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## What Physics Instructors Might Do to Support Immunosuppressed Students in the Return to In-Person Instruction: *Thoughts from one chronically ill and immunosuppressed physicist*

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## What Physics Instructors Might Do to Support Immunosuppressed Students in the Return to In-Person Instruction: *Thoughts from one chronically ill and immunosuppressed physicist*

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As I type, it is late September 2021, and emails are streaming into my inbox about my university's return to in-person instruction in just a few weeks. I wish I could say I feel excited or relieved or grateful for all of the incredible care that went into planning for this, but I actually just want to scream. Because no matter what we do, we are still in the midst of a

global pandemic with variants that are "covered in ultrafast-drying Gorilla super glue" that "make [them] extremely effective

in attaching to human cells and gaining entry,"<sup>1</sup> and returning to in-person instruction is not safe. I know this in my gut because I am chronically ill and immunosuppressed, and my survival depends on my careful assessment of risk in this pandemic climate.

And yet... we will return to face-to-face instruction. And your students—including your high-risk students—will be looking to you to create as much safety for them as you can muster. I'm here to share with you what I think that could look like for students like me. I am a white, wealthy, cis-gendered, thin, immunosuppressed female physicist and physics education researcher. My positionality as an immunosuppressed physicist affords a "unique standpoint"<sup>2</sup> that troubles prevailing narratives of normality in the COVID-19 pandemic, and the perspectives that my standpoint affords are limited by my not having been the target of the ways in which the COVID-19 pandemic has intersected with and amplified racism, classism, transmisia, fatmisia, xenophobia, and epistemic violence fueled by colonization.<sup>3-9</sup>

What I most want instructors to know is that the past 18 months have been traumatic for many immunosuppressed people, and the trauma is ongoing. This trauma is due in part to the virus itself and the risk it poses to bodies like mine. A recent study<sup>10</sup> reports that certain vaccinated immunosuppressed people were 82 times more likely to develop a breakthrough infection and 485 times more likely to become seriously ill or die than vaccinated, non-immunosuppressed people. Those are staggering numbers, enough to take my breath away. Surviving in a climate with this kind of risk—where the risk itself is breathing around humans—requires a level of hypervigilance that makes fight-flight-freeze the operative mode.<sup>11-13</sup>

As if this risk were not enough, the normalization and amplification of ableist narrations of disabled and chronically ill people during the COVID-19 pandemic has been deeply

traumatizing.<sup>14</sup> At the start of the pandemic, a rhetoric of *disposability* undergirded the broad social messaging that "only chronically ill and older people were dying"<sup>15,16</sup> of COVID-19. This messaging implies that people *should not worry about the pandemic unless they are chronically ill or older*, as though the serious illness and death of chronically ill

and older people need not concern the general population. As the pandemic waned on, we

adopted a rheto-

ric of *invisibility*, reflected in (i) messaging about a "return to normal," with language that "vulnerable people can just stay home,"<sup>17</sup> and in (ii) public health guidelines that imply that it is safe to resume pre-pandemic activity once vaccinated,<sup>18</sup> when the vaccine is not effective for many immunosuppressed people.<sup>19</sup> More recently, news outlets<sup>20</sup> have framed immunosuppressed people as *dangerous*, based on studies that show that the virus can evolve in immunosuppressed patients, calling us the source of "variants of concern circling the globe."<sup>21</sup>

T.L. Lewis defines ableism as "a system that places value on people's bodies and minds based on societally constructed ideas of normality, intelligence, excellence, desirability, and productivity," and Lewis notes that "these constructed ideas are deeply rooted in anti-Blackness, eugenics, misogyny, colonialism, imperialism and capitalism."<sup>22</sup> The ableist discourses of disposability, invisibility, and danger I describe above, which pathologize and minimize immunosuppressed people, are often marshaled to rationalize choices that increase the risk of spread. Like other oppressive ideologies,<sup>23</sup> they refuse to acknowledge our deep interconnectedness, including the impact our individual actions have on one another in a global pandemic, and thus the responsibility we have to keep one another safe. The discourses do not name the ways that this ideology is harmful to us all, including capitalistic prioritizations of labor and efficiency over safety and community care. And, like many harmful rationalizations, the discourses are self-inconsistent in ways that adapt to the needs of the dominant group at the expense of the oppressed group.

For example, given that it is the very nature of viruses to evolve and that viruses evolve through spread, the logic of immunosuppressed people as dangerous is self-inconsistent in ways that serve the dominant group. This logic goes something like: disabled people are dangerous sources of viral evolution so should just stay home, so that non-disabled people

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can contribute dangerously to viral evolution by resuming high-risk activity. Among other things, believing that immunosuppressed people are the dangerous ones (and that the danger they pose can be mitigated by their individual action) recuses the dominant group from taking responsibility for the risk that their behavior poses.

As this example illustrates, I want you to know that the risk I have experienced during the COVID-19 pandemic has been *significantly* increased by ableist ideologies. These ideologies justify risky behavior that increases community spread, making it more likely that I will contract COVID when I participate in activities that are necessary for my survival or functionality (like going to the doctor, or, if I were a student, attending class).

Instructors, I also want you to know that what many universities are doing as we return to in-person instruction is dangerous and deploys similar ableist narratives. For example, many institutions are not offering accommodations that allow vaccinated immunosuppressed students to continue learning remotely; institutional communication often assumes that COVID risk is mitigated by the vaccine; and the assumed general sentiment is that we are all celebrating being together again. These narratives treat the presence, safety, and needs of immunosuppressed students as less important than the wishes of those who want to “return to normal” and believe this is safe. “Safety” is often defined from the able-bodied standpoint (reminiscent of notions of “safety” in former CDC guidelines that unmasking was safe for vaccinated individuals). The deployment of ableist narratives in support of educational decision-making and policy is not unique to the COVID-19 pandemic; ableism is “normal” in K-12 and higher education, and it is entangled with and reinforces other oppressive ideologies.<sup>24,25</sup>

All of this means that your following university policy is unlikely to be sufficient to keep me and students like me safe. If I were an instructor welcoming me into a classroom, there are some additional steps I would take. In our current state of collective trauma and nervous system dysregulation, my own perspective is that safety and care are more important than anything you are going to teach your students.<sup>26</sup> As such, I would seek to:

- 1. Enact trauma-informed practices.** Trauma-informed frameworks are a response to the realities and impacts of trauma on our well-being and capacity to learn. Frameworks for these practices<sup>27</sup> include principles of prioritizing relationships over deliverables, setting clear expectations and communicating with transparency, and taking opportunities to affirm students. This means: get to know your students, tell them what they need to do to be successful with clarity and detail, and notice and praise what they are doing well.
- 2. Cultivate a community of care.**<sup>28</sup> Trauma-informed practices complement community care principles: the former emphasizes safety, the latter taking care of one another and ourselves. In communities of care, we are genuine in asking, “How can I help?” Not, “How

can I take this hard thing away?” but, “Is there any relief I can offer you?” or “Is there any comfort my presence can bring?” Community care means that when harm is reenacted through ableist discourse or when one person’s actions increase risk for another person in the community, this is acknowledged and repair is offered. Community care can be as expansive as organizing course culture around negotiated community norms, and as small-scale as inserting a get-to-know-you activity where you ask students if there are any accommodations they might need, or any ways you can work to make them feel safe.

- 3. Take responsibility for your role in keeping immunosuppressed students safe.** To me, this means taking responsibility for enforcing safety protocols so that high-risk students don’t have to and offering accommodations as you can. Unfortunately, basic safety protocols have become sources of polarization, and immunosuppressed students may not only risk disclosure of their disability status to their peers in asking for adherence, but also risk social and material consequences for doing so. Plus, we should not be asking our high-risk students to do this emotional labor to keep all of us safe. Importantly, this principle also means taking responsibility for the role that ableism has played and continues to play in your thinking and decision-making during the pandemic, and working to contest and destabilize these narratives. This could start with reading a book or following a blog written by a disabled and/or chronically ill author,<sup>29-32</sup> hiring a consultant or coach focused on disability justice,<sup>33,34</sup> and/or joining a professional learning community focused on dismantling ableism.<sup>35</sup>

Here’s the thing: It is very likely that you have students who are immunosuppressed or otherwise at high risk. Approximately 2.7% of Americans take immunosuppressive medication, many more are immunocompromised,<sup>36</sup> and an estimated 19.8% of U.S. adults aged 18-29 are at increased risk for complications from COVID-19 due to a medical condition.<sup>37</sup> You probably won’t know which of your students, if any, are at high risk; disclosure of disability status is a risky business for a variety of reasons.

Even without knowing if or who your immunosuppressed students are, the steps I outline above are worth it: I learned from Black feminist scholarship that when we act in service of those whose bodies are most attuned to harm, we reduce harm *for everyone*.<sup>2,38</sup> This global pandemic has been globally traumatic, whether we want to attend to this or not; we *all* need trauma-informed spaces, community care, and collective responsibility. Also, importantly, community care means asking students what *they* need; what your students need will inevitably be different than what I would need, particularly those who are living at the intersection of different axes of oppression than me.<sup>39</sup> Listen to them. Love on them.

And love on yourself. You are a part of your classroom community that deserves care. And reader, if you are yourself high risk and being asked to choose between your safety and

your job, I'm so sorry. I see you, and this is impossibly hard.

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