, health care workers in the pandemic were deemed exemplary heroes not because their actions maximized these tropes, but went against them. Thus, admiring them presupposes values 'alternative' to celebrating market values.

Healthcare work during the pandemic could not maintain social distance and, was performed under circumstances of uncertainty, and most importantly, nurses and doctors did not seek out 'responsibility passes' to protect themselves from risk. Doctors did not reject patients because they had 'irresponsibly' become infected nor were they left to the benevolence of others. In fact, over and over again, hospital staff claimed that even though they had not imagined nor 'bargained' to work under these circumstances, what kept them at their posts was a commitment to what they had trained for, i.e., saving lives. Clearly, their *relational* role was deemed important and a responsibility to help when faced with brute vulnerability of patients. The hospital workers' sense of obligation thus came from a certain conception of themselves as being *trained to be ones-caring* or being relational selves. Moreover, healthcare workers never stopped clamoring for PPE for themselves. Thus, what is deemed exemplary here is 'being a certain way' antithetical to liberal subject-hood, but not lauditory of *self-sacrifice.* They in fact echoed the basic care ethical insight that rights are 'what is due to us by virtue of our connection to those with whom we have had and are likely to have relations of care and dependency' (Kittay 1999: 66); and their not being cared-for themselves was registered as a genuine 'democracy deficit' (Tronto 2013) not to be addressed either by the marketplace or charity. What was being pushed for was a systemic overhaul.

In summary, the behavior of care givers in the pandemic and our admiration for them as 'caring persons' shows a commitment to relational selves. In the early days of care ethics, Nel Noddings explained that 'the source of ethical behavior' lay in 'twin sentiments – one that feels directly for the other and one that *feels for and with that best self*, who may accept and sustain the initial feeling rather than reject it' (Noddings 1984: 80, emphasis mine). The first sentiment can be a natural affective response; but the second occurs in response to remembering the first. 'This memory of our own best moments of caring and being cared for sweeps over us as a feeling – as an "I must" – in response to the plight of the other and our conflicting desire to serve our own interests' (1984: 79–80). During the pandemic, the 'best memories' of care are of the labor of

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hospital workers, and this becomes the source of a moral 'I must' for us all, but in a radically different ethos prioritizing relations and responsiveness to need.

I wonder if the spirit of Nodding's point above parallels Linda Zagzebski's (2017) more recent efforts to base moral theory on the basic emotion of *admiration*. According to her, admiration detects the morally good. 'We identify the excellent with the admirable, and we detect the admirable by the experience of admiration' (2017: 2). Accordingly, our admiration of healthcare workers during the pandemic signals their excellence and the affective aspect of the emotion that could motivate behaviors consistent with it. Of course, relying on admiration to reveal an alternative normative value raises questions of trusting our emotions and whether the 'admirable' is always indexed to the 'good'. These remain topics for further inquiry. Our point here is to point out a potential crack in shape-shifting neoliberalism attempting to adapt to the pandemic. The hope is that manipulating this crack could disrupt the existing paradigm from within and help us 'imagine another world' post-pandemic.

In this way then, focusing on the practice of health-care workers in the pandemic (the scenario we began with) can lead us to a different ethical world with lessons for addressing the broader political vulnerabilities of migrant workers (our second image). Remember that care ethics may begin from interpersonal care; but as our analysis shows, the *perspective* of care includes much larger conceptual shifts. But the difficult question is whether and how we can be motivated to leave 'our avarice, our data banks and dead ideas, our dead rivers and smoky skies behind us' and walk lightly into its new world. The answer in a nutshell might be to trust our emotion of admiration that arose from within living with the horror.

Conclusion: on mattering

The notion of care is not innocent. And neither is vulnerability to a virus. Care ethics claims that 'un-mattering' and neglect of dependency relations lead to unmet needs – as it did in the pandemic. Living through Covid-19, however, can be a 'tenderizing moment' that loosens the grip of neoliberalism and becomes an opportunity for transvaluation. It enables us to see what has traditionally not mattered and that hitherto hidden values do matter after all. These *matterings* are what we care about. They are reflected in our affective lives that show our normative commitments and therefore, indicate how we should live differently. By focusing on what came to matter in Covid-times, the pandemic can become a radical resource for transformation.

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