Interview with Two Anarchist Nurses in New Orleans

CrimethInc.

8th April 2020

Clara: This is Clara with the Ex-Worker, and I'm really excited today to be speaking with two radical nurses on the frontlines of the struggle against COVID–19, Vi and Sasha. Could y'all introduce yourselves and tell us a little bit about the situations that you're in?

VI: Yeah, thanks for having us so much. I'm Vi; I am a nurse in New Orleans. I work at a Level I Trauma Center in the emergency room, which means that I am typically in situations where people are in pretty bad accidents or need emergency care at the highest level that can be offered in the city. I've been working there for about two and a half years, and now we're kind of in the center of this COVID outbreak, so that's what we'll be talking about.

SASHA: And I'm Sasha. I am a med-surg nurse at a Level I Trauma Center in New Orleans, and the floor I work on is usually mostly focused on infectious disease, like AIDS, MRSA, TB. Most of my patients are usually pretty stable and just need things like IV antibiotics or certain kinds of monitoring. But now, during this crisis, since just two weeks ago we have transitioned to being the COVID–19 floor. So when someone in the emergency room sees someone with COVID–19 and they need hospitalization, but they're not in critical condition but still need to be monitored or given oxygen, they come to me.

Clara: Well, I have to say, I am so grateful to y'all for the work that you're doing and so reassured to know that there are radical people who are on the frontlines of this crisis. So, since me and many, many of our listeners are just stressed out by the ambiguous flow of information, trying know what to trust and what's going on, I wanted to start off just by asking a little bit of fact-checking/myth-busting about the medical situation. Since y'all have had the opportunity to see things up close, can you tell us, in a nutshell, what do you think is the most important medical information that everyday people need to know about the pandemic? Are there things that people are freaking out about that they really don't need to be? Or on the other hand, things that people should be more careful or conscientious about that we're not paying as much attention to?

VI: Yeah, I think that's a really, really good place to start, and I'm excited to bounce off of each other on this with Sasha. I think we have a lot of thoughts about this, especially as people who have lives outside of being nurses. And I would say that one of the hardest parts about this, sifting through this information, is that unfortunately a lot the directives that are coming from the CDC, which is the Center for Disease Control, from the World Health Organization—which are not benevolent, neutral organizations that we generally want to just immediately fall in line with. But unfortunately in this situation, a lot of the directives coming out of public health centers along with the state at large—which I would say are around social distancing, social isolation, quarantining, these terms that we're becoming more familiar with. I will say, first off, they are the only way to minimize the full extent of how widespread this virus could be, and I think that part is not a conspiracy. And I think you've probably at this point heard a lot about this term 'flattening the curve', and that is largely a term that comes out of a public health discourse in order to not overwhelm hospitals so that people get sick at a slower rate so that hospitals can take care of them, which generally increases the survival rate in pandemics. So it's not a term that means that this won't affect less people; it means, how will our healthcare systems be less overwhelmed so that more people will survive? It's a little confusing, and I think I would say that largely the

recommendations to be extremely cautious about your daily movements in a situation with a virus that's this contagious is really a good option and a good way to think about it.

One thing that complicates that or makes it something that people can think about based on their own lives is that, unfortunately, in a lot of situations in our country and I think especially in subcultures, a lot of people do not live in multigenerational homes or communities, and a lot of people don't live with folks who are immunocompromised. And so I think sometimes there are situations where people exist in communities that are actually relatively insulated from the severity of the illnesses—though I wish that we did live in super-rich, multigenerational communities with people with all different sorts of health conditions and problems. And so I think sometimes there are communities or pockets of people who are relatively insulated who might be able to have a little bit more mobility, that we can talk about later, about strategically what that would mean. But I think that for folks who do live in multigenerational communities, who do live around folks who are immunocompromised, there really can't be any downplay on how important it is to be really, really careful about one's daily movements. Because every day we're finding out how truly contagious this virus is, and also we're learning that while the majority of people who contract it have mild cases or even asymptomatic cases, meaning they don't show that they are sick, this is still an ongoing situation and the virus is changing, and it changes based on location and based on populations of people. And so there's still a lot of information we don't have.

But I'll pause and see what our friend Sasha has to say about it.

SASHA: Yes… sorry, I was taking notes while you were talking. I think one of the biggest things that we have to acknowledge is that there's a lot of misinformation coming from the centers of information that we as nurses are used to relying on for the latest evidence. I think a lot of my friends or people in the community don't even realize what exactly we do as nurses, and one of those things that we do specialize in is we are infection control professionals, basically. We're taught a lot of things in school, and we're constantly keeping up on the research and implementing it where we work, but a lot of those guidelines that we rely on come from places like the Center for Disease Control, which is run by the US government, and a lot of that information now we're realizing pretty quickly—we're so used to taking that information for granted as being based on science, and now it's becoming really clear that it's based on politics. It's kind of a mindfuck to think about how the institution that we're supposed to rely on for scientific research on how to prevent infection is actually politically constructed by whoever is in the government. So we're seeing so much information coming from the CDC that is actually not based on evidence; it's based on working with the realities of what supplies are. As nurses, people are looking to us for advice on what is actually effective in preventing the spread of this infection, and the truth is we still don't know because we're in an early stage of this pandemic. And also the information that we're so used to relying on is becoming really clear that it is very politically tainted with people whose interests are just keeping society going, based on what is actually going to prevent people from panicking or what is actually going to allow healthcare workers to feel like they can keep doing their jobs safely. Things such as wearing bandanas as a form of mask to prevent you from getting the infection while you're working—that is something that the CDC has been recommending with no evidence. So we're kind of in the dark as much as a lot of

other people, I think, although we do have things to base it off of: prior epidemics that are similar.

VI: Yeah, I think you bring up some really good points and contradictions, and that's kind of what I was trying to get at with saying that these are not benevolent or neutral organizations, the CDC and the World Health Organization, or even your local health department. They all are operating off by constantly readjusting this algorithm based on: what are the labor demands of the places that they're offering advice on? Who are the populations? What is the profit motive? Who is elected on these boards? Who's in charge? There's this kind of invisible calculation going on that we really don't have much access to about how these recommendations get made.

And I will say, in terms of myth-busting, I think two things we could offer, because there's so much we could say about the politics of information right now, but two things I think we could walk away being very clear about, one Sasha brought up, and the other I'll bring up. One is that in the absence of any access to masks, clearly anything that covers your face from another person's face is going to be a form of harm reduction for contracting a virus that largely spreads through droplets (which are things that leave your mouth when you're talking, coughing, or emitting any kind of fluid). But we know from the fact that a lot of places in the world have never had access to masks, and a lot of studies have been done there—for instance, there's been some studies done in Vietnam in different healthcare settings with people who only have access to fabric masks, which are like a lot of these homemade ones people are making, and the difference between that and a surgical mask or medical masks. And the percentages are pretty significant. So on average a cloth mask is going to protect you from around 44% of droplets and particulates, and a surgical mask is going to go up starting in the sixtieth percentile, and then goes higher based on the quality of the mask. So clearly something is better than nothing, although when we're talking about people on the frontlines, we shouldn't be settling for just something—and that's a different topic. But in terms of people who need to protect themselves going out into the world, yes, a cloth mask could be acceptable. But you need to be thinking about how often you're washing it and sterilizing it, i.e. as much as possible. And then secondly, what kind of situation are you going into, and is that the most appropriate protection you have for yourself?

Another thing we're seeing a lot of is—and again, I get it, people are scared and people want to feel like there's a barrier between them and this invisible world that they feel like could hurt them—gloves are only useful if you're wearing gloves and you're not touching yourself or really anything else that's contaminated. So, if you touch yourself or anything that could be contaminated, you have to immediately change your pair of gloves. That's why we have handwashing, right? Frequent handwashing is to deal with the fact that we're constantly touching things, so we need to be constantly washing our hands. So when people wear gloves and then they play on their cell phones, or they open a door, or they touch their face, anything else they touch is now potentially going to transmit that. And if they're touching their face, they're not protecting themselves at all. It's something that now we're seeing more of because it makes people feel better, but you actually still have to use the same logic you do with your hands; you need to be changing those gloves as frequently as you should be washing your hands.

SASHA: Absolutely, and there's a couple points I want to raise off of that. One is that I'm noticing that in a lot of the discourse among my friends and communities that people are forgetting about one of the most important anarchist healthcare technologies that we have, which is harm reduction. People are thinking that it's either you're completely perfect and doing everything right, or this kind of nihilism where you're not doing anything at all, and I think most of us live in the gray area. And I think that we can't stop living our lives, we can't stop seeing our people when we need to see them. We can't stop going to the store. And we need to be okay with that, the fact that we're going to not be perfectly isolated individuals because that's not how we live. And we need to take steps to reduce the harm of our interaction with others during this pandemic. Part of that is for me being better about what Vi was talking about, hand washing and being mindful of secretions from your face that you produce, covering your cough.

Part of what I've been noticing about people having this kind of all-or-nothing mindset to spreading the infection is this kind of fetishization of protective equipment, or what we in healthcare call PPE, personal protective equipment. People are kind of using masks all the time, without really knowing what kind of masks are good for what. And people are using gloves all the time without acknowledging the fact that you're just creating another surface for bacteria and viruses to accumulate. As opposed to less sexy interventions that we have to prevent infection, like hand washing and covering your cough. I see people, even in mutual aid projects that I've been involved with here, people saying you have to use gloves at all times at every point in the process when you're doing anything that might come into contact with others. That just creates a false sense of security in terms of gloves just being another surface for pathogens to accumulate on. And also, because, as Vi was saying, since if you're truly using gloves correctly, you have to change them really often—you're possibly going to make the situation worse in terms of leading to shortages of this personal protective equipment that healthcare workers need on the frontlines. So, I think that one of the biggest ways that we can reduce the harm of our social interactions that we just have to keep on engaging in in order to survive is to do these less sexy interventions like hand washing and covering your cough, as opposed to wearing masks or wearing gloves all the time. Because those are just ways to feel like you're doing something and to look like you're doing something, when actually, if you look at the actual science of how things spread, you're not actually helping anything and could possibly be making things worse.

One last thing I want to talk about in terms of myths and facts about how this spreads is our perception of the restrictions on people gathering in groups and socializing with each other. This is one of the first times where we have anarchists and anti-authoritarians that care about preventing the spread of this virus really heeding and sometimes actively promoting these rules put in place by governments about gathering in groups. There's a lot of social shaming about people interacting in public or getting together in groups. One thing I want to say about that goes back to harm reduction is that it's inevitable that we're going to have to come into contact with other people throughout this. This is going to last for months, and were going to have to come into contact with other people. We do need to try to avoid as much as possible our interaction in groups and interaction with others, but it's going to happen anyway, and we have to acknowledge that and be at peace with that and take other

steps to prevent spreading infection when we do end up doing that. Again, I can't emphasize enough how important the idea of harm reduction is to that.

Secondly, something that I've been struggling with and I've been noticing: someone posted a meme that said, "How bad can this be? Anarchists are urging people to obey the government!" And then I saw a riff off of that meme where someone was like, actually, no, there's a difference between *expertise* and *authority*. What anarchists are urging people to do is to respect the expertise of people who know about infection control, not necessarily to respect the restrictions of the government. That's something I think we need to think really hard about. It really sucks to be in a position to tell other people what to do about how to live their life, but what we could do is recommend things and encourage people to follow them as much as possible while still acknowledging people are going to break that all the time and not reacting in a state-like manner when people don't do that: not social shaming people, not calling 311 or calling the police on people when they are interacting in groups in public. Yeah, that's just something I've been thinking a lot about: the difference between authority and control versus expertise and harm reduction.

Clara: I'm really glad that you brought up that distinction because it gets at something I've been thinking about a lot in the last few weeks, where, as an anarchist, myself and most people that I know have an intuitive and often very well-founded suspicion of the state, the government, the corporate media, etc. So I know a lot of people's initial reactions has been to distrust, to not believe what we're being told, what we've been told to do. Just like, this is a smokescreen for rising authoritarianism and fascism, etc. And the problem is that it's not necessarily *not* that, but also…

What I have often seen in the communities that I've been a part of is a rejection of authority, but there being a sort of vacuum of expertise that's untainted by authority to fill that gap. So what ends up happening is people trusting in really just kind of, anything that promises a solution for a health issue or whatever that doesn't seem to be tainted with the same sort of associations with the state or corporate media or corporate medicine or whatever. And so I want to see if we can explore this a little bit more, I'm curious: how do we as anarchists, as people who admire and at times even fetishize rebellion, disobedience, these sorts of values that in non-pandemic circumstances, we want to really foreground—how do we balance these challenges around distrust of authority but also this need for expertise to be able to survive a situation like this?

SASHA: Something I want to interject about that, it's a metaphor I've been thinking about lately: We don't want to throw the baby out with the bathwater, but we also don't want to drink the bathwater because of the baby. [laughter] Meaning, just because a lot of expertise about how to prevent infection does involve telling people what to do, that doesn't mean we want to stop telling people how to be safe. But at the same time, we don't want to be just uncritically absorbing every kind of admonition from experts about how to be safe because, as we've been talking about, all that stuff is political.

VI: I think this is kind of the central contradiction. I'm not surprised that we launched straight into this because I think this is what is on everyone's mind—well, I shouldn't say everyone, I mean, I'm kind of taking leaps with the general imagined audience of The Ex-Worker. But I do think we need to think about kind of a balance of our practices of intuition,

of how we know how to take care of ourselves and each other, and balance that with the fact that we really have not dealt with a kind of widespread pandemic in our lifetimes since the beginning of the AIDS epidemic (which I definitely identify, and which many people will identify as a plague). I do really think of these moments as plagues, and as plagues that have hit different people at different times in ways that really illuminate the most fundamental contradictions of society. I think we do need to be looking a lot to our elders; we still have elders who survived the Spanish flu, we have elders that survived different outbreaks at different times around the world, and we still have elders who survived the beginning of the AIDS epidemic in this country. This literally is a novel virus, which just means new. That's why you hear novel, novel, novel; it just means new, right? And I think a lot about how if you took some photos of what it looks like for us to be approaching our patients right now—I know nurses who lived through the first two or three waves of the AIDS epidemic in this country, and they talk about how similar it felt in terms of this extreme unknown, and at some times completely overdoing it with protection. We know the ways in which people were made to feel like lepers during that epidemic, and that is happening now, for sure. I cannot stress how isolating it is to be afflicted with this virus right now and to be on the frontlines taking care of people. It is a horrible feeling to be alone in a room suffering, to not be able to have a visitor, and for every single person you interact with to be covered in multiple layers—well, if they're lucky enough to have access to that equipment—to show up in that. And it is not how we want to work. Generally, nurses are people of touch and of a kind of connection to the human and to the body. We don't want to be in these kind of alien NASA hazmat suits, but we are realizing that we're dying if we don't have them and also we could kill other people if we don't have them because we can infect someone else. So I'm kind of going on this tangent to give you the sense of how dire it is when you really are in a situation where you're caring for people who definitely or we have a really high suspicion have this virus and need immediate care. And so to realize that some people around you are going to the full extent that they can while also still going into massive rooms of people who have this virus and individual rooms of people who are dying from this, doing the best they can to protect themselves and their other patients; and so when we come home, we are also doing our best to protect ourselves and to protect the people we live with, but we do need to give each other some grace and some care.

We cannot become and internalize a kind of hypochondriacal individualist mindset where everyone is a vector and any interaction could be contagion. That is a *pathologic* way of thinking that will reinforce the kind of world that every capitalist and eugenicist and fucking statist that controls these things would love to see play out. I'm sorry because I'm not giving a solution to this, but I think my solution is a little bit of patience and grace as we figure out the right ways to take care of ourselves in this, but also to be really mindful of how we make strangers and loved ones feel about their own bodies and about their own interactions during this time. I don't think this is a time of shame. I think this is a time of collectively checking in about the best information we have and what are the best practices we can make for ourselves, for our houses, for our affinity groups. It's actually a time of collectivity in these decisions, because there's such a massive onslaught of information, and the only way that we can do this is if we check in together and try to bounce off of each other the

best information we have that makes sense for where you're at and what kinds of risks and what kinds of interactions you and your loved ones need to have to survive.

SASHA: I think it's so important to be talking about AIDS in regards to this. A lot of people have been saying that it's inappropriate to compare this to the AIDS crisis; but when you compare things, you're looking at similarities as well as the differences. And I think it's really important as far as talking about dispelling myths and facts that we recognize that we are still in the point with Coronavirus where people during the AIDS epidemic were when they were calling it GRID—gay-related immune deficiency. That's how little we know about it. We're still having to deal with bodies piling up, just like they were at that time. There's still so much we don't know, and I think that's really important to recognize.

I also think that the whole thing that Vi was talking about, about the ways people were stigmatized during that time for being vectors of the virus is kind of parallel to now, when I was talking about harm reduction and victim-blaming. People during the AIDS crisis were being blamed for the death of their own community by doing things like having promiscuous sex. And now we're seeing the same thing where people are being blamed for going to funerals for loved ones who have died from this, or people are being blamed for just living their life, and I think it's really important to acknowledge the parallels between that.

And the way we deal with these patients that do have to be in isolation for their own good or for the good of their community puts us as nurses in kind of a really weird, almost cop kind of role that makes me really uncomfortable, in that we are restricting people's freedom in order to protect the rest of our community. We have to keep people in these isolation rooms and tell them they can't have any visitors, and we are encountering them with all sorts of PPE on, and it's very dehumanizing for them, and people sometimes want to leave. And we often can't stop them, which I don't think we should necessarily. But I think it's really important to consider the balance between protecting the community and also protecting people's individual freedom that we as nurses are really on the frontlines of.

Clara: Yeah. I wanted to come back to this question of negotiating risk within affinity groups, households, etc. One way that anarchists have initially responded to the COVID–19 crisis is to think about some of the structures and logics of anarchist organization that we rely on for other things—around affinity groups, around security culture, and so forth—as tools that we could apply for survival, medical and social survival, in a pandemic. I'm curious from y'all's perspective on the frontlines, do you have any insights about how these kinds of anarchist frameworks might (or potentially might not) be useful to us as we're trying to organize, to reduce harm, to minimize risk, and to be able to continue to live our lives and to resist and while maintaining connections and as much health and safety as we can?

VI: I really like that question. I've been trying to think about how the concept of the affinity group, which I feel like maybe would be cool for us to just elaborate. The way I understand an affinity group is a small—there's never been really a number to it in my mind, but I would say maybe three to seven—group of people who all share some kind of common beliefs and interests and ideas of action, of how to operate in a situation that could be potentially really dangerous. That could mean potential for state repression or potential for arrest, or it could even mean a very life-threatening situation. There have been these kind of magic numbers thrown around from epidemiologists, from public health officials—"groups less

than ten, groups less than ten." And I'm like: hmm, you know, some of us do know how to work really efficiently in smaller groups to get really monumental tasks done.

I think that this is a time for affinity groups. I don't believe this is a time for strict social isolation. I believe this is a time where we could really relearn and flourish in smaller operating groups of people who have already shared a lot of overlapping risks, whether that be they live in the same house, or a group of people that were doing a lot of things together as this outbreak came about and so have already shared a lot of space that puts them in similar risks. It could be coworkers that have come together that realize that they're going to be in and out of the same risks together. I think it gives an interesting model for how to operate still having a sociality within quarantine. Rather than breaking off in your home or at work as an individual and being like, well, I just have to do what's best for myself, it gives us an opportunity to experiment: what would it be like to link up with a few people who I share really similar risks with and also share some beliefs with, or have a working relationship to feel like I know how to make decisions with, to break down some of that isolation?

I've been experimenting with this a little bit at work, where I've been with nurses and doctors in moments of breakdown, where they're really, really in conflict with whether or not they can fulfill an assignment that they need to do or take care of a patient they need to take care of. When we get down to the heart of it, I hear things like, "Well, you know, at the end of the day, no one's looking out for me, so I just have to look out for myself." In that moment—I mean this might really sound cheesy, but I just say, "I'm looking out for you, and I really care about you. How could we work together, or how can we find the people we need to so we can still take care of this person, or we can make this situation safer, or you can feel less alone?" I think doing that also when we see our friends struggling is really important, like when we see people just having this total breakdown around, can I even go to the store? Or can I do this thing? Can I do mutual aid work? Is that too risky? Using that model of breaking down isolation.

I do actually think that this is a time where, when we have events or when we organize something, we should be trying as much as possible for people to be self-organizing within the groups that they're already quarantined with. Those groups can be talking to each other through the means that we have, rather than having a really big neighborhood meeting because you want to get together your neighbors and you bring everyone together—that is really not a good idea right now to do that. So what are the ways that we could really encourage people within their households or within their little groups to organize together so that we can communicate amongst those groups? And I do think we have a lot of that experience, and I think this is just a fantastic way to overlay that model of organizing that has many, many decades of experience, that actually really lines up with some of the ways we know to reduce transmission at this time.

SASHA: While you were saying all that, Vi, I was literally walking to my corner store to buy a pack of cigarettes. In terms of talking about anarchist technologies that can help us through this, I will reiterate that I think harm reduction is absolutely crucial. A lot of us know harm reduction as a way to help people that use drugs to do so more safely, or ways to not shame people who do sketchy things like, you know, unprotected sex. Instead, be like, "Okay, you're going to do this kind of sketchy thing because you're a human that likes to

live their life and have fun. But what are ways instead of being like, you're a terrible person and kind of casting you out, to be like, okay, you can still do this sketchy thing and still be a part of our community? Here are some other things that you can do to reduce the harm that you're doing to yourself and your community while still living your life." I think it's really crucial to recognize how important that is, both as an anarchist technology that preserves the freedom of the individual within the community, but also as something that really does have proven track records in reducing things like infections. Because when you tell someone that if you don't do this one thing, whether it be not doing drugs, not having unprotected sex, or not social distancing—if you don't do this one thing, then you're an asshole, an antisocial miscreant that is part of the problem—if you tell people that, then they're just going to have a nihilist attitude about everything. Whereas if you acknowledge people's humanity and existence and allow for that, and also provide tools that people can use to reduce the harm of that, you're going to have a lot more people on board with the overall strategy of stopping the bad thing, and you're going to preserve people's freedom at the same time. And we just have mountains of evidence that harm reduction is actually way more effective in stopping blood-borne illnesses among drug users than just telling people not to use drugs, and I think the same thing can be true for stopping the spread of this pandemic. If we give people tools to adapt to their own individual circumstances how they can prevent spreading epidemic as opposed to just telling people to do this one-size-fits-all thing.

The second thing, in terms of what are some anarchist tools that we can use to fight this: I don't have a word for this, but I think a lot of anarchists have kind of a critical literacy of the power that is involved in all forms of knowledge. Everything that we're told is true comes from somewhere and someone that has an interest in something. I think our ability to kind of assess that and kind of almost pick and choose different strategies depending on the situation is really important. Taking strategies and practices and ideas from lots of different traditions is something we're so used to doing. I think that's really important, and I think it's something we can continue to do as people that are fighting this crisis. We're not indebted to any particular authority or institution about anyone's particular approach to fighting this. We can be flexible and pick and choose different tactics and strategies that work for us, and I think that's something that we're going to have to keep on doing if we're going to fight this. We have to learn from lots of different struggles and people from different ideologies and not be totally adherent to any one of those but kind of just pick and choose what works for us and what is in line with our values. Does that make sense?

Clara: Oh yeah, absolutely. Speaking of anarchist technologies for fighting this crisis, obviously, the term mutual aid network has been totally trending recently. Everyone from Ocasio-Cortez to all sorts of media figures are talking about them. So there's been lots of discussion about mutual aid around food, household goods, childcare, emotional support, etc. From y'all's perspective as healthcare workers, what sorts of mutual aid initiatives do you think would be critical for people to undertake to support health in particular? Obviously there are some things that we need really specialized skills around. Are there things that you can think of that anyone can do regardless of their skills or background? Or are there types of specialized skills that you think we should be collectively prioritizing to network to make sure that we have access to?

VI: Oh, I mean, there is so much we can do. There is so much everyone can do. As it relates to health particularly—I mean, I'm not interested in making distinctions between all of the kinds of ways we reproduce life and health, like obviously these are all interconnected. But I think that there are some really simple ways that mutual aid projects that are related to food and food systems, which I see a lot going on, to rent strikes, to labor struggles, can also be supporting people who might fall very sick to this illness, or also maybe help prevent that.

One of the small things that I've been experimenting with and I know some other comrades have is a model that is given to us also from harm reduction and Narcan trainings. Narcan is the shorthand or kind of brand of Naloxone, which is an opiate reversal, for someone who's had an overdose from an opiate, which could be anything from heroin to a pill that has opiates in it to fentanyl-laced drugs. It's an injection that you can give into a muscle, or if there is an IV established you could give it through the vein, or you can give it through the nose, and that's the trainings that people do for that reversal agent.

I do think this is a time where we could be learning about the body systems that are most affected by this virus and some simple clues—especially for people doing mutual aid like food delivery or prescription delivery—ways to clue in to see if someone is in distress. That does not require someone who is a medic or even EMT trained, let alone is an active healthcare worker. But there are some ways that I would encourage healthcare workers and medics who are trained in their communities to reach out to mutual aid groups and do some basic trainings on recognizing someone who is in respiratory distress. There are models for that. We teach people, regular people who have no absolutely no background in healthcare how to recognize if someone is not breathing from an overdose and administer a drug that's a shot. That's a pretty complicated situation that has been proven to save thousands and thousands and thousands, at this point probably millions of lives, right? And it's a training that's very reproducible and is really easy to teach without jargon, is really easy to teach to multiple ages of people, multiple levels of literacy of people.

So I think in this situation, though it's not as cut and dry as an overdose, there's ways that we could be on the lookout for people who, especially as this time goes on and mutual aid networks start gaining ground, of people whose health is declining and could need intervention. That's something that could really be shared, and that doesn't require you knowing the life cycle of a virus, or obviously it's not going to require you even knowing how to do any kind of assisted respirations, you know, helping someone breathe, as much as just knowing, oh, I saw this person yesterday and I see them today and they seem to not be doing as well, and what are some signs to look out for? I feel like that is something that should be more common knowledge in general, about people whose breathing is getting more difficult.

I also think we cannot underplay how important it is that if people do not have access to food, especially to food that nourishes the body, and if people do not have access to ways of relieving stress, and ways of surviving capitalism, like not having to pay rent and being able to survive without their jobs—that is our most at-risk population, people who are struggling to make rent every month, people who are struggling to make it to their jobs because they're already sick. So those are indispensable to people's survival during this. So I see anyone

right now who's working to support their neighbors, community members, strangers, for rent strike, and are producing food systems that capitalists and our cities and states refuse to provide for us, that is absolutely 100% indispensable to survival. Because if people can't eat and people are going to work sick, I guarantee they are the people I'm going to be seeing in the hospital with the worst outcomes.

SASHA: Yeah, Vi really took the words right out of my mouth in terms of mutual aid in terms of health. One of the biggest problems with our Western medicine system that we're trained in is that it isolates health in terms of just biophysical processes that can be helped with medicine or surgery. What we're really seeing now is how crucial the whole person is and their community is to their health. Honestly, I am concerned for the minority of people that are infected with COVID–19 for their ability to breathe on their own, but I'm actually more concerned for the vast majority of people who won't ever have those complications for how they're going to survive the shutdown of society as we know it. We live in a city, New Orleans, where the majority of people who live here became unemployed overnight, and I'm really concerned how that's going to affect people's health. People not being able to get food, people not being able to keep their housing—that's going to affect people's health. When we're talking about mutual aid, we have to talk about how to support people in dealing with the collapse of our capitalist economy, how people are going to just do the basic things like feed and house themselves. So mutual aid about those things is incredibly crucial to people's health.

I also think that we need to democratize health knowledge, as Vi was saying. So many of the things that we're trained in as nurses are things that you can teach yourself. There's this whole mystique about it that you have to be educated on it. But I'm going to tell you right now, half of everyone I know that's a nurse learned half of what they know from YouTube videos that anyone can look up, things about how to stop the spread of infection or things about how to recognize someone's respiratory status overall and when you need to get them to a hospital. In terms of mutual aid things that healthcare workers can be doing, I think that we can be demystifying a lot of this stuff and teaching people that it's not that complicated, a lot of the things that we do, and helping people understand their own power and their own intuition of when someone's not doing well—recognizing that infection control is not rocket science. You don't need fancy equipment all the time to stop the spread of infection. I think more healthcare workers should be spreading that knowledge to people about how they can empower themselves to look out for other people who aren't doing well and also use the wealth of knowledge that is available for free on the internet about how to protect people around them.

VI: I'd be happy to debate this with someone who thinks this is "too risky", but, you know, I have a different concept of risk given the work I do. If you're delivering food to an elderly person who you're in communication with regularly about food deliveries, one great way to know how they're doing is whether or not they can make it to the front door and open the front door to get those groceries. I think that there's some really good logic for doing no-contact deliveries. But at the same time, there's a safe way to stand at the bottom of someone's stoop or away and just see: is this person able to get to the door to get their groceries? Or is there some system in place that if people choose, they would like a wellness check—not

a wellness check in the sense that someone needs to come with supplies to take a blood pressure or whatever, but just to know, hey, when we do the delivery today, we'd love to just see you, and we can wave to the front door. I think people have been so terrified of spreading and transmitting things, which comes from a really, really good place of wanting to protect people. But at the same time, and I want to say this very carefully because I don't want to alarm people, in New Orleans right now, there's a massive percentage of people who are not making it to the hospital. Every day, we are getting more and more calls from paramedics who are showing up and people have already passed. Those people are often elderly folks that live alone whose families can only check on them every now and then. Their families are doing the best to keep an eye on them and check on them, but we all know this is one of the most tragic aspects of this horrific society that we live in that has no plans for people as they age, right? Families do their best to scrape by and take care of their elders, but we don't have a system to support anyone taking care of their elders. So this is what happens: old people live alone, and they die alone. This is what we're seeing. This is an illness that largely affects the elderly. And I cannot stress how important it is that this is the time to reach out in your neighborhoods, in your communities, if you're doing mutual aid, to think about who are the elders in this population? Is anyone able to check on them? What is a safe way we can check on them? It does not mean you have to go inside that home. But again, this is the moment that social isolation and quarantine is telling you, don't leave your house. Well, what about people that can't even make it to the phone or to the door to pick up support because they're declining and no one knows?

We can't solve all of the problems that our society has posed us with, but I would encourage people to think beyond just this idea of in order to do the least harm with mutual aid, I have to drop something and then run away, and if a door opens I might contaminate someone. No, what are ways that we could actually be incorporating just checking on our neighbors? It's something simple as, when I take my walks every day now, I ask my neighbors, how are you feeling? A lot of my neighbors know I'm a nurse, and frequently I will get someone who'll be like, "Honestly, the baby actually has a fever right now and I'm really freaked out. What do you think I should do?" These are things that we can help people with, or at least just be an ear to break down that isolation. So I just urge people to just not be so caught up in their head that they're not medical experts. Obviously, don't give advice that you're not prepared to give. But you can reach out, you probably know someone. Worst-case scenario, you could help someone call an ambulance. I just think that we can't be too afraid to do some basic human things like check on the people that live around us.

SASHA: Just to add to that, speaking of democratizing knowledge about how to tell if someone's doing okay: yes, whether or not someone can make it to the door is a great indicator if they're having a hard time. Another thing that people don't even realize that they can do to assess if someone's having a hard time with this is you can call them on the phone. If they can't finish a sentence without getting out of breath, they are basically in respiratory distress and might need to go to the hospital soon. Things like that, things that you kind of know intuitively where someone's not doing well: that's half of what we do all the time as nurses.

And just to echo what Vi was saying about people doing mutual aid projects fearing spreading infection: you have to realize that if we don't do this mutual aid work, people are just going to end up going out anyway to get their needs met. They're going to go out to the supermarket if no one brings them something. People become so afraid of spreading a virus by bringing people food, for example, but it goes back to what I've been saying this whole time, it's harm reduction. You could take every step you can to prevent spreading any pathogens, but if you let the fear of doing that stop you from providing crucial mutual aid, people are just going to go out and live their life anyway and put themselves at more risk. I think it's a lot more risky for an older person to have to go to the grocery store to get their food than if someone drops them a package that maybe wasn't sanitized 100% perfectly.

Clara: Can y'all tell us a little bit about the situation in New Orleans, where you are right now? We've been hearing these nightmare stories about the ways that nurses and healthcare workers are being mistreated in the places where they work, about lack of key equipment and all these sorts of things. How is the infrastructure holding up? What are the most urgent things that y'all need? And are there kinds of support that folks who are not working in healthcare can offer to y'all—in terms of safety, in terms of labor negotiation, in terms of anything with your conditions?

VI: Thanks for asking that. And I'm interested to talk about Sasha's response because we might differ on this, which would be exciting because you know, The Ex-Worker loves a good healthy dose of debate. But the question of resources and infrastructure right now is truly a day-to-day situation. We never know really what we're walking into and how much equipment we're going to have access to until we get to work because the numbers change all the time, the rumors fly. It's also a matter of how many patients are coming into the hospital each day, which is changing drastically. So, I would say, a lot of people have reached out to me and I know a lot of other healthcare workers about masks in particular because they're reading that healthcare workers don't have enough access to N95 masks, which are those turquoise masks that you see that are for airborne precautions, and airborne precautions are to protect against pathogens like bacteria or viruses that can travel through the air in much smaller form than a droplet. The side note to that is that there's a lot of debate in the virology/pathogen community about how to classify coronavirus because it kind of exists between droplet and airborne. So the jury is still out on that one, which is why the safest thing for frontline workers is to be able to have access to these airborne masks, right, because we don't totally know yet all the routes of transmission. Or, we know the routes of transmission. We don't totally know yet where to draw the line between this droplet/airborne discussion.

So, my position on that is that if you cannot provide numbers of masks to healthcare workers in the hundreds, let alone the thousands, that I am not going to hoard masks and wear them when my coworkers and comrades cannot wear them. So for me in the emergency room, it's all or nothing: we all get masks, or none of us get masks. I'm not going to wear a mask when my fellow worker does not have a mask. So, we need numbers so high that frequently I would say if you have a cache of masks under twenty, I would look at who in your immediate community needs them the most. Now, we're starting to get resources because of how incredible people are at gathering resources, who are finding ways to crowdsource or fundraise mask numbers much higher, that could go to like a local health-

care place. But you know, I'm at the place where, if me and my coworkers don't have masks to go into rooms with patients who are extremely critically ill that we know have this virus, we have a much bigger problem on our hands than whether or not we're going to get a mask that day. Like, we have some serious decisions to make about how we're going to handle that situation and we have to do that together. And having a handful of masks that someone sent out of love is not going to solve that problem, if that makes sense.

So my feeling is that we have to recognize ourselves as workers and as human beings who are capable of dying in this process, and we have to decide together at work what our limits are, at the same time that we fulfill the fact that we have taken an oath, whether it's just to ourselves, to protect our patients and to try to keep our patients alive to the best of our abilities. So I would say, if you have access to masks in the hundreds, please get in touch with people doing frontline healthcare work; especially don't forget the paramedics, the EMTs, who are out there frequently with way less equipment than we are. But if you just have a few, I would say think about who in your community could use them: who's immunocompromised, who's elderly, who's doing mutual aid work who could use those masks.

SASHA: Yes. So, to answer your question about what the situation's like in New Orleans: in terms of the epidemic, we've known for weeks now that the spread of the virus here and the mortality, the death rate from the virus here, is really outpacing anywhere in the world. We are really bracing ourselves, I think, this coming week or two for the healthcare system to be totally overwhelmed, for there to be a lot of deaths. A lot of that is attributed to Mardi Gras, thinking that people from all over the world, including places that were already hit hard by the virus, were all here in the city and then all of us were rubbing shoulders with them and sharing drinks and other things with them the whole time. So in terms of the numbers, we're really seeing the number of new infections and the way people are dealing with those infections is really kind of outpacing other parts of the world, which is really scary.

In terms of what support we need to deal with that, I will echo what Vi said. The shortage of PPE, or personal protective equipment, is really kind of universal across hospitals and even across regions in the United States and the world. Because of that, I think the response to that shortage really has to be systemic and not individualized. I've personally been getting a little overwhelmed with how many people are offering me their own personal mask supplies and things like that, and people not really fully knowing what exactly we need. I am honestly not that concerned about my own health in dealing with this. I personally think that I have probably already been exposed to it and am pretty much an asymptomatic person, but I am really concerned about my coworkers who are maybe older or have more health conditions or are pregnant or have family members that they live with who are older. I'm really concerned about the janitorial staff that has to clean every room between every patient, who are often immigrants, who aren't trained at all in terms of what the risks are, who don't know anything about this virus and just really feel scared about even cleaning a room. And they should be scared, because they haven't been properly trained or educated on what's actually going on. That really slows down our ability to care for more patients, if we can't get the rooms ready in time for new patients to come up because there hasn't been

any training or education of the people that do the really basic, material work that needs to be done to get these rooms ready for patients.

So I agree that the individualized support in terms of people offering masks and things is often kind of unhelpful, as are things like food. You should see the situation in my break room right now. Every shift we come on, there's just tons of food donated by local restaurants. Which is good, but it's literally piling up in our break room. We don't have enough room in our refrigerator for it. It really is like a symbol for the individual, "thought and prayers" response to a really systemic problem.

I think what we really need is a systemic solution, and for me that is increasing worker militancy. The people that are closest to the problem are closest to the solution. And I think if frontline healthcare workers such as nurses and patient care techs and janitors were more included in the discussion of what the preparation and the response to this would look like, we would be seeing a lot more efficacy in people being protected, and we would be seeing less people dying, ultimately. Because when frontline workers don't feel prepared to deal with this, it slows things down, and there's delays in people being cared for.

What I personally need is, I know that in our radical milieu there's a lot of people with organizing experience, who have organized in really different and weird conditions. I think that there's a lot of frontline healthcare workers that just need basic "Organizing 101" support, like how to organize your coworkers. I'm not the biggest fan of organized labor necessarily, because I think labor unions create their own kind of authority and bureaucracy. But a lot of people don't even realize that you can organize in your workplace and help shift people's consciousness to recognize their own power just by talking to people, and you don't need necessarily a union to do that. I think that really the only way we're going to address the things that we need, like PPE shortages and staffing and safety, is if we get the thousands of kind of ordinary people that are on the frontline of this more oriented and educated about how they can come together and fight the administrations, fight the management, and have more of a voice.

VI: And I do want to say something very blatant about the condition in New Orleans, which is that, particularly in the hospital kind of environments that Sasha and I are in—we don't work in an elite, private healthcare institution. We are in a safety net hospital in the heart of a predominantly Black and predominantly impoverished city. That is the reality of New Orleans. Our hospital is the only hospital that cannot turn away any patients. And the predominant population of people that are being affected by this virus and are coming in and having the worst outcomes are poor, Black New Orleanians, straight up; there is no other way around it. You know, media loves to paint this virus as this kind of classless, post-racial virus. It's like, "It's affecting young people, old people, white people, Black people. It knows no…" You know, I've seen these insane headlines that talk about how that's why people should be so afraid of this, because they can't go back to somehow looking at the historical conditions of society as to who's going to be affected by it. That's fucking bullshit. We know who is having the worst outcomes in this virus, and it is devastating. I feel like there's not enough discussion going on right now about the intersections between race and class in this virus; it's absolutely inescapable for me and what I see day to day. Yes, a bunch of old, rich, white people are also going to die from this, and that is a reality, but in terms of the

highest toll in suffering and in terms of the younger people that are suffering the most, there is absolutely an inescapable direct line in terms of race and class in the city.

So in terms of what we need, we need the toppling of white supremacist capitalist society that creates the conditions to where we have a reproduction of a crisis the city is no stranger to. Of seemingly a "natural disaster" and who is affected most by it. This is not new for this city. Part of the reason that I'm so grateful and proud to work in the setting that I work in is that I work around a lot of people—especially around a bunch of women and under a lot of leadership of Black and brown women and men who are doctors and nurses who survived Katrina and led hospitals through the crisis of that—who have been prepared for this, for something like this to happen. So I also just want to say that, because there's a lot of people who are working really hard who have been prepared for this, who are working in spite of dismal conditions that the healthcare institutions and the city and state have provided us within. I'm incredibly proud of the people that I work alongside, and I think that I am absolutely indebted to the knowledge of people's survival in this city, and that is the reason that I'm able to provide the nursing care that I am is because of the caliber of my coworkers I'm surrounded by.

SASHA: That being said, our coworkers' families are dying from this. On my floor the other day, we just had a nurse die. Not one of my coworkers, but someone that worked at another area hospital. It really shook everybody to their core to see a nurse that was providing frontline care—who had some other health conditions, but was not really old—die right in front of us. So yes, healthcare workers are dying. And I think that it's really taking a toll on people, and people are just going to stop showing up for work. They already have. So until we get better protections and people that are coordinating the response to this taking this more seriously and letting us know what the plan is. We still have yet to see any management where I'm at really acknowledge the severity of what's going to happen or prepare us for it. We're still being kept in the dark about all of that. I think if we had more of a collective, organized voice to demand that, then we would be seeing more preparation—from these people, by the way, that make many times the wage that we do. The CEO of our hospital makes a million dollars a year, straight up. And people who have advanced degrees in preparing for this exact thing, who have yet to even dignify us with any kind of plan or anything, really, besides occasional emails that are hard to decipher. I think that we could demand better and we could get better preparation for all of this if we had more of a collective voice.

Clara: Speaking of destroying the white supremacist, capitalist society that is responsible for all these terrible health outcomes stratified along all these lines… This crisis is really bringing up these huge questions for me about the relationship between the various societies we envision and healthcare. I've been thinking about the way that healthcare kind of occupies this strange role where on the one hand, it's cited as a reason why utopian visions for a horizontal, non-capitalist society could never work because we need the kind of complexity and very capital-intensive forms of care that people often need. But on the other hand, the profit-driven U.S. healthcare system is often pointed to in the U.S. and around the world as an example of how capitalist healthcare is fatal to so many people. So there's this contradictory or pulling-in-opposite-directions situation of, on the one hand, it seeming

unrealistic to have a utopian vision, and on the other hand, the current vision we have being totally inadequate and oppressive—which leaves us in this place of stasis or inaction. And thinking about that as an anarchist, I also feel like the contemporary political conversations even before the viral outbreak about healthcare have often kind of been stuck in another unhelpful binary, between on the one hand this neoliberal nightmare that we currently live in of private health insurance and fuck the poor, or on the other hand this sort of Obamacare vision of big government and total dependence on the state and bureaucracy and stuff. It's so frustrating to try to wade through these contradictions as an anarchist and come up with some sort of transformative vision. So, I'd really love to hear any thoughts that y'all have about how we can break out of these binaries and what a more transformative vision of health and care could look like in a future society.

SASHA: I haven't heard a whole lot of people use the need for high tech healthcare as a way to dismiss utopian visions. I mean, I hear a lot of more conservative people saying, oh, well we have the best healthcare in the world because it's privatized and capitalist—I don't engage with those people very often. But what they're missing is the fact that when you actually look at our health outcomes, we are way behind countries and societies where more basic community health perspectives are more emphasized, kind of what I was talking about before. If everyone has a place to live and healthy food to eat, then they likely won't ever need to get some sort of crazy surgeries or be on a ventilator necessarily, that we prize so much in this society. Yes, we have a lot more access to high technology, but we only need that because our society is so sick because we don't have the basic things we need all the time. If everyone had the basic things they need all the time to just be a healthy person, which are really just like the basic material needs of life, then people wouldn't end up needing as many intensive medical interventions. And then I think of places like—I mean, I'm a communist, but like a lowercase-C communist, I'm not an authoritarian—but you look at places like Cuba, where they have a general vision of a communist society where everyone has what they need, and they have the best doctors in the world. They're being shipped all over the world to fight pandemics and fight plagues, and I think it's really buying into the propaganda when we think of us being a high tech capitalist society enabling us to have good healthcare when actually, you look at places that have implemented more of a community version of health where everyone has what they need, actually having way better health outcomes. Sorry, I feel like I sound like a tankie right now.

Yeah, I guess I'm really passionate about this topic, and I'm starting to realize more what you're asking. I feel like in our anarchist community there's a lot of distrust of science as being part of capitalist technocracy. But I'm really inspired by certain radical science fiction authors like Ursula Le Guin and Octavia Butler and Samuel Delany, where they imagined societies where people are motivated for their love of humanity and their love of life to invent things that help people, and I think we're already there. People that invented the ventilator or people that invented antiretrovirals to help people with AIDS—they're not motivated by profit, they're motivated by love of humanity. Just because it took a lot of money and resources to develop those things doesn't mean that we can't have those things in a society that is motivated not by profit but motivated by a love of life and humanity. I think it's totally possible, and we're already seeing it, that solutions to problems that have plagued us since

the beginning of humanity, solutions can be generated from people's own desire to help those around them thrive. That is one of the hopes that science fiction is giving me, is that science and technology that helps people and the earth thrive is not always tied to an endless strive for profit.

And when we're talking about high tech capitalist societies as being necessary for stopping things like plagues, we really have to look at how it actually went down. I think it's really important to look at AIDS as an example of that. AIDS activists, a lot of whom were queer and trans and anarchists and communists, they were the ones that really helped stop the plague within their communities, while high tech capitalist healthcare systems were failing them. People were dying from the treatments to AIDS before activists were inventing things like harm reduction and safer sex, and taking care of each other. And activists actually forced high tech medicine to respond to the crisis and forced them to change their priorities, and forced them to make certain drugs available for free. We have this technology, medical technology, modern medicine, but it doesn't have to be used in the service of maintaining hierarchies. It can be appropriated toward helping the people that are affected.

It'a the same thing with the opioid crisis. Modern medicine is constantly appropriating communities' responses to these crises, like harm reduction and Narcan, all this stuff. Even when you look at the history of medication abortion, it was women in Brazil that were using over-the-counter heartburn medicine, basically, to induce abortions on their own; now that has been adopted as standard medical practice. These are grassroots practices that don't require a whole lot of technology or investment from capital in order to use, and they are the ones that are actually being adopted by modern medicine. People think of power coming from outside of themselves to stop things like pandemics, but in reality, it's people that are closest to the problem that are often closest to the solution. We don't necessarily need high tech capitalist healthcare to save us from this. They need us to learn how to deal with it.

VI: And on that, I will say, I think one of the best ways to see the crisis between tech and labor and patient outcomes that is going on is with the ventilator shortage. And I mean, all you have to do is click on any news source right now or pick up any paper and you'll see that on the headlines. And you know, ventilators are machines that basically act as your lungs, outside of your lungs being able to do an effective job at breathing for yourself. For your kidneys, that's called dialysis, for your heart, that's called ECMO. For your lungs, it's called a ventilator, and it's called mechanical ventilation, where a machine puts a certain volume of a certain amount of oxygenated air at a certain pressure into your lungs, and then actually helps get that air out of your lungs. It's an incredibly complicated closed system of breathing between a human and a machine that requires not a lot of ingenuity or expertise to assemble the parts, but requires many, many years of experience and extremely complicated biophysics to understand the settings of it that will actually improve a person. Because if you're on a ventilator, it means you're not breathing for yourself, and so the two options are: you get weaned from a ventilator and you learn to breathe again, or you don't wean off of a ventilator, and someone, either doctors or a family member, decides to take you off of it and you die. Those are the only two outcomes. And so the ventilator is this bastion of advanced medicine, and at the same time it in and of itself as a machine does not keep people alive. It's a team of people that know how to work a ventilator and, more

importantly, are able to recognize all of the other signs and symptoms that go along with showing whether someone's going to be able to be weaned off of it or not. I'm really lucky to be in a hospital that has a 40% extubation rate. The national average is 5–10%, meaning the work that's being done where I am, people are coming off of ventilators at a much more successful rate than the rest of the country. I really do attribute that to people's courage and ingenuity and ability to improvise in the situation that we're in. And also, this is early in the crisis.

But these are not things that we can replicate outside of a hospital system yet. What it would take to replicate those outside of a system is a full-scale revolution that meant that doctors and nurses and other healthcare workers did not have to show up to an institution to work, but were able to work in communities, sharing their knowledge and resources in settings that were autonomously controlled. That is the only way in which a ventilator outside of a hospital right now could do anyone any good. And so, this is not just a problem of technology. This is a problem of all of the ways in which you learn to do some of these things are funneled into these institutions that do not allow for any kind of community or individual autonomy. The problem is the system of healthcare that is outside of the individual and outside of the community and that the individual can have absolutely no control over.

So until we have either a mass desertion or extraction or revolution of healthcare who are able to work directly in communities with people with these technologies, at that level, they are actually useless outside of specialized institutions. And we are in the middle of a pandemic where we might not be able to make that kind of turn that fast, but as Sasha was saying, there's a lot of other ways at a lower-tech level that we can be supporting people and caring for people. That also might mean supporting and caring for people that don't want to go to a hospital and die in a hospital. That might be a place where mutual aid could be extended in the future.

We are starting from a place in this society we live in—or, the society I live in, which is in the United States—that is so profoundly death-phobic, that is so profoundly terrified of death, that will take all measures to kind of villainize it, avoid it, separate it from life, separate it from any kind of relationship to the greater project of being a human on this planet, that it's seen as this problem to solve and as this absolute enemy. It's seen as that by our highest technocrats in the health field, too, whose goals and markers of success in the work they do is to make leaps and bounds in the progress of keeping people alive. A lot of that technology has been incredible in keeping people alive in even very simple circumstances. And I am very much suspicious and against any kind of analysis that takes us to a place of, well, death is inevitable, and plagues have always been around, and so we have to accept the death of anywhere from 100,000 to 2,000,000 Americans because of this and just get over it, this is what nature intended. All of that has its roots in an extremely eugenic and fascist discourse that we can go into the history of, and that kind of logic needs to be obliterated from any kind of radical consciousness.

And, we cannot escape death in this situation, and people are going to die. Lots of people are going to die, even with the best possible outcomes and interventions. How do we grasp both that inevitability and the fact that there is a lot of preventable death? There are a lot of people dying who absolutely should not be dying, and who are dying because of the horrific

conditions that people live in in this country, that the rest of the world, in some ways, is just realizing, of how absolutely inadequate the conditions are that people are supposed to survive within the greatest empire that's ever faced human civilization.

And so, to me, we're wedged within that as anarchists as people who often have historically and currently tried to conceptualize death as something that's *not* unnatural, that is something that's a part of being human and being an animal and being on this planet; and also stood up for and take an action in the face of absolutely unjust and unnecessary death. This is an opportunity for us to face some of those bigger fears and also break down alienation and implore and instill and fight for dignity, despite what people's outcomes are from this. And the way that people are dying right now from this virus is not, is deeply not on terms of autonomy and dignity, and is desperate. So there are some immediate and big both systemic changes and… there are some big calls to action there.

I think moments of plague that we're in right now, they offer us opportunities to really, really lay bare the absolute contradictions of the world that we live in, and can sometimes give us the time and the reflection we need to make clearer where we are in this fight. And I hope provide courage to face it. If all of our decisions are made in an absolute fear of death—fear of death of ourselves or fear of death of anyone we come in contact with—we're not going to be able to have the courage or make the decisions that we need to make sometimes in order to really face the level of crisis that this is posing: one, on a base level to just humanity and survival, but on another of the reproduction of that and the options that people are going to have moving forward to be able to have a life. To have more than just a bare life, but to have a life worth living.

Clara: Awesome. Thank you so much for speaking with us!

SASHA: Thank you for having us!

find each other.

anti-copyright
creative commons zero (cc-0)
do whatever you want

CrimethInc.
Interview with Two Anarchist Nurses in New Orleans
8th April 2020

https://crimethinc.com/podcasts/the-ex-worker/episodes/76
The discussion starts off with updates and concrete advice about protecting our individual and collective health, and then covers a wide range of topics: harm reduction, the politics of information, the legacy of the AIDS epidemic and the activism against it, more and less helpful ways of supporting healthcare workers, balancing rejecting authority with respecting expertise, horizons for mutual aid, and so much more.

lib.edist.ro