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Plantation Politics, Paranoia, and Public Health on the Frontlines of America's COVID-19 Response

"Plantation politics" pervade multiple institutions in the United States, including public health. Drawing from my experience working as a volunteer at drive-thru COVID testing sites in the United States, I critically examine the relationship between public health, the military, and capitalism when racial slavery serves as the sociopolitical backdrop of everyday life. I ponder what it means for Black people to toil for a country, in the midst of an emergent communicable disease outbreak, that would weeks later launch into protests for and debates about their entitlements to freedom, safety, and security. Starting from experiences of Black women on the frontlines, I reveal complexities that underlie and undermine notions of care as altruistic, natural, or ethical "in the wake" of chattel slavery and in the midst of racial capitalism. [plantation politics, COVID-19, public health workers, racism, racial paranoia]

Introduction

"I call her Kizzy. You know Kizzy, from Roots?" Dr. Williams says as Tania, the site's nurse practitioner walks up to our tent. Like many days, today is steaming hot and humid. The heat of the Texas sun is beaming down on our skins, shades of brown, with only our baseball caps or visors and the small white event tents and maybe a touch of sunscreen (if we remember) between us and its rays. But if you have spent time in southeast Texas, you might know that the shade is ineffective, the heat wraps around you, smothers you, assisted by the humidity, droplets of water that surround you like a blanket. It holds you, but not lovingly.

Tania approaches our tent to pick up the latest of our requisition forms. We are at Station Two, the registration tent. We, volunteers and public health workers, are responding to the latest public health emergency, COVID-19. Dr. Williams greets her, "Hey Kizzy." Tania smiles and laughs a little bit, understanding the reference. They had spoken earlier about how we were out in the sun, doing outside manual labor, like slaves. Tania jokes, "If I were a slave, I would be trying to get in the house. I can't do all this." There are four of us, all Black women. We laugh, I think, at the

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irony. Here we are, all highly educated, two dentists, a nurse practitioner, and a Ph.D. student at a prestigious university. Yet, we all somehow ended up out in the field(s), not in the house, nor in the comfortable air-conditioned offices we spent many years and dollars securing for ourselves.

I did it by choice. I signed up to volunteer with the Medical Reserve Corps, a loose network of volunteers coordinated locally across the United States, to learn about opportunities to donate my time, skills, knowledge, and informed judgment developed during my Master of Public Health (MPH) degree. I did it partly out of a deep sense of responsibility to my community, but partly out of guilt for being a graduate student and not using my MPH.

They, on the other hand, did not. They were activated by the federal government to work at drive-through testing sites that were rolling out across the country. They went from being county employees, dentists, and nurse practitioners who served the needs of low-income children and women, to being administrative clerks, quality control personnel, sometimes "hot-zone" COVID swabbers, and outdoor laborers overnight. With a call "from a Washington, DC number," they went from having five-day work weeks in overly air-conditioned offices to shift work, and eventually to long six-days-a-week jobs in the Texas heat.

For many of the county workers, this was not their first rodeo. A few years ago, they were activated for Hurricane Harvey response as well. That time, they also worked outdoors and changed from their normal hours and jobs, but this time it was a bit different. This time, the disaster was not localized and did not (and does not) have an endpoint. This time, there were smothering masks and sweat-soaked gloves, long and brutal shifts, and, of course, the immediate risk of contracting an illness or bringing it home to one's family.

Though these women were paid, this article considers the significance of their invoking slavery with reference to the labor demanded of them by their country. What does it mean to be activated, especially involuntarily, and to toil for a country that would weeks later launch into protests for and debates about your entitlements to freedom, safety, and security as a Black person?

Plantation

This article is undergirded by an understanding of many systems of the United States as having derived from plantation logics. Anthropologists and others have demonstrated how "plantation politics" penetrate the university, public health, and everyday life more broadly in the United States (Dancy et al. 2018; Rusert 2019; Squire et al. 2018). More importantly, as my colleagues demonstrate above, slavery and the plantation remain in Black memory and on the tip of Black people's tongues. Christina Sharpe has theorized the Black diaspora to be living in the wake of slavery, "where the past that is not past reappears, always, to rupture the present" (Sharpe 2016: 9). It is therefore potentially curious, but not unexpected, that Black Americans continue to use metaphors that structure (our) lives around plantation categories of labor like the house and the fields. Slavery is in our roots.

When social theorists discuss the place of plantation politics in public health, the discussion tends to focus on the brutal uses of Black women and men in harmful medical experiments. The Tuskegee Syphilis Experiments (Reverby 2009; Rusert

2019; Washington 2006), the development of gynecology by J. Marion Sims (Cooper Owens 2017; Washington 2006), and the unauthorized use of Henrietta Lacks's cells (Skloot 2010) structure our understanding of medicine unethically using Black people as merely "bodies" that are imagined, it seems, as property of the state, worthless but for their biological material. Yet, as Deirdre Cooper Owens has sharply demonstrated, Black people—women, it must be said—also feature as skilled caretakers in these very environments (Cooper Owens 2017). J. Marion Sims, after conducting experimental surgeries on Black women without anesthesia to pioneer therapies that were ultimately for the benefit of white women, retained his test subjects as nurses who would tend to new patients. Likewise, a key individual in the Tuskegee Syphilis Experiments was nurse Eunice Rivers Laurie. Recognizing Rivers's positionality as a Black woman but also her agency, historian Susan L. Smith has argued that Rivers was "neither victim nor villain" in her role (Smith 1996).

Social roles in the plantation were not limited to and cannot be flattened into a simple master–slave binary. It is a complex. There were less powerful Whites, including the slave master's wife and slave patrols. There were free Blacks, who, in some places served as overseers. As well, there were entire free states later in slavery, Black and White abolitionists, as well as actors wholly unconcerned with slavery, though who also likely stood to profit from it. There were also, if not power divisions, class divisions among enslaved people. Drawing on the work of Malcolm X, Adia Benton (2014) has pivotally pointed out how the "house negro" was "a kind of managerial class" among slaves, yet "while the managerial class strongly identifies with the master class, its members recognize they will never be fully incorporated into it."

The creation of power structures within the master–slave complex allows for the covert co-optation of emotion, of identification, of bodies, and of persons. A vision of a binary master–slave set, like its settler–colonist parallel, forgets these distinctions and devalues the ways in which they continue to scaffold and construct everyday life. It ignores the people who are caught up in the interstices of the complex or, worse, invisibilized by them. Plantation logics that continue to color our worlds today still extend beyond any master–slave binary. Sensing this, scholars have drawn distinct parallels between modern-day roles in the university (Squire et al. 2018) that I argue extend into multiple realms of cultural and economic activity, and into the realm of public health. Who makes, who fulfills, and whose bodies suffer the consequences of demands in the name of public health are all familiar and all calculated configurations. And they are all structured by the plantation.

Activation

Dr. Williams got a phone call on a Saturday evening. She did not know who it could be, so she did not answer at first. But they called again. She answered this time, and the voice on the other end, a woman, told her she was being activated for coronavirus response. She was to report to her posting, on the other side of the county, on Sunday morning. She would take on an entirely different role in the following weeks. She would not know what that entailed until she was on the ground, but even then, her role changed weekly, sometimes daily. However, she had been activated before. As a longtime public health employee, she was no stranger to this kind of call, though the COVID-19 response would prove to be more difficult, less certain, and more

drawn-out than other responses in which she had taken part, including in the aftermath of Hurricane Harvey.

I heard about activation the entire time I was there and even before I began. People often shared their activation stories with one another: where they were when they got "the call," who they spoke with, their immediate reactions. They joked about what would happen if they got the call in the future, given what they knew three, five, or seven weeks into their work on the sites. One of those jokes—"Next time, I'll say I don't speak English"—speaks to the existential dread that was often associated with their active duties. For many, especially salaried workers who did not receive the added benefit of collecting 1.5x pay for their overtime (though they were paid for it), the costs and discomforts did not always add up. They anxiously awaited their return to air-conditioned offices, desks, and even the sometimes-mundane work they were used to and that they had worked hard to achieve in school or over their careers. To be activated was to be thrown into another world, a life that they might have led under other circumstances, had they not worked hard not to have it. Part of this frustration might result from their interpretations of the comforts that a managerial class could and should provide, when parsed not only economically but also socially and understood in relation to the types of work they do. The very idea that they could work their way out of the field was challenged. However, my colleagues never engaged in this discourse with the intent or outcome of demeaning the type of labor they were doing. Instead, they recognized it as *hard work* and felt the irony of having worked hard not to work hard and yet ending up here. If they had a choice, they would do something else, and they had.

Many meanings of activation collapse in the context of this response. Three resonate here:

Activate (n).

(1) "to set up or formally institute (an organized group, such as a military unit) with the necessary personnel and equipment" (Merriam Webster)
(2) "to put (an individual or unit) on active duty" (Merriam Webster)
(3) "Make (something) active or *operative*." (Lexico, emphasis added)

The references to the state and, specifically, to the military should not be lost here. The public health and military complexes share a great deal of terminology and history. Many public health campaigns and much public health knowledge has been developed with the soldier in mind. Efforts to vaccinate for, treat, and cure illnesses have often sprung out of concern for soldiers' health. For example, the use of prisoners as the "model organism" for the soldier (Comfort 2009) was spurred by a military need to reduce the impact of malaria on World War II operations. Perhaps because public health and the military have developed in tandem, the use of similar terminology is both striking and rings out as mundane in everyday life.

Despite the image one might conjure of the *activation*—or its related terms *mobilization* and *deployment*—of the American soldier, beating his chest into battle, activation marks a liminal state. Television and video game depictions may push us toward imagery of the soldier's bravado. However, activation for me always recalls an image of my father. He was in the Army National Guard when the Gulf War—for him, Operation Desert Storm—broke out. The war ended before he would be

deployed, but he was activated, along with many of his friends who prepared to leave their families for an uncertain amount of time to fight a war. To this day, many of them may not be able to fully articulate the geopolitics that structured that operation, but they would have been the operatives. The image activation conjures for me, then, is my father before I was born, young and thin and countrified, and shaking in his boots waiting to fight a war for a country that will imprison more than one in four men who look like him in their lifetimes.

The active soldier is poised, on the precipice of becoming, an operative of the state. Involuntary activation, a subtype of activation that may not capture the actuality of public health workers' situations but does capture the affect, constitutes a condition through which we might think more deeply about the meaningful differences between an agent and an operative. The slight tension between a "*will to power*" (Nietzsche 1956) and a more insidious *carrying out of the will of the powerful* is one that matters. It is equally engaged and consequential when we map contemporary conditions onto the plantation. The state and other corporations emerge as masters who can involuntarily commit a person to their wills, endowing them with duty that is sometimes masked as power. The soldier, the firefighter, the valiant health care worker, and the emerging class of essential workers who are grocery store clerks and restaurant workers are venerated as heroes by the people and by the state even—or especially—as their lives are put at risk and they are denied rights and options, including the right to health care and the option to stay home. The hero, or patriot, denotes an agency that is, at the very same time, denied.

Interlude: On the Volunteer

A focus solely on activation might eclipse some of the other persons present on the front lines. Volunteers, too, must deal with the tensions on agency presented for those who are activated. This context differs somewhat from "international clinical volunteerism" (Sullivan 2018; also see Berry 2014; Erikson et al. 2014) in which the commodity tends to be the "experience" for volunteers. Similar in both the U.S. and international contexts is that, despite the connotations around volunteering for "needy" others, volunteers often do so out of need themselves. Previous research I conducted among volunteers in Tanzania, many of whom were in pre-clinical stages of medical schooling in the United States and other Western nations, exposed to me the ways in which neoliberal demands for experience shape the volunteer terrain. Volunteers, like unpaid interns, often take part in the free-labor market to satisfy demands that range from proving one's compassion (also see Adams 2013) to getting to know the right people from whom one can extract recommendations or, if lucky, a job. The volunteers I worked with at the coronavirus testing sites, the ones who lasted anyway, tended to be people who found themselves temporarily out of work.

Under neoliberalism in the United States, the state extracts excess value by calling on citizens to sacrifice their bodies at the altar of the economy. This is true in the case of military operations that, in the end, enrich the powerful, but it is also true in the case of domestic volunteering. Vincanne Adams (2013) has demonstrated how, in the aftermath of Hurricane Katrina, this was presented in the form

of a vast network of charitable organizations and volunteers who were to do for free what the state failed to. As Zoë Wool's (2015) work has demonstrated, a logic of sacrifice permeates the relationship between the soldier and the state as well.

A long battle for health care and other benefits for first responders at the forefront of the 9/11 response might also shed light on how the state tends to interpret frontline work, on whatever front, to be sacrificial. This logic allows the state to extend honors rather than meet demands for care by the people whose bodies—and, of course, whole lives—are on the line. Sacrifice of the body is also implied in the relationship between volunteers and the state. This means that some of the most vulnerable people in our country, people with neither income nor health insurance, threw themselves at the "opportunity" to work on the frontlines of the response against a deadly virus that, if they were exposed, the state may refuse to rid them of without sure financial ruin. Rooted in the objectification of the slave in which she or he "becomes a non-person" (Kopytoff 1986: 65), under the conditions of racial capitalism, the body is objectified (Sharp 2016) and rendered as capital. Ralph and Singhal (2019) have noted "how different forms of death manifest in different sorts of social consequences" (p. 873). Extending that, I would argue that different forms of debility, disability, and illness also manifest in the context of neoliberal expectations of bodily sacrifice, which allow the government to extract value from its citizens without guarantees.

In this context, it is unsurprising that it is common for volunteers to be *volunteered*, whether explicitly or implicitly. On a blogpost of an organization I follow for my current work on dermatology, I came across an article titled "Derms on the Frontlines of Fighting COVID-19" (Skin of Color Society 2020). It was staged as an interview with one of the society's members. I kept reading the first sentence of the respondent's first answer: "The dermatology department *was volunteered* to help with frontline COVID efforts in the hospital (…), so I stepped up to fulfill the call to action." Assigned as an attending physician for a non-dermatology-specific hospital service that included seeing COVID patients, the physician stated of her experience that:

> [The] scary part was knowing how much close contact I had with COVID patients each day. It made me think about my own mortality more than I ever have before. It allowed me to truly relate to frontline workers who walk toward the risk of getting COVID each day they come to the hospital.

The nature of this work as volunteer or paid labor does not alter one's proximity to risk or mortality. To be volunteered only changes the extent to which one has a choice. Being volunteered cannot be flattened as activation in itself, though the portmanteau "voluntold" is common in the military and some other professions' lexicons. Of course, activation is much more tied up in the promotion of state goals. Nonetheless, people in power, many of whom do not occupy the frontlines that they construct, decide who encounters precarity. The powerful distribute risk, even to volunteers.

Paranoia

"What's the matter, y'all don't want to test Black people?" a middle-aged Black man in a white car asked me as I turned him away from the testing site for the third time that day. The process seemed simple: Sign up online, call a nurse's hotline to have someone triage you and verify your information, then come to the drive-thru testing site with a generated code and get a coronavirus test. But for some reason, his code did not work. It could be that I was typing in the wrong code or mis-transcribing from his handwritten note, so one of the times I sent him home to just grab his laptop and show me the number on the screen. That did not work either. It had to be that he was not calling the nurse's hotline, but it was difficult to communicate directions to him through a closed window, the only thing besides the surgical mask I was wearing protecting me and him from potentially infecting one another. The insidiousness of asymptomatic transmission disrupted our interaction.

I felt terrible. I felt a little ill. The first time he drove up, one of the other women registering people had walked up to his window. I laughed as she approached him, telling her that he looked like my uncle. They clashed because after his code did not work the first time and she tried to shout directions at him, she noticed that his radio was on, possibly impeding him from hearing her. She asked him to turn the radio down, and I do not know how she said it, but however she did it, he did not like it. She was ready to turn him around right then, but I told her that I have an abundance of patience, that I get it from my mom, and besides, he looked like my uncle and I wanted to help him. But after typing in the code myself to ensure that it *really* did not work, I turned him away. And he came back and I turned him away. And he came back and I knew I would have to turn him away again after his code didn't work even after he showed it to me on his laptop screen and said, though I had no way of ensuring the veracity of the statement, that he *did* call the nurse's hotline. I even asked the site manager if there was anything we could do, but at the time the protocol was: No code, no functional code, or no ID, no test. And the site manager did want to help. He wants to help everyone, but he is lawful good, which, in the real world, often impedes doing good.

When I turned him around this last time, he asked me with all seriousness, "What's the matter, y'all don't want to test Black people?" And I went into a momentary crisis. Of course, I wanted to test Black people. I was volunteering my time, around 60 hours a week, because I had read the literature on health disparities and knew that, despite the data not yet manifesting at the time (this was early April), the United States would undoubtedly be a place where Black people were more harshly affected by a pandemic. I was admittedly indignant. I was a Black woman! Everyone in the registration tent that day was a Black woman. In fact, everyone who was there in registration regularly, six days a week, was a Black woman. The man had been helped by two of us. If he had made it further than registration, he might have also been swabbed by a Black woman and another Black woman would verify the information on his sample and pack it for assessment in the quality control tent.

Later, I started to worry that he was right. As John Jackson has argued, paranoia among Black folks in the United States is not unwarranted (Jackson 2008). To name only a few of the U.S.'s governments human rights abuses: The government and its localized agents have firebombed Black neighborhoods (Messer et al. 2018; Sanders

and Jeffries 2013); given syphilis to people in Guatemala (Rodriguez and García 2013); and run mind control experiments among prisoners in the United States (Hornblum 1998). While paranoia may indeed impede progress (Jackson 2008), freezing people in place instead of sparking them to action, it is not nonsensical. While people are not and do not have to be consistent rational actors, paranoia *is* rational. For instance, why would Black people believe their vote is valued (whether it counts or not, after all, is not the question) when they watched scores of Black people have the poll doors shut on them in Kentucky as recently as June 2020 (Watkins and Mencarini 2020)? Paranoia can be expected when the systematic atrocities committed against certain, specific groups of people have persisted for centuries. Sedgwick (2003) has noted "for someone to have an unmystified view of systemic oppressions does not intrinsically or necessarily enjoin that person to any specific train of epistemological or narrative consequences" (p. 127). *Knowing* that sometimes some patients were paranoid does not give us insight into what they might *do* with that paranoia.

Paranoid thinking penetrated the testing sites. Michelle, a Black nurse, worked her shifts in the "hot zone," the only station in the mobile sites in which staff were supposed to come into direct contact with patients. That means that every day, for one-and-a-half to two-hour shifts, Michelle would don personal protective equipment that included a thin gown that draped over her clothing (usually scrubs), a hair cover, an N95 respirator mask, a face shield and one–two pairs of gloves depending on her personal preference. As temperatures were often above 80 and sometimes shot up near 100, the hot zone, designated as such to indicate level of risk of transmission, was easily transformed into a designation of workers' body heat. Nurses routinely emerged from their shifts doffed and drenched in sweat from head to toe. The outdoor testing model deployed in Houston, perhaps designed from the comfort of an air-conditioned office, was obviously not designed for its sweltering heat and humidity. Nurses therefore spoke of two reasons for moving patients along as quickly and efficiently as possible: reducing exposure to COVID-19 and reducing their exposure to direct sunlight.

One day, Michelle described her interaction with a patient at another site. The patient had gotten through the, at the time, convoluted process of registering online and then through the nurses' hotline, through on-site registration, and was in the hot zone, about to be tested by Michelle. Right as Michelle was going to begin swabbing, the final step in this process, the patient, a young Black woman, became unsure and distressed. She asked Michelle, or maybe wondered out loud, whether the government could be trying to *give* her COVID-19. Hot and apparently confused about why someone would wait until that far into the process to consider this possibility, Michelle said that the "prison nurse inside me came out." She asked the patient in her typical no-nonsense manner, "Look, do you want the test or not?" I cannot remember if the patient did or did not take the test after all, but I do remember Michelle's reaction after telling the story. She laughed, but then her facial expression became serious. She, a nurse acting as an agent of the state but also always in the embodied reality of being a Black woman, entertained the possibility.

The testing site may have invoked in Michelle's patient a "black sense of place" (McKittrick 2011) in which she was "materially and imaginatively *situating* historical and contemporary struggles against practices of domination *and* the difficult

entanglements of racial encounter" (p. 949, emphasis in the original). The Black sense of place associated with the testing site, or the clinic–laboratory more broadly, has a distinct historical genealogy rooted in events like the Tuskegee Syphilis Experiments (Rusert 2019). Rusert has noted how people like Booker T. Washington in the post-slavery era presupposed places like the majority-Black Macon County as a perfect laboratory and Black folks as bioavailable, as part of a broader strategy to reimagine post-slavery Blacks as useful to the nation. Confrontation with the nurse, medical instruments, and the barriers of personal protective equipment recall imagery of the clinic–laboratory and may have invoked in this patient a sense of the imagined bioavailability, violability, and "killability" of Black people in the United States demonstrated at Tuskegee and ongoing as health disparities between Black and White people in the United States persist and, in some areas, grow. Attending to a Black sense of place here requires understanding a Black patient's moment of refusal and a Black nurse's willingness to believe in the possibility of scandal both as ways of creatively understanding and managing an experience with the state in a certain kind of place.

Michelle, having been a prison nurse, matters here, too. Prisons and plantations share space in a Black sense of place as two interconnected sites that have served as central sites for slavery and post-slavery dispossession of Black people (McKittrick 2011). Prisons have been sites for unethical and inhumane medical experimentation, as in the case of cosmetics, mind control drugs, and even dioxin testing of prisoners in the Holmesburg Prison in Pennsylvania until as recently as 1974 (Hornblum 1998). Anthony Ryan Hatch (2019), moreover, has demonstrated how the use of psychotropic drugs to basically perpetually subdue prisoners has pervaded U.S. prisons. Like Eunice Rivers, mentioned earlier, Black people have often served as operatives in these endeavors, employed to facilitate the smooth uptake of interventions.

Michelle's apparent suspicion of the state's intervention points to the uncertainty involved in being endowed with duty, masked sometimes as power, as Black people in the United States. This paranoia has a slightly different character than the one experienced by her patient. Without the explicit social structuration offered by the plantation's organization, paranoia results from the vague and creeping suspicion that one can never be sure where she stands. Audre Lorde (1984: 112) keenly argued that "the master's tools will never dismantle the master's house." What happens when we are duty-bound to work in the master's house and the tools available to us are the master's? If public health and medicine more broadly—constructed within the very same modern paradigm as racial slavery and racial capitalism, and alongside the military–industrial complex—are the master's tools, does there exist an ethics of care and maintenance of life that can be deployed in an ongoing COVID-19 world that does not tacitly threaten to enrich and further empower the master-state?

Conclusion

I return to the question that began these reflections: What does it mean to toil for a country that continues to engage in debates about your entitlements to freedom, safety, and security—debates about your value as a human being? I struggled with these questions as I was dragged through (or by) the months of March, April, May,

and June 2020, each deserving to be named for its momentousness, each toting its own monstrosities. Inundated with media that told me that *this* moment—where COVID meets the resurgence of the #BlackLivesMatter movement—was the apocalypse we had all been waiting for, I had been coerced into forgetting that the apocalypse has been here.

Since 1441, the apocalypse has come and come and stayed for so many Black and indigenous people around the globe (King 2019; Shange 2019; TallBear 2016). The apocalypse is not only ongoing, but frustratingly old. What it means to toil for a country that debates about your value as a human being can only be answered by a story that demands a broader time scale than I have given. The question cannot be thought in the present with relation to what I am doing without conjuring the meanings that might be understood by my mother, her mother, or her mother's mother and on and on. What it means to participate in such a drama is, in short, to be a Black or indigenous person in America (or the broader Americas). Kristen L. Simmons and Kaya Naomi Williams (2018) have written about how difficult it is "to think and write our intellectual projects amid a thick atmosphere of violence and dispossession at the university within which we [are] called to simultaneously play the roles of *both victim and perpetrator of harm*" (p. 146, emphasis added). They continue, "the simple fact of working every day in spaces that [are] predominantly white and predominantly male, within an academic discipline shaped by settler colonialism and white supremacy: all threaten to suffocate when we had come intending to create."

If apocalypse is, as its etymology suggests ("Apocalypse" 2020), truly about uncovering or revelation, what this apocalypse reveals is that any work we do for the settler state, its extractive corporations, and even—or especially—for the university threatens the comfort of knowing we did good work. Black and indigenous people are all the time caught up in a complex of relations that threaten us, and neither the clinic nor the classroom provide the comfort or sacred space we are time and again promised. We are all the time left feeling threatened in spaces structured by plantation politics, threatened to suffocate. Suffocation and breath have long been a part of conversations on Black life at the hands and knees of White supremacy and anti-Blackness. I once naively read as ironic Frantz Fanon saying of himself in *Black Skin, White Masks*: "I must free myself from my strangler because I cannot breathe" (Fanon 2008 [1952]: 12). Really, I thought it was an embellished metaphor.

I read *Black Skin, White Masks* for the first time in 2018 after "I can't breathe" had become the rallying cry for the #BlackLivesMatter movement four years earlier in the wake of Eric Garner's murder. Garner was killed by NYPD officers using a banned chokehold. When police officers in Minneapolis killed George Floyd in an uncannily similar manner, I no longer apprehended Fanon's words as metaphorical. Who gets choked in the streets by police? Which people are most exposed to toxicity in America's and American industry's "sacrifice zones" (Bullard 2000; Nixon 2011)? Whose bodies are placed on the frontlines with or without the guarantee of care for themselves during an international crisis shaped by a highly contagious but, after all, preventable disease? The reality of Black life in the United States is that of a physical and psychological manifestation of being unable to breathe. "Racism is in every step and every breath we take" writes Imani Perry (2019: 11). It is indeed also present in the breaths we do not take, the ones we cannot because we have been

suffocated by police, or by asthma, or by COVID-19 by way of the very actions we take to ensure survival in the master's house by providing care.

Questions of care in the wake of chattel slavery (Sharpe 2016) cannot be untied from questions of power, precarity, vulnerability, and indeed value. These together underpin plantation culture. Care and the multiple forms it takes must be vigorously analyzed and critiqued as it connects to COVID-19, which is, as it reaches the Americas, always already entangled with Black life and Black death. Care, often thought of as altruistic, natural, or ethical (Noddings 2013), was not an afterthought of slavery. Putting Black bodies on the line to tend to others was, and is, intentional. It is no mistake, as Chelsey Carter and Ezelle Sanford, III (2020) have pointed out, that Black women in places like "hyper-segregated" St. Louis have been the first people to die of COVID-19. The United States continues to have a labor problem and a disease burden problem that are tightly connected and stretch well beyond the COVID-19 crisis. Care workers, whether in the domestic or health sectors, are expected to bear the body burdens of everyone else. Black women mentioned earlier sensed deeply the connection between the care and the body burdens they are expected to bear and those of enslaved women before them.

This is not about Blackness. This is just one reflection that might put forth a partial answer to the call from Faye V. Harrison (1998) for anthropologists to focus on *racism*, rather than race. "Blackness is," rather, "an immense and defiant joy" (Perry 2020). Exposing today's "cultural and structural logics" (Harrison 1998) as, if not self-same, at least derivative of those of the plantation should serve as a reminder to those of us who have forgotten that the myth of White supremacy still functions to induce harm today, everywhere we are in America.

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