


Biopower under a state of exception: stories of dying and grieving alone during COVID-19 emergency measures

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ABSTRACT

During the COVID-19 pandemic, restrictions for visitors and caregivers in healthcare settings and long-term care (LTC) facilities were enacted in the larger context of public health policies that included physical distancing and shelter-in-place orders. Older persons residing in LTC facilities constituted over half of the mortality statistics across Canada during the first wave of the COVID-19 pandemic. Using the poststructuralist work of Agamben, Foucault and Mbembe we conducted a thematic analysis on news reports. The extracts of media stories presented in our paper suggest that the scholarship on (bio)power and necropolitics is central for understanding the ways the COVID-19 crisis reveals the pragmatic priorities—and the 'health' and political values—that undergird the moral imagination of the public, including the educated classes of advanced Western democracies. Our critical analysis shows that by isolating individuals who were sick, fragile, and biologically and socially vulnerable, undifferentiated population management policies like social distancing, when piled on the structural weakness of health systems, reproduced inequities and risk for those in need of medical care, advocacy, and social companionship in acute moments of illness, death and grief. Considering the unprecedented deployment of governmental power via public health interventions based on social regulation to protect the population during the crisis—how can we understand so much death and suffering among the most vulnerable?

INTRODUCTION

Ariis Knight had cerebral palsy and was unable to communicate directly with the staff at the hospital where she was an ICU patient. Ariis' family, friends and her personal support worker had no access to her when she died on 18 April 2020. Unable to communicate, she died separated from her circle of family and friends, because of hospital policy banning visitors to protect patients, staff and community members from contracting COVID-19. At the time of her death, she was not COVID-19 positive (Browne 2020). Ariis Knight was only one of thousands of patients in hospital settings, and residents in long-term care (LTC) facilities, nursing and retirement homes who died isolated from their loved ones, as a result of mass-scale public health policies to reduce the spread of COVID-19. Unlike Ariis, however, many individuals living in LTC facilities died without access to basic medical care, or the satisfaction of their most basic human needs. As reported by the Canadian military humanitarian

mission on deaths in LTC homes in the province of Ontario (Canada) during the first wave of the pandemic, 'patients died from neglect, not COVID-19 ... all they needed was water and a wipe down' (Howlett 2021). Like Ariis, many of those patients neither lacked social support systems, nor did they express wishes to be left alone at the time of their death (Conway 2014; Guo and Jacelon 2014; Hemati *et al.* 2016). Yet, they died away from their support system, caregivers and loved ones because of weaknesses in the healthcare infrastructure and policies of containment for COVID-19.

In Canada and around the world, restrictions for visitors and caregivers in healthcare settings and LTC facilities were enacted in the larger context of public health policies that included physical distancing and shelter-in-place orders (Ricci 2020; Stall *et al.* 2020; Tanigushi 2020), which have become generally known as 'lockdowns'. When the pandemic initially hit, given the limited scientific knowledge about the virus and the lack of effective treatments, the main objective of public health authorities was to curb the spread of the novel and deadly COVID-19 virus and to mitigate its negative effects on the Canadian healthcare infrastructure, which was unprepared to handle them (Attaran and Houston 2020). To be sure, at a time of scientific uncertainty and with limited human and material resources to assess and respond to the risks posed by the novel coronavirus, these policies were (and still are) reasonable measures intended to control social interactions to break the chains of human-to-human transmission of the virus, thereby reducing its potential morbidity and mortality effects at a population level (Ahmed, Zviedrite, and Uzicanin 2018; Lewnard and Lo 2020; Rashid *et al.* 2015). In other words, these unprecedented measures were deployed for the public good. Seen as such, these measures were universally implemented but their effects have been hardly equitable. They have, in fact, unevenly affected populations in positions of physical and socioeconomic vulnerability (Baral *et al.* 2020; Mishra *et al.* 2020; Okonkwo *et al.* 2020; Pirrie and Agarwal 2021). Here, it is important to remember that principles such as utility and justice, and in a liberal democracy, freedom for individuals' autonomy and for human dignity are central for equitable public health policy. This is so because, in the words of Pellegrino and Thomasma (1988),

involuntary and coercive measures must be undertaken with a clear perception of the dangers they pose to a



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democratic society: loss of personal freedom to choose a lifestyle, dependence on governments to define values and concepts of the good life, and the imposition of cultural homogeneity. Involuntary measures also assume a benign, wise and responsive government—something history finds singularly rare (Pellegrino and Thomasma 1988, 375)

Older persons residing in LTC facilities constituted over 80% of the mortality statistics across Canada during the first wave of the COVID-19 pandemic (Aiello 2020; Canadian Institute for Health Information (CIHI) 2020). As made repeatedly clear in the news reports analysed for this article, this high number of deaths cannot be understood as the direct outcome of viral transmission. Instead, it was the unstable and already ill-equipped healthcare infrastructure and policy vacuums that created risky environments for the elderly in long-term care homes (LTCH) (Gomes 2020; Pirrie and Agarwal 2021; Tanigushi 2020). It is in this context of the combined effects of physical distancing policies and lack of resources (including personal protective equipment (PPE)) that many caregivers learnt only after the fact that their elderly loved ones had died alone, sometimes prematurely due to dehydration and access to medications (Olson 2020). Others had to witness their relatives' last moments via virtual platforms, but only if technologies and supporting staff were available. As a result, many, if not most, families and caregivers were unable to offer physical and emotional support to their loved ones in such profound moments of acute illness, death and grief. The stories of these individuals, their families and caregivers have been presented in the media and constitute the empirical basis for the present interrogation of the politics of dying alone as a result of COVID-19 policies of containment.

This paper is based on a thematic analysis of Canadian media stories describing the harrowing experiences of people who died alone during the COVID-19 pandemic, and the social and emotional effects of such deaths on their circles of care. In what follows, we first briefly discuss the context, in particular the lack of preparedness at all levels of government that contributed to the deaths of so many elderly patients in LTC settings during the COVID-19 pandemic. We then outline the negative effects of social distancing policies and their indirect role to the conditions of undignified dying in LTC facilities, and the ongoing individual and social traumas such conditions of death have caused. To situate these policies and their effects we draw from Foucault and Macey (2003) conceptualisation of biopower, Agamben and Dani (2021) reconceptualisation of this notion as 'bare life', and Mbembe (2003, 2019) concept of necropolitics. We argue that this scholarship offers a framework for understanding the depth of the politics of death, and in particular the politics of 'letting die', made evident during the first wave of the pandemic when a disproportionate number of elderly and frail persons lost their lives (Banerjee 2020; Canadian Institute for Health Information (CIHI) 2020). This framework can help us to raise questions on the ways in which certain persons are discursively, ideologically, politically and clinically positioned as disposable in the context of governmental policy predicated on the generalised public good. In line with Agamben and Dani (2021), our intention here is not to interrogate the science behind 'viral infectivity', nor 'social distancing mandates' (eventually renamed as 'physical distancing'), neither to provide solutions to the crisis; instead, we want to 'interrogate the extremely serious ethical and political consequences that derive' (Agamben and Dani 2021, 26) from such mass scale deployment of public health securitisation of the population at times of crisis.

BACKGROUND

As previously mentioned, older persons residing in LTC facilities constituted over 80% of the mortality statistics across Canada during the first wave of the COVID-19 pandemic (Aiello 2020; Canadian Institute for Health Information (CIHI) 2020). The negative health outcomes of populations residing in LTC institutions cannot be evaluated or understood only in terms of biomedical vulnerabilities to the virus. Instead, negative health outcomes for vulnerable groups need to be understood in terms of a system-level infrastructural weaknesses and lack of public health preparedness to protect and manage population health in situations like COVID-19. For example, due to provincial autonomy in matters of health services, Canada has no national coordination mechanism to collect and manage public health data and infrastructure (Attaran and Houston 2020). Also, while all Canadian citizens and legal residents have access to publicly funded healthcare services, Canada has one of the lowest OECD's hospital infrastructure as reflected in bed capacity (2.5 per 1000 inhabitants in comparison to 2.8 in the USA, 5.8 in France and 8.1 in Germany) (OECD 2020). In terms of LTCH capacity, although there are publicly funded options, the supply has been increasingly privatised under a for-profit model, which has been increasingly dominated by large corporations (Brown 2021). This model has direct effects on the adequacy of care received by residents as the labour force often is characterised by low qualifications, low unionisation, poor job security, unsafe working conditions and low pay (Banerjee *et al.* 2019; Banerjee *et al.* 2021). Perhaps, as a result, LTCH under privatised corporate management experienced up to five times the rates of deaths that municipally funded and run facilities experienced during the first wave of the pandemic (Banerjee 2020; Pue, Westlake, and Jansen 2021).

For residents in LTCH settings, a population at risk due to age and usually affected by chronic and complex health conditions, lack of preparedness, including the non-availability of basic PPE, weak health infrastructures, and the labour conditions under which LTCH personnel operates led to a catastrophic result during the first wave of the COVID-19 pandemic. It is in this context of scarce material resources and political preparedness that social distancing mandates and the *cordon sanitaire* of social isolation, banning visitors in health and LTC settings, can be justified as the central—and perhaps only—policy mechanism/discourse for both prevention and protection of vulnerable groups and the general public. This can be seen in continuous exhortations to 'stay home, stay safe' and 'stay home, stay safe, save lives', which became a mainstay of government officials' narratives (Crowe 2020).

Social distancing measures can be effective mechanisms to avert the rapid spread of infections across geographical areas and populations (Ahmed, Zviedrite, and Uzicanin 2018; Lewnard and Lo 2020). These policies are based on a logic of likelihood of exposure—rather than actual testing of confirmed cases—to manage physical interactions among social groups. In addition, these policies are not harm neutral (Rangel 2020; Rangel *et al.* 2020; Mitropoulos (2021)) and may produce diminishing returns over time in terms of risk management and social costs (Markel, Stern, and Michalsen 2006; Stern and Markel 2009). For example, they are disruptive of productive social and economic activities, including education, and psychosocial connections that are central determinants of health at both population and individual levels (Kawohl and Nordt 2020; Markel, Stern, and Michalsen 2006; Purtle 2020; Stern and Markel 2009). As Mitropoulos (2021) noted, paraphrasing Agamben and Dani (2021):

... lockdowns have encouraged the displacement of risk on to individuals and private households, whose chances of survival become determined by access and connection to infrastructures of care, food, communication and, not least, inherited wealth.

Lockdown policies are also difficult to implement because they require strict regulatory frameworks. These regulatory mechanisms may also grind against human rights concerns, such as freedom of movement and the right to participate in political gatherings, including protests against governments' public health policies (Eliadis 2020; Gostin and Powers 2006; Mykhalovskiy *et al.* 2020; Pellegrino and Thomasma 1988). As a result, they may erode the capacity of individuals to mobilise against degrading conditions, such as experiencing illness and death away from loved ones, or the effects of mass unemployment brought on by widespread business shutdowns, or the negative long-term effects of school closures on students. These public health measures can therefore trigger psychosocial harms across entire populations even if they are well-intentioned (Horton 2020; Poteat *et al.* 2020). As we will see, for older persons, social isolation resulting from physical/social distancing rules can have and did have severe health consequences (Diamantis *et al.* 2020).

THEORETICAL FRAMEWORK

While the cascade of deaths in LTCH homes may have been caused by the disruptive effects of the COVID-19 crisis, it is, as we argue here, the biopolitical order and a value system organised around efficiencies of neoliberal logics, such as the increasing privatisation of these services. These logics, in particular government's defunding of basic services and their subsequent economic liberalisation for profit, underpin 'the generalised instrumentalization of human existence' and the disregard for the dignity and physical well-being of certain 'bodies and populations' (Mbembe 2003, 14). The logics that inform the application of policies whose effects are the neglect of the basic human rights, dignity, well-being and life of the elderly in LTCH settings, and other vulnerable populations, needs interrogation. When we consider the central role of expert-produced, mathematically informed (COVID-19 mortality and morbidity models) and legally enforced (eg, suspending entire sectors of social and economic activities and implementing 'stay-home' orders) mandates for COVID-19 risk management, how can we comprehend so many deaths among the most vulnerable, in particular frail older persons residing in LTCH, and how to understand and address the indecent circumstances of their death? To sketch potential responses we discuss the ways in which COVID-19 policies of 'social control' reveal the innerworkings of biopower and the necropolitical effects of the state of exception during the pandemic.

Biopower

The literature on biopolitics follows the work of Foucault (1990) on the emergence of biopower at the end of the nineteenth century, that is, the transformation of the sovereign power of the state ('take life and let live'), to a regime of government hinging on a new capacity to harness the productive capacities of the population ('make live and let die'). This transformation is a departure—but not necessarily a rupture—from a previous form of sovereign power, the power to kill (Foucault and Macey 2003). Scholars in this diverse tradition (Lemke, Casper, and Moore 2011) have drawn attention to the ways in which techniques of government of the vital processes of the population (including health phenomena) have become intensified and become the main organising principle of the relations between the state and

citizens in advanced Western democracies (Dean 2015; Dean 2010; Rabinow and Rose 2006). This was not an accident, nor was it planned. Instead, this new logic of government can be seen as the result of the assemblage of different forms of scientific knowledge, ranging from advances in statistics, clinical medicine, life sciences, epidemiology, demographics to actuarial techniques for risk calculation within regulatory regimes (Valverde 2007; Barry, Osborne, and Rose 2013; Diprose *et al.* 2008; O'Malley 2000; Roth 2010; Valverde 1996). These advances have made it possible to understand and predict risks to both individuals' and populations' vital and productive potentialities, fostering the production of material and political life.

Biopower is thus a 'politics of life itself' via a capacity of the modern state to protect, promote and enhance the productive and vital strengths of the population to harness its political and economic expansion (Rabinow and Rose 2006). However, this capacity is not unidirectional. In liberal societies, this capacity is predicated on the state's ability to negotiate the tensions between 'self-governing subjects' and the interests of the vitality (economic, political and otherwise) of the nation's population. In this way biopower presents a paradox. On the one hand, it requires the erasing of distinctions among individuals and social groups by approaching them as an *undifferentiated* mass to be managed through rationalising disciplinary processes—a 'man as species' (Foucault and Macey 2003, 243). In this way, the population becomes both a resource and a problem. On the other hand, it requires the atomisation of individuals so that they can responsibly and reflexively engage in risk assessment calculations (Beck 1992; Sørensen and Christiansen 2014) and, as autonomous subjects, individuals self-govern for the well-being of the nation (Rabinow and Rose 2006). This is anatomopolitics, and it is essential for the ultimate accomplishment of biopower in late capitalist societies: the neoliberal and cosmopolitan exhortation to govern and be governed at a distance through direct policies and cultural reframing of citizens' expectations of the state, market institutions and their peers as liberal subjects (Brown 2006; Crawshaw 2012; Rose 1999).

Necropolitics

Whereas Foucault was interested in understanding *power over life*, Mbembe 2003 is concerned with *power over death*. For Mbembe, 'the ultimate expression of sovereignty resides, to a large degree, in the power and the capacity to dictate who may live and who must die' (Mbembe 2003, 11) and by extension, in what manner people are supposed to die. He asserts that 'sovereignty means the capacity to define who matters and who does not, who is disposable and who is not' (Mbembe 2003, 27). Necropolitics ought to be understood as the management of death and its conditions of possibility. This is different from dying under the aegis of informed consent, individual autonomy, proper medical care and dignified conditions versus excluded, uncared for and ignored, as we have seen in the deaths of the elderly in LTCH facilities due to lack of infrastructure and the immediate effects of separation from the advocacy and care of family members. These necropolitical logics reveal that not all lives, and by extension not all deaths, are equal. Death and its conditions of possibility exist in a hierarchy defined by the state and various actors, including experts (such as epidemiologists, healthcare providers, etc).

These concepts are important for understanding how the protection of the population, thought of as a unified whole, is predicated on ignoring (even if unintendedly) the biological and social vulnerabilities of those without value in a regime of vitality

(Rabinow and Rose 2006), and with it, the dignity of individuals. The necropolitical logics of a state of exception lump together the poor, the feeble, the sick, the disabled, the racialised other and the non-citizen together (Mbembe 2003) and predetermine their social value as disposable subjects (Giroux 2006). This de facto social hierarchy produces a dynamic of inclusion and exclusion as the very centre of biopolitical projects in advanced democracies, which have been deeply restructured following neoliberal modes of governance (Brown 2006). In his analysis of the structural conditions that led to the deaths of the poor, racialised, sick and elderly in the aftermath of Hurricane Katrina, Giroux (2006, 2014) argues that:

What many people saw as incompetence or failed national leadership was more than that. Something more systemic and deep-rooted was revealed in the wake of Katrina – namely, that the state no longer provided a safety net for the poor, sick, elderly, and homeless. Instead, it had been transformed into a punishing institution intent on dismantling the welfare state and treating the homeless, unemployed, illiterate, and disabled as dispensable populations to be managed, criminalised, and made to disappear into prisons, ghettos, and the black hole of despair (Giroux 2014, 56).

Giroux (2014) points the *necropolitical* rationalities that undergird the governing logics of the neoliberal state of late capitalism. In a similar way, these logics underwrite expert discourses, policy choices and their unintended by-product in a time of biological viral threat: the indignities of living, dying and grieving under COVID-19 emergency responses.

In fact, it is in permanent states of exception (states of emergency)—which are created through ‘real’ or ‘fictionalised’ enemies (Agamben and Dani 2021, 23); for example, the all-out war against terrorism, or the all-out war against a novel and deadly virus—it is in these moments that necropolitics become most obvious. Such states allow the power of death to suspend life (2003, 2019), and the power of death and its conditions to become normalised. For example, in the context of COVID-19, individual-level vulnerabilities disappear, and the subject is redrawn as part of an undifferentiated ‘at-risk’ population, which becomes a problem that requires the rolling out of public health directives for mass-scale management techniques, via quarantines, stay-home orders and the closure of social spaces (from workplaces and schools to playgrounds, regardless of actual risks of transmission). This also includes the transfer of public funding for vaccine development and acquisition to global for-profit private corporations, the deployment of mass-scale vaccination campaigns by state and private institutions. The individuation of risk, however, can be seen in the articulation of legal and moral imperatives for individuals to protect themselves and others—from themselves and from others, as the enemy is in our midst or even (within) us. These imperatives include physical distancing policies, legally enforceable ‘stay home’ orders, suspension of public gatherings (including political rights to public protests), the dutiful observation of mask wearing (even in public spaces regardless of extremely low-risk exposure), exhortations to have sex via digital platforms and glory-holes (BC Centre for Disease Control (BCCDC)), and the potential production of vaccination passports (Office of the Privacy Commissioner of Canada (OPC) 2021) by each and every member of the population to be able to re-enter ‘public social spaces’ from work and shopping to education and travel as demanded by government and private agents. All of this, to protect lives, both individual and collective, but also to protect weakened public institutions, like hospitals that cannot cope with the demands of the crisis.

This set of policy possibilities was unthinkable in advanced western democracies before COVID-19, which as a living organism, constantly mutates producing new potentially dangerous varieties, which reinvigorates calls for ever-expanding measures of social control. This despite high vaccination rates with highly effective vaccines to prevent the worst outcomes of the virus. These policies become justifiable under the state’s declaration of a state of emergency or, as Agamben and Dani (2021, 26) have noted, a ‘state of exception’. As they discuss in reference to COVID-19 regulations, the distinction between the two is of central importance (*ibid.*, 82–84). Emergency measures are supposed to be transitory and implemented to make possible a return to a previous state, while a state of exception inaugurates a new order because the previous order has fallen (*ibid.*, 56, 82–83). Given that economic imperatives, including previously untouchable areas such as international trade and travel, education, culture, and even politics have been reduced in the all-out war against COVID-19, Agamben’s political critique is worth considering.

According to Agamben, what we are witnessing is a new biopolitical order, which requires the deployment of new rules for economic, cultural and political organisation of entire societies, and which is being established with the assent of educated classes that can safely work and consume at a distance (*ibid.*, 61–62). The biomedical and ethical implications of undignified dying laid out in the news articles presented below suggests that in Western societies something new has occurred in the moral and political imagination underpinning discourses and (in)actions on the part of public health and government actors, biomedical experts and the general public.

METHODOLOGICAL JUSTIFICATION AND DATA SELECTION

National and regional mainline news media, that is, media that attempts to select stories based on an objective assessment of newsworthiness, offers a social archive of significant events in public life, although sifted by editorial teams (Entman 2010; Neiger 2020; Zandberg, Meyers, and Neiger 2012). To be sure, mainline newspapers often adopt editorial styles that reflect the values and political preferences of different groups (eg, liberal or conservative viewpoints) (Amenta *et al.* 2017; Lee Plaisance 2005). Despite these limitations, they offer a window into the distinct experiences, concerns, reactions and values of reporters and their subjects as events unfold. In a moment of global crisis, like the COVID-19 pandemic, mainline news reporting captures material that reflects and informs the experiences of everyday citizens, and sparks debates on policy effects, social accountability and ethics (An and Gower 2009). These everyday debates are of central import for understanding the choices made by policy makers, the role of experts (including public health officers and healthcare professionals), and the concerns of the public at large in a time of crisis. The stories published were presented in mainline news media during the COVID-19 crisis and describe real-life cases of unintended suffering caused because of social isolation policies in healthcare settings. As such, they can help us understand and interrogate the extent of the suffering caused and the forces at play that permitted it.

For this paper, only English media were searched. Utilising the database Factiva we selected two influential Canadian national newspapers and a major regional one: *Globe and Mail*, *National Post* and the *Toronto Star*, respectively. We looked for stories containing the keywords ‘dying alone’ and ‘died alone’ during the period of 1 January 2020 to 30 June 2020. Our search produced 8 results for the *Globe and Mail* (12 total, 4 duplicates), 12 for

the *Toronto Star* (40 total, 28 duplicates) and 2 for the *National Post*. In addition, we used the same criteria to identify text-based news stories reported by the Canadian Broadcasting Corporation (CBC). This process excluded news story that fit the same criteria but were available in video or audio formats on CBC. The search within the CBC database yielded 9 results (10 total, 1 duplicate), for a grand total of 31 stories all sources combined.

Thematic analysis was used to analyse the data captured. Utilising an inductive approach, the authors read all articles, and identified, categorised and organised the main themes via open coding (non-theoretical). The codes were then reorganised by establishing relationships of similarity and difference, and two main themes emerged: (1) *Structural conditions*, identified in 12 stories; (2) *Disenfranchised grief*, identified in 14 stories. The theme labelled 'structural conditions' grouped codes containing elements such as hospital conditions, funding, labour, and so on, while the theme labelled 'dying and grieving alone' contained emotional distress, anger, trauma, and so on. These themes will now be discussed considering the conceptual framework described earlier to flesh out how they relate to the conditions of possibility that generated the medical and political neglect of vulnerable populations in a time of crisis.

RESULTS

Structural conditions

As discussed in the introduction, despite visitor bans, LTC residents remained most vulnerable to the rapid spread of the novel coronavirus during the first and second waves of the pandemic. Elderly patients and residents represented 80% of the total mortality in Canada by 25 May 2020 (Canadian Institute for Health Information (CIHI) 2020). Separated from their circles of care and the advocacy of their loved ones due to long-standing vacuums in emergency preparedness and social isolation policies, a large number of these elderly persons died under conditions that can only accurately be described as undignified. For example, writing about the high mortalities in Quebec nursing homes, Monpetit states

It was understaffed LTC homes that generated the most vivid traumas to date: elderly patients left unattended for hours and dying alone, sometimes in their own filth (Monpetit 2020).

In this rapidly evolving crisis, journalists began to report the gaps in the regulatory frameworks of LTC homes and in the larger public health apparatuses at the levels of the provinces and the federal government, as was later documented by the Auditor General of Canada. With governments unprepared for the crisis, despite clear indications of the vulnerability of the elderly in congregate settings, policy responses at the provincial level, for example, prioritised the safeguarding of human and material resources, such as the utilisation of PPE, via social control measures. The biopolitical logics of this set of public health priorities and measures reorganised material and social relations to warrant the safety of the public but in so doing, contributed to eroding the dignity, safety and health of this vulnerable population. In the words of physicians writing to inform the public on the unfolding tragedy in LTC settings due to their low priority in resource allocation,

Low staffing ratios are so extreme that even basic care is an impossibility, let alone the provision of intense end of life care. There are also shortages in medications like opioids — used to relieve pain and breathlessness at the end-of-life — as the critically low supply is being shunted to acute care hospitals for patients on mechanical ventilators who require sedation ... For months, healthcare systems have inten-

tionally focused efforts on building capacity in the acute care sector to prepare for the potential surge of critically ill COVID-19 patients seen in countries like China and Italy. At the same time, little to no attention was given to expanding and allocating scarce palliative care resources for those individuals who wouldn't have access to critical care, including the majority of Canada's nearly 200 000 nursing home residents (Quinn and Stall 2020).

The historical underfunding of the entire healthcare system or, in the words of Gomes (2020), 'the caring economy' in Canada becomes blindly evident. This reality sheds light on the tensions between the biopolitical logics and their procedural implementation of risk elimination strategies (at the population level), as well as the place that some populations—relegated into obscurity, like the elderly in LTC homes—have come to occupy in the hierarchy of the public health and collective imaginations. Namely, the crisis has revealed, in a dramatic display, the necropolitical effects of the biopolitical logics that undergird the policies that have underfunded health systems to address upsurge demand, LTC facilities and elderly care for decades. The resulting material and moral suffering, even if unintended, seems unjustifiable at least for some; in the words of a palliative care physician,

The objections I have heard to limited physical visits with PPE are around PPE availability and risks to visitors themselves, or to the contacts of visitors afterwards. I understand that if PPE is truly so limited that we must either equip health workers or visitors, that would be a deal breaker. But in Canada, because of our collective action, we are mostly not in this overwhelming dilemma. Most places are conserving PPE, but (are) not this desperately undersupplied. The PPE required would be a very small amount to meet a very profound need. For those who would visit, there is a risk of imperfect application of PPE, especially amidst the tears and emotions that will occur. But with support from healthcare providers, it could still be done in a way that is mostly safe (Bezanson 2020).

In the letter, Dr Bezanson clearly identifies the stakes of the pandemic and the difficult choices that ensue. However, he argues,

I believe restrictions and sacrifices that we require must be proportional to the real risk, both to the individual and the collective. And they must be weighed against the added suffering we are imposing on loved ones and patients who will die separated (ibid).

The argument put forward by this physician is polysemic. The writer attempts to speak in the language of harm reduction and the realities of resource scarcity by recognising that while risks may be very real and high, other values and needs must be weighed. But this kind of logic is disavowed in the discursive order of COVID-19 interventions—where risk elimination is the goal, and where human relationships are reconceptualised as a problem to be transcended to achieve it. This is, in Agamben's terms, exemplar of the procedural administration that structures a continuous state of exception—a state where the values of bourgeois democracy with 'niceties', like right of free movement, assembly or access to one's loved ones at the care of institutions, no longer apply. It is under this state of exception generated by the COVID-19 response that a return to *bare life* is possible—a state where mere survival is prioritised over political and ethical concerns and where as a consequence, certain individuals 'may be killed and yet not sacrificed' without the fear of punishment. This is so because the preservation of 'health'—or, in the case of COVID-19, the avoidance of contagion—becomes 'a juridical obligation that has to be fulfilled at all costs' (Agamben and Dani 2021, 29). This is noted by a journalist when he asserts,

By locking out loved ones, we have placed highly vulnerable patients in solitary confinement – unable to leave their rooms and deprived of social interaction. This torture is not acceptable for prisoners and it's certainly not acceptable for our elders. As a result of forced isolation, many have seen their health decline markedly. Residents of LTC are not only dying of COVID-19, but also dying of neglect. Family caregivers don't only provide essential care. They are watchdogs (Picard 2020).

Picard's words are poignant, as the physical and social isolation of the elderly in LTC homes was done under a *state of exception* in the name of the public good, as well as for the protection of this vulnerable population. Yet, under this state of exception, the ethical implications of such policies were bracketed because political subjectivity has been suspended in the name of the pure survival—bare life (Agamben and Dani 2021, 38). Tensions between the need for physical distancing in the face of COVID-19, and the role that social support plays in patients' well-being have, at this point, been made abundantly clear by scholars and patient advocates who see family members as part of the caregiving team. But even during the acute first wave of COVID-19, this sentiment was captured, for example, in a document by the Canadian Foundation for Healthcare Improvement titled 'Essential Partners in Care: More Than Just a Visitor' and in social media through the hashtag #notjustavisitor. Nevertheless, the pleas of these caregivers and advocates had no place under the necropolitical logics of risk reduction and control enacted in the context of an ever-expanding state of exception. The suffering of those who were separated from their loved ones under the label of 'visitor' reveal a misrecognition of their roles as partners in care, and the moral injuries of healthcare workers that had to witness and even perform the undignified treatment of their patients under the state of exception. In the words of a nurse

"The trauma from that will change you forever," the veteran nurse said. She asked that her name not be used, saying nursing home staff are fired for speaking out. Even with non-COVID deaths, the little traditions that honour a life are gone. Now, death is dehumanised, she said. All residents' bodies are treated the same way under the official directives. Workers bring the gurney to the room, make sure the wheels are locked, the height is right and put the body inside the bag, which is a struggle. Once that is done, workers must wipe the flimsy bag with bleach, their resident inside (Welsh 2020).

As we have seen in the excerpts of media reports presented here, journalists and healthcare professionals provide a clear picture of the disconnection between public discourses that justified lockdowns as a means to protect the vulnerable and structural weaknesses that caused the widespread undignified dying circumstances among LTC residents. This begs the question, paraphrasing both Gomes (2020) and Agamben and Dani (2021, 31): what kind of caring economy and politics of health and ethical order can be built on social distancing principles at a time of crisis? To partially address this question, digital platforms were seen as the bridge to redirect care and companionship via connectivity—but what do we know about the experiences of those whose autonomy and choices were curtailed, and had to witness and grieve the death of their loved ones at a distance?

Dying and grieving alone

The psychological effects of dying and grieving at a 'social' distance cannot be underestimated. Most of the articles describe the traumas caused by such policy framework. The following story from the CBC is but one example:

Jennifer Patrick was terrified of dying alone. The 65-year-old was diagnosed with pulmonary fibrosis nearly 2 years ago. She relied on progressively higher and higher concentrations of oxygen and a few months ago was moved to a Calgary nursing home. Since the diagnosis, Britt Patrick said her mom just kept repeating her fear — "I don't want to die alone" (Rieger 2020).

In the report, we learn that Jennifer Patrick died 2 days after being diagnosed with COVID-19 and that she died in isolation. Britt Patrick, Jennifer's daughter, only had the option of connecting with her dying mother on the phone, but she could not recount/understand their last conversation because her mother's frailty and respiratory difficulties made it challenging for her to speak clearly. Isolation mandates forbade Britt Patrick from being present with her mother during those moments of acute emotional distress. The disconnection and precipitation of the events significantly constrained the family's ability to grieve. The process was particularly difficult for Jennifer Patrick's grandchildren, as described by her daughter:

"They're struggling with it, they're asking, 'When can we go out there? Are we going to the funeral?' They're asking very obvious questions for children that I can't answer and that's frustrating, to not be able to let them know when we can visit Grampy, when we can do these things," she said (ibid).

These questions reflect the disenfranchisement of grief that occurred in Canada's LTC homes and hospitals because of mass scale 'social distancing' policies. The loss of a loved one and the loss of the moral right to be present during death and grieving cannot be considered only as a personal private matter, nor as the inevitable and unintended product of unfortunate circumstances. Instead, it needs to be assessed as a society-level crisis of ethics as it tacitly assented to separate the sick, the vulnerable and the frail from their circles of care with potential wide-ranging consequences. Jennifer's family was not an exception, as succinctly expressed by Moira Walsh from the Toronto Star:

Across Canada, the emotional devastation from COVID-19 will impact a generation of adult children who could not say goodbye to their parents and the front-line workers who stood in for families if they had time. Otherwise, women and men died alone (Welsh 2020).

The emotional devastation described above encompassed more lives than those of the fragile and the elderly dying in isolation and their direct circles of care as we saw in the circumstances of the death of Ariis Knight. Another example is a woman whose young brother died of non-COVID-19 related causes. His sudden death shook a vast network of grief-stricken family members and friends who could not make sense of it. To offer a venue to participate in her brother's final rituals, she had to live-stream the small burial ceremony and manage his friends' emotional distress while trying to deal with her own grief: "I'm doing a live-stream, I can't even be mourning at the actual burial because I'm distracted by trying to share it with the people that can't come," she said (Hristova 2020).

In the same piece, the journalist tells us that "People are dying alone because of physical distancing. Families can't gather to grieve because of the virus" (ibid). He goes on to say, "They can't mourn the way they would want to or in the way a loved one might have wished" (ibid). Based on the articles we analysed, digital tools were generally considered poor substitutes to engage with profound human processes, such as vulnerability, illness, frailty and end of life. As noted by *Toronto Star* columnist Rosie Dimano,

A society with even a shred of kindness must find a more compassionate means of allowing intimate contact between the dying and their anxious loved ones. Saying goodbye is a precious ritual for everyone involved. A Skype, a Zoom, is a poor substitute, often depending on the availability of a personal care worker or sympathetic nurse, themselves over-worked to the bone with coronavirus outbreaks at more than 100 long-term homes across Ontario. The price of fatal contagion is being paid excruciatingly high by our vulnerable elderly. As of Thursday, nearly half of Canada's 1191 coronavirus deaths had occurred in elderly care facilities, far beyond what public health officials had projected (DiManno 2020).

The psychological effects of living, dying and grieving at a distance, even under an abundance of digital platforms for connectivity, may have significant and long-lasting impacts on families and caregivers. Dimanno's observation brings together the ways in which structural conditions, such as limits in the availability—and willingness—of healthcare personnel to substitute the presence and the touch of a dying person's loved ones. In addition, one must interrogate the psychoemotional effects and the social effects of transplanting social relations, including the rituals of death and dying unto virtual spaces. We must ask whether technologies such as smart phones and digital platforms can effectively connect people in processes of acute illness, dying and grief—when bodies and minds are fragile, and the senses of the ill person may be declining. We must interrogate whether people, regardless of cognitive state, emotional distress, education, age and socioeconomic status, can and should make the space to develop the necessary technological dexterity and social skills required and demanded from neoliberal subjects (Brown 2006) for effective connectivity to replace co-presence in real time and space. In Agamben's discussion of the ethical and political effects of lockdowns in Italy (2021, 18), he mirrors all the elements of disenfranchised grief described above.

The dead—our dead—have no right to a funeral, and it is unclear what happens to the bodies of the people we love. Our neighbour has been cancelled, and it is surprising that the churches are keeping quiet on this. What are the human relationships becoming, in a country that has resigned itself to the idea of living like this for the foreseeable future? And what is a society that values nothing more than survival?

For some, Agamben's ideas can be seen as subversive. Ultimately, most of us suspended the richness of our day-to-day relationships by transposing them unto digital spaces not only to protect ourselves, but mainly—and sometimes solely—to protect the most vulnerable among us. We did not want to be a vector of contagion in a moment when treatments and cures were not available and under conditions of scarcity of contact tracing technologies, testing mechanisms and PPE, and low health systems' upsurge capacity. Still, Agamben's questions are vividly poignant and necessary (even if controversial) considering the abundance and the indignity of the deaths of the elderly and frail individuals—particularly since we knew early in the pandemic that they were the most vulnerable to the effects of COVID-19.

Discussion and conclusion

Social distancing policies were implemented to protect all of us from potential contagion and the cascade effects of such spread on healthcare systems and individuals' well-being. Scaled-down versions of these policies, like selective schools and workplace closures, have shown effectiveness in reducing the spread of respiratory conditions for short periods of time. However, the COVID-19 crisis was not a short-term event (and we can fully appreciate it now), and different versions of mass scale social

distancing mandates, including legally enforceable stay home orders have been in place for months at a time affecting the long-term financial and psychosocial well-being of children and vulnerable workers. Furthermore, the mass scale implementation of these types of measures did not consider the actual differences in terms of risk exposure across population groups, and individual-level biological and social vulnerabilities, which were known since the early days of the epidemic. By isolating individuals who were sick, fragile, and biologically and socially vulnerable, undifferentiated population management policies like social distancing, when piled on the structural weakness of health systems, reproduced inequities and risk for those in need of medical care, advocacy and social companionship in acute moments of illness, death and grief.

Considering the unprecedented deployment of governmental power via public health interventions based on social regulation (regulation of movement, closure of borders, income subsidies, etc) to protect the population during the crisis—how can we understand so much death and suffering among the most vulnerable? The snippets of media stories presented here suggest that the scholarship on biopower is central for understanding the ways the COVID-19 crisis reveals the pragmatic priorities—and the 'health' and political values—that undergird the moral imagination of the public, including the educated classes of advanced Western democracies. The stories, though surprisingly few considering the thousands of deaths in LTC facilities during this time, nonetheless show that governments and the public knew the humanitarian emergency underway in LTC facilities located in Toronto, Montreal, Vancouver and other large Canadian cities. Yet, mass scale protests against this humanitarian emergency were non-existent—even as groups of relatives of the isolated elderly protested outside of LTC facilities and clamoured for public support and government action. It should also be noted that calling this situation a humanitarian emergency is not exaggeration, as shown by the fact that the Canadian military had to eventually intervene and provide care following the political pressure exercised by advocates and family members of residents in LTC facilities in the face of mounting deaths.

Therefore, as argued by Giorgio Agamben, COVID-19 can be understood as a state of exception and, as such, it reveals the necropolitical effects of the contradictions of the neoliberal order. On the one hand, we can see the effects of decades of defunding of health systems and public institutions, the privatisation of care and the deepening of self-responsibilisation for risk management undertaken by neoliberal forms of citizenship (Brown 2006; Cristian Rangel and Adam 2014). On the other, we see the exercise of sovereignty to determine the lives worth saving and those condemned to die. Here we must recall that Mbembe (2003) goes beyond biopower to account for how, in our contemporary world, 'weapons are deployed in the interest of maximum destruction of persons and the creation of death-worlds, new and unique forms of social existence in which vast populations are subjected to conditions of life conferring on them the status of living dead' (pp. 39–40). His point is that some people already exist in different states that lie somewhere between life and death.

It's important to highlight, as argued elsewhere (author's own 2020), that these public health interventions are being advocated and implemented not just by political actors but by an assortment of healthcare professionals and biomedical scientists working with the state, universities, science advisory boards and healthcare facilities. This is of central import because: (1) Despite vaccinations, COVID-19 may become an endemic condition with mutations that may pose further risks for differently resourced

populations, and (2) As the global public becomes more aware of events that may emerge in different locales soon due to population mobility and climate change, similar calls for measures of social control to manage risks may be normalised. Therefore, we must take stock of the stories of those who were left behind or negatively affected by the current risk thinking, its biopolitical imperatives and its production of bare life as endured by the most vulnerable in society. To be sure, while resource management is essential at a time of crisis, the moral imperative to do no harm—both physical and moral—must be recentred among healthcare professionals in charge of designing policy for emergency management.

Public health scholarship that draws from harm reduction frameworks, although mostly focused on the specifics of drug use and sexually transmitted infections, could offer a way for public health professionals and other biomedical experts to understand the dangers of ‘all-out war’ cognitive frameworks and discourses when managing novel diseases, including those of viral nature. From harm reduction in HIV, for instance, we have learnt that viral infections do not land on generalised bodies occupying equal social spaces (Denis-Lalonde, Lind, and Estefan 2019). Instead, they can be neatly mapped on the contours of syndemic factors, which include biological risk profiles and the social policies that reproduce poverty, stigma and the marginalised of vulnerable social groups. In those cases, strategies that reduce risks of infections and their resulting medical and social harms, rely on accepting health risks as recalcitrant realities of human social life that can be managed, but not eradicated—in a search for a disease-free human futurity—even in increasingly biomedicalised health worlds (Crath, Rangel, and Gaubinger 2021). Equally important, they provide frameworks for working directly with the communities most affected, taking seriously their priorities, and the development of peer networks of care, support and advocacy (Shotwell 2020). To be clear, biomedical experts, public health officers, politicians and the media already have a vast body of work that draws from the literatures on harm reduction, syndemics and the historical lessons of the HIV crisis. We humbly suggest that they offer an alternative to a necropolitical order, for more democratic politics of human dignity and health at times of crisis.

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