Chapter 4

Whose Lives? What Values? Herd Immunity, Lockdowns and Social/ Physical Distancing

As in the case of face masking, disagreements about mass public health measures such as lockdowns and physical distancing have dominated the discussion around Covid-19. Policy-oriented discourses such as recommendations and media briefings have argued for more or less severe measures, ranging from national curfews to mandated social distancing, or mitigation strategies built on the premise of quickly reaching herd immunity. All these different measures have been extensively debated in the media and other public forums and continuously monitored by international organizations such as the World Health Organization, the US Centers for Disease Control and Prevention and European Centre for Disease Prevention and Control. Policy arguments have also been revised or refocused in tandem with a growing body of research and natural experiments as countries began to introduce either mandatory or voluntary policies. This chapter examines various arguments deployed in this debate and the complex dialogue between political, scientific and popular values and discourses.

It is fair to say at the outset that, once again, at least some of the resistance to such measures can be explained by the structural and material incoherence of public policy in many areas of the world. As Devi Sridhar, Chair of Global Public Health at the University of Edinburgh, explains (Sridhar 2020), in the case of the UK the late imposition of a full lockdown followed by cycles of short lockdowns, which were not accompanied by an effective test and trace strategy, with people actively encouraged to go abroad on holidays in between these short lockdowns, left many exhausted and confused. Hence, she concludes:

> It's no surprise that those offering easy, compelling solutions – 'You can have your life back by Christmas'; 'It's either the economy or health'; 'This virus is practically harmless to those under 55'; have found a willing audience in a frustrated and fatigued society.

Hickman (2020), Professor of Public Law at University College London, has similarly argued that public policies have obscured the distinction between advice and information about legal prohibitions, which has led to a form of material incoherence that he calls 'normative ambiguity':

> This phenomenon meant that the scope of individual liberty was unclear and at times misrepresented. Whilst the coronavirus guidance was drafted to fulfil well-intentioned public health objectives, by implying, even unintentionally, that criminal law restrictions were different or more extensive than they in fact were and by failing accurately to delineate the boundary between law and advice, the coronavirus guidance failed to respect individual autonomy in a fundamental way.

https://doi.org/10.1017/9781009030687.004 Published online by Cambridge University Press

Furthermore, the arguments supporting the need for and the measures adopted in the implementation of restrictions have been interpreted and applied very differently in various areas of the world, giving some the impression that the measures imposed on different populations are arbitrary and indeed not to be trusted. Early in the pandemic, China introduced a full-blown lockdown in several provinces and imposed very strong measures of control, including barricading of villages, hiring of community guardians, financial rewards for reporting those who broke lockdown regulations and phone apps to track the movement of citizens (Feng and Chen 2020). Several European countries, including Spain and France, also introduced formal curfews forbidding citizens to leave their homes. In Spain, even children under 14 were not allowed to leave their home for a period of six weeks (Hedgecoe 2020), placing immense pressure on them as well as their parents. The level of stress caused by extended confinement varied considerably, depending on the nature of the space in which families experienced the lockdown. Those higher up the social and economic scale, who had more room to work and live, naturally experienced lockdowns and curfews differently from those whose living space was more restricted. As one contributor to a Twitter exchange about the wisdom of lockdowns put it, 'Lockdown is a luxury of the middle classes. . . . Middle classes work from their gardens'.

At the other extreme, the Norwegian government's attempt to introduce an emergency bill allowing the imposition of a limited curfew for a few hours a day, and only in extreme cases, was defeated even before reaching Parliament due to massive public resistance. Similarly, Sweden built its strategy on responsibility and trust rather than enforced restrictions and introduced few behavioural restrictions compared to most other countries (Orange 2020). The UK's approach to lockdown perhaps constitutes the starkest example of structural incoherence and led to widespread confusion and loss of trust. It started in March 2020 with the three-point slogan 'Stay home, protect the NHS, save lives', a clear message that was well received, in part because the National Health Service (NHS) is a widely trusted and much loved institution with which a majority of British people readily identify. In May 2020, however, this slogan was replaced with 'Stay alert, control the virus, save lives', leading to much confusion. Not only was the reference to the much loved NHS lost, but the 'stay alert' message – which replaced an action with a subjective cognitive state – was too vague. Even government ministers were unable to articulate what 'stay alert' meant in practice. Finally, the government went back to the initial slogan of 'Stay home, protect the NHS, save lives' with the third national lockdown in England in January 2021. By then, the argument supporting the need for lockdowns had lost much ground.

Some of the national differences in the way the pandemic was handled might of course reflect differences in the severity of the outbreaks across regions and nations. Importantly, however, they also reflect differences in values and priorities. Lack of attention to differences in the cultural norms and values that underpin the various measures adopted to control the pandemic may be partly responsible for the increased confusion and resistance on the part of sections of the public in various localities. At the level of policy making, the rationale for adopting any measure has to be woven within a broader narrative of the pandemic and its implications for various sections of a given community: child/adult, young/elderly, healthy/vulnerable, wealthy/poor, working/retired and so on. And given that narratives are ultimately 'symbolic interpretations of aspects of the world occurring in time and shaped by history, culture, and character' (Fisher 1987:xiii), degrees of compliance with or rejection of imposed restrictions, especially those that involve major disruption to people's daily lives,

https://doi.org/10.1017/9781009030687.004 Published online by Cambridge University Press

will naturally vary among locales and communities, as some of the examples we discuss in this chapter demonstrate.

4.1 Structural/Material (In)coherence *or* Science vs Values in the Great Barrington and John Snow Declarations

Structural and material incoherence in the scientific discourse about Covid-19 may be ascribed to a lack of acknowledgement of the values underpinning the adversary position rather than inconsistencies in the findings. The debate that followed the Great Barrington Declaration[1] warning against the 'damaging physical and mental health impacts of the prevailing Covid-19 policies' is a case in point. The Declaration was written by Dr Jay Bhattacharya, Dr Sunetra Gupta and Dr Martin Kulldorff and released to the public on 5 October 2020. It was originally signed by some 30+ members of the medical community but went on to attract the signatures of over 42,000 medical practitioners, over 14,000 medical and public health scientists and over 787,000 concerned citizens.[2] It recommended an approach that its original signatories dubbed 'Focused Protection' and defined as follows:

> The most compassionate approach that balances the risks and benefits of reaching herd immunity, is to allow those who are at minimal risk of death to live their lives normally to build up immunity to the virus through natural infection, while better protecting those who are at highest risk. We call this Focused Protection.[3]

Writing in *The Guardian* soon after, on 10 October, Sridhar (2020) accepts that the solution to the crisis 'cannot just be locking down continually' but points to several instances of material incoherence in the Declaration, without specifically engaging with the values that inform it:

> . . . how do you distinguish the vulnerable from the healthy? This isn't just about age – Covid is proven to have worse outcomes in people who are overweight, of particular ethnicities, or have preexisting conditions they may not even be aware of.

The Declaration was soon countered by another manifesto, the John Snow Memorandum, first published in *The Lancet* on 15 October 2020 (Alwan et al. 2020) and to date boasting more than 6,900 carefully vetted signatures by scientists, researchers and healthcare professionals.[4] It argued that '[a]ny pandemic management strategy relying upon immunity from natural infections for COVID-19 is flawed'; that '[u]ncontrolled transmission in younger people risks significant morbidity and mortality across the whole population'; and that this additional human cost 'would impact the workforce as a whole and overwhelm the ability of healthcare systems to provide acute and routine care'. Its authors further dismissed the herd immunity approach as 'a dangerous fallacy unsupported by scientific evidence'. By framing the issue as a question of evidence for or against herd immunity, the debate quickly reached a dead end. Although the theory of herd immunity is embraced by the authors of the Barrington Declaration, evidence claims and arguments in its favour are almost absent from the text. The Declaration tells a different story. Driven by

[1] The Declaration was written and signed at the American Institute for Economic Research, Great Barrington, Massachusetts – from which location it acquired its title.
[2] https://gbdeclaration.org/view-signatures/. [3] https://gbdeclaration.org.
[4] https://www.johnsnowmemo.com/.

https://doi.org/10.1017/9781009030687.004 Published online by Cambridge University Press

a desire to 'protect people', the group wished to counter 'grave injustice' and the 'devastating effects on short and long-term public health'. The consequences of 'current lockdown policies', they argued, include

> lower childhood vaccination rates, worsening cardiovascular disease outcomes, fewer cancer screenings and deteriorating mental health – leading to greater excess mortality in years to come, with the working class and younger members of society carrying the heaviest burden.

As Cayley (2020) notes, 'whether these harms outweigh the benefits of flattening the curve is a moral question, not a scientific one'. While dismissing the validity of its scientific claims, Greenhalgh et al.'s (2020) critique of the Declaration therefore ultimately focuses on issues such as the inhumanity of shutting away the most vulnerable. It also asks questions such as 'who funded this piece of political theatre', thus casting doubt on the integrity and characterological coherence of those who issued the statement. Addressing the issue as an expert in political economy, Murphy (2020) uses stark images to highlight the inhumanity of what is proposed by the Declaration. What it suggests is best described as a 'cull' of the population, he states; its content has everything to do with 'far-right economics' and little to do with epidemiology or science. His article begins by reminding its readers that 'The Nazi's first victims were the disabled, which they saw as an economic drag on society', and ends by evoking a saying that has had considerable resonance in Anglophone and European societies since the Second World War:

> Remember, first they came for those they deemed to be the elderly . . . You can fill in the blanks.

By failing to engage with the values to which the Great Barrington Declaration appeals and focusing instead on the scientific evidence for herd immunity, the John Snow Memorandum fails to argue on the terms of rationality evoked by and relevant to the narrative elaborated by the authors of the Declaration. Furthermore, by not acknowledging the values that underpin that narrative, the authors of the Memorandum fail to address what Fisher refers to as the question of consistency, that is, 'whether the values are confirmed or validated in one's personal experience, in the lives or statements of others whom one admires and respects, and in a conception of the best audience that one can conceive' (Fisher 1987:109). In this respect, Tang (2020) does more justice to the values of the story by acknowledging them as valid, comparing the proposed approach to that already adopted to protect vulnerable sections of the population (mainly the elderly) against influenza, while pointing out the structural incoherence in the proposed 'Focused Protection' approach in the case of Covid-19, where no vaccine was yet available at the time:

> So I appreciate and understand the concerns and the sentiment behind this declaration, and of course other diseases are important and need attention, but without these anti-COVID-19 'tools' [i.e. vaccines], I cannot see how they will achieve this 'Focused Protection' for these vulnerable groups in any practical, reliable or safe way.

In asserting the need to engage with the Declaration on its own terms of rationality and address the values that underpin its narrative of the route out of the pandemic, we do not seek to support its arguments or imply that they are informed by scientific evidence. We merely wish to stress that arguments against lockdowns and other measures for which scientific evidence may be lacking can be driven by a commitment to positive values (such as

https://doi.org/10.1017/9781009030687.004 Published online by Cambridge University Press

concern about growing social problems and inequities among children and young people). Engaging with such arguments on their own terms rather than by recourse to lack or otherwise of scientific evidence can be crucial in creating a productive dialogue with people who hold these values.

An impression of structural and material incoherence can also result from the oversimplification or deliberate undermining of the values that underpin medical expert opinion. In September 2020, two open letters were sent to the UK's four chief medical officers expressing conflicting views among medical experts about how the government should handle the then emerging second wave of Covid-19. Sunetra Gupta, a professor of theoretical epidemiology at Oxford University, Carl Heneghan, director of the Centre for Evidence Based Medicine at Oxford, Karol Sikora, a consultant oncologist at the University of Buckingham, and 30 others called on the government to adopt a more targeted approach by shielding the most vulnerable groups in society rather than imposing local or national lockdown measures.[5] Trish Greenhalgh, a professor of primary care at the University of Oxford, published an opposing letter – endorsed by 22 colleagues – which supported the effort to suppress the virus across the entire population. This letter argued that it would be impractical to cut off a cohort of vulnerable people from the rest in an open society, stated that this is especially the case 'for disadvantaged groups (e.g. those living in cramped housing and multi-generational households)', and pointed out that '[m]any grandparents are looking after children sent home from school while parents are at work'.[6]

Interestingly, both letters – which mainly express differences in values regarding how to define and shield the most vulnerable – were met with criticism regarding lack of evidence, particularly quantitative data to support their claims, as can be seen in the following Twitter comments on the letter by Greenhalgh and colleagues:[7]

Freeman London:
I am afraid that there is little science in this response. What does this even mean? 'a) While covid-19 has different incidence and outcome in different groups, deaths have occurred in all age, gender and racial/ethnic groups and in people with no pre-existing medical conditions. Long Covid (symptoms extending for weeks or months after covid-19) is a debilitating disease affecting tens of thousands of people in UK, and can occur in previously young and healthy individuals' – Of course all cohorts are impacted but what about the numbers!? All decisions should be risk/reward based referencing scientific/analytical data. We are destroying our country from an economic, health and social perspective. Our children will pay the price for decades to come. You must see the big picture here and stop making statements like the above that have no quantitative, scientific basis.

Lesley Atkins
Well said. There has been no intelligent or systemic calibration of the impact of this virus. No thought given to the destruction of people's lives and health and well being; instead we have been subjected to a daily dose of propaganda masquerading as science.

The demand for 'science' and quantitative data to support the claim that 'deaths have occurred in all age, gender and racial/ethnic groups' arguably misses the point – namely,

[5] https://twitter.com/ProfKarolSikora/status/1307972101463212032.
[6] https://blogs.bmj.com/bmj/2020/09/21/covid-19-an-open-letter-to-the-uks-chief-medical-officers/.
[7] See Comments section at: blogs.bmj.com/bmj/2020/09/21/covid-19-an-open-letter-to-the-uks-chief-medical-officers/.

https://doi.org/10.1017/9781009030687.004 Published online by Cambridge University Press

that vulnerable groups are not easily defined and shielded and that everyone therefore needs to be protected, whether through lockdowns or other measures. Knowledge about the exact size of the various groups affected by the virus would not add to or weaken the core argument simply because the argument is not about facts and statistics but about values. Just as the author of the Twitter post (Freeman London) does not see the need to back his claim that we are 'destroying our country from an economic, health and social perspective' by numbers because the assertion is a value statement, Greenhalgh et al.'s argument does not hinge on scientific evidence. What Greenhalgh and colleagues are ultimately suggesting is not that more or fewer lives would be lost if the argument for herd immunity wins, or that the economy is not adversely affected by lockdowns, but rather (implicitly) that *all* lives must be valued and protected, irrespective of the numbers involved and the impact of lockdowns and other restrictions on the economy. This is fundamentally a moral argument about the value of human life and recalls the experience of Dr Clarke, the palliative care doctor whose visceral account of observing the 89-year-old Winston die of Covid-19 we discussed in Chapter 2:

> You could argue – indeed, some commentators have essentially done so – that there was little point to a man like Winston. He was 89 years old, after all, and probably hadn't been economically productive for three decades. He was lucky, frankly, to have had an innings like that. Of course the young must come first. . . .
>
> But to those of us up close with this dreadful disease – who see, as we do, the way it suffocates the life from you – such judgments are grotesque. . . .
>
> Winston, though vulnerable, was loved and cherished. His death was not inevitable, his time hadn't come. He was no more disposable than any of us.

It is important to acknowledge, however, that different people can appeal to the same or similar values to support opposite points of view. Cayley (2020), for instance, argues that in framing the issue as one of not overwhelming the health system to such an extent that doctors are forced to make a decision about who lives and who dies on hospital wards, we merely mask the fact that we are quietly making similar decisions outside the hospital setting without acknowledging them:

> If someone loses a business, in which they have invested everything, and then their life falls apart, have they not been sacrificed or triaged, just as surely as the old person who we feared might not get a ventilator? Moral decisions are difficult, but they should at least be faced as moral decisions.

Giorgio Agamben, who has been a vocal critic of Covid-19 restrictions – not only lockdowns and various restrictions on mobility but also measures such as the mandatory use of face masks – also appeals to our sense of shared humanity when he argues (Agamben 2021:60):

> . . . the Church has radically disavowed its most essential principles [in the context of Covid-19]. Led by a Pope named Francis, it is forgetting that St Francis embraced the lepers. It is forgetting that one of the works of mercy is visiting the sick. It is forgetting the martyrs' teaching that we must be willing to sacrifice life rather than faith, and that renouncing one's neighbour means renouncing faith.

Interestingly, too, the argument against herd immunity is often informed by a belief in the value of autonomy and personal freedom rather than the value of all or some human

https://doi.org/10.1017/9781009030687.004 Published online by Cambridge University Press

lives *per se*. Many people instinctively reject the idea of 'following the herd' uncritically and prefer to think of themselves as free and independent human beings. As Larson (2020: 23) points out, the very term herd immunity 'provokes perceptions of people being herded like sheep and assuming an unquestioning herd mentality, lacking autonomy, and just doing what the "system" dictates'.

To return to the letters by Gupta et al. and Greenhalgh and colleagues, some responses to the latter used the interdependence between health and the economy to point to instances of structural/material (in)coherence, as in the following tweet, which starts with the incoherence of sacrificing the very economy on which the NHS depends for survival and then goes on to question values such as the acceptance or otherwise of a certain threshold for overall Covid-related deaths and the disregard for civil liberties:[8]

> **Dental Law & Ethics**
> Question 1) How do you 'protect the NHS' by bankrupting the country, the tax base of which is primarily used to fund the NHS? Question 2) How do the supporters of the nationwide lockdowns feel we should address the disastrous international consequences of said lockdowns. For example, the UN have stated nearly 250 million people face starvation as a direct result. Question 3) How many deaths directly attributable to the lockdown are acceptable? Spike in suicides (e.g. 500 directly related to the lockdown in Thailand in a country with less than 30 COVID deaths), 350 K people not getting the cancer care they need and the 3 million missed screenings which will see a spike in cancer deaths due to missed early treatments and diagnosis. Question 4) Why was Prof Petersons model (which has been widely criticised by anyone who got to examine the source code) so readily accepted whilst Sunetra Gupta's Oxford model was ignored? Question 5) Are those who support the lockdown regime willing to accept the loss of the civil liberties of their children going forward?

Paradoxically, an explicit aim of both letters (Gupta et al.'s and Greenhalgh's) was to argue against a polarized view. The letter by Gupta et al. argues that the debate is stuck in an 'unhelpfully polarised' deadlock between those who claim that Covid is 'extremely deadly to all' and those who believe that it 'poses no risk at all'. Greenhalgh et al. also explicitly argue against polarization:

> 'Facts' will be differently valued and differently interpreted by different experts and different interest groups. A research finding that is declared 'best evidence' or 'robust evidence' by one expert will be considered marginal or flawed by another expert. It is more important than ever to consider multiple perspectives on the issues and encourage interdisciplinary debate and peer review.

Unfortunately, in the heated debate that followed the publication of the two letters these values of conciliation, the need to embrace uncertainties and the importance of interdisciplinary debate – all of which are explicitly promoted by the authors of both letters – were rarely acknowledged or discussed.

A final limitation on the potential resonance of either side of the debate initiated by the two letters for large sections of the global community is, as one comment put it, that it is all

[8] Again, see Comments section at:https://blogs.bmj.com/bmj/2020/09/21/covid-19-an-open-letter-to-the-uks-chief-medical-officers/#comment-5080833679.

https://doi.org/10.1017/9781009030687.004 Published online by Cambridge University Press

about the UK, with no consideration given to the very different environments in which the pandemic has had disastrous consequences for various sectors of society:[9]

> **M Lyndon**
> . . . This open letter is about the UK. In countries where people literally face starvation, lockdowns probably aren't effective. The only bright side to a very dismal picture is that such countries typically have younger populations and lower rates of diabetes and obesity.

Writing on the London School of Economics blog early in the outbreak, on 27 March, Broadbent and Smart (2020) were already aware of differences in the way restrictions on mobility would be experienced in various parts of the world. They argued that a one-size fits all approach cannot work, and focusing especially on Africa and the potential for widespread starvation they pointed out:

> The crunch question is this: what is the case fatality rate of social distancing in Africa? We have no idea; but that is the figure that should be considered when implementing social distancing measures. The scientific community, including both epidemiologists and economists working together, should be putting as much effort into estimating that case fatality rate as into estimating it for COVID-19.

In addition to fatalities resulting from potential starvation, Broadbent and Smart (2020) further highlight the impracticalities of social distancing in some parts of a country such as South Africa, where there is a very high level of interdependency among households:

> In a South African township, living conditions are extremely crowded. Socialising is unavoidable. You might as well tell people to emigrate to Mars. In the bubonic plague, the aristocracy left London for the countryside; the poor of London could not isolate themselves, and so they died. This may be our situation.

The living conditions they describe are not restricted to South African townships but are typical of many parts of the world, as well as within certain communities in Europe and the USA. Alser et al. (2020) make a similar argument in relation to the particularly dire situation in Gaza, which has already suffered a prolonged blockade since 2007:

> Unlike the 'one size fits all' approach, measures that have proven successful in other countries might not be effective in densely populated and disadvantaged environments such as Gaza. Avoiding social gatherings or observing the two-metre distancing measure could well be viewed as foreign concepts and its effectiveness will be limited among Palestinian extended families living in overcrowded refugee camps.

Other interdependencies go beyond individual households and extended families; these interdependencies connect the city with the informal settlements that often provide it with vital services. Talking about the challenges involved in implementing Covid-related restrictions in Sierra Leone slums, Wilkinson (2020) points out that

> Informal settlements and their residents are part and parcel of the city system, often subsidising and contributing to life elsewhere in the city. This makes control efforts built

[9] Once again, see Comments section at: https://blogs.bmj.com/bmj/2020/09/21/covid-19-an-open-letter-to-the-uks-chief-medical-officers/.

https://doi.org/10.1017/9781009030687.004 Published online by Cambridge University Press

on containment and reductions in movement difficult to implement, especially if they impinge on people's already threadbare livelihoods.

Narratives revolving around the wisdom or otherwise of lockdowns and other restrictions that take no account of the specific social, political and cultural realities of a given population clearly will not resonate for members of that population and will not be seen as coherent from their perspective. However scientifically valid and rational they are, the lived experience of each community will ultimately determine its response to such measures and its ability to abide by them. In Fisher's terms, narratives that are at odds with our immediate experience of the world will be seen as lacking in both probability and fidelity. Inhabitants of a South African township or a Gaza refugee camp will see the contradictions inherent in a narrative that asserts the need to abide by social distancing given the physical reality in which they live, and will judge it as lacking in material coherence. The narrative will also not fare better from the perspective of the logic of good reasons, and especially the third criterion of *consequence*, as we defined it in Chapter 2 (Baker 2006:152):

> This criterion focuses on the real world consequences of accepting the values elaborated in the narrative. Here, we ask '[w]hat would be the effects of adhering to the values – for one's concept of oneself, for one's behavior, for one's relationships with others and society, and to the process of rhetorical transaction?'.

Similar considerations will be at play in assessing narratives that attempt to negotiate the tension between health and the economy from a variety of other perspectives.

4.2 Health, the Economy and the State: Resonance and Lived Experience

The tension between health and economic priorities has featured in many debates and venues beyond the sources discussed above, and beyond the medical establishment. Bolsover's (2020) analysis of pro- and anti-restriction discourse on social media in the USA from the early phase of the pandemic cites angry tweets that are concerned about the impact of lockdowns and other restrictions on small businesses:

> Had to stop at the local Walmart today. It was PACKED. Just goes to show you how unethical this lockdown is. I can go to a packed Walmart to buy art supplies but I can't go to the tiny local art store to buy art supplies. The disproportionate hit to small businesses is criminal.

Others point out that at the same time as these restrictions are hitting small businesses hard, they are benefitting big companies hugely, especially online companies like Amazon, in the process bringing up the issue of control over the media and the power of big business to shape policy:

> Lockdown increases Bezos wealth by tens of billions, who would have guessed that Amazon would benefit from hundreds of millions of other businesses closing down worldwide – many never to reopen? The Bezos-owned Washington Post says 'Lockdowns must continue'.

Even those who argue for lockdowns share the concern with the growing wealth and influence of big companies:

> It's wild to me that people think lockdowns are corporate/government conspiracies. The conspiracy you should be worried about is one where everyone is told that it's safe to

https://doi.org/10.1017/9781009030687.004 Published online by Cambridge University Press

> resume daily life as usual, when it's not, because fucking Walmart is worried about their bottom line.

In addition to the impact of restrictions on small as opposed to big businesses, some of the debate has also revolved around the distinction between essential and non-essential businesses, where areas of structural and material incoherence could be identified and questioned. Henry (2021) contests the distinction, arguing that 'small businesses are deemed non-essential, yet they provide the same products that essential, big-box stores sell on their shelves', and concludes that '[a]ll businesses should remain essential with mandatory social distance measures, capacity limits, and necessary safety protocols, so permanent closures and lay-offs are no longer a trend'. Some of the tweets cited in Bolsover (2020) question the distinction between essential and non-essential services and institutions beyond the sphere of (corporate) business, in ways that reveal deep-seated mistrust of the official institutions in the USA:

> Does anyone else find it ironic that we are all on lockdown, and businesses are closed, just to try and save lives, yet abortion clinics are still open? #openohionow

The debate about the relative importance of health vs the economy has thus tended to spill out into other areas of political, religious and social life where tensions of various kinds have been fermenting for many years. These tensions may be behind a lack of trust in the same institutions now elaborating particular narratives that promote measures such as lockdowns. And since any narrative is ultimately a story of values, as Fisher asserts, the third criterion that informs the logic of good reasons, namely *consistency*, is not met from the perspective of those members of society who mistrust these institutions. For the criterion of consistency – as we have already pointed out – requires a positive answer to the question: 'Are the values [that explicitly or implicitly inform the narrative] confirmed or validated in one's personal experience, in the lives or statements of *others whom one admires and respects*' (Fisher 1987:109; emphasis added) and, we might add, *whom one trusts*. Lack of trust in the institutions that promote and impose restrictive measures such as lockdowns also means that these institutions lack characterological coherence, in Fisher's terms. The narratives they promote are therefore not accepted as reliable or genuinely intended to safeguard the interests of the population.

Some of the protests against lockdowns and other restrictions focused specifically on their impact on the livelihoods of ordinary people rather than the economy as such. This represented a major concern and a good reason (in Fisher's terms) for questioning the wisdom and necessity of lockdowns from the perspective of the lived experience of a large section of all populations. Even in wealthy countries like the UK, '[t]he biggest victims of lockdowns and curfews have been blue-collar workers, the self-employed and those whose livelihoods depend on servicing the better-heeled in the metropolises of early 21st-century capitalism' (Coman 2020). But as we have already seen to some extent in the previous section and as Carothers and Press (2020) point out, the livelihood argument against lockdowns was particularly strong in developing countries, 'which have larger informal sectors where economic margins are thinner and remote work is often impossible'. In April 2020, Aljazeera reported that thousands of street vendors in Malawi marched with banners such as 'Lockdown more poisonous than corona' and 'We'd rather die of corona than of hunger'.[10] In Kampala, the capital of

[10] www.aljazeera.com/economy/2020/04/16/informal-vendors-rally-against-coronavirus-lockdown-in-malawi/.

https://doi.org/10.1017/9781009030687.004 Published online by Cambridge University Press

Uganda, street vendors likewise continued to scurry to the windows of vehicles in traffic lights and jams, without masks. For them, isolating at home meant starving to death: 'The street is their workplace, livelihood and home' (Anguyo and Storer 2020). In South Africa, those working in particularly vulnerable sectors such as hospitality and retail 'protested against limitations on in-person operations' (Carothers and Press 2020). Protests that focused on the impact of restrictions on livelihoods often turned violent: 'In Lagos, Nigeria, a police spokesman said that workers in the Lekki Free Trade Zone had assaulted police, injuring several officers, after being told they could not work due to public health measures' (Carothers and Press 2020). In Malawi – 'one of the poorest countries on the continent where more than half of the population live below the poverty threshold' – civil rights organizations applied for a court order to stop the government implementing the lockdown, citing 'the government's failure to announce any measures to cushion the poor'.[11] In countries with a very high level of poverty, the issue of individual livelihoods therefore featured very prominently and invited strong responses (Figure 4.1). Arguments about the impact of restrictions on the economy as a whole, or on small vs big businesses and essential vs non-essential services, were relatively

Figure 4.1 Malawi sex workers protest restrictions on opening times of bars during Covid-19 crisis, 28 January 2021. AMOS GUMULIRA / Contributor / Getty Images.

[11] www.aljazeera.com/economy/2020/04/16/informal-vendors-rally-against-coronavirus-lockdown-in-malawi/.

https://doi.org/10.1017/9781009030687.004 Published online by Cambridge University Press

less prominent, reflecting the importance of visceral, lived experience – rather than abstract arguments about health vs the economy – on people's immediate assessment of the validity of Covid-related narratives.

The lived experience of populations who had reason to mistrust the state and official institutions also played a major role in shaping their responses to Covid-related restrictions. Carothers and Press (2020) point out that a recurrent theme in anti-lockdown protests concerned a perceived harshness and inconsistency in the way lockdowns were enforced and a misuse of the new rules by different regimes 'for repressive ends'. The Freedom House 2020 report, 'Democracy under lockdown' (Repucci and Slipowitz 2020), acknowledges that the crisis of democratic governance around the world predated the pandemic, but points out that many governments 'are also using the pandemic as a justification to grant themselves special powers beyond what is reasonably necessary to protect public health'. In Egypt, the military regime 'used COVID-19 as an opportunity to further repress political activists, rights defenders, lawyers, journalists, and doctors, arresting dozens, denying them basic assistance in places of detention, and placing several on terrorist lists' (Repucci and Slipowitz 2020). Liberia, likewise, witnessed a 'brutal and corrupt enforcement of curfew orders by security forces', and in Zimbabwe, the pandemic gave the authorities licence 'to arrest, abduct, rape, assault, and intimidate human rights activists, opposition party leaders/ supporters, civil society leaders, journalists, and other dissenting voices on "allegations of violating lockdown conditions"' (Repucci and Slipowitz 2020). In Uganda, '[t]he violent arrest of 23 citizens taking refuge in a shelter serving the LGBT community in Kampala, targeted for their alleged "public gathering"', similarly raised concern regarding widespread discrimination against lesbian, gay, bisexual and transgender (LGBT) groups (Storer and Dawson 2020). Elsewhere, lockdown measures were selectively enforced on some segments of the population rather than others. For example, in Bulgaria 'Romany neighborhoods were placed under harsher movement restrictions than areas where Roma did not constitute a majority', and in Kuwait 'authorities put greater restrictions on noncitizen neighborhoods than on areas where mostly citizens live'[12] (Storer and Dawson 2020). In the UK, young men aged 18 to 34 who belong to ethnic minorities were found to be twice as likely to receive fines for breaking lockdown rules as their white counterparts.[13] From the perspective of those at the receiving end of such discriminatory practices, the narratives justifying lockdowns and other restrictions lack coherence and consistency and can have little or no resonance. No amount of rational argumentation or scientific, quantitative data brought in to support the need to abide by such measures can compensate for the immediate impact of such communities' lived experience on their decision-making process.

4.3 Transcendental Values and Conceptions of Freedom

Much of the resistance to lockdowns and other such restrictive measures during the Covid-19 crisis was informed by a specific understanding of the balance between individual freedom and social responsibility, and hence the boundaries of legitimate intervention by the state. According to Carothers and Press (2020), protests that advocated individual

[12] Non-citizens are 'a stateless Arab minority in Kuwait who were not included as citizens at the time of the country's independence or shortly thereafter' (Minority Rights Group International). They are known as *bidoon*, literally meaning 'without [nationality]'. See https://minorityrights.org/minorities/bidoon/.

[13] www.bbc.com/news/uk-53556514.

https://doi.org/10.1017/9781009030687.004 Published online by Cambridge University Press

freedom over restrictive public health measures such as lockdowns and quarantines were 'generally concentrated in developed countries', including much of Europe, the USA and Canada. They were characterized by a 'wariness of science and immersion in misinformation' and 'highlight the distrust of authority that is coloring so much of global politics today'.

Bolsover (2020) identifies various understandings of freedom that underpin the debate about pandemic measures, all of which reveal a negative view of liberty as *freedom from restrictions*, with **freedom of movement** as a recurrent theme. Many anti-restriction posts considered freedom of movement as the ultimate expression of freedom, as evident in the following tweet, quoted by Bolsover (2020):

> #OpenCalifornia #opencalifornianow it's time people of the great nation of America to open your doors and not let a silly virus stop you!

Here, freedom of movement is conceived from the perspective of right-wing nationalism, which places much value on the protection of what it perceives as core American values (or, in other cases, core British values, core Chinese values, etc.). For some, like the author of the above tweet, these are transcendental values that trump any other value – or, for that matter, scientific evidence – because they are part of the core identity of those who hold them, a fundamental means by which they demonstrate that they belong to the community they have come to identify with. However, concerns have also been raised from a very different ethical perspective about how emergency measures negatively impact freedom of movement for vulnerable groups. In an article in *OpenDemocracy*, Mezzadra and Stierl (2020) argue that the 'stay at home' message is highly problematic for 'people who do not have a home and for whom self-quarantine is hardly an option, for people with disability who remain without care, and for people, mostly women, whose home is not a safe haven but the site of insecurity and domestic abuse'. The consequences of blanket restrictions on movement, moreover, are particularly serious for vulnerable groups who need to move in search of safety and whose freedom of movement was already restricted prior to the pandemic (Mezzadra and Stierl (2020)):

> Migrants embody in the harshest way the contradictions and tensions surrounding the freedom of movement and its denial today. It is not surprising that in the current climate, they tend to become one of the first targets of the most restrictive measures.

Not only are migrant populations subject to confinement measures that are legitimized by often spurious references to public health, but they are also deprived of 'this freedom to move' that for them represents 'safety from war and persecution, safety from poverty and hunger, safety from the virus'.

Like freedom of movement, the **right to religious assembly** constitutes a transcendental value for many worshippers, of all creeds. Bolsover (2020) quotes one tweet expressing frustration with what is clearly seen as interference in religious life in the USA – 'I'm tired of pastors getting arrested for having church services' – but similar sentiments have been expressed by other congregations in different parts of the world. Protestors in ultra-Orthodox Jewish neighbourhoods in Jerusalem, for instance, responded violently to police attempts to 'clear yeshiva classes and religious gatherings being held in violation of lockdown rules' in January 2021 (Hendrix and Rubin 2021). Many Iranian religious leaders resisted the closure of pilgrimage sites 'as an affront to their beliefs', and the caretakers of

https://doi.org/10.1017/9781009030687.004 Published online by Cambridge University Press

holy shrines refused to close them down (Iran News, February 2020).[14] In the holy city of Qom, one individual expressed his anger at restrictions on religious assembly by deliberately licking the grid of a shrine (Hendrix and Rubin 2021).

Not all worshippers, of course, and not all religious communities have questioned restrictions on religious assembly in the context of Covid-19. The rector of the All Saints' Anglican Church in the Waterloo region of Southern Ontario, Canada found it 'puzzling that religious communities have been at the forefront of the protests' (Veneza 2021). His own congregation had moved to virtual media to conduct their faith, prioritizing the need to 'care for one another' and recognizing that 'the simplest way and best way we can care for one another is to protect one another'. Moving to online services, he argued, had further allowed more people to participate who would otherwise not have been able to attend. Imam Abdul Syed of the Waterloo Mosque in the same region confirmed that his congregation, too, was 'willing to do its part to deal with the health crisis before returning to in-person worship' (Veneza 2021):

> "We want to see [the coronavirus] gone from the world," said Syed. "We want to see Canada as a safe place for everyone so, we don't want to put any lives in jeopardy."

Here we have two religious communities based in the same region, which seem to identify with the larger, national community in which they are embedded and are hence willing – indeed, feel obliged – to adhere to any measures that they believe would serve its welfare. Such wildly different responses to restrictions on religious assembly by equally devout communities reflect differences in political cultures, the degree of trust in policy makers and the medical establishment and a sense of belonging to a community that is either restricted to or is larger than their immediate religious group. They also reflect different understandings of freedom – in the latter case of worshippers in the Waterloo region, understood as freedom *to* rather than freedom *from*.

Ultra-religious groups of all creeds aside, concerns have also been voiced about the consequences of restrictions on religious assembly for vulnerable minority groups. Ekeløve-Slydal and Kvanvig (2020) report that in India lockdown rules were used by Hindu state officials to target the Muslim minority populations, and Hasan (2020) confirms that the targeting of Muslims was sanctioned at the highest levels:

> The government itself has blamed around a third of India's confirmed Covid-19 cases on a gathering held in Delhi by a conservative Muslim missionary group called the Tablighi Jamaat; one BJP minister called it a 'Talibani crime'.

In Georgia, religious assembly was allowed for Orthodox Christians during Easter but the authorities 'reacted with hostility when Muslims wanted to gather for Ramadan' (Ekeløve-Slydal and Kvanvig 2020). Such instances of structural and material incoherence in the implementation of restrictions serve to undermine trust in policy makers and the medical establishment, at the same time as strengthening the need among minority groups to demonstrate identification with their religious community rather than with the overall society in which they live.

14 https://en.radiofarda.com/a/man-seen-licking-shrine-grids-despite-coronavirus-arrested-in-iran/30462926.html.

https://doi.org/10.1017/9781009030687.004 Published online by Cambridge University Press

A 'Factsheet' on coronavirus issued by the United States Commission on International Religious Freedom at the start of the crisis, in March 2020, predicted the impact of restrictions on movement on various religious communities and called for addressing their concerns to ensure both respect for their human rights and efficacy of implementation of health policies (Weiner et al. 2020):

> It is important for governments to account for religious freedom concerns in their responses to COVID-19, for reasons of both legality and policy effectiveness. From a legal perspective, international law requires governments to preserve individual human rights, including religious freedom, when taking measures to protect public health even in times of crisis. From an efficacy perspective, considering religious freedom concerns can help build trust between governments and religious groups, who in past public health crises have played a critical role in delivering health interventions. Such concerns include the cancellation of large gatherings, among them religious activities, where viruses easily can spread.

Freedom of religious assembly is a particularly sensitive issue for many, whatever their creed, and efficacy of implementation in this area – as in many others – requires trust in medical advisers and policy makers. But trust is negatively impacted by perceptions of structural and material incoherence that remain unaddressed. As many have pointed out, pandemic restrictions do not distinguish between religious gatherings and other kinds of public events and do not provide a rationale for failing to do so. Writing on the UK Human Rights Blog, Keene (2020) argues:

> Ultimately, the right to practice religion is specifically protected by the ECHR [European Court of Human Rights] in a way that e.g. attending a football match is not. But overall the impression is given that worship and religious services have been considered together with other public gatherings or activities.

For Keene, this is particularly problematic because the evidence given to the UK Parliamentary Science and Technology Committee by the Chief Medical Officer and the Chief Scientific Adviser for England confirms that 'there has been at best very limited tailored analysis of the specific risk of transmission of Covid-19 in the context of religious services'.

4.4 Public Health Recommendations and the Values and Principles of Evidence-based Policy Making

This brings us to the nature of the medical evidence which has informed policy making throughout the pandemic and the values that underpin it. In the scholarly debate about mass public health measures, some have argued that the pandemic has changed the values and ground rules of evidence-based policy making. Since its emergence in the early 1990s, evidence-based medicine has been founded on the idea of transparent access to the evidence base underpinning healthcare recommendations, through systematic reviews of state-of-the-art research (Timmermans and Berg 2003). As such, medical evidence has arguably been detached from the expert and made available through texts that are accessible to everyone. According to Axe et al., authors of *The Price of Panic: How the Tyranny of Experts Turned a Pandemic into a Catastrophe* (Axe et al. 2020), the current pandemic has reversed these principles and replaced democratic access to evidence with 'a tyranny of experts' in which a 'narrow, professionally biased thinking dictates policy for everyone' (Axe et al. 2020:156),

https://doi.org/10.1017/9781009030687.004 Published online by Cambridge University Press

or as the authors put it in an article following the publication of their book, 'government bureaucrats with narrow expertise gained the status of infallible oracles' (Richards et al. 2020). A similar view is expressed by Norman Lewis on *Spiked*: 'The experts have set the goal, and the politicians have cast themselves in the role of their spokespeople' (Lewis 2020). This approach has allegedly not only 'mystified expertise' (Lewis 2020) but also maximized 'a certain kind of safety, to the neglect of other goods'. This is not necessarily a result of bad intentions on behalf of the experts, Richards et al. (2020) claim, but a result of their limited perspective:

> Such officials tend to think in bulk, to focus on the quantity of abstract life protected in the near term, rather than the quality of actual lives lived over the long term . . . Looking for problems is a physician's job. Misdiagnosis could be considered malpractice. This makes them risk-averse and hypervigilant. They tend to respond to the worst-case scenario. But you, as a patient, have different aims. What you deem best for you, weighing costs and benefits, may not be what is best for the doctor who is treating you.

According to Richards et al. (Richards et al. 2020), the status and obscurantism of this new elite of medical expert bureaucrats made it possible to mask material and structural incoherence in their recommendations for some time in the initial stages of the pandemic:

> In downplaying the danger early on, the World Health Organization seemed to be carrying water for the regime in Beijing. . . . But in March, the UN agency reversed course. WHO Director-General Tedros Adhanom Ghebreyesus pointed to a scary model from the Imperial College London, which predicted as many as 40 million people could die worldwide without draconian efforts to reduce the spread of the virus. It would be more than a month before non-experts learned that the model was little more than high tech, unreliable conjecture.

From a very different angle, the same experts have been accused of putting *too much* emphasis on the values of evidence-based medicine, especially randomized controlled trials. 'The search for perfect evidence may be the enemy of good policy', Trish Greenhalgh says in an interview with *Science*: 'As with parachutes for jumping out of airplanes, it is time to act without waiting for randomized controlled trial evidence' (Shell 2020). A paper Greenhalgh co-authored with Henry Rutter and Miranda Wolpert (Rutter et al. 2020) encourages public health experts to embrace uncertainty rather than searching for a unified evidence base:

> Even when an evidence base seems settled, different people will reach different conclusions with the same evidence. When the evidence base is at best inchoate, divergences will be greater. Unacknowledged or suppressed conflicts over knowledge can be destructive. But, if surfaced and debated, competing interpretations can help us productively to accept all options as flawed and requiring negotiation between a range of actors in the complex system.

The debate about various measures enforced to control the pandemic is thus closely linked to a debate about scientific rationality and its underlying values. The various issues and examples discussed in this chapter, moreover, clearly demonstrate that neither pro- nor anti-restriction discourses can make absolute claims to reason or rationality. Ultimately, we reiterate, arguments both in favour of and against lockdowns and other social restrictions are backed by values and normative commitments that are narratively rational even when not backed up by scientific evidence.

https://doi.org/10.1017/9781009030687.004 Published online by Cambridge University Press