

“I Can’t Breathe”: Biopower in the Time of COVID-19

An Exploration of How Biopower Manifests in the Dual Pandemics of COVID and Racism

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In this article, we apply Agamben’s theory of biopower and other related concepts to the COVID-19 pandemic in the United States. We explore the similarities between the COVID-19 pandemic and the pandemic of racism. Concepts such as *bios*, *zoe*, *homo sacer*, and states of exception can be applied to understand inequities among marginalized communities in the COVID-19 pandemic. We recommend that nurses and health care workers use critical conscientization and structural competency to increase awareness and develop interventions to undo the injustices related to biopower faced by many in the COVID-19 pandemic. **Key words:** *biopower, COVID-19, critical conscientization, disparities, inequities, nursing, nursing education, pandemic, race, racism, structural competency, structural racism*

THE PURPOSE of this article is to explore and apply Agamben’s theory of biopower, with its constructs of *bios*, *zoe*,

and *homo sacer*,¹ as manifested in dual pandemics of COVID-19 and racism in the United States. These dual pandemics are suffocating us, through an infectious disease (COVID-19) and through racism (police brutality). The American Public Health Association declared racism² and police violence a public health crisis.³ As 2 nursing faculty with backgrounds in public health, we have noted how the praxis of biopower, as theorized by Agamben,¹ has insidiously increased at a dizzying, rapid rate without an acknowledgment in most sectors of the United States. In this article, we aim to make Agamben’s theory of biopower accessible to a wider audience by illustrating how these theories are enacted in everyday life and their relevance to current events. Specifically, we will explore how biopower occurs through States of Exception during the dual pandemics of COVID-19 and racism. Finally, we will briefly discuss how the tools of conscientization⁴ and structural competence⁵ should be used by nurses to mitigate biopower. We note that nursing’s foundational premises from the

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This manuscript is dedicated to Breonna Taylor, George Floyd, Ahmaud Arbery, and countless others murdered by racist state sanctioned violence.

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Statements of Significance

What is known or assumed to be true about this topic?

The COVID-19 pandemic exacerbates the numerous health disparities already present among marginalized groups in the United States. Agamben's theory of biopower has been explored by other nursing scholars.

What this article adds:

Agamben's theory of biopower has been explored by other nursing scholars. Agamben's theory of biopower has not been applied to the phenomena of the COVID-19 pandemic. We apply Agamben's theory of biopower to understand the disparities experienced by many in the dual pandemics of COVID-19 and racism. We explore how nurses might use critical conscientization and structural competency to mitigate injustices related to biopower.

American Nurses Association's (ANA's) Code of Ethics⁶ require nurses to attend to the sociopolitical landscape for individuals, communities, and population.^{7(p3)} In August of 2020, the ANA and the American Academy of Nursing issued a call for nurses to address racism and injustice in response to the disproportionate rates of COVID-19 in communities of color resulting from structural, systemic, and institutional racism.⁸

THEORY

Agamben's biopower in nursing

Several nursing scholars explore how biopower manifests in the nursing profession.⁹⁻¹¹ Georges⁹ argues that nursing epistemology needs to move beyond diversity and cultural competency and use a more critical epistemology to develop nursing knowledge to analyze injustice in health care. Georges defines biopower as "power over life"^{9(p6), 12(p131)} and explains,

Other more recent scholars, most notably Agamben, have invested the term with a broader

purview and used it to signify an ongoing theme in Eurocentric thought from classical times onward in which "sovereignty," as a socially constructed phenomenon, included the power over life and death of those being ruled. All power, Agamben asserts, is by its very nature bio-power, and the ultimate locus of power is the ability to determine who lives (*bios*) and who dies (*zoe*).^{9(p6)}

Georges further advocates that nursing theorists use Agamben's theory to explore "new ways of exploring the phenomenon of bio-power"^{9(p9)} and build on the politics of compassion.⁷ Perron et al¹¹ expand on the praxis of Agamben's biopower by asserting that nurses' clinical practice is not neutral and cannot be assumed to be in the patients' best interests. Rather, "Nurses are at the flexing point of the state's requirements and of individual and collective aspirations. They occupy a strategic position that allows them to act as instruments of governmentality. Consequently, nurses constitute a fully fledged political entity making use of disciplinary technologies and responding to state ideologies."^{11(p536)}

Nurses operate at the juncture of *bios* and *zoe*—or who lives or dies—in their work and in their effort to balance advocacy with the machinations of a health care system that centers profit and efficiency over compassion. Cloyes¹⁰ questions the assumptions in humanist, emancipatory endeavors that do not attend to the "othering," which unknowingly reproduce concepts of Agamben's biopower: *bios*, *zoe*, and *homo sacer*. Cloyes argues that nursing praxis would benefit from a more critical lens and is complicit in reproducing categories of othering.¹⁰ We interpret this to mean that humanist rhetoric in nursing misses biopower which is, as Agamben argues, ubiquitously present. We argue that nurses must critically analyze social injustices in health care through the lens of Agamben's biopower.

Agamben's biopower: *homo sacer*, *bios*, *zoe*, and states of exception

Biopower was first developed by Michel Foucault in his work *History of Sexuality*.¹³ Since Foucault's conceptualization, biopower

has been theorized by many scholars such as Giorgio Agamben with different nuances. Agamben defined biopower as power over life; this power is state sanctioned and includes the concepts of *homo sacer*, *bios*, and *zoe*.¹

Some theorists such as Foucault¹³ view biopower as neutral; however, others such as Agamben¹ view biopower as more coercive. Biopower can work toward the common good or social contract. It is not the existence of a social contract we critique but rather it is *the way* a social contract is arrived at—whose interests are preserved in the contract, whose lives must be expendable in order for the social contract to exist? Whose lives matter?

A simplified example of a social contract—or neutral laws for the common good—is traffic laws. We all agree to drive in one direction on the same side of the street for safety. In contrast, Agamben's conceptualization of biopower is not concerned with the existence of a social contract. We foresee the usefulness of Agamben's theory of biopower¹ to analyze the way power is enacted in a fascist manner by the nation-state. Some acts of biopower such as state declarations are the enactment of power and are aimed at the common good. We are not concerned about acts designed to promote the common good. Other acts of power are not aimed at the common good and are determined by the perceived worth of an individual or population.

Homo sacer

Homo sacer is the process by which someone is devolved from *bios* to *zoe* for biopower to exist. With no rights ontologically, *homo sacer* can be removed from *bios*—or political citizenship and belonging—and can be killed with impunity and can have their rights revoked at any time with impunity.¹ The very exclusion of *homo sacer* from the body politic defines the existence of *bios* and *zoe*.¹⁰

Agamben expands on the Roman idea of *homo sacer*, or sacred human to frame how we think of worth or dignity.^{1,10} Cloyes

argues that the distinguishing groups of people as worthy and unworthy is prevalent in everyday humanist, modern political systems, such as advocacy or multiculturalism, which are "rooted in this profound division between mere existence and legitimate agency..."^{10(p234)} *Homo sacer* must exist via ontological devolution to justify the existence of *zoe* or bare life. *Homo sacer* is devolved by the state power to determine who is excluded from political agency.^{10,14} The manner in which *homo sacer* is killed, or who does the killing, is not the nation-state's concern; rather, the nation-state is solely concerned with its maintenance of power and survival of the state, through *zoe* or bare life (W. Southerland, unpublished data, April 2016). Agamben's conceptualization of *homo sacer*¹ is directly opposed to the ANA Code of Ethics that asserts that every human being has inherent dignity.⁶ The nursing profession's value of human dignity requires that nurses resist processes that delegitimize the dignity of others. To resist, the process of conscientization—or an understanding of the world that recognizes social and political contradictions⁴—must be part of nursing curriculum and professional development.

In the context of the dual pandemics, the disenfranchised are excluded—such as ex-felons who cannot vote, immigrants in detention, persons with a disability, the elderly, people who are LGBTQ+, or people of color who fear for their lives among others. *Homo sacer* are those who have been stripped of rights; their survival requires escaping the obligatory haunting and enslavement by the power that has the ability to kill them at any moment with impunity (eg, Black people). As highlighted in the "pandemic of racism," Black people are shot by the police at higher rates than white people. For example, the chances that a white offender remains alive during a police encounter after publicly witnessed homicidal actions are significantly higher than a Black person during a police encounter as illustrated in the case of Kyle Rittenhouse.¹⁵ The COVID-19 pandemic has also unveiled the existence of *homo*

sacer. For example, at the time of this writing, the US Congress has failed to pass COVID relief funds for American families,¹⁶ dismissing the basic financial needs of low-wage essential workers who have higher COVID mortality rates due to structural factors such as wealth distribution and racism.

Biopower: bios and zoe

Agamben's definition of biopower is the *socially constructed power over life to determine who lives and who dies*.¹ Agamben's conceptualization of *bios* is similar to the idea of *biographical* worth. Those deemed *bios* are inscribed into—or have representation, language, and voice in—the nation-state as a citizen in a democracy. In contrast, *zoe* is the zoological equivalent of an animal without worth, language, or voice in the body politic.¹⁷ Agamben also terms *zoe* as “bare life,” which is likened to primal life.¹ The sovereign nation-state controls all aspects of bare life (*zoe*); *homo sacer* is excluded from the realm of law and yet must be fully subjected to control by the sovereign nation-state for biopower to exist. Using the example of the holocaust, Agamben showed how institutions in power deemed certain groups of people, which Agamben calls *homo sacer*, as unworthy of life, termed “*zoe*” also called “*bare life*,” in contrast to people deemed worthy of life and citizenship, termed “*bios*.” A few examples of those unworthy deemed *zoe* during the holocaust included people of the Jewish faith, gay people, priests, gypsies, people with mental or physical disabilities, communists, trade unionists, Jehovah's Witnesses, anarchists, Poles and other Slavic peoples, and resistance fighters. In these examples, *zoe* operated by “othering” people by their religious, sexual orientation, ethnic, ability, political affiliation, and labor identities.¹⁸

States of exception

Biopower is enacted during times of crisis called “states of exception,”¹⁹ such as during the dual and related pandemics of COVID-19 and racism. “States of exception” occur in

times of crisis when governments exert biopower.¹⁹ We will discuss how states of exception and biopower are used during the dual pandemics of COVID-19 and racism.

PRAXIS OF BIOPOWER DURING A STATE OF EXCEPTION

Structural racism and COVID-19 via biopower

Biopower is inextricably related to intersections of identity such as race and citizenship. When disparate incidences of COVID-19 began to manifest in the early days of the pandemic, many called COVID-19 an equal opportunity disease. Much like the refrain that “white lives matter too” in response to the Black Lives Matter movement, the idea of COVID-19 “leveling the playing field” misses powerful structural factors that shape health outcomes. Certainly, white lives matter and COVID-19 affects white people. We do not argue these facts. Rather, we call attention to the disproportionate COVID rates affecting Black, Indigenous, and people of color due to structurally embedded systems that are designed to dehumanize and judge the worth of racialized and disenfranchised people.^{20,21}

Structural racism is defined as “the ways in which societies foster discrimination through mutually reinforcing inequitable systems.”^{21(p77(11))} People who benefit from existing systems (eg, education, financial, employment, housing) are more likely to be white. Their access to life-sustaining resources enables them with the choice to follow governmental mandates for safety such as social distancing and quarantine or isolation. People who are made *zoe* (usually the minoritized and racialized) have less access to resources and choice to decrease their risk of contracting COVID-19.

Health care as an apparatus of biopower

Biomedical criteria applied to *homo sacer* at the point of triage and treatment serve

as gatekeepers to their chances of surviving COVID-19. These criteria guide resource allocation such as testing and treatment like ventilators. A recent systematic review found wide variation in ventilator allocation guidelines during COVID-19 among 26 US states. Some states' guidelines listed prioritized categories of people such as pregnant patients, those of younger age, and health care workers. Some guidelines recommended de-prioritizing patients who have a lower life expectancy due to underlying comorbidities.²² Communities with higher risk for chronic comorbidities and contracting COVID-19 are influenced by multiple social determinants of health such as race, employment, citizenship status, food and housing security, and socioeconomic status. Communities of color living in crowded housing, high poverty, and little access to health care have higher COVID-19 infection rates.²³ People who are *zoe* are more likely to be essential and low-wage workers with little to no access to benefits such as paid sick leave or health insurance and more likely to lack access to personal protective equipment. Low-wage earners who contract COVID are faced with the decision to isolate often in a multigenerational household or earn money to provide for their family's basic needs. For those without rights (*zoe*), care in a hospital intensive care unit for assisted ventilation is simply out of reach. Much less, those who are *zoe* often cannot enter through the doors of the clinic to receive initial testing for COVID-19, thereby deterring any chance of ventilator eligibility.

Health care is not considered a right but a privilege in the United States. Those who are *zoe* suffer the structural violence of lacking health care access, coupled with the systemic and structural violence that predisposes them to increased risk for chronic comorbidities, placing them at a higher mortality risk from COVID-19. Biomedical criteria fall short of accounting for health inequities shaped by social determinants; these criteria perpetuate the idea that *homo sacer* can be denied resources, enact-

ing biopower by killing them slowly with impunity.

Essential workers as bare life

Through biopower, the nation-state controls all aspects of bare life (*zoe*). Agamben's *zoe*—or bare life—also extends to manual and domestic labor,¹⁷ and "essential workers" such as grocery store staff, health care workers, migrant workers, and first responders are placed at a highest risk for exposure to COVID-19. COVID-19 is a state of exception, and essential workers who are *zoe* risk their lives to maintain the survival of those who are *bios*. The use of biopower can be seen in both policies and actions of the nation-state regarding the status of *zoe* and *bios* and the changed decision-making processes based on the *zoe* and *bios* distinction. Examples of a state of exception include lockdowns, social distancing guidelines, and travel restrictions. For example, several governors in southern states in the United States pushed for early reopening of businesses,²⁴ impacting essential workers who are most often from marginalized, poorer communities of color (*zoe*).²¹ COVID mortality rates by race can be examined within and across these states. Alabama, for instance, reported race data for 60% of their cases as of early September 2020. Of those cases, 42% of those deaths were among Black or African American people, even though Black and African American people comprise 27% of the population, indicating a racial disparity.²⁵ Biopower becomes sanctioned and normalized at a policy level.

While we concur from a scientific public health perspective that public health strategies such as masks, social distancing, and quarantine and isolation to contain the virus are necessary, we have concerns about possible enactments of state-sanctioned biopower that serve to consolidate power rather than serve the common good. Detaining asylees and prisoners, increasing the use of martial law, and rationing resources such as ventilators are acts based on the perceived worth of categories of people such as the elderly,

the imprisoned, and the detained. Decisions of people's hierarchical worth are enacted in an autocratic process, which is manifested in the deliberation of the worth of some people (*zoe*) and their access to safety and lifesaving resources. The dual pandemics of COVID-19 and racism have revealed that not all communities have access to rights.

Biopower, racism, and the criminal justice system/police brutality

The second pandemic of police brutality is also an outcome of biopower and the perceived worth of racialized people. Racism and police brutality have been denounced by national professional associations such as the American Nurses Association and the American Academy of Nursing,⁸ the American Public Health Association,^{1,2} and the American Medical Association.²⁶ These professional organizations urge for the cessation of police brutality and racism.

Police brutality is a symptom of a racist criminal justice system institutionalized by biopower. For example, in the school-to-prison pipeline, Black people are incarcerated at disproportionately higher rates with loss of voting rights and life opportunities and disenfranchisement in a relegation to a permanent second-class status.²⁷ In the current nation-state “we have rights, but not rights to rights.”¹⁷ These “rights” can be taken away in a moment's notice or, more accurately, in a heartbeat. The COVID-19 pandemic has illuminated how those who are incarcerated have little to no access to health care and environmental living spaces for proper social distancing and ventilation,²⁸ let alone personal protective equipment.²⁹ Detainees in U.S. Immigration and Customs Enforcement (ICE) detention centers have little recourse to legal representation³⁰ or health care while being exposed to COVID-19. Basic survival is constructed both explicitly in resource allocation algorithms and implicitly in the constant struggle for health care, resources, and safety. Those in the contested and constant struggle for rights are *homo sacer*.

Brutality includes not only physical violence but also emotional, psychological, and sexual violence. Alang et al³¹ argue that police brutality is more than police misconduct; it is the deep mistrust and psychological toll among communities and victims who have been historically targeted and dehumanized even without conscious intent by state agents or perpetrators. These insidious effects of physiological responses of increased morbidity, the continued witnessing of racist reactions to brutality, and the legal and medical financial strains of exposure to blatant violence contribute to the cumulative allostatic load.

Dehumanization is equated with Agamben's *zoe* and *homo sacer*—or those who can be killed with impunity. The chronic denial of testing, triage, and treatment for COVID-19²¹—essentially, access to life and breath—parallels the acute, increasingly publicized death by asphyxiation of Black people at the hands of state-sanctioned police, namely, biopower.

RECOMMENDATIONS FOR NURSES TO MITIGATE BIOPOWER

Nurses' responsibility to honor the inherent dignity of each human as proposed in the ANA Code of Ethics⁶ can be achieved through the process of conscientization and its praxis. Nurses can move from understanding health inequities by individual, behavioral, or cultural differences to an understanding of how structural factors, which are the sociopolitical factors, shape health—and intervene accordingly. These structural factors are the broader determinants of health such as racism,^{2,5} colonization, poverty, and historical trauma. For example, nurses must recognize how sociopolitical factors shape COVID-19 inequities including connecting how trade policies, globalization, climate change, and war determine COVID-19 outcomes. See the Table illustrating how several of the ANA Code of Ethics Provisions⁶ intersect with critical conscientization and

Table. The American Nurses Association (ANA) Code of Ethics Provisions Intersections With Biopower, Conscientization, and Structural Competency

ANA Code of Ethics Provisions ⁶	Agamben's Biopower in Contrast to ANA Code of Ethics Provisions	Strategies: How Critical Conscientization and Structural Competency Might Mitigate Biopower
<p>Provision 1 "The nurse practices with compassion and respect for the inherent dignity, worth, and unique attributes of every person."</p>	<p>A person who is devolved to <i>homo sacer</i> is denied their inherent dignity, worth, and unique attributes.</p>	<p>Through critical conscientization and structural competency, the nurse reclaims their practice to resist devolution of individuals to homo sacer.</p>
<p>Provision 3 "The nurse promotes, advocates for, and protects the rights, health and safety of the patient."</p>	<p>The nation-state, under the guise of democracy, enacts biopower and allegiance to the state through negation of the "rights to rights," which often occurs in states of exception such as civil unrest or pandemics.</p>	<p>Critical conscientization and structural competency are strategies for nurses to resist biopower and to advocate and protect the rights, health, and safety for patients.</p>
<p>Provision 5 "The nurse owes the same duties to self as to others, including the responsibility to promote health and safety, preserve wholeness of character and integrity, maintain competence and continue personal and professional growth."</p>	<p>Biopower denies patients' wholeness of character and integrity. Nurses operate at the juncture of biopower, having to choose between <i>bios</i> and <i>zoe</i> in a system designed to reward efficiency.¹²</p>	<p>Critical conscientization requires continued personal and professional growth and can be promoted by the use of the Peace and Power Framework.³⁹</p>
<p>Provision 6 "The nurse, through individual and collective effort, establishes, maintains, and improves the ethical environment of the work setting and conditions of employment that are conducive to safe, quality healthcare."</p>	<p>The normalization of and complicity with biopower prevent nurses from creating ethical environments that are conducive to safe, quality health care for all.</p>	<p>Structural competency provides a framework for nurses to understand how larger structural factors impede health. The pedagogy of conscientization and structural competency provides the framework for nurses' capacity to act for a more ethical environment for safe, quality health care and transformative change.</p>

(continues)

Table. The American Nurses Association (ANA) Code of Ethics Provisions Intersections With Biopower, Conscientization, and Structural Competency (*Continued*)

ANA Code of Ethics Provisions ⁶	Agamben's Biopower in Contrast to ANA Code of Ethics Provisions	Strategies: How Critical Conscientization and Structural Competency Might Mitigate Biopower
<p>Provision 8 "The nurse collaborates with other health professionals and the public to protect human rights, promote health diplomacy, and reduce health disparities."</p>	<p>Biopower and the condition of <i>zoe</i> signify that human rights are secondary to the sovereignty of the state. Under biopower, power is totalitarian and can be enacted with impunity during States of Exception.</p>	<p>Conscientization is the awareness of injustice and structural competency provides the pedagogical tools for nurses to act in alignment with this ANA provision.</p>
<p>Provision 9 "The profession of nursing collectively through its professional organizations must articulate nursing values, maintain the integrity of the profession, and integrate principles of social justice into nursing and health policy."</p>	<p>Biopower negates justice by categorizing groups of people unworthy of dignity and respect with impunity.</p>	<p>In contrast to biopower's impunity, professional organizations and nurses should be accountable to maintain the integrity of the profession and integrate principles of social justice. Conscientization and structural competency guide nurses to praxis.</p>

Abbreviation: ANA, American Nurses Association.

structural competency, which may mitigate biopower and promote social justice.

Critical conscientization and survivance

We assert that nurses' role as change agents calls for the nurses to embrace strategies such as Freire's Critical Conscientization,⁴ and structural interventions made possible by a structural competency.⁵ We recommend that individuals mitigate and challenge biopower through critical conscientization and survivance. Critical consciousness was theorized by Paulo Freire⁴ to transform education among the disenfranchised poor in Brazil. The model was based on transformative knowledge where education connects with the learner's lived experience to dialogue and connect theory into action (praxis). The process of conscientization entails empowering individuals to participate in social change by first recognizing the contradictory experiences revealed through participatory dialogue.⁴ One of critical consciousness' core attributes includes "illuminating (and changing) power structures."³² In contrast to biopower, critical conscientization preserves dignity and recognizes the wisdom of each. Health care provider education must include critical conscientization to develop compassionate, socially responsible health care workers.

Survivance is defined as "an active presence, the continuance of native stories, not a mere reaction or a survivable name. Native survivance stories are renunciation of dominance, tragedy and victimry."^{33(pvii)} Literally and figuratively, the word "survivance" combines "survival" and "resistance."³³ Survivance is much more than mere survival (*zoe* or bare life). Survivance is the proud autobiographical worth and thriving reclamation of life and indigeneity.

Critical conscientization is the mechanism to survivance. Once we become aware of the covert, insidious, and normalized operations of biopower through conscientization, we can then resist. This resistance, which is speaking truth to power,³⁴ challenges the victimry of biopower. Speaking truth to power

requires moral courage.³⁴ Critical consciousness and survivance give rise to a newer pedagogical tool known as structural competency.

Structural competency

Structural competency is intended for health care workers and, similar to critical consciousness, implores us to recognize the power of structural factors that foster health inequities.³⁵ Metzl and Hansen⁵ describe "structures" as institutional and social conditions that influence interpersonal clinical interactions such as stigma. Structures create infrastructures that uncritically privilege dominant groups. Structural factors include racism, colonization, and poverty. Medical and nursing education has used structural competency as a pedagogical framework to equip professionals in training to recognize their status and privilege conferred on health care workers.^{36,37} Structural competency guides us to acknowledge and use our agency—which is defined as the "social capacity to act"³⁸—as health care workers. Structural competency guides health care workers to use our agency and examine our blind spots and the normalized hegemonic structures to acknowledge inequities that shape the lived experiences of the disenfranchised.

Chinn and Falk-Rafael³⁹ provide a Peace and Power framework for emancipatory group process grounded in Paulo Freire's work, which models a just, cooperative teaching and practice that addresses power. Coupled with conscientization and structural competency, this theoretical framework of Peace and Power can create just interactions among people to live in ways that challenge existing conditions that support biopower and promote equity and justice for all. We recommend that using a structural competency lens, the Peace and Power process be adopted by nurses.

Training and education

Nursing education curriculum and professional development training must be

critically transformed. Conscientization and survivance must be integrated into our profession's definition of critical thinking; critical thinking must be human-centered and decolonized. Nurse educators can transform the curriculum from the old paradigm of individualistic, behavioral, or cultural approaches to one that addresses structural factor.^{35,37} Nurses must use an intersectional lens to address how biopower manifests in multiple identities such as gender, ethnicity, class, and sexual orientation.⁴⁰ Structural competency is the pedagogical framework that can guide us as health care workers to use our agency to mitigate inequities.^{5,37}

As nurse educators, we observe that social justice and attention to the social determinants of health are perceived to be "soft" and less rigorous classes with loose requirements (ie, able to taught by anyone) compared with biomedical classes, yet we assert that the longer-term systemic outcomes of social injustice are just as fatal as the lack of individual biomedical knowledge and skills. We assert that academic rigor in social justice content is just as important as biomedical content. Many nurses lack the theoretical understanding of highly abstract but relevant theories pertaining to the structural causes of health disparities.^{35,41} Because of this, nurses miss the opportunity to participate in and contribute to research and interventions on structural causes of disparities. Nurses have the opportunity to mitigate unjust outcomes by addressing power relations and embodying compassion.^{7,39} For example, nurse educators can create transformative and healing learning environments using critical caring pedagogy.⁴² Nurse educators have a unique platform to role model compassion to their students, who, in turn, can practice compassion with their patients.^{7,42}

Nursing theorists who study the politics of caring bid nurses to exercise their moral obligation to political activism and advocacy.³⁴ Given this, how might the nursing profes-

sion adapt or respond to the enactment of biopower on marginalized communities during the dual pandemics? This could be accomplished via training, education, and advocacy through practice.

Advocacy through practice

Nurses can facilitate equitable decision making and work to deter the political exclusion of those deemed *zoe*. Biopower might be mitigated by authentic community engagement and collective, democratic decision making. Nurses can embrace community engagement in research and practice. The US profit-based health care system rests on the Eurocentric myth of scarcity. Praxis should include the exploration of compassion and its central role in nursing. Compassion-based care, not profit, should be a metric for a critical outcome.^{12,43} We recommend the use of equity tools—noting which intersecting identities are the most vulnerable in a manner which enables survivance.

CONCLUSION

We observe how the emergence of the COVID-19 pandemic has made manifestations of biopower visible in an oddly normalized manner. Conscientization,⁴ structural competency,⁵ and the emancipatory group process of "Peace and Power"³⁹ provide pedagogical frameworks that guide nurses to recognize power structures facilitated by the unacknowledged forces of biopower and propose interventions that mitigate the effects of these structures. Health care workers must make visible and center those at greatest risk for harm—those whose lives are symbolically (and too often literally) at risk of not being able to breathe. We look forward to the day when accountability, political will, moral courage, and the collective, common good for equity, survivance, and social justice will prevail.

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