WAITING & CARE IN PANDEMIC TIMES

A collection of papers
on COVID-19
by the
Waiting Times Project

Contents

EDITORIAL

Waiting and Care in Pandemic Times Collection [version 1; peer review: not peer reviewed]

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Abstract

This editorial introduces a collection of research articles and reflections on what it means to wait during the time of the COVID-19 pandemic. Written from conditions of lockdown, this collection gathers together the initial thoughts of a group of interdisciplinary scholars in the humanities and social sciences who have been working on questions of waiting and care through a project called *Waiting Times*.

Keywords

COVID-19, UK Government, waiting, time, care, lockdown

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This article is an Editorial and has not been subject to external peer review.

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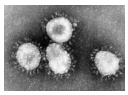

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In early March 2020, a meme began to circulate on social media that used a quotation from J.R.R. Tolkien's *The Fellowship of the Ring* (1954), part of *The Lord of the Rings* trilogy voted the UK's favourite novel in a BBC poll in 2003. As they wait in anticipation of the tasks that lie ahead, the hobbit Frodo says to the wizard Gandalf: '"I wish it need not have happened in my time"'. Gandalf replies: '"So do I, and so do all who live to see such times. But that is not for them to decide. All we have to decide is what to do with the time that is given us"' (Tolkien, 1974, p. 78). As is well known, Tolkien's conservative and romanticised version of a modest English courage found in hobbits, alongside his vision of a world torn apart by technologies of war, was profoundly influenced by his experience in the trenches of World War I and then living through a second global conflict. The meme is clearly meant both to convey regret that anyone should live to see times shot through with such profound losses and to inspire courage in the face of what lies ahead, while comfortingly positioning its readers as up to the task.

The question of 'what to do with the time that is given us' in the current moment of the coronavirus pandemic is certainly pressing, both for those thrust into conditions of impotence and anxious waiting in which there seems to be little to be done, and for those expected to act under conditions of urgency and emergency. But the idea that people understand that the current crisis has somehow released time – a time that might be used but that might also be dangerously misused – is worth attending to. What would it mean to look at COVID-19 not just as a public health and political crisis that requires action, but also a crisis of time – a moment where questions of temporality and its relation to care have come urgently to the fore?

This collection of papers represents the initial thoughts of a group of interdisciplinary scholars in the humanities and social sciences who have been working on questions of waiting and care through a project called *Waiting Times*, funded by the Wellcome Trust. We begin from the understanding that waiting is one of healthcare's core experiences. It is there in the time it takes to access services; through the days, weeks, months or years needed for diagnoses; in the time that treatment takes; and in the elongated time-frames of recovery, relapse, remission and dying. Our aim in this project is to open up what it means to wait in and for healthcare by examining lived experiences, representations and histories of delayed and impeded time. Contextualising healthcare practices within broader social organisations of time allows us to grasp the meanings, potentialities and difficulties of waiting in current times. The aim of the research is to move beyond thinking focused on the urgent need to reduce unnecessary waiting times in the UK's National Health Service (NHS), towards a more comprehensive understanding of the relation between waiting, care and changing experiences of time.

We are writing from the experience of lockdown in the UK in March and April 2020, where whole populations have been instructed that waiting at home in order to 'flatten the curve' of the outbreak is a form of care – for selves, for others and for the institution of the NHS. And we have been asking ourselves how a longer history and broader perspective on delayed and impeded temporalities might help to make sense both of the potentialities and dangers of these current waiting times. Lisa Baraitser and Laura Salisbury address this question by thinking through the terms used by the UK Government to describe their response to the pandemic: containment, delay and mitigation. Through a psychosocial reading of each term, they outline how the difficulties inherent within waiting might be used to help understand the relationship between time and care and the necessity of paying attention to the ever-present possibility of violence and failures of care *within* acts of care.

Martin Moore historicises the appeal to 'save the NHS' in the current pandemic in the context of longer-term anxieties about the service's capacity to survive increasing demand and public and policy discourses that have framed it as being 'at risk'. The paper therefore works to understand the current discourses about waiting in order to protect the NHS as part of a longer history in which time has been experienced and understood as both a threat to the service and its capacity to care, and a way of managing or caring for an institution with a potent place in the national imaginary.

Stephanie Davies was just beginning ethnographic research in a GP surgery in Hackney, London, when its first case of COVID-19 was reported and treated. Her paper explores what it might mean for a service already experiencing itself as in a chronic crisis of funding and capacity to come into contact with another crisis of time and of care.

Jocelyn Catty writes from her experience as a child and adolescent psychotherapist working in the NHS to ask what happens to the offer of time, care and rhythmic continuity that sits at the core of psychoanalytic psychotherapeutic practice, under conditions of emergency. She notes how adolescents' experience of anxious pressure and uncertainty, particularly in the face of a future that seems unable to unfold in ways that could be productively used, is now mirrored in experiences of a broader population held in the waiting time of lockdown.

Jordan Osserman and Aimée Lê use a quite different tradition of psychoanalytic thinking to work through what failures of authority might mean in the context of COVID-19. Teasing out the relationships between time and power, and writing from the position of those in precarious employment, Osserman and Lê suggest that in these current waiting times – in the suspension of 'business as usual' – there is potential for radical action and for a reconfiguration of the socio-political sphere that would place care at its core.

Michael J. Flexer also argues that the time of COVID-19 represents a distinct, but currently unexamined, temporal moment. Using semiotic methods, he traces how the mechanical actions of the virus, through becoming social, create what he names as 'a new viral time' – a time that reveals that we have already arrived in a new historical epoch. This epoch, he argues, holds revolutionary potential. While the current socio-economic order attempts to reimpose temporal certainty and fixity through

hastily conceived political actions, it is the possibility for profound re-imaginings of our productive and social relations that should concern us most.

Finally, Martin O'Brien's essay considers the relationship between the experience of life shortening chronic illness and the current COVID-19 crisis, using his own experience of living with cystic fibrosis to interrogate the temporal experience within the global pandemic. Having now lived beyond his own life-expectancy, he draws on his own concept of 'zombie time' to understand the presence of death as a way of life. O'Brien's art practices form the basis for his analysis of living through a pandemic that mimics his own sick and coughing body. O'Brien argues that we are currently occupying a widespread zombie time, which frames other people as carriers of death. It is only through finding new ways of being together that we can survive.

Data availability

No data is associated with this article.

References

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RESEARCH ARTICLE

'Containment, delay, mitigation': waiting and care in the time of a pandemic [version 1; peer review: awaiting peer review]

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Abstract

In this paper we take up three terms – containment, delay, mitigation – that have been used by the UK Government to describe their phased response to the COVID-19 pandemic. Although the terms refer to a political and public health strategy – contain the virus, flatten the peak of the epidemic, mitigate its effects – we offer a psychosocial reading that draws attention to the relation between time and care embedded in each term. We do so to call for the development of a form of care-ful attention under conditions that tend to prompt action rather than reflection, closing down time for thinking. Using Adriana Cavarero's notion of 'horrorism', in which violence is enacted at precisely the point that care is most needed, we discuss the ever-present possibility of failures *within* acts of care. We argue that dwelling in the temporality of delay can be understood as an act of care if delaying allows us to pay care-ful attention to violence. We then circle back to a point in twentieth-century history – World War II – that was also concerned with an existential threat requiring a response from a whole population. Our purpose is not to invoke a fantasised narrative of 'Blitz spirit', but to suggest that the British psychoanalytic tradition born of that moment offers resources for understanding how to keep thinking while 'under fire' through containing unbearable anxiety and the capacity for violence in the intersubjective space and time between people. In conditions of lockdown and what will be a long and drawn-out 'after life' of COVID-19, this commitment to thinking in and with delay and containment might help to inhabit this time of waiting – waiting that is the management and mitigation of a future threat, but also a time of care in and for the present.

Keywords

COVID-19, UK Government, waiting, time, care, violence, psychoanalysis, World War II

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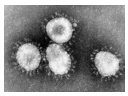
Open Peer Review

Reviewer Status *AWAITING PEER REVIEW*

Any reports and responses or comments on the article can be found at the end of the article.



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Introduction

On 12th March 2020, Professor Chris Whitty, the UK Government's Chief Medical Advisor, stated in a news conference: 'We are entering a delay phase'. Global 'containment' of novel coronavirus, first detected in Wuhan, China, had not worked and this was now a crisis. COVID-19 was spreading, with Europe as its new epicentre. The UK's own 'containment' phase of its domestic strategy – testing, quarantine and the tracing of known contacts with a patient – was soon abandoned and the UK abruptly moved into the more obviously temporal 'delay' phase of the public health operation (Policy Paper, 2020). Processes of social distancing, self-isolation and then, ultimately, 'lockdown' were instigated in an attempt to lengthen and flatten the peak of the outbreak and reduce the number of cases *at any one time*. This, it was hoped, would give the health service a chance of survival and help to manage the outbreak in a population assumed to be unable to cope with more than 12 weeks in isolation. 'Timing', as Whitty put it, was 'everything' (Whitty, 12 March, 2020). Yet, as one National Health Service (NHS) consultant put it as early as 16th March, despite a month of planning 'what has blindsided us is the speed at which the hypothetical became real and then became obsolete' (Anonymous, 2020a). The increase in cases happened so rapidly in a system already operating at almost total capacity after a decade of austerity that, according to this anonymous report, by 16th March the system was already overwhelmed, even though the UK Government claimed in mid-April that hospitals were still running 'below their ceiling' (Whitty, 13 April, 2020). But with cancelled operations and outpatient appointments now pushed not into a planned future but a suspended time that cannot easily be held in mind, it will take time to know about the full secondary health effects of COVID-19 and the results of the Government's interventions. There will be a cascade of impacts on the economy and the NHS that will affect the delivery of timely healthcare for years to come.

Everywhere we look, the commentary on the COVID-19 pandemic focuses on the question of time and timing. These questions include: how to make timely interventions – acting swiftly and decisively while also trying to instigate practices of waiting and delaying; when to instigate and when to end lockdowns that suspend and transform the temporalities of work, sociality and economic and political activity that play out in acutely uneven ways; how to implement systems that wait for 'the hypothetical' and then are flattened almost immediately;[1] managing phenomenological experiences in isolation that give rise to time cycling or becoming sluggish or of being 'outside of time'; and the prospect of the deep violence of the effects of governmental responses to the virus that will not been known about for decades. Although the strategy of 'containment, delay and mitigation' suggests a linear temporality that seems to echo something like the progression of a disease, the experience of living with and through these phases has suggested a much less straightforward set of temporal experiences. Just as diseases themselves frequently have much more complex trajectories that include suspensions, remissions, recursions, set-backs and recurrences, it has been hard to know precisely which phase of the strategy we might be inhabiting at any moment, or whether it is either practical or ethical to imagine one term superseding the last.

As humanities and social science scholars working on histories and experiences of waiting in and for healthcare, we are concerned to understand how questions of time intersect with those of care in these current times. What are the discourses of care being ostensibly offered by 'containment, delay and mitigation'? The mantra that has emerged in the UK has been 'stay at home; protect the NHS; save lives'. The explicitly temporal strategy of delay, from where we are currently writing, indeed invokes a call for care for an institution that on the one hand retains a particular place in the British cultural imaginary ('our' NHS, as Boris Johnson now repeatedly names it),[2] yet on the other is routinely described, and experienced by those working within it, as 'dying'. Particularly since the reforms of 2013, the NHS has persistently been represented as staggering on in an ongoing and enduring crisis brought on by chronic underfunding, creeping privatisation and a withdrawal from Europe that has already led to further staff shortages, demoralisation and burnout of staff at every level.

Public debate has aligned some aspects of the Government's strategy, particularly in its initial articulation, with dangerous inaction, while the Government has insisted that the 'delay' we are now in is a form of care, especially for the most vulnerable. We would like to articulate an alternative view in which delay holds within itself the possibility for care, but only insofar as it must also 'know' about violence: violence that might express itself in knowingly 'letting' certain groups of people die; in exposing vulnerability to shame; or in denying responsibility for political decisions that have kept the NHS running in permanent crisis. These are forms of social violence that entail the intentional use of power that results in harm, although they are not always recognised in these terms. We argue, here, that knowing about these forms of violence relies on using the temporality of delay to pay care-ful attention over time to the possibility of harm in states of extreme vulnerability and powerlessness. To do this we must move in the counter-direction to the UK's strategy (containment to delay to mitigation) and instead begin in delay. From there we will work 'backwards' to understand 'containment' through a psychoanalytic lens, in order to finally offer some thoughts on what mitigation of harm might mean in a (post) COVID-19 context.

Delay

In the opening phase of the UK Government's strategy of 'delay', the notion of building 'herd immunity' emerged under the auspices of a care for 'lives' and protection for the 'most vulnerable' – those over the age of 70 and those with 'underlying health conditions'. But there was already a tense relation here between different temporalities. As Boris Johnson suggested in a much-circulated interview on 5th March: 'One of the theories is that perhaps

[1]See Flexer, 2020.

[2]See Bivins *et al.*, 2018. See, also, Moore, 2020.

you could take it on the chin, take it all in one go and allow the disease, as it were, to move through the population, without taking as many draconian measures' (*This Morning*, 5 March 2020). In other words, delay might require some populations, seemingly those less likely to suffer the most severe effects of the virus, to be exposed *without* delay, while the most vulnerable were shielded – contained within their homes. Targeted containment and delay, which was never fully actualised as a policy, was linked to an idea of 'strik[ing] a balance' (*This Morning*, 5 March, 2020) between relatively minor interventions, such as advice on hand-washing and moderate social distancing, and the more 'draconian' strategy of lockdown.[3] Yet, as was quickly established, the political discourse that took up the epidemiological modelling underpinning this strategy dangerously condoned a form of thinking in which some lives – the elderly, the chronically ill and the disabled – were deemed more expendable than others. For many, this particular configuration of 'delay' was experienced as a form of inaction that seemed all too clearly underwritten by an ongoing violence experienced by particular populations and articulated by the black feminist poet Audre Lorde: 'some of us were never meant to survive' (Lorde, 1978, p. 31).

Can delay then be felt as care; is it indeed care, or is it a form of abandonment as some are arguing[4] – an abandonment of those most in need of care? As is now emerging, those who need care include those who contract the virus; the healthcare workers who care for them but who may themselves require care; those affected by the severe and lasting effects of an economy under lockdown; those who find themselves trapped at home in situations that are physically and mentally dangerous; those already living in food poverty or without homes and unable to self-isolate; those in care homes; those in prison; those in forms of work deemed essential despite the lack of provision for safe working; or those forced to make impossible choices between work and acute states of poverty. If it is a form of abandonment at the point that care is most needed, then it constitutes what the philosopher Adriana Cavarero has called 'horrorism' (Cavarero, 2009). Horrorism is a form of violence that offends the human subject at an ontological rather than socio-political level. It describes a form of violation of another that occurs when that other opens themselves, or finds themselves open, or is compelled to make themselves open, both to care and harm at the same time. An infant might be a paradigmatic figuration of this form of vulnerability, but in a (post) COVID-19 world, so too are many others: keyworkers with no protective equipment; detainees who already face shortened life expectancies; children who depend on school to provide the only meal of the day; and, as is increasingly becoming clear in the global north, people of colour – whether those working life-long in the UK heath service who represent almost half of all medical professionals, or those in the US living in urban centres and who, due to enduring conditions of racism, have a higher likelihood of not being able to access to healthcare. Care, in this case, must avoid horrorism. It must not, however unwittingly, inflict harm at the very point that care is needed.

We can think of care broadly as a set of social capacities: those that are necessary for birthing and raising children; for sustaining and maintaining kinship groups and community connections; and forms of social reproduction that underpin every aspect of capitalism's proliferation that have always been gendered, classed and racialized – women's work, poor women's work, poor women of colour's work (Baraitser, 2017). Although we can and should pay close attention to 'state care' or 'caring economies'[5], the often mundane temporalities of socially reproductive labour – temporalities of waiting, repeating, staying, returning, maintaining, enduring, persisting – that involve *not* moving on are easily overlooked. Indeed, they are sometimes set against the heroic exactitude of the timeliness of healthcare: care in acute situations such as cardiac arrest, surgery and A&E settings, even though the majority of day-to-day healthcare practices have elongated temporalities at their core. Consider the 'watchful waiting' routinely used in general practice in which a patient and practitioner must wait to see if and how a symptom develops or whether a medication takes hold; the slow unfolding of trust required to communicate psychological distress that forms a vital part of the therapeutic alliance in mental health treatment; or the uncertain and unknowable time of palliative care at the end of life. Even Boris Johnson, not always known for his attention to detail, was able to acknowledge that during the 48 hours in intensive care at St. Thomas' hospital, London, it was the minute-by-minute watchful waiting of two nursing staff, Jenny McGee and Luís Pitarma, that enabled his recovery and, in his terms, 'saved my life' (Johnson, 2020b). When we overlook care that takes time, or is itself a practice that waits to see what giving time to a situation may bring, we enact the antithesis of care. We fail to think carefully about care.

What we might say, then, about care is twofold: that it is bound up in particular ways with enduring time, and that it requires a form of knowing-about, or thinking-about, the antithesis of care – failures to care, horrorism or the perverse pull to enact harm when care is most needed. We want to argue that these failures can, if we can pay attention to them, bring on new ways of thinking – forms of 'care-ful attention' whose temporal forms are waiting, staying, maintaining, enduring, returning, repeating and persisting. Care, from this perspective, is not just a relational practice that develops over time, or one that takes time; it is a practice that *produces* time in conditions that are otherwise felt to be stuck and unable to change. In her discussion of what she calls 'care time', Maria Puig de la Bellacasa elaborates how care both takes time and involves 'making time of an unexceptional particular kind' (Puig de la Bellacasa, 2017, p. 206). Although, affectively, care time can be enjoyable, she writes, it is also 'very tiresome, involving a lot of hovering and adjusting to the temporal exigencies of the cared for' (p. 206). Much care in an intensive care unit takes just this form. Care time, as Puig de la Bellacasa states, is not future-orientated or a matter of righting past wrongs, but 'suspends the future and distends the present'

[3]See https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/874290/05-potential-impact-of-behavioural-social-interventions-on-an-epidemic-of-covid-19-in-uk-1.pdf

[4]See, for instance, Anthony Costello's frequent contributions to The Guardian.

[5]See Care Collective, 2020.

(p. 207). It produces the time for care-ful attention by pushing back on the anticipated joys or indeed horrors of the future, the pleasures of the present or the accumulated regrets of the past. In this sense *care time is the time of delay*.

The meaning of delay in English hovers between two contradictory impulses: to put off or defer action, so that delay opens up the time of lingering, loitering, dithering or procrastinating; and a more forceful impulse that has to do with detaining, holding up, making late and hindering progress (*OED*). On the one hand, delaying puts aside the future in the name of a temporal hiatus that slows the time of progress and appears to offer an approach to present time that might make it possible to grasp it; on the other, delay remains futural – the possibility of deferral is precisely premised on the yet-to-come, on what Jacques Derrida calls the *'a-venir'*. For instance, for Derrida, the relational encounters of hospitality, justice and mourning all retain their ethical potential through the necessity of their postponement, their delay (Derrida, 1992; Derrida, 1994; Derrida, 1995). And in the realm of politics, for Derrida, there is an imperative for democracy to function through this delayed temporality in order that it remains open to revision and resists the closure of identity in which all difference is eradicated (Derrida, 1997). In the French etymology, there is an even clearer distinction between waiting as an interval that intervenes in the flow of time (*dans un délai*) and an excessive slowness or being behind the times (*retard*, *attardé*). We could say that if there is an agony in delay that is distinct from simply waiting, it is this awareness that despite the desire to foreclose the future and push back the past, to loiter and linger and dwell in the delay, there remains a temporal drag that nevertheless insists on a relation between past and future. The present is never 'free time', in other words – freed from its obligations to a future based on its experience that it is always already past. Delay, rather, reveals how the present drags with it a past that is always already obliged to a future. In this sense care that entails hovering and adjusting is already weighed down with its cultural and historical situatedness, its past lives that it cannot shake off.

What might it mean to go on knowing about this violence in the temporality of delay? In *Delay of the Heart*, the final part of David Appelbaum's three-volume philosophical meditation on time and ethics (Appelbaum, 2001), he elaborates delay as closely bound up with knowing and the problems of the closure of thought – with the way that thought both remembers and projects into a future, but is unable to inhabit the present. For Appelbaum, as for Locke, thought is essentially retentive in its 'grasping again what was once present' (Appelbaum, 2001, p. 2), in retrieving conditions from the past and projecting them into the future. From this perspective, cognition is parthenogenetic, in the sense that it gives birth only to more thought. This is thought's primary concern: to reproduce the conditions of its own reproduction through the smooth and uninterrupted operation between retention and projection.

But, for Appelbaum, such thought misses something fundamental that becomes visible in the temporal hiatus we call delay. In delay it appears initially that there are two positions of experience. From the perspective of the one lagging behind there is no delay, there is only the other who has pulled away at a pace that produces a discrepancy and who cannot now inhabit the place of being 'behind'. We can be delayed, but it is the other who waits. Delay from this position is denied. From the other perspective of the one ahead, delay is a fact: there is another who lags. Delay therefore produces two modes of thought: denial and fact. But for Appelbaum, there is a third position of experience that entails neither fact nor denial. He calls this the 'view from the heart' which breaks into the smooth running and endless flow of thought. Delay of the heart is the introduction of a somatic element, the heart, into the sphere of cognition. It arrests thought and allows a different form of judgment to emerge, allowing delay to 'weigh' a situation differently from the procedures and logics of thought (Applebaum, 2001, p. 5). Appelbaum reminds us that the root meaning of delay is *laxare*, to relax or decontract (p. 7). In delay, something in thought, then, slackens. The appeal to the heart is not so much a gesture towards tenderness or the poetic but an approach to thought in the condition called delay that creates a stop in its movement, that brings disarray and a new form of relationality: 'Severed from its impulse to self-reproduction, thought is momentarily related to the other' (Applebaum, 2001, p. 7). Thought as the 'lurching gait of projection, the reaching back and throwing ahead', and thought's essential preoccupation with its own reproduction, is interrupted. Delay of the heart operates as a suspension of thought's movement in order to bring on a new form of judgment.

Appelbaum's appeal to the somatic, to the asynchronous force of something that offers a 'sidewise' approach to thinking that releases the habit of thought from its self-perpetuation, echoes a host of other philosophical perspectives – feminist, black feminist and Afro-pessimist perspectives in particular – that speak to the impossibilities yet necessities of remaining and dwelling in delay, not only as an ontology but as a politics and an ethics. Christina Sharpe, for instance, names this as 'wake work' (Sharpe, 2016). 'Wake work' is the work it takes to go on living in the wake of the violence of slavery that cannot be overcome, where both mourning and melancholia are suspended, producing a time that must nevertheless be endured at a somatic and affective level in order that care as a form of thinking can emerge[6]. The delay of the heart interrupts the violence of synchronous thought that seeks endlessly to reproduce itself, while refusing to 'know' about that violence. Such synchronous thought is violent to the degree that it denies the existence of what is outside itself and its own movements; it fails in its encounter with an other out of which something new, a new thought, could emerge. We could say that in this sense, delay – the suspension of time but also the suspension of the self-reproduction of thinking, of more of the same – holds open the possibilities for care for the future at the point that it can know about violence.

Containment

If we can conceptualise delay as a form of care – one that suspends the impulse within thinking to reproduce itself in its failure to know about violence - can we turn this back to think about the question of containment, care and time? As we have seen, the UK Government's initial 'containment' phase of its response to the outbreak of COVID-19 was over by the 12th March.

[6]See also the work of Fred Moton on 'fugitivity' and living 'in the break' (Moton, 2003); Best and Hartman on Fugitive Justice (Best & Hartman, 2005); and Frank, B. Wilderson III on Afropessimism (Wilderson, 2020).

But the question of containment has not gone away, although it is now an issue focused more on the psychosocial than the microbiological. In conditions of forced isolation and social distancing, questions of how to contain anxiety and fear, of how to manage in the delay while knowing about violence, and of how to endure ourselves and others during this time of elongated waiting, have become pressing[7]. A recent Review in *The Lancet* of studies of the psychological impact of quarantine concluded that where people are suddenly and forcibly rendered passive in relation to their circumstances, there is high prevalence of symptoms of psychological distress and disorder: emotional disturbance, depression, low mood, insomnia, post-traumatic stress symptoms, anger, emotional exhaustion and irritability (Brooks *et al*, 2020). Qualitative studies of the SARS outbreak identified a range of other psychological responses, including confusion, fear, grief and numbness. *The Lancet* Review concludes that 'the psychological impact of quarantine is wide-ranging, substantial, and can be long lasting' (Brooks *et al*, 2020, p. 8), although it can be mitigated if people are kept informed about the decisions taken and can understand and align their actions with them[8]. Waiting in conditions of uncertainty becomes particularly disturbing or traumatic when people's usual strategies for dealing with anxiety are removed and when uncertainty becomes overwhelming, as in situations where sources of income disappear overnight, when 'safety nets' seem unresponsive and require waiting far too long, and particularly when the 'brick mother' that is appealed to in the phrase 'our NHS' – an institution that can provide safety, care and a containment capable of holding us together when we are at our most vulnerable – is itself perceived to be under immediate existential threat[9].

There is a history we can draw on here that ties together a socio-historical literature on waiting during times of war in the twentieth century and the emergence of the concept of containment in psychoanalytic thinking in the British School of 'object relations' psychoanalysis. This latter tradition can be understood as a part of a wider attempt to use the relatively new discipline of psychoanalysis to understand and perhaps even mitigate the devastating violence of the two global, industrialised conflicts of the twentieth century (Pick, 2014). In this psychoanalytic literature, distress, for example, is not simply imagined as the easily comprehensible result of experiences of anxious waiting under conditions of threat; rather, the difficulties of waiting become entangled with an understanding of psychological experiences in general and the management of violent and destructive instincts and drives. Suggestively, and as we will elaborate below, in this psychoanalytic literature the term 'containment' is used to represent what happens when unbearable and existentially threatening states of mind are understood rather than enacted. 'Containment', in this context, is also the prerequisite for the possibility of thinking that could allow itself to know about violence.

In 1940, during the waiting time of World War II known in the UK as the 'Phoney War' (when there were no major military land operations on the Western Front and no civilian experiences of aerial bombardment), the British psychiatrist and later psychoanalyst Wilfred Bion wrote a paper concerned with the inevitability of a devastating air-attack on London. There, he addressed the likelihood of civilian panic and the potential for an 'epidemic of shell-shock' comparable to what he had observed and experienced first-hand in World War I. Responding implicitly to Stanley Baldwin's 1932 statement that the experience of 'total war', in which military and civilian populations face devastating attacks from the air, was now inevitable – 'the bomber will always get through' – Bion wrote about the possibility of providing 'psychological A.R.P.' [air-raid precautions] (Bion, 1940, p. 195). With the explicit aim of taking care of the civilian population newly exposed to military conflict, Bion suggested that people must not be left to languish in a kind of waiting time in which anxiety could take hold. Instead, as soon as an air-raid siren goes off, '[t]he alarm […] must be a call to action, and there must be an action to which every man and woman is called' (Bion, 1940, p. 189). In particular, Bion drew attention to the fact that isolation itself 'can help produce that loss of social sense that is one of the characteristics of panic fear' (Bion, 1940, p. 185). Isolated and isolating waiting, which can lead to mental distress or what the later Bion described in 1962 as 'a nameless dread' (Bion, 1984b, p. 116), must be replaced with communal, careful effort directed towards need in the present and the idea of a survivable future.

It is important both to note and trouble the ways that the current coronavirus crisis has been framed in the UK by looking back to World War II. In the second of his daily briefings on 16 March to the nation, Boris Johnson spoke of the need to take 'steps that are unprecedented since World War II' and of acting 'like any wartime government' (Johnson, 2020a), reaching for a wartime imaginary in calls for national unity and resolve. For the British civilian population in general did not collapse in the face of aerial bombardment in the way many feared it might, although the idea that people did not experience psychological distress and lasting trauma from the Blitz was, first, useful propaganda (see *London Can Take It!*, 1940), and later a significant part of the mythology mobilised to shape ideas of postwar British exceptionalism. The establishment of the NHS in 1948 was also a direct response to the Beveridge report of 1942 that sought to produce a Welfare State capable of supporting reconstruction and aimed at rewarding national efforts and wartime sacrifice. The injunction to 'save the NHS', displayed prominently on the podium during the UK Government's daily briefings, thus also makes a significant link back to that conflict and the postwar settlement.

[7]A recent Ipsos MORI poll has suggested that people are more concerned by the effects of social and psychological response to the pandemic than the physical illness COVID-19 (Holmes *et al,* 2020, pp. 1–2).

[8]This matches Healthwatch's 2019 submission to NHS England on people's views on A&E waiting times. The report concluded that those who are triaged on arrival, have the next steps explained to them and are kept informed of changes due to other circumstances, are more positive about their experience, even if they end up waiting a long time.

[9]The term 'brick mother' was used by Henri Rey, who had a strong influence on trainee psychiatrists in the Maudsley Hospital in South London in the post-World War II period. For him, the term evoked an idea of safety, continuity, stability and asylum – in its true sense – for patients who were frightened of breaking down. For further on the sense of the NHS under threat, see Moore, 2020.

Of course, the archive tells a more complex story of the reality of the waiting during World War II than a straightforward narrative of resolve and 'pulling together'. Although admissions to psychiatric hospitals declined in 1940 in comparison to 1939 (Jones, 2012, p.31), the detailed report of the psychological effects of bombing in the city of Hull (Burney, 2012), for instance, demonstrated that experiences of fear and anxiety produced considerable and lasting trauma, if not total civilian collapse. Many people did make good use of the call to communal action, however: some by taking on roles on the Home Front explicitly associated with the war effort; others working at living on and getting on through domestic practices in which a relationship to an imaginable near future was maintained. This is matched in the present moment by the speedy emergence of community care networks, the revival of mutual aid groups and significant levels of volunteering to support NHS provision. As we write, the effects of a large-scale loss of life and its inevitable griefs and traumas, felt at both an individual and collective level, are breaking through the period of anxious waiting. Nevertheless, the traumatic effects of waiting and enduring through the lockdown persist alongside the imminence of existential threat. The desire both to 'look after' and be 'looked after' sits in a paradoxical relationship to modes where waiting – which might be care, but also might be violence and neglect – seems like the only thing to be 'done'.

Between 1946 and 1952, Bion undertook an analysis with Melanie Klein, who had moved from Berlin to London in 1925. Bion went on to work closely with Klein's idea of 'projective identification', which can be described as the way we may initially defend ourselves from impossibly difficult emotional experiences by temporarily splitting off undesired and sometimes valued parts of the personality and putting them into another person. For Klein and Bion, projective identification represented the lifelong repetition of experiences of early life in which the baby's need, hate, love and its fear of death, were projected into a primary care-giver who would hopefully be 'capable of reception of the infant's projective identifications whether they are felt by the infant to be good or bad' (Bion, 1984b, p. 36). In receiving them in this way, the carer 'contained' and processed these elements – in Bion's terms they 'digested' them – in a way that enabled the infant to feel it was 'receiving its frightened personality back again but in a form it can tolerate' (Bion, 1984a, p. 115). For Bion, then, a crucial part of early development was the child's experience of care-givers who could be relied on to act as containers for their projective identifications and offer them back in forms that could be experienced as nourishing rather than destructive or contaminating.

Bion went on to represent projective identifications as particular kinds of thoughts that are full of feeling; indeed, he suggested in a 1962 essay that thinking evolves as a capacity for containing, absorbing and processing 'thoughts' otherwise experienced as intolerable. Bion believed, however, that such thoughts were vital communications that needed to be understood, and 'containment' became his term for the capacity of one individual (or a group or even an institution) to hear, absorb and work to understand the projections of another person as a meaningful communication. The task became to understand and convey these split off and projected thoughts back in a modified form that could, over time, be tolerated. For Bion, the aim of psychoanalysis was thus for analyst and analysand to suspend the unreflexive action that would risk getting rid of 'thoughts' experienced as contaminating or lacerating to the self and instead to hold, absorb and digest them over time and within psychical understanding. Containment became the process through which the analyst processed and gave back the feelings within thoughts as material with which one might think.

In his 1940 Penguin Special, *The Psychology of Fear and Courage*, the psychoanalyst Edward Glover described how humans can be like bombs: 'people are charged with high explosives, in other words with very powerful, and sometimes uncontrollable, emotions' and they 'split where the cover is thinnest, that is to say, where our defences are weakest' (Glover, 1940, p. 27). Such a metaphor was timely for a book published as the 'Battle of Britain' was raging, but, even decades after both wars, Bion continued to describe 'thoughts' via an imaginary of bombs and missiles. For him, the only way to transform thoughts experienced as aerial bombardment was to suspend the mobilisation that sought to rid the psyche of them, what he called 'evasion by evacuation' (Bion, 1984a, p. 117). Instead, he said that analyst and patient must learn together how to wait and to think, using time itself as a container. For if thoughts are 'evacuated at high speed as missiles' (Bion, 1984a, p. 113), genuine thinking becomes a space of containment that allows the violence of the world to be taken into the self and digested over and through time, rather than unthinkingly expelled as invasive or intolerable. Such thinking, imagined according to the processes of a body able to digest rather than be torn open by explosive, incendiary 'thoughts', produces a space and time where violence might be suspended, delayed and therefore thought about, rather than simply enacted. Although there were practical benefits in encouraging communal, collective action to contain the anxiety of waiting time in wartime, for the later Bion it was waiting itself and thinking with others that came to be a 'shelter', a container, for an experience of time that enabled the possibility of an authentic 'psychological A.R.P.'.

By the summer of 1940, just after the waiting of the 'Phoney War' but before the Blitz was to bring total war to London, Melanie Klein was writing notes on her British patients' experiences, observing that anxiety, if unprocessed, could lead to patients either acting rashly in the form of a manic evasion of threat, or otherwise falling prey to a dangerous paralysis: put another way, either not waiting long enough or waiting too long[10]. Klein has been criticised for interpreting her patients' anxieties in relation to their inner psychic reality rather than as an understandable response to an external threat. But her point was

[10]In the current situation, not waiting long enough is visible in panic buying or attempts to amplify prematurely the potential of as yet unproven treatments. Waiting too long can be witnessed both in public health strategies and in individuals delaying accessing emergency care because of fears that acute care might expose them to danger, or that the provision for care has already been overwhelmed. In the first week after lockdown in the UK, A&E visits fell by 25% (Thornton, 2020).

that what really mattered for any individual was their ability to understand their reactions to that external threat and respond with care and attention to what it demanded of them, rather than to act out anxieties that actually had their origins elsewhere, in their own past experiences.

In a lecture delivered in 1940, Klein noted that in the face of increasing existential threat, she saw some patients use their analysis to develop their capacity for thinking. She saw their 'courage grow, depression diminish, and the capacity to make decisions, etc. increase when hatred and guilt connected with early phantasies had been analysed' (Klein, 1940). For Klein, it was precisely the capacity of analysis to contain and understand projective identifications, and the hatred and guilt that they produced, that enabled such patients not only to act carefully when required but to hold on to 'the feeling that goodness cannot be ultimately exterminated'. Klein stated that this need to connect with 'goodness' in the moment might sometimes look like a temporary denial of the reality of historical danger: 'We look at nature, we read a book, we play with a child, we enjoy food, etc., and we have to remind ourselves that our life and country is at stake' (Klein, 1940). But, she noted, if this careful attention to 'good objects' is used not to deny reality but as a commitment to the endurance of what might sustain us – the care of others and the care of a nourishing rather than contaminating world – it may 'help us to take steps to preserve goodness externally, and may internally help us to keep calm in the face of danger' (Klein, 1940). As Bion would later come to understand it, the containment of various forms of mental distress is dependent on a person's belief that there is some entity or function, both internal and external, that can endure 'under fire' and enable us to understand our thoughts and feelings.

These ideas of containment as a capacity for 'thinking' brought on to deal with 'thoughts' experienced as violent attacks on the mind were born from particular scenes of anxious threat during the twentieth century, but continue to have significance for our current times, we believe. As we have noted, following Maria Puig de la Bellacasa, care time works to make time of a very particular kind, suspending the future and distending the present by 'thickening it with myriad multilateral demands' (Puig de la Bellacasa, 2017, p. 207). As she puts it: 'feelings of emergency and fear, as well as temporal projections, need often to be set aside in order to focus and get on with the tasks necessary to everyday caring maintenance' (Puig de la Bellacasa, 2017, p. 207). Feelings of emergency that can produce a panicked sense that any action is better than waiting, alongside more amorphous fears of what the future may or may not bring, both need to be wound back while focusing in the present on the needs of others if care, in the sense described above, is to be provided. Such care thickens the time of the present; nevertheless, it also retains a weakened commitment to the future – an 'after' into which selves and others are imagined as enduring. When linked to time, 'after' refers to a later, subsequent moment; but 'after', in many of its oldest usages, also means 'behind'. 'Looking after' might be understood as a process of putting the object of one's care ahead of one's own position at the very moment one is positioned ahead. We might say it entails the delay of the heart. To 'look after' thus suggests the capacity to hold oneself back, to get behind those being cared-for, so that their needs can be responded to and they become the future towards one which is inclined. This is not any grand narrative of the future, but a rhythmic inclination that consists of persistent and persisting attention: a form of thinking that produces time that finds its place in the inter-generation, understood broadly, between self and others, as self finds a future in its relationship with another into which it might lean.

Significantly, the most recent NICE guidelines on the treatment of Post-traumatic Stress Disorder, including in the wake of major disasters, have reinforced the 2003 recommendations of the value of psychological containment and delay – of 'watchful waiting' (NICE, 2003). 'Watchful waiting', in this context, steps back to enable immediate needs of shelter, food and clothing to be attended to. It does not offer complex psychological interventions too quickly; rather, it encourages the use of existing social and familial care networks for support, offering sufficient psycho-education and sense of presence through repetition to enable people to access specialised services if and when they are required (NICE, 2003, p. 18). The evidence underpins the value of a strategic and thoughtful delay in action that requires services to contain their own anxiety and sense of emergency sufficiently that 'thoughts' might not overwhelm their 'thinking'. Psychological therapies in this context might 'look after' us by both putting us ahead, while also waiting for us in our time of need. Such repetitions of care-ful attention and thinking, offered both as 'watchful waiting' and timely action, represent a commitment to a temporality of 'looking after'; they affirm a belief in someone or something enduring through the bombardment of anxious 'thoughts' to produce a feeling of time that can be held on to long enough that it might be used.

Mitigation – on not being able to touch

The final part of the UK government's tripartite strategy is 'mitigation'. It is triggered once a disease is widespread and it is no longer possible to either contain it or to slow its spread. Mitigation signals the belated shift to saving as many lives as possible and is the time of the most extreme measures coming into force: the use of the army on the streets to maintain public order; the closure of Parliament; the extreme enforcement of lockdown through centralised surveillance; and the rationing of care. Mitigation is an acknowledgement that containment and delay are no longer efficacious. If to mitigate is to attempt to make something already bad less severe, serious or painful, to lessen the gravity of an offence or mistake (*OED*), then while it admits a tendency to enact violence at the very point that care is needed, it also contains a shadow of acknowledgment that a mistake and an offence against care has indeed occurred.

In a healthcare context we can talk of mitigating pain, where pain is not just an offence to the body but includes the pain of psychological, social and spiritual suffering – what Cicely Saunders, the founder of the Hospice movement, named 'total pain'. One of the core principles of palliative care is the refusal to separate bodily pain from its other social and cultural determinants when offering holistic mitigation of suffering at the end of life. As Yasmin Gunaratnam notes in *Death and the Migrant* (2013), although 'pain needs a body', relying on flesh

'to register and receive it' and 'allow it passage' (p. 133), it arises from multiple, often unacknowledged sources. In tracing the stories of ageing and dying in the health service for those who have migrated to the UK since World War II, including the many migrants who have cared for others within the health service (a disproportionate number of whom are now dying of COVID-19), she brings together Pierre Bourdieu's notion of social suffering (Bourdieu, *et al*., 1999) with Saunders' account of 'total pain' (Saunders, 1967). In doing so she works to recognize how pain is accrued and suffered over a lifetime (Gunaratnam, 2013, p. 137). Following this, we would suggest that mitigation, as a form of palliative care, needs to attend carefully to the total pain of COVID-19, and the conditions of radical uncertainty it produces, in ways that can respond to the multiple. This would acknowledge the suffering of individuals in the present, but would not erase the cumulative effects of ongoing racism and social inequality, the brutalities of neoliberalism that have damaged working conditions in the NHS and its capacity to care[11], and the ongoing human-induced loss of habitats for non-human animals that have increased the likelihood of zoonotic disease transfer. All of these determinants, and more, find their 'body' in the person dying of COVID-19.

One of the threads that runs through *Death and the Migrant* is the social and political life of touch. In so many instances, care at the end of life entails profound experiences of touch – of washing and being washed, of being held, handled and caressed, of using the hands to express total pain by 'praying' through handling a rosary or 'mala'. These experiences of touch counter the numerous forms of intrusive touch that also accompany illness and the end of life: being prodded and poked and instances of unwanted touch – experiences that are always already gendered and raced. Touch may be delivered violently; it might also be withheld as care fails. However, Gunaratnam draws our attention to the value of touch in cross-cultural palliative care as something that materialises a particular kind of 'looking after' when language and established procedures cannot necessarily make sense of what is needed. As Gunaratnam puts it:

> Radical doubt and uncertainty are not unique to cross-cultural palliative care. They can surface in situations where routines of care become ineffective, where trust and communication breaks down and professionals have to work out and improvise not just what to do, but also what kind of care they want to create and be part of. (Gunaratnam, 2013, p. 101)

Touch, offered in the space and time of radical uncertainty, speaks of the potential for new possibilities of mitigation and containment to be found; it also speaks of the permanent possibility that care might fail.

Perhaps one of the most difficult stories to emerge in the UK press to date has been the death of Ismail Mohamed Abdulwahab, who on the 1st April 2020 was the youngest person in the UK to die of COVID-19. What made his death particularly painful to know about was not just how young he was, and the inexplicability of why a young boy who appeared to have no underlying health conditions should die of COVID-19, but that he died alone. Because of the risk to his family's health, he could not be touched, held and comforted by those who loved him. For patients in an induced coma on a ventilator in intensive care, this form of touch was initially prohibited, although on 15th April the UK Health Secretary described being 'moved' by stories of people dying alone and introduced new guidelines (Hancock, 2020). These guidelines permitted physical presence that would give 'people the chance to say goodbye', while attempting to mitigate the risk of infection. But care in conditions of radical uncertainty has also been offered in other ways – in the form of Facetime or Zoom contact, for instance, which sometimes offers containment and mitigation of pain and sometimes fails. In the absence of routines of care that would usually involve physical proximity, we are being pushed to improvise and to decide what kind of care we want to create and be part of.

The psychoanalytic literature makes much of the importance of physical proximity and analyst and patient meeting and waiting together regularly. It is the regular repetition of the act of understanding and containment that produces the conditions in which thinking can take place and time can potentially be used rather than got rid of in unthinking action. Instead of waiting *for* something specific to happen, the emphasis is on waiting *with* and responding, in the present, and in the time of thinking, to the anxious bombardment of thoughts whose qualities can become knowable, in all their difficulty and violence. But how can we wait *with* one another under the conditions of a profoundly unknown and unknowable future; how can we wait together when physical proximity is the thing that must be avoided? It is perhaps worth remembering that, almost from the very beginning, psychoanalysis has taken place under the agreement that there should be no physical contact between analyst and patient[12]. This idea of holding in mind, emphasised by psychoanalyst D. W. Winnicott (1960), alongside Bion's notion of psychological containment, indeed emerged in the name of an offer of contact through understanding rather than via material touch. But under material conditions of lockdown, or those that require a two-metre space between people, the idea of 'holding' in space might be less psychologically useful than the idea that there may be ways in which unbearable fear and anxiety can be contained within *time*. In a psychic imaginary now dominated by fears of contagion, of being invaded by 'thoughts' and anxieties that are as 'viral' as COVID-19 in their capacity to spread and to seep through domestic and bodily borders, a form of holding might still be able to occur through a sharing of verbal and embodied communication in time – a being *with* that enables containment in and of time.

How, then, might we think of using contact in time, a waiting *with* in time, as a way of containing the waiting time that COVID-19 has demanded of entire populations? It is clear that

[11]See, also, Davies, 2020.

[12]Freud describes using techniques of hypnosis and touch in *Studies in Hysteria*, but stated in 1893 that the 'talking cure' should be undertaken without physical examination or the laying on of hands (see Freud, 1893).

virtual environments are already enabling some people to remain in contact in time. From psychoanalysis to Seders to birthday parties – communication technologies have been making more bearable the requirements of isolation and social distancing that might otherwise be experienced as intolerable, even as the withdrawal of touch for some communities produces losses that simply cannot be mitigated (see Anonymous, 2020b). For those able to use these technologies, the greater challenge might be remaining in contact *with time itself*, particularly with the time of waiting and delay. Waiting can be experienced as an intolerable impingement on freedom; it can also be easy for distraction to dominate when much of life starts to be lived online. Feelings of lack of agency can produce obsessive rituals of checking information that work as attempts to reinstate a feeling of time's forward movement, but only fill the present by filling in for time's ever-weakening dynamism (see Salisbury & Baraitser, 2020). Isolation and social distancing are also palpably intensifying for some the demands of those sectors of the economy that were already or have been able to move swiftly online. Following the clear trends of neoliberal labour practices in which responsivity, availability and forms of affective labour have replaced clocking on and off, the sensation of capital occupying all areas of human life and of endless busyness has not left many of those whose work is deemed to be able to continue online. At the same time, those whose work outside of the home is deemed 'essential', alongside many populations who live without the privilege of conditions that would enable social distancing or self-isolation to take place, endure the exhausting practices and anxieties associated with attempting to mitigate the essential vulnerability produced by coming into physical contact with others. While many people remain contained, more or less tolerably in more or less impermeable spaces, others face the discomfort, sometimes the agony, of containing their anxieties and using practices of decontamination and the physical barriers of Personal Protective Equipment to mitigate the fact that bodies are not impermeable and that contact with others is essential for material care.

It is understandable that the temporality of the urgent might be prioritised in the current circumstances. There are immediate needs and demands that need to be cared for. But it is also clear that the call to action that Bion suggested in 1940 was implicitly a call to thoughtful action rather something that might be used as an evasion of thinking. For Bion, thoughtful action required what he later called 'patience' – the possibility of containing the anxiety of uncertainty and using it instead as the ground for the possibility of thinking. As he went on to suggest, there is always pressure to ward off the uncertainty of not knowing by leaning on prior knowledge despite those circumstances no longer obtaining, or adopting a new certainty too quickly while excluding other elements that might bring a new pattern of meaning into view (Bion, 1970, p. 124). As Steve Hinchliffe (2020) has argued, the understandable tendency in the present COVID-19 crisis to lean on particular kinds of epidemiological models of evidence, partially because they have the virtue of imagining futures that seem potentially knowable and can be relatively simply communicated, risks filtering out other forms of experiential evidence that might be important in shaping an effective response to an ongoing and evolving situation. The capacity to keep thinking under conditions of radical uncertainty, to be open to the unknown and to the complexity of the present moment, can seem almost impossible when the pressure is on to act, to mitigate in conditions of urgency. Nevertheless, for Bion an openness to what is unknown enables a relationship between, rather than a confusion of, internal and external reality, and the formation of an alliance for thinking made in contact others that could suspend action until it is thinking's precipitate, rather than its substitute.

Conclusions

The UK's plan to follow a strategy of 'containment, delay and mitigation' implies a linear, progressive temporality, even though it has been clear, almost from the beginning, that the idea of moving from one phase on to another does not map easily on to the complex reality of a pandemic. At an explicitly political level, as the experiences of South Korea and Germany are suggesting, delay and mitigation should not be thought of as simply superseding strategies of containment – testing, quarantine and contact tracing – even after it is clear that the virus is spreading in the community and even though such containment is resource heavy. Maybe it is obvious that containment of the virus can never be separated from the need to delay and to mitigate. But perhaps it needs to be reaffirmed at this point that any future mitigation must not throw aside all attempts to stay with practices of care that seek to contain and delay cases of COVID-19, if it is not to inflict 'horrorism' and abandonment at the moment when care is still needed.

We have argued here that by thinking the terms containment, delay and mitigation through in psychosocial terms and within a more enfolded and recursive temporality, we might be able to keep more in touch with and learn something from the failures that are always a possibility within any caring encounter. To be explicit, this requires thinking the temporality of the response to COVID-19 in a more care-ful fashion, as a time that would enable the figures of containment, delay and mitigation to hover and adjust themselves in relation to one another. Our point is that this more recursive temporality of repeating and returning is likely to be able to know more about ongoing violence as it holds back from narratives of battles to be won. Such a temporality might, in turn, allow us to know more about the ever-present possibility of failures of care that get written out of discourses of healthcare heroism – to know how such failures occur, what they might communicate and something about how such failures could be contained, delayed or mitigated. We have circled back to a point in twentieth-century history that was also concerned with an existential threat requiring a response from a whole population, but we have done this not in the name of invoking a fantasised narrative of 'Blitz spirit'. Instead, we have suggested that the British psychoanalytic tradition born of that moment insisted that one must keep thinking while 'under fire' and that there are possibilities of containing unbearable anxiety and the capacity for violence in the intersubjective space and time between people. This commitment to thinking in and with the process of delay and containment might yet be drawn upon as we inhabit this time of waiting – waiting that is the management and

mitigation of a future threat, but also a time of care in and for the present.

Data availability

All data underlying the results are available as part of the article and no additional source data are required.

Author contributions

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RESEARCH ARTICLE

Historicising "containment and delay": COVID-19, the NHS and high-risk patients [version 1; peer review: awaiting peer review]

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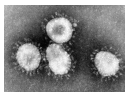
Abstract

Despite the first case of the novel coronavirus only being reported to the WHO at the end of December 2019, humanities and social science scholars have been quick to subject local, national and international responses to COVID-19 to critique. Through television and radio, blogs, social media and other outlets, historians in particular have situated the ongoing outbreak in relation to previous epidemics and historicised cultural and political responses. This paper furthers these historical considerations of the current pandemic by examining the way the National Health Service (NHS) and discourses of risk have figured in public and policy responses. It suggests that appeals to protect the NHS are based on longer-term anxieties about the service's capacity to care and endure in the face of growing demand, as well as building on the attachment that has developed as a result of this persistence in the face of existential threats. Similarly, the position of elderly, vulnerable and "at risk" patients relates to complex histories in which their place in social and medical hierarchies have been ambiguous. It thus argues that the ways in which time appears as both a threat and a possibility of management in the current crisis form part of a longer trajectory of political and cultural thinking.

Keywords

pandemics, Charles Rosenberg, National Health Service, risk, general practice, health inequalities



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Open Peer Review

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COVID-19, the NHS and high-risk patients

Historians and social scientists have long theorised the 'sudden disastrous event' of epidemics as social and cultural stress tests (Porter, 1999, p. 79). In a classic exploration of the AIDS crisis in the late 1980s, Charles Rosenberg conceptualised the temporal and 'dramaturgic form' of epidemics, noting that they mobilised 'communities to act out proprietory [sic] rituals that incorporate and reaffirm fundamental social values and modes of understanding'. Together with their 'unity of place and time', this public character meant that – for scholars – epidemics formed 'an extraordinarily useful sampling device – at once found objects and natural experiments capable of illuminating fundamental patterns of social value and institutional practice' as well as widely-shared 'cultural assumptions' (Rosenberg, 1989, p. 2).

Despite the first case of the novel coronavirus only being reported to the WHO at the end of December 2019, humanities and social science scholars have been quick to subject local, national and international responses to COVID-19 to critique (Manderson & Levine, 2020) – some even applying Rosenberg's dramaturgy in their analyses. Through television and radio, blogs, social media and other outlets, historians in particular have situated the ongoing outbreak in relation to previous epidemics (most notably the 1918 flu pandemic), and historicised cultural and political responses – especially that of quarantine (though cf: Lachenal & Thomas, 2020). Indeed, the peculiarity of the UK government's own measures have also been historicised in relation to its political, economic and public health histories.

However, further consideration of the way the National Health Service (NHS) and discourses of risk have figured in public and policy responses to COVID-19 can also reveal the way in which historical precedents are continuing to shape contemporary life in relation to the epidemic. Appeals to protect the NHS are based on longer-term anxieties about the service's capacity to care and endure in the face of growing demand, as well as building on the attachment that has developed as a result of this persistence in the face of existential threats. Similarly, the position of elderly, vulnerable and "at risk" patients relates to complex histories in which their place in social and medical hierarchies have been ambiguous. The ways in which time appears as both a threat (too much demand, too little time to cope) and a possibility of management (delay attending, target bodies with better chances of survival and utility) in the current crisis form part of a longer trajectory of political and cultural thinking.

The NHS in "Contain and Delay"

As the mass celebrations of the National Health Service's 70th "anniversary" in 2018 attested, the British public has developed a particularly strong psychosocial attachment to the NHS (BBC Four, 2018); following Rosenberg, its centrality to practices of governance and social and cultural configurations during the ongoing COVID-19 epidemic is indeed telling. A core, and very visible, feature of the UK's "contain and delay" strategy has been to appeal to the public to, in essence, stay away from institutions of the NHS as much as possible. Ministerial podia have been adorned with slogans, repeated by the Prime Minister and Public Health England, to 'stay home, protect the NHS, save lives' (see also: Baraitser & Salisbury, 2020, *Waiting in Pandemic Times*). On one level, there is a very practical aim in this appeal, as implied within the Department of Health and Social Care's policy papers: this distance will prevent overwhelming services and ensure that spaces associated with other forms of medical containment and delay are not themselves sites for spreading the virus among the public and vulnerable key workers. As with previous, smaller outbreaks of conditions like Swine Flu in 2009, delaying the spike in cases until the summer will have benefits as 'flu and other winter bugs are not driving GP consultations and hospital admissions' (Department of Health and Social Care, 2020). In short, the public's failure to wait for care of other conditions might not only threaten individual lives, but the life of the service itself.

At the same time, the appeal to 'protect the NHS' also aims to leverage cultural love and attachment to the service in order to encourage adherence to social distancing regulations. This has not only been seen in the way that "protecting" the Service and "saving lives" literally follow on from "staying home" in the grammatical construction of the soundbite; NHS workers themselves have posted signs on social media attesting that 'we stay here for you – please stay home for us'. Such appeals construct the service as a subject that waits for citizens in their time of need (though cf: Davies, 2020, *Waiting in Pandemic Times*), and uses this temporal dedication as a way to suggest that the social rights of citizenship come with expectations of performing health-protective behaviours (Berridge, 2007; Mold *et al.*, 2019; Reubi & Mold, 2013). Appreciation for the risk health workers experience in waiting for, and with, our infected selves has been manifest in overt displays of 'clapping for carers'. The designation of "carer" nominally broadens this appreciation from medical professionals to encompass everyone involved in forms of care work. However, though for some this broad appellation holds (and in spite of the international origins of the practice), association with the National Health Service in particular is evident in the use of additional media, notably signs saying "thank you NHS".

Historicising NHS attachment and its existential threats

Returning to Rosenberg's framing, however, we might consider these developments in a more historical light. In his first exploration of epidemics as a 'sampling technique', Rosenberg used the example of cholera epidemics in America during 1832, 1849 and 1866 to detail and explain 'the magnitude of the changes effected in American society' between those years (Rosenberg, 1962 [1987], p. 4). The changing responses to epidemics in those years highlighted in particular the effects of secularisation, urbanisation, and a growing materialism and rationalism on public health. By contrast, political, societal, and public health responses to COVID-19 have shown up how a number of long-term discourses and practices that still structure health governance.

For instance, the current cultural expression of attachment to the NHS is in some ways at a peak in the present, most likely as a result of post-imperial globalisation, austerity and a broad remaking of the welfare state since 2010 (on austerity's ongoing effects: Osserman & Lê, 2020, *Waiting in Pandemic Times*). Large sections of the British public configured post-2008 financial stringency and large-scale structural change as an existential threat to the NHS, reacting to these developments with growing campaigns to "save our NHS". Failures to meet prominent performance metrics, most tellingly waiting times (Sheard, 2018), were put forward as evidence of mortal under-investment (rather than offering a sign of poor care), and so powerful has this response been that post-Brexit politics have been fought on the battleground of who would spend the most on the health service. Indeed, the fact that the NHS simultaneously assumed centre stage in the consciously inclusive Olympics opening ceremony and the divisive, and consciously exclusionary, Brexit campaign, is indicative of how the service has been integrated into diverse visions of post-imperial British identity in ways impossible to foresee in 1948. As leading historians of the service have suggested, moreover, the sheer media saturation of the most recent "anniversary" was on a scale not seen in previous reflections (Bivins *et al.*, 2018).

However, this appreciation of the service is certainly not novel. One Mass Observation participant in 1949 remarked how the NHS was 'one of the finest things that ever happened in this country', and a 'godsend' for people previously priced-out from healthcare under earlier mixed economies of care, even using waiting itself – the 'crowded doctor's surgeries and queues for spectacles' – as evidence (Mass Observation, 1949). Likewise, letters to the press shortly after the tenth year of operation noted how any 'proposed survey will show that the ten years of the NHS, in spite of many difficulties and mistakes inevitable in a new social experiment, has done much', most notably extending 'the provision of medical services to all, without payment at the time of need' (Barrow, 1959). For these commentators, an appreciation of the NHS was born from direct experience of the painful social exclusions of mixed systems of provision; a combination of state insurance, mutual funds, contributory schemes, public assistance and private procurement that – though expanding interwar healthcare coverage considerably (Doyle, 2014) – had failed to provide rights of access to many who were unemployed or "dependent" (such as married women and children), and which was regularly criticised for its inequalities and inequities (Digby, 1999, pp. 306–24; Gorsky, 2011a). Yet, even as time passed, new generations were born, and these experiences moved more to the margins of living memory, attachment to the service did not fade. Foreshadowing current developments, existential threats to the NHS's capacity to wait for its ill subjects mobilised populations in its defence. Activism around hospital closures locally in the 1960s and 1970s transformed over the 1980s into a defence of the NHS nationally (Crane, 2019). At first, growing affect for the NHS emerged as the public interacted with its local institutions (Crane & Hand, *unpublished study*), before becoming the focus of left-wing political resistance to Thatcherite reforms and grounds for an identification with the values of universality and equity within the service (Crane, 2019). Into the 1990s and 2000s, moreover, this attachment also became a focus for more overt political management, with the development of national logos and Prime Ministerial forewords to NHS histories (see, for instance, Tony Blair's inscription for Rivett, 1998).

Equally, current-day constructions of COVID-19 as a hazard that could overwhelm the NHS's capacity to endure have precedents. Medical professionals warned the public about overwhelming the NHS almost as soon as it launched. Early forecasts for the cost of the NHS to the Treasury were predicated on problematic assumptions (Cutler, 2003) – itself highlighting the difficulties of modelling the future that have haunted discussions of COVID-19 (Hinchliffe, 2020). As Roberta Bivins has noted, the 'advent of the NHS, with its promise of free access to a complete medical service, released a tidal wave of pent-up medical need, and shone a spotlight on the complete inadequacy of existing systems to meet that need' (Bivins, 2015, p. 12). Local medical authorities discussed the possibility of a 'breakdown of the hospital system' (Exeter & Mid-Devon Hospital Management Committee, 1950, p. 102), and newspapers ran headlines of 'grave situation' within Britain's hospitals (Exeter Express & Echo, 1950).

General Practitioners (GPs) were perhaps most sensitive to this surge in demand, however. Partly this was because they acted as the gatekeepers to hospitals. They were thus the first port of call for all problems that patients felt required medical assistance (Loudon & Drury, 1998). Yet, their complaints about growing workload were also driven by the politics of a largely conservative profession. The British Medical Association (BMA) had fought strongly against a universal health service, and many GP members expressed anxieties about a loss of independence should salaried service be imposed (Klein, 2006). Despite retaining their position as independently contracted workers after 1948 (Lewis, 1998), GPs regularly lamented their loss of status relative to the patient, complaining that the "freeness" of the NHS removed any economic or psychological barrier for patients to attend surgeries. For some GPs, the NHS was thus most notable for the 'changed attitude of the patient – the demanding attitude' it produced (British Medical Journal, 1949, p. 199), with a minority going so far as to complain that patients treated them as 'a servant' (Hadfield, 1953, p. 699). For others, without the fee, patients filled up their waiting rooms with trivial complaints (Cartwright, 1967, pp. 44–52), as 'the old pride in not going to the doctor unless it was absolutely necessary' disappeared (Weir, 1953, p. 2).

Regardless of the service's continued existence (and popularity), GPs warned that the NHS was strained to its financial limit, alleging that supposed patient greed and short-sightedness risked the whole enterprise. 'People used not to attend the doctor for colds or a nose-bleed before 1948', lamented one practitioner. 'Now more than half the patients in the average doctor's waiting room have no right to be there. They are sabotaging the service and stealing their own money'. The letter continued to appeal to patients to recognise that 'doctors are human and have only limited powers of endurance' and, though not formally asking them to stay away from the service, offered suggestions for interacting with the GP, such as leaving

messages at the right time and avoiding night calls 'if you can' (G.P., 1951, p. 2.). Into the 1960s, the BMA produced posters asking patients to 'help your doctor to help you' through their behaviour (British Medical Journal, 1962, p. 4) – a campaign that earned Ministry of Health approval (British Medical Journal, 1966) – whilst Conservative politicians argued that waiting rooms filled with 'more and more people whose only complaint is that they are refusing to pay for their own aspirins and cotton-wool' risked the service's operation by reducing GP recruitment and retainment (British Medical Journal, 1965, p. 1317). By the 1970s, some GPs had even argued that 'the financial survival of the NHS probably depends to quite a large extent' on patients' capacity to wait, abstain, and endure outside of the service, to treat their own "minor ailments" before seeking consultation (Marsh, 1978).

These concerns dovetailed with broader efforts among GPs to limit the temporal extent of their duties. GPs pointed to the physical and mental strain of their 24-hour a day, 7-day a week contracts, suggesting their life was one of 'constant anxiety' as a result of this 'continuing responsibility' (Manchester Guardian, 1958). In response, over the 1960s, 1970s and 1980s, they produced appointment systems, rotas, out of hours services, and demanded holiday as a way to curb the effects on their social and psychological life (Armstrong, 1985). Political agreements and financial arrangements struck in the 1966 GP Charter facilitated such innovative modes of time reclamation (Bosanquet & Salisbury, 1998; Lewis, 1998). However, such complaints and innovations also neatly aligned with the longer-term politics of service funding, as well as efforts to ensure patients sought the right attention for their particular ills. The financing of the service has been the focus of consistent dispute since its foundation, but since the 1980s healthcare professionals, left-wing politicians and critics of service retrenchment have mobilised models of health service specific inflation to critique existing levels of investment (Klein, 2006, pp. 142–6). Likewise, one only need peruse the range of posters created to help patients "choose" the appropriate service for their complaints to see the way that concerns about patient decision-making was problematised in relation to financial constraints into the twenty-first century (see also, NHS England's own 'Time to Care' initiatives: Davies, 2020).

Ambiguities of risk and vulnerability

These efforts to target services for particular type of patients in a bid to reduce money had been foreshadowed by programmes to re-site chronic disease care from hospitals to general practice during the 1970s and 1980s (Moore, 2019). Their languages and practices of risk management – spreading out from post-war epidemiology (Berlivet, 2005; Oppenheimer, 2006; with precedent in early twentieth century medical insurance: Rothstein, 2003) – have also found echoes in efforts to deal with COVID-19. People considered particularly vulnerable to the virus on the basis other health conditions have been categorised as 'very high risk' and advised to self-isolate for a considerably longer period than the general population. This emphasis on prioritisation has manifested in other social measures – such as attempts to provide preference in home food delivery or reserved shopping times – encompassing other groups considered vulnerable, like the over 70s. Building on the changing tone of public health campaigns from the 1950s onwards, efforts to control individual behaviour have also looked to mobilise emotional responses to the risks to these groups (Berridge & Loughlin, 2005; Elizabeth *et al.*, 2019; Hand, 2020). The language of self-isolation – as opposed to quarantine – not only highlights the individual's responsibility in the crisis, but "staying home" has been framed as something which will also save the lives of the most vulnerable – our parents, grandparents or sick relatives.

At the same time, political and media responses have also underlined the marginal status of the most vulnerable groups. Many early reports of COVID-19 deaths came with claims that the patient was either old or had 'underlying health conditions'. These appeals were almost intended as reassurances, a call to reduce the alarm or panic of the supposedly young and fit. Once again, such strategies recall the prioritisation of clinical and public health services towards those who might be considered productive or reproductive, and were seen to be reproductive of particular national subjects. Though the political, cultural and economic factors driving development were complex, the growth of public British health services during the twentieth century nonetheless began with national insurance tied to employment (Gorsky, 2011b) and antenatal, maternal and child welfare services, which developed within contexts of eugenic, imperial and racist discourses of 'racial fitness' (Porter, 1999, pp. 165–95). At the same time, over the late nineteenth and early twentieth centuries hospitals frequently tried to exclude "chronic" and elderly patients from their walls, resulting in their institutionalisation in old poor law hospitals with little emphasis on rehabilitation or care (Levene, 2009; Weisz, 2014).

Even with the creation of the NHS, the language of inclusion for elderly patients and people with long-term illness or diverse physical impairments was often at odds with practice. For instance, geriatrics and rehabilitation specialisms developed as means to prevent "bed blocking" in acute hospitals, and they received little state support (Bridgen, 2001; Gorsky, 2013; Martin, 1995; Thane, 2003). Elderly patients found themselves stuck between divisions of health and social services, with neither wanting (nor having the budgets) to provide the support and care required (Bridgen & Lewis, 1999, though also: Welshman, 1996). Indeed, the marginality of age, impairment and long-term illness intersected with structural discrimination and the politics of race and migration. Since its foundation in 1948, the NHS has depended upon – and been shaped by – racialised and migrant labour (Kyriakides & Virdee, 2003; Simpson, 2018), with many of these 'architects' of the service now aging and dying within its walls (Gunaratnam, 2013). Xenophobia in the medical professional meant that "marginal" specialties like geriatrics were developed by migrant doctors (Bornat *et al.*, 2016). Despite its reliance on such a diverse labour force, however, the health services nonetheless vacillated between hostility and violent indifference towards racialised patients

(Bivins, 2015), particularly those with chronic conditions (Ahmad, 2000). The NHS was even incorporated into hostile environment policies that wreaked further damage to these patients, NHS staff, their families and communities (Gunaratnam, 2013). In the absence of concerted state efforts to address inequalities, the needs of – and support and services for – elderly, "disabled", chronically ill and racialised patients thus became the focus of political activism and charity, as well as local co-operation with interested clinicians and service providers (Bivins, 2007; Jackson, 2009, p. 21; Millward, 2015; Moore, 2019, p. 57; Sewell, 2015; Valier & Bivins, 2002).

Similar patterns of marginalisation are playing out today. For instance, programmes to care for the elderly and vulnerable have once again relied on the mobilisation of hundreds of thousands of volunteers (to undertake phone calls, food deliveries and other tasks), whilst the continued reliance on racialised labour in key worker roles – combined with the persistent effects of structural violence – have meant that BAME communities are dying disproportionately of COVID-19. Moreover, though at the time of writing (May 2020) we have thankfully yet to see Government funding decisions forcing NHS staff to choose who might receive life-saving respiration and who misses out, the existence of standardised (yet culturally loaded) technologies for weighing the costs of different interventions against quality and quantity of life are of concern to those whose lives are often constructed as of "lesser" value (on the history of these technologies: Armstrong *et al.*, 2007; MacKillop & Sheard, 2018). Indeed, concerns among disability rights groups, and other organisations and communities, have been (legitimately) heightened by ethical discussions regarding "brutal" decisions on treatment that might be required soon (British Medical Association, 2020), and by suspicions that the biopolitical calculations of loss embedded in conceptions of "herd immunity" (Hinchliffe, 2020) are still informing government and NICE policy (despite utterances to the contrary).

Questions of who the NHS is willing and able to wait for, who does this waiting and how the continuation of some lives rather than others are prioritised in the temporality of crisis, have thus long been full of tensions and paradoxes. At present, prioritisation in risk minimisation – of stricter measures for some groups to prevent infection – does not seem to carry over to clinical decision-making where "value" is judged on different terms.

Conclusion

As Lachenal & Thomas (2020) have suggested – also in conversation with Rosenberg (1989) – the coronavirus pandemic might be best considered to be an historically novel event, and historians should not rush to fit its ongoing devastation within any previously recognised frame. We can see this to some extent with the NHS. Previous outbreaks of infectious disease have strained the post-war British health services, albeit not in the same way as COVID-19. Struggles here often related to difficulties procuring sufficient vaccine material, or to coping with queues for vaccinations when demand spiked (Millward, 2019, pp. 114–46). Moreover, efforts at containment were often local, reflecting the existence of local public health structures. By contrast, the current crisis is unprecedented in the NHS era, both in term of its scope and the national quarantine measures imposed.

Nonetheless, whilst trying to learn "lessons" from previous epidemics might be a problematic mission, it is nonetheless reasonable to place contemporary reactions in relation to longer-term trends in order to understand both where they have come from, and the particularities of local and national forms. From the preceding review, for instance, it is clear to see how the policy response to contain and delay has been framed within longer-term anxieties about health service demand and underfunding, decades-old frameworks of risk and long-held cultural and political values which have placed racialised, older and more vulnerable publics in a place of ambiguity. Themes of waiting, endurance and existential threat – how the NHS has been considered to historically (and biographically) wait for us, how we must now wait for the NHS if citizens and institutions are to endure, and whose existence might be threatened regardless from their ambiguous status as "vulnerable" – appear consistently throughout the history of the service. Equally, it is notable how governance strategies have sought to harness deep-rooted cultural expressions of attachment for the NHS in order to support its more individualising appeals for self-isolation and social distancing. For researchers, then, epidemics like COVID-19 not only show the socially and culturally novel – such as the new forms of sociality configured with technological change – but also how the present is continuously shaped by values and practices with long antecedents. This suggests that in order to gain better traction on the temporalities of current strategies of epidemic management – the constructions of urgency, priority, containment, delay and projection – we need to have a grasp on the historical structures and values shaping approaches to disease control.

Data availability

All data underlying the results are available as part of the article and no additional source data are required.

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RESEARCH ARTICLE

The politics of staying behind the frontline of coronavirus [version 1; peer review: 1 approved]

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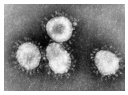
Abstract

Intended as a contribution to the *Waiting in Pandemic Times* project Collection in response to COVID-19, this short paper views the coronavirus crisis in terms of its unpredictable effects on the interior life of the National Health Service (NHS) workforce. Based in part on ethnographic observations from the 'frontline' of the NHS during the hours that immediately followed a first suspected case of coronavirus at a general practice in London, it charts the collision of the ensuing crisis with working definitions of the nature of time in its relation to care. It considers what it might mean for healthcare practitioners at this particular moment in the NHS's history to be living through an experience of 'the ordinary' breaking down. The paper also follows hints of new temporal modes of care appearing during this same period when one kind of crisis in the NHS has been put on hold, and another (the crisis of coronavirus) is just getting underway.

Keywords

COVID-19 pandemic, NHS culture, ethnography of care, Dejours, temporality and healthcare



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Open Peer Review

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During a crisis on the scale of coronavirus, the invisible forces holding an institution's 'time' in place (Hammer, 2011)[1] can seem to collapse, as they suddenly lose their power to regulate the institution's everyday life in the drastically altered situation. I was a researcher undertaking an investigation of waiting in a London general practice when I heard the news that the virus, seemingly so far away, had arrived, having entered literally through the front door. In the hours that followed the first suspected case, all thoughts were immediately drawn towards the virus, siphoned off from wherever they had happened to be only an hour before and, after having being relied upon for so long to replenish everyday life in the surgery with its essential quality of 'everydayness', many long established orderings of time and space – meeting times, consultation times, waiting room times, lunch-time, opening and closing times, patterns of movement through the building - were reduced to just the remainders of what was left over after the coronavirus had taken hold. So too were the ordinary patterns of behaviour and identification that had belonged to them; of employees knowing how to compose themselves as those who 'work for the National Health Service (NHS)'. Through rapid modes of improvisation and with an intensity that might have come from the combined energies of so many people all furiously channelling what was going on around them, they very quickly began to reconstitute themselves as those who work for a different kind of NHS, one still in the process of being formed out of a time of national emergency. This all seemed to take place over the course of a single morning, just a day after the first suspected case of coronavirus had entered the building.

The question I'd asked myself then, as now, was what happens in a situation like this, when a person who is used to having almost every minute at work accounted for in advance, finds that they are living through an event not orderable by the standards of the everyday? The orderings of time that are usually seen to be of utmost importance for the future – recording, inspecting, reviewing for instance – are suddenly made to appear extremely relative alongside the infinitely more pressing and immediate demands of the present: the saving of life, the protecting of one's own life, and the need to survive the crisis. At such a moment, a person might get caught up in the end of one set of working conceptions of time, before another has even begun to circulate. Yet, for those healthcare workers who might now be experiencing something like this in their own NHS workplaces, the failure of the ordinary to assimilate the fears, risks and demands connected with an unknown virus, is an event that they have had no choice but to find some way of working through. So how are they keeping time in such a crisis? (Catty, 2020, *Waiting in Pandemic Times*).

The interior life of the workplace is said by Christophe Dejours to hardly ever be allowed to show itself, except in very rare situations (Dejours, 2007). The hiddenness of its invisible inner workings and affective economies is believed to be partly due to a lack of interest by the public whose currency is mainly that of the name or brand of the organisation (the part that faces outwards), but also because the workers themselves are thought to be complicit in secreting the inner-functioning of their own institution with whom they are required, at least in part, to identify. At this time of great public interest in watching the collision of coronavirus with healthcare systems all over the world, the growing intensity of collective identification with the aims of the NHS and its projection onto the workforce, could mean that the privately felt realities for NHS staff, of becoming part of a temporality of crisis, are even more likely than usual to remain hidden from view.

On the surface, the crisis appears to have prompted new modes of agency that have begun to emerge in NHS settings hinting at a shift in the perspectives of its workforce. They are like what Ricoeur describes as reconfigurations of the 'conditions of possibility', in that they come about as a result of alterations in how the past and the future can be collectively thought about (Ricoeur, 1990, p. 227). This is discernible in the celebration of activities and practices, that may not always have been considered reasonable for NHS employees to have engaged in before now. For example, carework that takes the form of a commitment to 'staying with, in spite of', has come to the fore in images and testimonials depicting doctors and nurses remaining steadfast at their posts, 'heedless of their own health as they work tirelessly to care for people in the face of the Coronavirus pandemic'.[2] It is not clear whether such practices (of *staying* to care for others) correspond to the experiences of frontline NHS employees as a multiplicity, or whether they are imposed from elsewhere, or a combination of both, but because NHS staff are *seen* to be working on behalf of others at their own risk, and often in a way that requires them to withstand the most concentrated and contagious parts of the pandemic over an indefinite length of time, those who *stay* in post, or return to posts they had previously left, appear to be choosing to exercise a form of altruistic endurance. Moore, (2020), *Waiting in Pandemic Times*) notices that in social media posted by NHS staff bearing the message, 'we stay here for you – please stay home for us', the NHS assumes the form of 'a subject that waits for citizens in their time of need'. When I try to look at the same messages from a place interior to the NHS, I see in them the outward signs of how some of the workforce are composing themselves in relation to the new situation: through a revivified identification with the NHS as a waiting, staying subject; 'we stay here for you, this is what we've always done'.

When glimpsed from below the level of image and identification, however, practices of staying and of 'being here for you'

[1] The time 'kept in place' refers to the local arrangements for inferring time from structures imposed or engendered; the 'specific temporal economy' of an institution (Hammer, 2011, p. 26)

[2] The full quote from the website is: 'From cradle to grave, the National Health Service, and the incredible professionals within it who care for us, is a part of British life. Today, more than ever, we should cherish those who dedicate themselves to our care, 'heedless of own health as they work tirelessly to care for people in the face of the Coronavirus pandemic' (NHS Heroes, 2020).

are like modes of care that have been made newly available to current NHS practitioners through the temporality of acute crisis. Inspired by affective investments in what is 'real' about care work during a pandemic - its resistance to appropriation as, just 'a task to be accomplished' (Dejours & Deranty, 2010, p. 451)[3] - they nevertheless need to be understood as coming after a much longer, drawn out time in which the normal working day has been organised around the assumption that care is something that can only be apprehended at the specular level of the organisation, and where time is reduced to being just one of the costs of its production. In other words, until now, healthcare of all kinds has tended to be seen as synchronic output; as happening all at once, with little attention to how a particular labour of care might evolve over time, or how a continued engagement with it might help to 'sustain interdependent worlds' (Bellacasa, 2012, p. 198).

Unpredictable, prolonged and intermittent timeframes are to be expected in the NHS, particularly in relation to chronic, multiple or undiagnosable illness of the kind that now makes up most of its workload. What might then be required more than anything else during the attendant long periods of suspense, observance or endurance that are so central to healthcare, are intuitive practices that can be receptive to the effects of time passing on the world of the patient. Though outwardly they may be focused on making more *'time for care'* (NHS England, 2019), policy initiatives that have sought to curtail the patient's and the practitioner's experience of time passing[4] have tended to result in many temporal practices of care being rendered as obsolete. It is the continuation of an older formulation of care as synchronic, that has made staying with the idea that the activity of care might still be worthwhile in and of itself, increasingly difficult to justify (Latimer, 2000). This is not to say that discretional practices of offering more time to some patients are not one of the inevitable consequences of making the offer to care in the first place, or that they haven't always gone on and won't continue to do so. But nevertheless, the growing concern amongst clinicians over finding themselves unable to spend time on the things that matter most to themselves and their patients, has been met until now with a response that questions their ability ever to have really known what it was worth their while having cared about in the first place. As one NHS England consultant put it, 'we wondered how health and care systems could design services that would improve peoples' lives, if the people running the system didn't understand what matters most?'.

Kathleen Stewart observes that 'there's a politics to being/feeling connected (or not), to affective contagion, and to all the forms of attunement and attachment' (Stewart, 2007, p. 16). I think it changes the way we think about the politics of staying at the frontline of a pandemic, if we remember that many of the most experienced members of the NHS workforce, those who have stayed or returned, and who are still working on 'our' behalf, bring with them a decades long history of attachment to the institution in relation to the slow collapse of a former symbolic order.[5] This is an order they worked hard to delay the future collapse of, even though they might well have wished to be released from it. It is a situation that has proven to be unendurable for many, as the annual problem of how to fill all the vacancies in British general practice affirms. Each year, a steady stream of doctors under the age of fifty, have made the decision not to stay, not to carry on. More than just a feeling of exhaustion from overwork, by the time they have left, many of these people, described quite tragically in one study as the 'lost to the NHS' (Doran *et al.*, 2016) have reached the point of feeling that they had in some way been locked out from the time when *real* care was taking place.

Superficially, I think it would be difficult to imagine a more complete reversal of the recent past than what we are seeing on this new frontline, where virtually everything that 'the NHS' *does* is seen as extremely valuable, heroic even, in its relation to a future that has yet to unfold. One of the most contagious forms of agency that a temporality of acute crisis seems to be able to offer us now, is a capacity to become so immersed in the *doings* of the present that nothing else seems to matter.[6] In this respect, coronavirus appears to have achieved in hours, what the long form strategies for 'releasing time' never could, which is to have forced the making of more time for care into the present. In fact, an orientation to *this time - as care*, has not so much been offered to the workforce as *required* of them, just as to a lesser extent, it has been required of everybody whose time is having to be lived out firmly in the present (in quarantine), so that others might have more time to live on.

As with the politics of any 'surge', the afterlife of this crisis and of all the time for care that has miraculously bubbled up around it, may depend on events that have yet to come to pass; where the surge 'might go, what happens, how it plays itself out and in whose hands' (Stewart, 2007, p. 15). As my own observations of general practice were cut short, I was one of those who couldn't stay to follow the energy, to see 'where it might go', but from what I did see of the frontline after the first shock, I would say that there is something very fragile and forgetful about the forms the ordinary is taking and what they have the power to release under the influence of crisis.

[3] For Dejours, 'to work is, first, to experience the real, that is to say, experience the breakdown of technical know-how' (2010, p. 170).

[4] Of the ten actions included the Time for Care programme, all of which are based on time looked at 'from the outside' so to speak, the majority can be described as attempts to deflect or deter face-to-face GP consultations wherever possible and to speed up the everyday activity of practitioners with the aim of producing more 'care' in the least amount of time (NHS England, 2019).

[5] 'The institutional and linguistic network (the province of duties, roles and obligations) and the values of a given culture' (Dashtipour, 2014, p. 5)

[6] The resulting tendency to see everything only in relation to the virus carries its own risks for those who are dependent on health and social care services at a time when their needs may have increased whilst the availability and integrity of care and support has been reduced overall. An example of this is the impact of the Coronavirus Bill on the integrity of existing legal safeguards for adults with care and support needs and their carers: https://www.nsun.org.uk/news/covid-19-the-coronavirus-bill

Data availability

Any insights are based only partly and tangentially on ethnographic observations of a clinical site. No results are included in the article which might be said to be based on the raw data collected during these observations.

Author contributions

Stephanie Davies is a Birkbeck PhD candidate based in the Department of Psychosocial Studies and part of the Wellcome Trust-funded *Waiting Times* research project. She was undertaking an ethnography of waiting in a London general practice at the time of coronavirus first making its appearance in the UK which has since been temporarily suspended. She has an MA in Rhetoric and is also a registered Social Worker who has worked in the NHS in community mental healthcare teams.

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RESEARCH ARTICLE

Lockdown and adolescent mental health: reflections from a child and adolescent psychotherapist [version 1; peer review: 1 approved]

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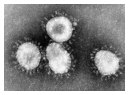
Abstract

The author, a child and adolescent psychoanalytic psychotherapist working in the UK NHS, ponders the varied impacts of 'lockdown' on adolescents, their parents and the psychotherapists who work with them, during the COVID-19 pandemic. She asks, particularly, how psychological therapies are positioned during such a crisis, and whether the pressures of triage and emergency can leave time and space for sustained emotional and psychological care. She wonders how psychoanalytic time with its sustaining rhythm can be held onto in the face of the need for triage on the one hand and the flight to online and telephone delivery on the other. Above all, the author questions how the apparent suspension of time during lockdown is belied by the onward pressure of adolescent time, and how this can be understood by, and alongside, troubled adolescents.

Keywords

Adolescent mental health, psychoanalytic psychotherapy, COVID-19 pandemic, deliberate self-harm, quarantine, temporality in health care



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Open Peer Review

Reviewer Status ✓

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	1
version 1 10 Jun 2020	✓ report

1 **Tom Burns**, University of Oxford, Oxford, UK

Any reports and responses or comments on the article can be found at the end of the article.

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Introduction

The time of the COVID-19 virus brings a strange shifting of priorities to my professional life as a child and adolescent psychoanalytic psychotherapist working in a Child and Adolescent Mental Health Service (CAMHS). COVID-19: the name itself encapsulates delay (Flexer, 2020, *Waiting in Pandemic Times*). Building into the term the origins of the virus in 2019, it provides a stark reminder that, having ignored warnings from the medical world and then the evidence before our eyes, we are now always already trying to catch up (Horton, 2020).

The world is in crisis, but it is hard to position the acute and chronic crises of mental health work in the NHS against the unfolding crisis we see on our screens. Are we high priority or low? Frontline or routine? Do we, like primary care staff, rush to 'man the barricades' (Davies, 2020, *Waiting in Pandemic Times*) – anxiety about the possibility of redeployment is spreading among mental health staff even where they are entirely untrained for physical health care – or do we hunker down at home to conduct therapy online for the foreseeable future? (What is foreseeable about the future, now, for the young patients, depressed, anxious or enduring the turbulence of adolescence, for whom the future was only hazily in view in the first place?)

Mental health has traditionally been lamented as the poor relation within the National Health Service (NHS), with psychiatry under-valued and repeated cries to achieve parity between mental and physical health ignored. How, then, are we to consider the seriousness of psychological and emotional labour conducted in services such as CAMHS during a national crisis? Talking to young people and children about their anxieties, or even their considerable distress, appears low priority when compared to doctors and nurses battling COVID; yet an adolescent death by suicide remains one of the most catastrophic events imaginable, for family, friends and professionals alike. In the time of the virus, we are thus adrift in the prevailing geo-spatial metaphors of the age: nowhere near the 'front line', we may find ourselves thrust suddenly towards it if a teenager attempts to harm him- or herself.

Adolescent time

The world gives the impression of having halted adolescent time. Exams are cancelled; school is out, or virtual; universities have sent their students home. For those in their teens, the COVID-19 pandemic arrives at a crucial time in development, as they transition from childhood to adulthood. Yet the time of adolescence itself often feels both chronic and acute, its difficulties regarded as perennial, even predictable, yet often plunging the young into crisis. Disturbed adolescents may try to arrest a march of time that feels relentless by retreating into depression, or into their bedrooms: to halt their progress towards a future that is perceived as bleak, or simply unimaginable.

What can we learn about time – now, in the time of COVID-19 – from this sudden suspension of time which is not actually a suspension at all? This questioning of the future which is, curiously, so familiar to many of the young people whose mental health elicits our care?

The decision to award GCSE and A level results, rather than postpone the exams, could be seen as a shocking pronouncement: that time waits for no one, that adolescent progress cannot, must not, be halted – even if, for those awarded a grade less than that which they might have achieved, progress is thwarted. Like their younger counterparts at the top of primary school, they must, even from their bedrooms, be ushered forwards to the brink at which they bid their school lives farewell. Those struggling with the pressure of work and exams may be relieved, but their world has also crashed down upon them and many are disappointed. Some lament a lack of control: the final academic effort, for which they were preparing, is denied them, and teachers, or government, will decide upon their grades. Yet for some, for whom the pressure of external life has been unbearable, perhaps there is the possibility of respite, and the lockdown may provide them with much-needed time for recovery.

Adolescent development 'runs unevenly' (Waddell, 2018, p. 26): how the time of COVID-19 intersects into each individual trajectory will vary hugely. While the media portray the young as oblivious – gathering in parks, spitting defiantly in the faces of police or the elderly – we hear our young patients report their varying responses, almost always ambivalent, anxious. For those with depression, existential despair, sometimes born of inter-generational trauma and loss, is known to dominate (Catty ed., 2016): how are they to believe that the future holds any promise when it appears to have been cancelled, or at least indefinitely postponed? For some, this will confirm a pre-existing belief, a bleakness. Meanwhile, they worry about grandparents, parents and, increasingly, each other.

There is an idea that psychoanalytic work with adults involves the recollection and processing of remembered trauma – that it is, as Wordsworth wrote of poetry, 'emotion recollected in tranquillity' (1805/1987, p. 42) – while therapy with children and adolescents is conducted during and alongside the unfolding of their key emotional dramas. Theory and clinical practice afford many contradictions of this dichotomy; yet it remains meaningful to conceptualise adolescent therapy as a 'being alongside' a teenager as they live through their most turbulent of times. How does lockdown impact on this sense of immediacy? During lockdown, young people are suffering a crisis that we appear to share with them, at least in this basic way: we too sit in our homes as we engage them in their therapy. Keeping a focus on the particularity of their experience – the extent to which the national crisis may or may not be impacting on their internal dramas – will need close attention. Yet perhaps they have something to tell us about uncertainty – about the future, about the passing of time – that they have long feared we did not understand. For some, we have finally entered into their world. There are implications here, too, for our work with their parents, now that we feel ourselves to share their most immediate circumstances: we are all in lockdown; we are all

worried about our ageing parents; we are all, increasingly, worried about the young.

Urgency and delay

Crisis time in adolescent mental health services relies on a red-amber-green system of case-flagging. Now only the reddest of the red cases can be seen in person, anxiously diverted from Accident and Emergency departments to the community clinic to avoid contamination. While those on duty manage these most critical of crises in person, the rest of the team connect to their patients via telephone and video-conferencing. Fears that mental health work will be deemed such low priority as to justify sending therapists into the medical settings for which they would be entirely, shockingly, unprepared, seem to abate as authorities determine that mental health emergencies are themselves 'priority'. At the same time, the urgency of attending to an unfolding mental health crisis is becoming clearer: articulated in a recent 'call for action' to include data collection on the psychological, social and neuroscientific effects of the pandemic on both the general population, vulnerable groups and those with the virus (Holmes *et al.*, 2020).

What, then, are the implications of mental health triage in this new world? In the early weeks of the lockdown, we wonder whether to activate a crisis response by focusing only on emergencies, keeping in touch with our regular patients for more frequent, but briefer, telephone updates. Implicitly, we are invoking ideas of triage (focusing only on emergencies in any detail or depth) and support (finding out how our patients are managing, rather than working with them). Yet it is clear that such a model will not serve us well in the longer-term: if nearly the whole CAMHS population is provided with brief, intermittent support rather than treatment, logic dictates that their mental health will deteriorate. Yet does such a distinction between support and treatment hold in a time of crisis? It is a distinction that has always been uncomfortable where it privileges the activity of psychological therapists over other mental health specialisms, such as nursing, occupational therapy or social work (deemed to be providing 'support' or 'risk management'); yet it has enabled us to retain an emphasis on the 'work' that is involved in psychological treatment and the process that unfolds between the participants in psychotherapy, patient and therapist. What the nature of such work may be during lockdown remains to be seen.

Meanwhile, mental health emergencies among the teenage population seem to have plummeted: we wonder, where are they? Have they too been suspended? There is anxiety about when the dam may break; an increase in anxiety, depression and self-harm are expected in the population as a whole (Holmes *et al.*, 2020)[1]. For those that come in, we find ourselves contorting the familiar NHS language of 'risk': do we mean suicide risk or COVID-19 risk? Where is 'safe' for a 16 year-old determined to kill herself, or a 13 year-old who has taken an overdose? A mother asks whether, were her teenage son to harm himself, she would be allowed to be with him in hospital; we cannot advise her. The focused maternal care that a teenager may specifically crave in such desperate moments becomes the one thing he would deprive himself of; the choices facing those with suicidal thoughts become starker now. We ask ourselves, can we provide a reassuring presence dressed in protective mask and goggles? Or should we retreat behind a computer or smartphone screen, through which we can, at least, be seen as ourselves?

Time and space

How do we keep time in such a crisis? There is a rhythm that psychotherapists and their patients come to live and breathe: the regular pulse of the psychoanalytic session, whether weekly or more frequent; the predictability of the starting time; the inevitability of the session end or the week's wait. This rhythm underpins the duration of a therapy as it unfolds in time and is the bedrock of the 'containment' (Bion, 1962) that psychoanalysis offers (Baraitser & Salisbury, 2020, *Waiting in Pandemic Times*). Can this rhythm, based on the fifty-minute hour, be maintained over the telephone or protected with the same boundaries as in the clinic?

In the rush of psychotherapists to online platforms and the telephone, can we maintain this steady pulse? For a teenage patient, does it still feel like his session time if he knows his therapist is going to ring? Will it still feel like time to stop if we are wrapped in the cocoon of sound provided by a telephone call in a quiet room; or if we have been trying to focus on each other's faces in a shaky video call? Despite the fact that most teenagers are more familiar with online discourse than we are, this shift raises issues of space too. Is it intrusive to conduct therapy online with an adolescent, looking into that most private of spaces, their bedroom? Alternatives are unlikely when families are crammed together conducting school and home lives under one roof. What is it like for a depressed adolescent to know that his therapist is telephoning from her own home? Or for a troubled teenage girl, reliant on self-harm to embody her misery, to bring her therapist into her home on a smartphone screen?

Decisions continue to need making: despite the impression that time has been suspended, in fact it waits for nobody. An offer of time-limited psychotherapy for a girl of seventeen-and-a-half is paused: can it still be done? The time-frame provided by the therapy model was to fit neatly into the time that remains for her as a CAMHS patient: upon her eighteenth birthday, she will be discharged. Despite the impression that the world has stopped turning, time is marching on.

Nothing sums up better the paradox of the crisis for adolescents or gives the lie more obviously to the notion of shutdown, suspension or postponement. Time is still passing.

Data availability

All data underlying the results are available as part of the article and no additional source data are required.

[1]This paper was written in the first two weeks after lockdown, when emergency presentations nationally were hugely reduced (BMJ, 2020); by the time of publication, it could be anecdotally observed that emergency presentations of adolescents in a state of mental health crisis had increased.

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RESEARCH ARTICLE

Waiting for other people: a psychoanalytic interpretation of the time for action [version 1; peer review: awaiting peer review]

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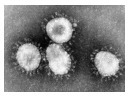
Abstract

Typical responses to a confrontation with failures in authority, or what Lacanians term 'the lack in the Other', involve attempts to shore it up. A patient undergoing psychoanalysis eventually faces the impossibility of doing this successfully; the Other will always be lacking. This creates a space through which she can reimagine how she might intervene in her suffering. Similarly, when coronavirus forces us to confront the brute fact of the lack in the Other at the socio-political level, we have the opportunity to discover a space for acting rather than continuing symptomatic behaviour that increasingly fails to work.

Keywords

psychoanalysis, Lacan, coronavirus, waiting, time, passivity, NHS



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Open Peer Review

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Any reports and responses or comments on the article can be found at the end of the article.

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Introduction

'A strike is precisely that kind of rapport that connects a group to work.'

(Lacan, 2006, p. 266)

We were on the picket lines when the UK woke up to the reality that responding to COVID-19 was going to require mass shut-downs. We had been thinking and speaking, in University College Union 'teach outs', about how participation in industrial action opens up a particular and generative kind of temporal space. Withdrawing one's labour dramatically disrupts the 'on-go' of daily life. One is thrown into a situation where time takes on a different quality: our relationship to the past is called into question ('What has brought me to the point? Where have I been placed within the economic structure?'), and we gain a new sense of agency over the future through a rearticulation of the self. We thought this had something in common with the scenario of a patient undergoing psychoanalytic therapy, and we were attempting to tease out relevant parallels.

This was the beginning of theorising an aspect of the psychic life of time rooted in a joyful form of collective struggle. It came to a dramatic halt with COVID-19, which suspended and indefinitely postponed strike action, while simultaneously throwing the causes for the dispute into sharp relief. What will happen to precarious staff employed on hourly and temporary contracts about to expire, accustomed to regularly moving across the country (or indeed the world) for insecure academic work, in the context of a pandemic and economic crash? How will university pensions, held in investment portfolios, endure a stock market freefall? Will we be told, yet again, that 'now is not the time' for rectifying the BAME and gender wage gaps, and that taking on unsustainable workloads in the shift to online teaching are simply part of being a team player during a 'chaotic time'?

Neoliberal economics has shaped our healthcare provision (and indeed our health) for decades, ever since the introduction of 'internal markets' to the NHS, but the extent which health has been deprioritised in order to create an 'efficient' and profitable health service is now showing its true face. Prior to the outbreak, hospital occupancy had repeatedly hit all-time record highs, routinely exceeding 95% of capacity, leading 92% of doctors in a BMA survey to say that the NHS is 'in a state of year-round crisis' (BMA, 2020)[1]. The doctrine of profitability means no margin of 'waste' — which means no ability to cope with everyday volumes of patients, much less an actual crisis. It has become increasingly clear that our physical health relies not only on epidemiology but on the questions of politics, economics and analyses of social life more traditionally associated with the humanities and social sciences. The boundary between the physical and the social body has fallen. Here, we attempt to offer some suggestions with regard to these extraordinary times.

Concomitant with widespread fear of illness and economic ruin associated with COVID-19, we have observed the emergence of an unusual form of optimism. As governments around the world begin to implement stimulus and rescue packages designed to mitigate the economic effects of the disease — associated in the popular imaginary with wartime spending measures — some are beginning to hope that if we simply 'wait' (or 'hang tight') under quarantine, the government will ensure that things will be 'okay'. Things will 'return to normal' eventually (as if returning to the state of affairs that gave rise to this crisis would be desirable), or even (in its more left-wing formulation), with the advent of socialist spending, a new and more equitable social order will arrive.

Keeping the racial implications of waiting in mind, we might remember colonial injunctions that the time was never right (so colonial subjects had to wait) for independence (Chakrabarty, 2009), or in the US context, for emancipation and subsequently civil rights, about which Langston Hughes wrote a lyric to the 'Hesitation Blues': 'How long/ have I got to wait?/ Can I get it now—/ Or must I hesitate?' (Hughes, 2001, p. 91).

So do we wait for these conclusions to sink in? This is a question of time, and also, clearly, a question of power. It is evocative of an early experiment in behavioural psychology, the Stanford 'marshmallow experiment', meant to explore the connection between delayed gratification and later successful life outcomes (Mischel & Ebbesen, 1970). In the experiment, children were given the choice between an immediate reward (a marshmallow or pretzel), or two rewards if they were willing to wait for 15 minutes. The study, and subsequent others like it, linked children who waited with better test scores, better jobs, even better bodies (Casey *et al.*, 2011; Mischel *et al.*, 1972; Shoda *et al.*, 1990). In mass media, the results of the study were promoted as a kind of neo-Calvinist doctrine of the persevering rich, as well as providing a handy economic allegory about the importance of obedience and trust when facing apparent deprivation. If you follow the rules (and don't, for example, hoard toilet paper), the second marshmallow will be coming along any second now…

The big Other falls apart

The researcher who dispenses the marshmallows is playing a role known psychoanalytically as the 'big Other'[2]. As theorised by Lacan, the big Other stands for the place from which people imagine that authority ultimately emanates, a kind of 'necessary illusion' that grounds the otherwise potentially infinite uncertainty of subjective speech and behaviour. ('The Other must

[1] Indeed, the latest NHS planning document suggested 92% bed occupancy as an aspirational target: 'Systems and organisations will be expected to reduce general and acute bed occupancy levels to a maximum of 92%. This means that the long period of reducing the number of beds across the NHS should not be expected to continue' (NHS, 2020).

[2] A more sophisticated iteration of the 'marshmallow experiment' suggested that children who have experienced food poverty and other forms of deprivation might choose not to 'wait' due to their understanding that the big Other's promise of eventual abundance would likely prove hollow (Calarco, 2018; Watts *et al.*, 2018).

first of all be considered a locus, the locus in which speech is constituted' [Lacan, 1997, p. 274].)

Individuals take on the mantle of the big Other insofar as they successfully appear to be a guarantor of futurity: my hands hold the keys to your fate. This is a structural relation between parent and child which, although eventually surmounted to varying degrees, becomes 'transferred' onto figures of authority actual and spectral.

However, as Derek Hook clarifies, 'we should not fix the Other in any one personage, or view it in a static way as embodied in certain lofty or powerful figures. … We as subjects constantly call upon, reiterate and thus reinstate the Other … [it] is a (trans)subjective presupposition which exists only insofar as *we act as if it exists*' (Hook, 2017, p. 23).

Consider the way investors are speaking about 'the market': 'the market right now is really shellshocked'; 'until the market sees some evidence that we've got the virus under control ... there isn't going to be a lot of confidence to buy'. This anthropomorphic creature we call 'the market' is, of course, the sum total of individual investors' financial behaviour. Yet, these investors do not decide whether to buy or sell stocks based directly on what they think other investors will do, but through the mechanism of a presupposed, transubjective third: *what I think other people think 'the market' is going to do* (see Tuckett, 2011).

In his late teaching, Lacan made a crucial emphasis on the notion of a *lack* in the big Other. At certain pivotal moments, we begin to realise that nobody is actually behind the curtain. The 'glue' that holds together a social order starts to melt.

The COVID-19 crisis is, of course, a prime example of such a moment. It is difficult to overstate just how incompetent and incoherent our political leaders have made themselves out to be. From Boris Johnson boasting that he was shaking hands with COVID-19 patients before contracting the virus (The Guardian, 2020); to the government denying that it promoted 'herd immunity' (Walker, 2020); to cabinet ministers openly contradicting WHO guidance in order to obscure the government's failure to procure adequate testing, hospital equipment, and PPE (ITV News, 2020) – it has become clear that there no longer exists a stable authority upon whose pronouncements we can rely (see especially recent exposes in the Guardian [Conn *et al.*, 2020] and Sunday Times [Calvert *et al.*, 2020]).

One of the ways Lacanian psychoanalysts approach the question of diagnosis is to consider how a patient responds when he is confronted with a lack in the big Other. Similarly, with the void in power that has emerged as a consequence of COVID-19, we are witnessing a variety of what we might call 'symptomatic' responses that index the coordinates of individuals' psychic structures:

- Denial: the big Other is perfectly intact. *The novel coronavirus isn't any worse than the ordinary flu, people are needlessly panicking due to social media and liberal commentators intent on discrediting our political leaders.*
- Conspiracy: we are being duped, a malevolent big Other is pulling the strings. *China designed COVID-19 as a biological weapon to destroy the West.*
- Deferral: give the big Other some time, and it will reconstitute itself. *Things are messy now, but if we just wait it out, they will return to normal. Once the government secures enough antibody tests, we can go back to work, the pubs will reopen, our holidays abroad will resume.*
- Panicked incapacitation: without the big Other, we are doomed. *The government is sending us all to our deaths and nothing can be done.*

In different ways, each of these responses indicate an attempt or wish to shore up the big Other, to retrieve some kind of guarantor of the body politic in the midst of its apparent breakdown[3].

Here we might also consider how a depoliticised portrayal of 'Science' itself constitutes a kind of 'big Other'. Much of the government's answer to criticism has been to claim that they are 'responding' to the 'latest' scientific findings and modelling -- effectively obfuscating the question of *which* scientists are being listened to and why, and 'passing the buck' for what are ultimately political decisions (see Scientific Advisory Group for Emergencies committee member Professor Graham Medley's comments on this in Conn *et al.*, 2020). As Richard Horton, Editor of The Lancet, lamented in The Guardian (2020), 'medical and scientific advisers to the UK government ignored [the] warnings' of the Chinese scientists who published their findings regarding the 'pandemic potential' of COVID-19 in the Lancet on 24 January 2020. 'For unknown reasons' Horton writes, '[the UK government advisers] waited. And watched' (Horton, 2020). (See also John Ashton's criticism of the pool of the government's scientific advisers, 'narrowly drawn … from a few institutions', [Grey & MacAskill, 2020])

As the clinician Thomas Svolos notes, 'If psychoanalysis has something to offer here, it is to recognize ... the proper place of the lack in the Other, and the very personal nature of the fantasies we make to cover over it, so that people can soberly address the unknown' (Svolos, 2020).

In other words, there is another approach: proceeding with the understanding that the lack in the Other was there from the beginning.

Things were always this bad

In a sense, we all knew this was coming.

[3] As feminist and critical race studies engagement with psychoanalysis has highlighted, the way one imagines and relates to the big Other and its inconsistencies is mediated through history, symbolic inheritance, and structural positioning along multiple axes of difference including race and gender (e.g. Chistopher & Lane, 1998; Fanon, 2008; Mitchell, 2015; Spillers, 1996). Likewise, the fallout from COVID-19 has differential impacts; while it is beyond the scope of this piece to explore, it is important to emphasise that the consequences of this disease will exacerbate existing inequalities and forms of oppression.

People were already perceiving that nobody was properly in charge. Regularly we received dire warnings about the NHS: waiting times at record highs, hospitals operating beyond capacity. Yet our transference towards the NHS as a safe parental figure (or 'brick mother') seemed to persist: people continued to believe that when they fell ill the NHS would provide adequate care (see Baraitser & Salisbury, 2020; Moore, 2020, *Waiting in Pandemic Times*).

Similarly, as fixed-term academics, we've long known that universities are simply not offering enough permanent posts for the majority of academics to do their work securely in the sector. Yet as a group we nevertheless persist as if we'll all eventually find the right job. (UCU's qualitative study on casualisation found an 'inability to project into the future' one of the significant mental health consequences of precarious academic work [Megoran & Mason, 2020, p. 20].)

Psychoanalytically, the practice of simultaneously accepting *and* rejecting a traumatic truth -- continuing to behave as if it isn't true – is called disavowal, summarised in the phrase: 'I know very well, but nevertheless' (Mannoni, 1969).

In our daily life before COVID-19, we were already constantly surrounded by pronouncements of apocalypse, post-history, crisis and collapse — but these were always warnings, as it were, from 'within' the current coordinates, as society as a whole appeared to continue as normal (see Flexer, 2020, this collection). We were both present during the California wildfires of 2018, and despite the massive loss of life and environmental destruction, economic activity continued as usual, with the occasional addition of masks, respirators and so on. This seems to be a model for the way our government initially hoped we would respond to coronavirus.

There is an opening

Before COVID-19, appeals for redistributive policies were easily diffused with the familiar language of technocratic neoliberalism: 'the numbers don't add up' 'this is not how it works', etc. The message was: 'your material suffering, while regrettable, does not have any bearing on the immutable laws of the economy'. With the sudden emergence of massive government spending — as we were writing this, the government cancelled £13.3 billion pounds of NHS debt — we're witnessing this logic disappear before our very eyes.

This suspension of daily economic activity and the seemingly iron-clad principles that upheld it, alongside the threat of the virus, has interrupted the circuitry that forced us to act as if the big Other existed, even when all available evidence indicated otherwise.

We began from the transformative potential of suspended time in strike activity, which relies on the conscious decision of workers to withhold our labour. Now we have entered a different kind of suspended time. From the collectivity of the strike, we have gone into self-isolation, imposed by the current crisis. These are also not mutually exclusive; workers as well as renters have seized this time to strike. In both cases, however, different kinds of suspended time produce an opportunity for the subject to consider her own agency in relation to the lack in the big Other.

It's common for a patient to seek out analysis because a feeling of enjoyment, or what Lacanians call 'jouissance', is somehow no longer available. This instability provides an opportunity to reconsider the relation to the Other. In the current moment, we have arrived at a kind of analytic situation through simply suspending the function of enjoyment. The stock market is crashing but of course in neoliberal capitalism what is also crashing is our jouissance. Our typical release valves — going to the pubs, shopping — are gone. Amazon is deprioritising shipping anything but 'essentials', only 'key workers' and urgent tasks allowed[4].

We actually have to live in a time that is supposed to be a 'waiting time' — subjectively experience it as our reality in the here and now.

Towards a theory of the act

Lacan in 1968, famously criticised student activists for posing what he took to be their hysterical demands to the powers that be: 'You want a Master. You will get one' (see Frosh, 2009). The protests of '68 were an explosion of activity, which we could counterpose to today's means of reinstating a powerful Other through passivity.

The *act*, as theorised in Lacanian psychoanalysis, has to be distinguished from 'acting out', or everyday action. The true act has such stakes that it simultaneously abolishes and transforms (in Hegelian terms, sublates) the symbolic coordinates of a given social order. So, how and when do we act?

First, we have to find a way of acting within the context of there being no big Other. This means our actions cannot be verified or guaranteed to succeed from the outset. Nor, however, can we rely on an authority to predictably stop or punish us in the way transgression is often intended. Acts will always appear to us as risks — serious ones. This is even true when they are the self-evidently 'right things to do' in retrospect.

The corollary to this lack of divine verification is that *the time to act never arrives*. Even as people fall ill with coronavirus, and are no longer waiting to potentially contract it, the question of what to do is not resolved, it is even intensified.

[4] This of course throws into question what is or isn't considered essential (such as medical care for trans people). It also shows how the 'essential' is now being reshaped as a space of jouissance by big business and the state: We can see a key revision of the role of 'unskilled' labour which previously operated in a largely mystified way. Michael Bloomberg previously said farming and factory work require less 'gray matter' than modern technology jobs ("You dig a hole, you put a seed in, you put dirt on top, add water, up comes the corn" [Moore, 2020]); now, everyone is clapping for the NHS, calling for 'land armies' of agricultural workers, trying to inject some cultural enthusiasm back into these sectors in lieu of adequately funding them.

We can say that an act never emerges from nothing, but only appears to in retrospect. We must be careful not to fetishize a moment of rupture for its own sake, or, as Baraitser (2017) reminds us, to fail to account for the preexisting context of *endurance within an impossible situation* upon which any significant rupture depends (the pre-existing 'state of year-round crisis' in the NHS, for example, which has led to this point). These would be further forms of acting out.

Lastly, an act must be collective but each of us cannot wait for another to start it. Those of us advocating for radical emancipatory change cannot simply make our individual appeals to 'socialism' as a self-evident intellectual solution to the problems we face, but must directly intervene to build it and create our own vehicles of mass struggle. Only through action can we instate *a new symbolic situation*. We can envision the collapse of neoliberal capitalism — a system that literally cannot function in the present situation — but without an alternative we will remain in the same symbolic coordinates. People are already beginning to figure out ways of coordinating activity during lockdown without risking their health, as technology creates an opportunity for greater international solidarity.

The emergence of 'mutual aid' groups across the country is an example of people coordinating responses to the crisis in the absence of adequate government provision. It is a first step but, at present, relies on the voluntary goodwill of people able to share what little they have with each other. The next step would be recognising the production and planning of resources in society — those zones where our intervention was once strictly forbidden — and seizing our right to directly provision to people's material needs rather than obeying market logic. (It is a consequence of attempting to act that one may come to embody the big Other. This is a very interesting problem and should be dealt with in a subsequent essay.)

We need to push our governments to value human life over economic gain, but we must also recognise that our own activity is what will make this possible, not the benevolence of a Prime Minister. Revisiting the period of post-war reforms that delivered the NHS should make this clear. While claiming to support the principle of a health service in theory, Churchill's opposition voted against the establishment of the NHS over a dozen times, including at Second and Third reading. The NHS was founded despite strong opposition from the Tories and the right-wing press, both of whom now praise it as a national achievement[5]. None of the institutions we rely on now – especially during this crisis – came about because they were handed down from above. They were formed through processes of social antagonism. This poses the question: Why do people today view themselves as outside of the historical process?

Attempting to pose these questions to ourselves as well, we decided to act, to directly engage with universities to demand two years' extension of employment for all casualised staff: a #CoronaContract (https://coronacontract.org/).

We have reached a point where continuing within the existing framework of society is no longer possible. The question is, will we desperately search for another way to shore up the big Other, relying on symptomatic behaviour even as it fails to work – or can we find a way to act?

Data availability

All data underlying the results are available as part of the article and no additional source data are required.

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[5] For more on post-war nostalgia as a form of austerity narrative (particularly the ubiquitous 'Keep Calm and Carry On' posters and their connection with the 2008 financial crisis), see Owen Hatherley's, 2016 book The Ministry of Nostalgia. On the role of social antagonism within the history of the NHS, see Stewart, 2002; Webster, 1990.

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RESEARCH ARTICLE

Having a moment: the revolutionary semiotic of COVID-19 [version 1; peer review: awaiting peer review]

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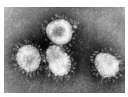
Abstract

The time of COVID-19 represents a distinct, but currently under-defined and under-theorised, temporal moment. Using semiotic methods, this paper examines how the mechanical actions of the virus, through becoming social, create a new viral time, heralding an already-arrived new historical epoch. This epoch, which is simultaneously both homogenous and undifferentiated at one tempo, and supercharged with change, events and radically uncertain futurity at another, is riven with revolutionary potential. The existential challenge posed to the faltering socio-economic order is evidenced by a panicked political response combining reactionary attempts to reimpose temporal certainty and fixity, with desperate material concessions to a public suddenly expelled from a previously subsuming dominant productive time of capitalism. As such, this temporal crisis offers the necessary, if not sufficient, moment for profound re-imaginings of our productive and social relations, and an opportunity to look beyond the possible end of the world, and towards the end of capitalism.

Keywords

revolutionary moment, viral time, Boris Johnson, power, historical epoch, capitalist realism, semiotics

This article is included in the Waiting and Care in Pandemic Times collection.



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Introduction

'What, generally speaking, are the symptoms of the revolutionary situation?' (Lenin, 1964: 213)

'Doesn't a breath of the air that pervaded earlier days caress us as well?' (Benjamin, 2003: 390)

The world is having a moment. The question is: what *kind* of moment is it? What are its temporal contours? How does it function, from within and without? And most pertinently, what unique threats does it bring, and what possibilities?

These are, as Marx said, 'days into which 20 years are compressed' (Marx & Engels, 2010: 468). For people living in the UK during the week from 16 to 23 March 2020, the mechanics of the economy, of the routines of everyday life, of school, of work, of leisure, of the exercising of personal liberty and, fundamentally, of the relationship between the citizen and the state changed more substantially than at any time since the end of the Second World War[1]. And they changed with the furious, implacable tempo of an avalanche. Yet the brief period of rapid change was simultaneously an open-ended duration of stasis, 'a period of contextually appropriate suspension' as a comment piece in the *Lancet Infectious Diseases* described it (Poland, 2020: 1). To use, and to temporarily confound, the distinction Benjamin makes between the 'social democratic' model of historical progress and revolutionary time, the current moment is both one of 'homogenous empty time' and of super-charged *Jeztzeit* (now-time) (Benjamin, 2003: 394-395)[2]. The following semiotic analysis will push at this contradiction, with an eye to potential symptoms of a revolutionary situation.

Viral time: the first casualty of war is metaphor

We've become so blasé about virality, and so boringly overfamiliar with it as metaphor, that we've somehow forgotten the meaning beneath the metaphor: blazing speed; invisible, ex temporised networks; resilience; ubiquity; hegemony. To go viral has come to mean to confound the expected relationships between distance and time, to distort them beyond what was previously considered possible, so that linear chains appear as simultaneity[3].

Aside from the almost inconsequential benefit that the well-worn corporate metaphors of virality will fall out of the public discourse, this viral time has disrupted our relations with and within time. At the heart of this disruption lies an epidemiological fact, or rather the space where a fact should be: the virus brings its own temporalities. There are certain, albeit variable, timeframes for stages of COVID-19: the time between infection and manifestation of symptoms; the time from first symptom to peak of illness, and through to the end of the illness; the periods of contagion, including the window in which human-to-human transmission can occur, and those sub-periods during which 'viable' virions can survive on various surfaces. Regardless of what these times might be, or how they may be stabilised by epidemiology, their current radical instability constitutes COVID-19's first temporal infection; we live in a viral time, the tempo and duration of which are unknown.

The present analysis is not concerned with the primary question of describing that temporality, but with two secondary concerns, in the first place: the temporality of describing that temporality, and the rapid infection of temporal instability. The former is a reflection of the latter. Radical temporal instability demands swift accounts. Of course, this neurotic compulsion to lay out a temporal road on a landscape of such uncertainty and unpredictability reminds us of nothing more than the cartoon character overrunning a cliff edge, legs spinning, suspended in the air, unaware – for some uncertain moment – that the trajectory they were imagining hopefully along the horizontal axis is about to be dramatically overwritten by a narrative imposed forcefully along the vertical. Such a moment within our moment is acutely exemplified by UK Prime Minister Boris Johnson's concentrated squinting to camera (statesmanlike concern), behind a Downing Street desk (metonym of authority), accompanied by the union flag (patriotic duty, national unity), talking about the 'latest steps' his government is taking, on 23 March (Figure 1). A few days later, he was self-isolating with symptoms. Within a fortnight he was in ICU.

That the attempts to describe and proscribe the viral temporality, that the impositions of temporal control and order are themselves the most obvious semiotic excess *qua* evidence of their failure and impotence, should be apparent from the arrival on UK doormats of a letter from the Prime Minister at the precise moment he was known to be struggling with the illness in hospital. Despite avoiding dating the letter, and despite the opening acknowledgement that '[i]n just a few short weeks, everyday life in this country has changed dramatically' (Johnson, 2020), the Prime Minister could not avoid making himself hostage to fortune, for any projection into an imagined future based on continuity with a present whose identity is anchored in the pre-COVID-19 era invites the laughter of a scornful Old Testament God: *Mann traoch, Gott Läuch*, as the Yiddish proverb goes[4]. Viral time then operates as a deep temporal instability that dialectically both provokes and is built upon repeated, defeated attempts to reinstate temporal order. That this relationship echoes that of the biochemical

[1] Both Stephanie Davies and Jocelyn Catty write of these temporal disruptions to the routines of healthcare professionals in their contributions to the *Waiting in Pandemic Times*: Catty, 2020; Davies, 2020.

[2] We are not unfamiliar with these simultaneously existing contradictory times. Hasn't the Groundhog Day crisis of Brexit been a temporal battle ground between the inertia of a zombie political consensus and the hot flushes of a geriatric reactionary change? As a political economy, we've been rehearsing this temporal duality for four years.

[3] The confusion over the boundaries of figurative and literal meanings of virality are nicely illustrated by a *New England Journal of Medicine* online conference taking the title 'Epidemics Going Viral: Innovation vs Nature' (Fineberg *et al.*, 2018).

[4] 'Man makes a plan and God laughs.'

Figure 1. Wile E Coyote between running off the cliff and before the anvil lands on his head. UK PM Boris Johnson announces lockdown measures, 23 March 2020 (BBC, 2020b). This is reproduced under the Open Government Licence v3.0.

relationship between the virus and the infected host's cells and immune response is no coincidence, where the virus imposes its temporality on epithelial cells used to longer, and predictable lifetimes. Viral time is not a metaphoric association between the viral action within our cells and the impact of a pandemic on our lives; it is the literal infection, proliferation and enforcement of the temporality of the virus on our social conventions of time. Given that this is mostly conducted not by virions or viral RNA but by our political, economic, medical and legal reactions to the virus, we can say that viral time is the *becoming social* of COVID-19.

Similarly, just as it is not metaphorical, neither is this conceptualisation of viral time a nod to the transhumanism or inhumanism of Keith Ansell Pearson's viroid life (Pearson, 1997). Pearson's neo-Nietzschean thrill at recognising the anthropocentric arrogance in our imagining humanity at the temporal centre of existence, as unrivalled subject, finds some analogue in the right wing and environmentalist commentaries of COVID-19 as 'overdue', 'corrective' or 'natural.' Such positions are underlaid by a simple, often-recurring misanthropic fantasy of weeding the garden of humanity; inevitably, the fantasist's murderous fetishes about people are really only about *other* people. Naturally, we could use this pandemic as an opportunity 'to think *trans*humanly the future' (Pearson, 1997: 7), but, modestly, we'll retain our preoccupation with humanity. Our argument is that viral temporalities only truly *become* as a literal consequence of the virus *becoming*, and only then when doing so in the cells of living humans and again, even then, only in clinically relevant (and palpable) ways. It should be otiose to observe that the same RNA being rampant in bats brought no viral temporalities, as there was no *becoming social*. In *becoming social*, COVID-19 imposes viral time, but this viral time is still dynamically and dialectically constituted in the social, and as such is composed not only of the – currently mysterious or at least uncalculated – temporal quanta of the virus but of the pre-existing social and productive relations. A longer piece of research than this current analysis ought to explore rigorously and critically the 'the incorporation of material-social factors (including gender, race, sexuality, religion, and nationality, as well as class) but also technoscientific and natural factors in the processes of materialization [of viral time]' (Barad, 2007: 224). Even describing viral time as radical temporal instability speaks to a certain blinkered position of privilege, for some, for the majority, radical instability is the very condition of life, materially, spatially and temporally.

It is precisely this position of privilege occupied by history. History is, perhaps, time seen from the vantage point of power. So it is possible that people, even the majority of people, within a moment can experience temporal instability without that moment being, inherently and historically, an age of temporal instability. In such cases, a temporal hegemony remains unchallenged by the conditions of the moment, and so the moment is not historic but rather is within the smooth flowing grand narrative of history, as understood from within that untroubled moment. Our current viral time offers a sudden challenge to this[5]. The temporal *becoming social* of COVID-19 constitutes an historic moment, as the defining characteristic of an historical epoch. This does not mean an epoch wholly accounted for by the *becoming social* of COVID-19. It is beyond folly to attempt to define an epoch from within. The COVID-19 epoch will outlast the period of viral time upon which it is entirely reliant as a sui generis epistemic origin, much as the blaze outlives the spark.

Incubation: the invisible arrival of an epoch

The origin of the moment lies outside it and prior to it, although is only discoverable from within. There was no arrival but only an absolute awareness of being in the midst, temporally and spatially (and indeed the distinction has vanished here) of the present moment, the moment as it presents presence. The COVID-19 epoch had already begun before we saw it; the lingering (20)19 in its moniker a constant reminder that it had the temporal jump on us (see also: Catty, 2020, *Waiting in Pandemic Times*). We did not know we were living in the COVID-19 age, just as, for an innocent almost-eternity that is now forever gone, we didn't know we lived in the pre-COVID-19 age. Where before, we lived just in time, now we live (and have lived) in history.

When journalists reach for cultural texts that 'predicted COVID-19', this meaning is only fleetingly possible, and a last vanity of an already passed age. An example from the right-wing Daily Telegraph is typical, summarising the plot of Steven Soderberg drama *Contagion* (2011) as 'eerily prescient … where marauding looters roam the streets fighting over food and supplies' (Prince, 2020). Caveating this with '[w]e haven't yet reached the dystopian breakdown of social order the movie predicted', Prince reconfigures the film from being perhaps speculative or merely fantastical to predictive. This moment of prediction is lost though as the past, as distinctly, consciously pre-COVID-19 is now a product of a present itself not yet fixed by the future. *Contagion* and similar films, books, and

[5] Although Martin Moore, writing in *Waiting in Pandemic Times*, offers a persuasive and nuanced account of how the present COVID-19 pandemic is both in tension and in step with 'values and practices with long antecedents' (Moore, 2020).

the esoteric and cynical rantings of hucksters and charlatans will not be understood as predictive *of* but projections *by* a COVID-19 epoch that was struggling to manifest itself in not-yet-conscious humanity. In some ways, this is the inverse of the resurrection Jalal Toufic argues that a community performs on its immaterially lost cultural traditions after a surpassing disaster (Toufic, 2009: 14). Rather than having to re-instate projective texts like *Contagion*, it is as if they were zombies before, and now re-arrive as a future tradition. As one user commented beneath the YouTube trailer for *Contagion* (enjoying rocketing views since early March): 'They should change the intro: Based on future true events.' Or, as another put it:

> There are movies based on true story
>
> Then comes this movie
>
> Now
>
> True story based on movie story 😑😑

What could be more intoxicating and potentially revolutionary than an epoch that has already arrived by subterfuge and demonstrates effortlessly that our speculative fancies can become truth? Here is a reversal of Baudrillard's account of the Gulf War that never happened: the fantasy apocalypses that became truth (Baudrillard, 1995). And it is not the becoming truth, but the epochal temporal sleight of hand by which they now will always have been true – or at least, a truth to come – that is the most shocking. In the pre-COVID-19 age, as under any *ancien régime*, we did not know we were naïve. We thought we were the present, but we were the past. We thought we were real, and in history, but we were just living a fiction that was waiting for the moment when it could become real. One is reminded of the joke: 'How did people in the medieval period already know to call it medieval?' But that joke provides a moment of terrible horror: a blank future that could be freedom or could be extermination (or both). As such, we conjure up protectors from our fantasy world. The remarkable spectacle of Kate Winslet and other actors from *Contagion* giving epidemiological advice or a UK *Guardian* sizzle reel for COVID-19 borrowing the filmic rhetoric of disaster flicks clearly shows how all bets are off when it comes to deciding the boundary between reality and its representation (BBC, 2020a; Topham & Lamborn, 2020).

These are the 'the breath of the air that pervaded earlier days' that Benjamin describes. Of course, at, or just past, the birth of a new epoch, and faced with the open blankness of a future that entails, people seek solace in reactionary gymnastics of the intellect and belief, to live only off those last breaths of air from the *before* times. Conspiracies that this was all just part of the plan or that we are moving through temporal terrain that has been mapped by seers and prophets, or more mundanely, by filmmakers and epidemiologists, all form part of the same strategy to make the new epoch move (or be stilled) according to the tempos of the lost status quo. The idea that dead pseudo-psychics like Sylvia Browne (Kettley, 2020), or paranoiacs-for-cash like David Icke (Edwards, 2020), are running the show is less alarming than the emancipatory explosion of viral time insisting that we make a new future for ourselves.

Day 18.5: illusory regimens of time

'This is the moment,' PM Johnson anaphorically mouths over and over in his post-illness press conference on 27 April 2020. 'This is the moment', again and again; whilst announcing it is absolutely *not* the moment (of recovery, of an end to lockdown, of change or 'victory'); whilst saying literally that he 'cannot say.' Timelessness makes a puppet show of power. Desperate to fill the timeless moment, times are created. In epidemiology: the time-course of viral reproduction; transmission times; quarantine times; epidemic time. In politics: the time of responses; the periods for fiscal support; timescales of legislation (their arrival, their duration and the time constraints they enact). In the media: timelines of the story; narratives and testimonials of those with and very evidently without the disease. In the home: new timetables to carve up the undifferentiated mass that has suddenly arrived or been made palpable. People running marathons in their own homes – the miles curled up and back on themselves in tiny Chinese apartments (Euronews, 2020) or French balconies (Moran, 2020) with the impossible hidden length of intestines – was just as much a measure, and a management through measuring, of time, as it was of (imagined) space. Pandemic is the condition of simultaneity confounding distance, as glossed by the BBC:

> The outbreak was declared a global pandemic by the World Health Organisation (WHO) on 11 March. This is when an infectious disease is passing easily from person to person in many parts of the world at the same time. (The Visual and Data Journalism Team, 2020)

This simultaneity creates implausible implications of causality such as the *Guardian* live feed headline suggesting that a lockdown in France was impacting on the election of a US presidential candidate by the Democratic Party: 'LIVE/ Ohio primary polls halted as French told to stay inside' *The Guardian* Coronavirus Live (2020).

Time as known is gone. The minute, as the gold standard marker of time in the old epoch, has vanished. It was once an authoritarian guard, keeping a watchful eye on how well, how *productively*, we managed our day: minutes to the tube stop; the minutes an integral part of the identity of every National Rail train, 'the seven past' means nothing now; the minutes of a break; 'just a minute' responses to urgent work demands. No one uses them now, any more than they use inkwells or floppy disks. Time is moving differently and hourly or half hourly chunks are sufficient for all purposes. There are no fag breaks, or 15-minute theatre intervals, or injury time added on. When we work through the internet – that vast machinic network that obliterates time and space – when we Zoom our colleagues and Skype our friends, the small change of minutes isn't needed to buy us anything. We can pay cash, in big denomination notes, and like the cowboy businessman Tom Cassidy in *Psycho*, we never carry more than we can afford to lose (Hitchcock, 1960). We have no need miserly to keep time with minutes.

Newly, time is kept through a daily logging of death and case figures. These figures are neither for epidemiologists – who are outspokenly clear on their limited relationship with the reality of the disease – or policy makers. Rather, they function to create a sense of shape, and specifically, of progress in the great expanse of empty time created by the crisis. Albeit, currently at time of writing, the progress of the line of the enemy army. More than any other rhetorical device, over-stretched analogies with the Second World War, already in the ascendant in UK political discourse since 2008, are the *lingua franca* of COVID-19. This time around, we are simultaneously the besieged of the Blitz in the bomb shelters and the lightning strike Luftwaffe of the *Blitzkrieg*. Time itself is weaponised against the timelines being dreamt up to mark time. In a timeless moment without a future, time is only the marking of time. It is now an epidemiological truism that rapidity of response 'buys time' (Wu & McGoogan, 2020: 1241) and that this temporal manoeuvre finds expression graphically in the (hoped for) flattened curve. Data, tips, tactics and strategies for this can be searched for in a present widened through datafication (García-Basteiro *et al.*, 2020) or in a past calcified into wisdom (Hick & Biddinger, 2020). For temporal urgency, it would be hard to beat the *NEJM* editorial of 1 April 2020 that adopts a war metaphor and an intense time window of 'ten weeks' where '[t]he aim is not to flatten the curve; the goal is to crush the curve' (Fineberg, 2020: 1). This war is powered by an immediate, global surveillance – lovingly called down by the people – that would embarrass the most assiduous police state. The emergence of 'nowcasting' real-time surveillance (Preis & Moat, 2014) whereby 'history is written daily' (Engelmann, 2020) makes the regimens of time a thickening of the present, as if the diachronic imaginary is so horrifying it has to be forced into a synchronic network.

A regimen of time is the recommended therapy for a loss of time. Again, this is not a metaphorical use of language. The viral time enacting on us through *becoming social* demands the temporal therapeutics common to all of medical authority's reactions to pathologies. Medical and state authority are woven together through these regimental commands – the virus will be made to conform to the regime's timeframe as this time chart from the UK Government's advice booklet shows (Figure 2). Law and medicine are conflated, just as the unpunctuated imperatives of the booklet's title – Coronavirus Stay at Home Protect the NHS Save Lives – collapse all times into an expansive perpetual present (UK Government, 2020a). If the future cannot guarantee the present, then the present must dictate the future, by writing it into a timeline, building it out of daily deaths and new cases and unemployment figures, like a

Figure 2. Isolation timelines taken from the UK Government guidance booklet 'Coronavirus Stay At Home Protect the NHS Save Lives' (2020). This is reproduced under the Open Government Licence v3.0.

sole survivor climbing out of a mass grave by stacking corpses. These temporal regimes attempt to assert meaning and causality, and – by extension – a sense of reliable, predictable futurity. The Financial Times conflates 'how' with 'when', and time with space, in its dynamic map of the COVID-19 spread (Visual & Data Journalism Team, 2020). Similarly, its header graphic, in rejecting disruptive viral time, forces an eerie timelessness, through its overlaid spatial simultaneity. The emptiness of the strangely, unconventionally centered Pacific Ocean, is at the same time the emptiness of Times Square (the spatio-temporal 'crossroads of the world'). If we cannot accept viral time, we are left with regulating the moment out of all time.

Ultimately, these regimes implode into nonsensical brutality, born from a techno-bureaucratic dictatorial assault on the unruly time. *The Sun*'s timeline of symptoms – proudly underpinned by 'scientists' – offers an illusion of technocratic control (Figure 3). But the insertion of what is presumably an average time until death – 18.5 days – appears as a monstrous diktat from an authority that knows it is reduced only to the performance of power. When is the fateful day, 'Day 18.5'? Is that noon on the 18th day or noon on the 19th day? When did the dreadful countdown start? Only knowing that could we possibly make any sense of this hard marker of curtailed futurity. In reality, in viral time, there is no 'Day 18.5' on which 'death' appears under the heading of a 'symptom'. This assertion, this linguistic-semiotic act, is the order-word as power-marker, so playfully described in the fourth plateau of Deleuze and Guattari's *A Thousand Plateaus (Deleuze & Guattari, 2004: 84)*. In the absence of real historical acts, all power has is its own enunciation and reproduction. This is what the UK Government means by its mantra of 'the right action at the right time.' This is the temporal regime public health authorities attempt to impose on viral time, slotting it into convenient weeks, just as every bacterial infection has obeyed the constraints of antibiotic regimens measured always in seven-day intervals. And this is the tactic reaching its apotheosis with President Trump presenting a timeline of his timely response to COVID-19 based on excising the month of February, and using this to then claim 'total authority' (McCarthy, 2020). Temporal disciplining is the last refuge of the ruling class scoundrel in retreat from radical viral time.

Opportunities of the revolutionary moment: will the universe survive?

COVID-19 has undone the subsumption of all social life, and all social time, under capitalism and has disrupted what Negri calls 'Marx's tautology of time, life and production' (Negri, 2003: 35), and torn apart an established temporal *Umwelt*, that had been so successful in presenting itself as enduring, eternal and inevitable. COVID-19 creates a temporality that ruptures this *Umwelt*. It has lifted huge sections of social life dramatically out of productive time, forcing it out through the imposition of its own *becoming social* viral time. An historical juncture therefore exists, with the suddenness of the COVID-19 age. In Lenin's terms, we have at least the first of the three symptoms of the revolutionary situation: a crisis 'when it is impossible for the ruling class to maintain their rule without any change' (Lenin, 1964: p.231). Already, almost immediately, we in the UK saw radical, swift reconfigurations of economic, productive and social relations – the crisis in the social (the *becoming social* of COVID-19 as viral time) required this abrupt amputation of productive work and time, and brought in new economic arrangements: a temporary guaranteed income for currently non-productively working furloughed workers; nationalisation of the rail operating companies, who became instantly unviable (if they ever were) as private businesses when their customer demand fell by 95% within a week;

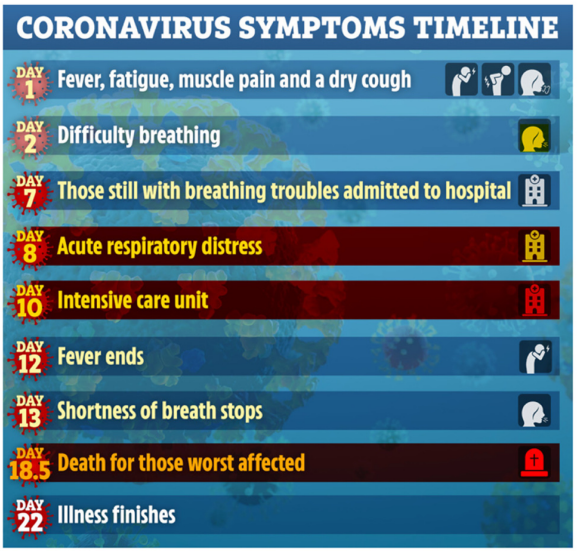

Figure 3. Coronavirus symptom timeline. Reproduced from The Sun website (Jones, 2020) with permission from News UK.

exemptions from business taxes; mortgage 'holidays' and 'support' for renters[6]; loans and grants to businesses unable to trade.

It is not exactly that these responses are unprecedented. Similar interventions have been seen in economies undergoing similar crises of productivity, but these crises have had their origins, as well as their consequences, in the domain of the social-economic-productive nexus. Conversely, the crises of industrialised warfare in the first half of the 20th century, and the context for Lenin's formulation of the symptoms of the revolutionary situation, drew *more* of human life into productive time, subsuming more of social life under capitalism, through the total war economies produced. What is un(der)precedented is that an *extra*-economic cause – the *becoming social* of COVID-19 as viral time – has led the ruling class voluntarily to force workers out of production, to eject social life and time from its vanquished subsumption under capitalism. And the ruling class did this not from any generous largesse (of spirit or of means), but rather to protect itself from a dual threat: to physical health, by viral infection, and to economic health, by infection of viral temporality. And to protect against viral time and to insist (at least rhetorically) on the return to the (past) business as usual, the legislation is littered, desperately, with the word 'temporary', as a swift medicinal remedy to the unavoidable word 'emergency' (UK Public General Acts, 2020). Granted, for individuals this unimagined parole from the capitalist temporal subsumption might only take the form of empty, homogenous time, the bored, listless, anxious flat plains of 'lockdown'. But what then might super-charge this time into a revolutionary *Jeztzeit* is that moment when the ruling class come back to take away what has been given, to demand that the people resubmerge themselves in the capitalist temporal framework, to insist that we all, hands in pockets, whistling, amble back through the open doors of the prison and turn the latchkey on ourselves again.

Of course, we might just do that. Lenin is explicit that the revolutionary situation does not fatalistically determine a revolution. Even if this first symptom coincides with or causes that second symptom – 'when the suffering and want of the oppressed classes have grown more acute than usual' (p.214) – it is incumbent upon us to manifest the third symptom, where the masses take on the duty of independent historical action (for more on the importance of struggle see the discussion in Osserman & Lê 2020, *Waiting in Pandemic Times*). Here is where the new epoch works in our favour. We are now in history, and within history we can take historical action. As Benjamin says: 'The historical materialist cannot do without the notion of a present that is not a transition, but in which time takes a stand and has come to standstill.' (2003: 396) Time has come to a standstill and can now take a stand. Being liberated from a future means also being liberated from the past. Revolutions – even as capitalistic as the American automobile revolution – change from impossible to inevitable in one beat less than a heartbeat; they have already arrived as the only living time. On the inner cusp of the age of the automobile, the disruptive figure of modernity in *The Magnificent Ambersons* Eugene Morgan (played by Joseph Cotton) remarked whilst swirling at an already-anachronistic belle epoque ball: 'There aren't any old times. When times are gone, they're not old, they're dead! There aren't any times but new times!' (Welles, 1942) Truly, the past has never been so dead as now.

But we can find hope in the fact that history, as Marx observes, springs to life, and that human actants can refute Hegelian grey fatalism[7].

> [T]omorrow or the day after, the result will actually spring to life as history lends the whole thing a warmth, vitality, and humour with which the later 'grey on grey' contrasts damned unfavourably. (Marx & Engels, 2010: 469)

Of course, speculative and dystopian fictions have repeatedly shown us the revolutionary potential of a terrible pandemic – or equivalent catastrophe – but these have always relied on the eradication of large quantities of people in incredibly short durations[8]. Here, we have relatively small numbers of deaths, in contrast to the tallies of dystopian fiction, and what has been destroyed in large quantities is time itself, specifically the productive time of capitalism, which has been consumed by viral time. As the already-said phrase made famous by Jameson has it, it is easier to imagine the end of the world than the end of capitalism (Jameson, 2003: 76). Senator (and then presidential nominee hopeful) Bernie Sanders mocked the US ruling class' conflation of the end of capitalism with the end of the universe on the floor of the Senate on 25 March 2020. Indeed, it was not even the end of capitalism, but rather this slight break, this possible early symptom of the coming terminal illness, manifesting in this specific case as an increase in unemployment checks that would exceed the wages of lowest-waged workers currently claiming unemployment. 'And now I find that some of my Republican colleagues are very distressed, they're very upset that somebody who's making 10, 12 bucks an hour might end up with a paycheck for four months more than they received last week. Oh my word, will the universe survive?' (Shepherd, 2020) It is not that the ruling class just find it easier to imagine the end of the world. It is that they would prefer it to the end of capitalism. This is evident in the political push to 're-start' the economy; better we all die than we all stop making money. Regardless, our historical material reality has forced an imaginary of the end of the world upon us. We no longer need imagine it. Now, we're faced only with the harder imagining. The one certain thing in our favour is that we have, for the moment, that very uncertain moment in which it can be imagined.

[6] This mealy-mouthed measure for renters is barely sketched on the Government's own website. The financial support that dare not speak its name (UK Government, 2020b).

[7] Many thanks to Laura Salisbury and her forthcoming paper for a rich account of how what she terms Beckett's *anachromism* – time in shades of grey – characterises the subsumption of all social times, including waiting times, within capital's labouring time (Salisbury, 2021). It was greatly influential on the writing of this paper.

[8] In terms of speculative fiction, my hopeful imaginary of the future has been moulded by the writings of Ursula K LeGuin.

Data availability

All data underlying the results are available as part of the article and no additional source data are required.

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RESEARCH ARTICLE

You are my death: the shattered temporalities of zombie time [version 1; peer review: 1 approved]

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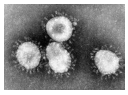
Abstract

This essay considers the relationship between the experience of life shortening chronic illness and the current COVID-19 crisis. Martin O'Brien uses his experience of living with cystic fibrosis to interrogate the temporal experience of living within a global pandemic. He returns to his concept of zombie time, the temporal experience of living longer than expected, in order to understand the presence of death as a way of life. The essay uses some of O'Brien's own art practices, and an analysis of his own sick, coughing body in order to think through what it means to live with cystic fibrosis during a pandemic, which mimics much of its features. O'Brien argues that we are currently occupying a widespread zombie time, which frames other people as carriers of death, and that we must find ways of being together in order to survive.

Keywords

Death, Zombie, Cystic Fibrosis, Performance, Art, Time, Cough



This article is included in the Coronavirus (COVID-19) collection.

This article is included in the Waiting and Care in Pandemic Times collection.

Open Peer Review

Reviewer Status ✔

	Invited Reviewers
	1
version 1 10 Jun 2020	✔ report

1 **Amelia Jones**, University of Southern California, Los Angeles, USA

Any reports and responses or comments on the article can be found at the end of the article.

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> *This used to be the most optimistic city in the world. Now the sun never rises. The shops are never open. The birds never sing. The streets are always empty. Cars lie abandoned, Buildings crumble or stand as empty shells. This city is full of places where flowers don't grow, gravel and dirt places, underpasses, places that look as though they've come straight from a horror film, places that are always empty, places that seemed to be made to walk through at night, places you would never take a first date, long passages, tunnels, non-places, dilapidated places, places where you would expect to be taken by a murderer. Perhaps this place used to be beautiful but this place seems as though it has experienced the apocalypse*.
>
> Text from *The Unwell*, 2016

My artist studio is full of coffins at the moment. They are stacked up on top of each other, still covered in bubble wrap. There are nine of them in total. These were to be the materials for my new performance *The Last Breath Society (Coughing Coffin)* at the Institute of Contemporary Arts (ICA), London. The work was due to be performed at the end of March. It was exploring ideas of community, closeness and loneliness in sickness and dying. This work couldn't happen but seems more relevant now than it has ever been. A few weeks ago, as the new pandemic ravaged throughout the world, I called a friend who was involved in the performance to let her know that it was cancelled. The first thing she said was 'Martin, it's like the whole world has caught CF'. I was diagnosed with cystic fibrosis (CF) when I was six weeks old, and my friend is the artist Sheree Rose, whose partner, Bob Flanagan, died from CF in 1996. Her assertion was startling for me, and I started to think about the experience and aesthetics of the pandemic, and the ways in which they mimic a life lived with CF. I began to think about the ways in which the experience of CF management, and our peculiar survival strategies were being taken up by a wider population. Gloves and masks are a regular part of CF experience, and social distancing is a very familiar term for anyone with the disease, as I will discuss in this writing. The symptoms of COVID-19 are also part of CF experience: coughing, shortness of breath, and exhaustion.

This piece of writing is an attempt to do two things. Firstly, to use CF experience to think through the current pandemic and tease out what a wider population might understand about illness, mortality, and isolation by looking at life lived with CF; secondly, to consider what it means to be sick in a time when everyone is suddenly becoming aware of their own mortality.

Growing up with CF means a constant facing of your own mortality. My older cousin died from the disease aged 12, when I was eight years old. This was the first time I understood death as part of life. This was the first time I knew that I would not live to see my hair turn grey. This was the first time I began to understand existence and temporality under the conditions of disease. The life expectancy for someone born in 1987 with CF is 30 years old; this information was plastered all over charity appeals for the CF Trust. I was sure I would die at 30. The temporal movement towards this age was the defining condition of growing up for me. Death was an obsession. I reached and surpassed 30. Death did not come for me. In attempting to understand what it means to live longer than expected, I formulated the notion of zombie time. This is the temporal experience of living on when death was supposed to happen. I have previously written about zombie time as being:

> […] a different relationship to death and life […] It's a form of enduring life when death is no longer the certainty it once was. It is no longer linear, it's full of breaks and ambushes. In zombie time, you keep moving but not towards anything, just for the sake of moving. No goals, only desires. No plans, only reactions. The only constant is the presence of death but not in the way it once was, for the zombie knows death and breathes in death. Death is in me, instead of somewhere else.
>
> (O'Brien & Bouchard, 2019: 263)

Zombie time offers a way of conceptualizing a changing relationship to mortality. The temporal experience in my childhood and early adulthood was one of moving towards a death date. As Lauren Berlant would have it, it is 'the embodiment toward death as a way of life' (Berlant, 2011: 114). Zombie time insists on a different temporal proximity to death. Like the Hollywood zombie which holds within it a paradox, in that it is both dead and alive, those of us living in zombie time experience death as embodied in life, rather than Berlant's movement towards death. We had come to terms with the fact that we are about to die, and then we didn't. This necessitates a fundamental change in how we imagine death and our position in relation to it. In *The Birth of the Clinic*, Foucault proposes that the sick living body is the anticipation of the corpse it will become (Foucault, 1973: 162). Perhaps, though, zombie time offers us a way of conceptulising sick life, not as an anticipation, but as already a corpse, one with new life breathed into it. The end of life is now ambiguous. Death is keenly felt as lived experience but not as something in an imagined future, rather something we are constantly living through. There is no grim reaper anymore; death is not external but exists within a person, as the experience of living. I want to suggest that the temporal experience of living in this pandemic might be something akin to zombie time in that it is necessitating a changing relationship to sickness and mortality for large portions of the population. As I will argue, the virus means that the previously healthy are thrust into a contiguity with sickness and death, which means they are forced to face their own mortality. Zombie time helped me understand my own experience of temporality and the way in which death functioned as part of life. It offered an articulation of something which I was unable to find elsewhere. Perhaps it might be useful for trying to describe the temporality of the pandemic and the ways in which people are forced to become acutely aware of death as part of their own life. There is a wide spread imagination of what death might look like for each individual and our families. It seems as though we are living in a temporary global

zombie time, one which shatters the temporalities of healthy living. These shards of temporal experience may well be put together again, but for now we exist in a liminal temporal space. The imagined futures are being changed fundamentally and much rhetoric is around surviving this crisis, 'no goals, only desires, no plans, only reactions' (O'Brien & Bouchard, 2019: 263).

The Last Breath Society (Coughing Coffin) is indicative of much of my practice. My work has consistently used the materiality of my disease (breath, mucus, coughing) to explore what it means to be born with a life shortening illness. I had often insisted on the isolation of dying young, as a lonely process, as one which renders a person outside of the dominant experiences of life. Indeed, the experience of living with CF can be solitary. Those of us with the disease are unable to be in a room with any others who share the condition. We must remain six feet apart from one another when outdoors. Those who best understand the *feelings* of CF are unable to be together, unable to talk about survival strategies, unable to hug, kiss or have sex. But my feelings about the loneliness of sickness and dying are changing. The Last Breath Society is, in some ways, a gathering of my horde.

The Last Breath Society is a semi-fictional group. It is a gathering of those living in zombie time and others who are forced to consider what death is because of their proximity to it. Perhaps now, my neighbors and co-workers should all be part of the society. Perhaps now, the politicians, who underfunded our health service, and the footballers should be part of the society. Perhaps now the doctors and post people, the nurses and the drag queens, the police and the deep-sea divers, should all be part of the society. The explorers and the singers, the cleaners and the stadium announcers should join the society. The young should now join the old in the Last Breath Society. Perhaps you should be part of the society. The grim reaper stands outside all of your doors now, and there is no way to ignore the knocking. His skeletal face peers through your window and watches you sleep, and it's terrifying. He has become a friend to me, but a friend that will one day betray me. I know not to trust him.

> *Time has ended here. The sun has vanished. Everything remains as it was but now the pavements and subways lie silent. The shops are full of dog food but there are no dogs to eat it. The machines still run but they no longer serve a purpose. The lights remain on, burning bright but they will eventually fade to darkness.*
>
> *But something still remains here. There is movement in this city. Something moves slowly through the darkness. They have replaced human life. They resemble us but they are not us. They fill the city with an unwell sound.*
>
> Text from *The Unwell*, 2016

As an artist, my work has often imagined worlds in which only the sick can survive. My film, made in collaboration with Suhail Merchant, *The Unwell* was shot in 2015 and first shown in 2016. It is set in a city, in which it is always night, human life has been replaced by the unwell. These are B-movie style zombies are always seen alone (I play all of them) staggering through an empty city, coughing. The opening of *The Unwell* is a series of empty streets, roads and buildings at night. Watching it back now, seems eerie, as I look out of my window at the empty London streets. The film imagines a new form of life, we never see how the city became over run by zombies, just the aftermath. As such, very little happens. The film uses the aesthetics of a dystopian apocalypse. Now though, as we enter into a strange shattering and reforming of our everyday, the figures in the film might be read as standing in for all of us who exist in zombie time. Unlike *The Last Breath Society (Coughing Coffin)*, which is attempting to bring people together, to combat the loneliness of temporalities that put barriers in the way of closeness, *The Unwell* demonstrates the distance between bodies and experiences.

There is never more than one unwell figure in any shot. They stand or walk alone, solitary and ambling, coughing and bleeding. In my work, the cough is a symbol of hope, a symbol of the future and a symbol of change. The cough functions as a sick language of sorts, as these unwell beings speak out to no one but themselves. The coughs become a soundscape of the city, ringing out through the night. I want to think about the figure of the solitary cougher, and its importance in understanding zombie time. In essence, this is the enduring image of zombie time. The lonely figure, coughing, afraid of infecting others or making life worse for themselves. But how might we become The Last Breath Society? How can we stand together in zombie time?

As someone with CF, I have coughed all my life. Although my regular coughing fits have often caused worry in public places, never have I so keenly felt the disgust and fear towards me as during the beginnings of the spread of COVID-19 in London. Simon Bayly suggests that the 'cough is the "creature voiced", but also what molests the vocal organs, barely fit for thought, let alone philosophy. Philosophy has sought to erase the cough, to eradicate its interruptive force' (Bayly, 2011: 166-167). He highlights 'Aristotle's rejection of the cough as merely the impact of the breath' (ibid: 167) and Husserl's 'consignment of all paralinguistics or kinesis expression to the category of the meaningless' (ibid: 167) as examples of 'philosophy's repulsion for the organic process of vocalization' (ibid: 167). It is difficult to ignore the philosophical importance of the cough now, though. As one of the most common symptoms of COVID-19, a focus on the cough has become one of the enduring legacies of the pandemic. For Steven Connor 'the cough is voice coerced by breath, not breath tuned and tutored into voice.' (Connor, 2007). The cough functions as a form of non-propositional language, this is a reflexive, interruptive language, in which 'the air is not expressed, pressed out into audibility, impressed into audible shapes and postures, but seems rather to be escaping, as though through a rent or gash' (Connor, 2007). David Appelbaum suggests that a 'cough is the detonation of voice' (Appelbaum, 1990: 2). I have explored the philosophy of the cough elsewhere, in which I develop Appelbaum's work by thinking through the ways in which the cough functions as a vocalisation of illness:

> If the cough is the detonation of voice, though, it is equally the forceful establishment of a different voice, one which does not adhere to language- the voice of illness. The cough interrupts, it is something that cannot be contained and demands its right to be heard. It functions as a disordering of the voice and of the breath.
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> (O'Brien, 2016: 132)

Zombie time is constantly ruptured by the excessiveness of coughing fits. They function as a marker of sickness. Appelbaum continues thinking about the nature of the cough:

> It is duller than the pierce of a cry which goes to the heart. On the terminal ward, one hears the cries first. But the coughs penetrate more deeply, into the compact soma of the body. There they contact an organic memory which reminds us of death and life as facts unembellished by feelings. If the world were cured of the common cough, we would be less prepared for our earthly passage.
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> (Appelbaum,1990: 2)

If the cough 'reminds us of death and life' (ibid: 2) then it is something to be avoided as it reminds us of the potential of death within life. The sound of the cough 'seems to initiate our deepest bodily identification. It is as if the cough speaks directly to the flesh of others, like a warning siren, triggering bodily memories of illness' (O'Brien, 2016: 132). Just as Foucault discussed the living sick body as anticipation of corpse, Appelbaum thinks of the cough as preparation for death. Somehow, in the sound of the cough lies the memory of death. The cough is an opening into zombie time. It ruptures our stable temporal experiences, and thrusts us into the peculiar shadow temporality of zombie time.

For someone with CF, the cough has always been a marker of identity. I can recognise a CF cough anywhere, the raspy, moist, phlegm filled sound which vibrates through the floor. The cough of another CF sufferer has a strange impact, a sense of shared experience with another, but also fear. This cough has the potential to make me very ill. But now, in the zombie time of COVID-19, the cough represents the virus and acts as a reminder of mortality, not just for the cougher but for all who hear it too. The cough is now synonymous with the virus. It is a reminder of the dangers of the outdoors, of surfaces, and more significantly, the dangers of other humans. Your own death is potentially in the lungs of another. The cougher holds your mortality in their chest, and you hold theirs in yours.

In *The Last Breath Society (Coughing Coffin)*, which we are still waiting to perform, people will enter into a dark space. The opening image will be a series of coffins, closed, laying on the ground. From within them, the sound of coughing emerges. The coffins are sealed shut, and the bodies are inside. In this instance though, the cough serves as a confirmation of life. The corpse does not cough. If the coughing body acts as a *momento mori*, it is also a reminder of breath, and of life. The last Breath Society is about coming together to remember we will die, but it is also a celebration of life, a defiant gathering for the sake of survival.

> *They stand on two feet and wear our clothes but they are not us. Do they eat and sleep? Do they dream or even recognise their own reflections? Their actions seem to serve no purpose, they amble through this urban wasteland coughing and spluttering. Their steps are laboured and clumsy. Their garments are covered in blood, the faces with great wounds and then the eyes. They witness but they do not comprehend, they are blank and without personality. The empty eyes gaze straight ahead but towards what future? What do they remember? Their coughs ring out all over the city. These bodies are like factories, mass producing mucus. They seem to breathe but we don't know if their hearts beat. Do they have the capacity to learn? To feel emotions? The only thing we can be sure of is that they are profoundly unwell.*
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> *They wear clothes that could define them but whoever they used to be no longer matters. They are simply unwell. They move alone but together they inhabit the entire city. Do they interact with one another? Are they ever lonely? Do they understand the nature of their existence? The meaning of all of this? Do they have the capacity to love? To hate? They smell like death. They thrive in the dark, they thrive in the cold. They know no masters. They own this city which was once ours.*
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> Text from *The Unwell*, 2016

In both CF and in the time of COVID-19, closeness is prohibited. Over the last 20 years or so, research into cross infection in CF has meant that I should avoid anyone else with the disease. All cultural representations of CF have focused on this aspect of the illness in recent years. There is an episode of the popular American hospital-based television series *Grey's Anatomy* (American Broadcasting Company, 2011) based on a patient with CF. He is a young man who comes into hospital for a lung transplant. The doctors soon discover that his girlfriend also has CF. The doctors say he is 'committing suicide' and they will not perform the lung transplant unless he and his girlfriend break up as he would be 'wasting the lungs'. In 2019 Hollywood did CF with the film *Five Feet Apart*: (Baldoni, 2019). It told the story of two CF sufferers who fall in love, they break the six feet apart at all times rule by 'stealing a foot'. These two examples are soppy, romanticised versions of sickness, and the tragedy of separation plays so well into the Hollywood trope of forbidden love. However, they do highlight something significant. The characters in these two fictions are looking for connection with someone *like them*. The disease prevents them from having a physical relationship. Remembering my own childhood, before cross infection was discovered, playing with the other children with CF in the hospital reminds me of the comfort of being around others that understand. It is startling to watch footage in the documentary about Bob Flanagan and Sheree Rose, *Sick: The Life and Death of Bob Flanagan, Supermasochist* (Dick, 1998), in which Flanagan would be a leader for an annual camping trip for children with CF. The footage

shows them sat together around the camp fire singing, creating community through physical closeness.

The implication of our inability to be together is that in our violent CF coughs there exists the potential for harm towards another. On our fingers, and even in our breath, there exists dangerous bacteria that might make someone else very ill or even shorten their life. In staying away, we are helping someone else but also helping ourselves. Physical closeness is craved but dangerous. In her book *Cruel Optimism*, critical theorist Lauren Berlant suggests that '[a] relation of cruel optimism exists when something you desire is actually an obstacle to your flourishing.' (Berlant, 2011: 1). Closeness in CF is a form of cruel optimism. This can be extended to understand the current situation. We long to be together with friends and loved ones, but that closeness that we desire is not simply an obstacle to an individual flourishing but to a population battling to survive a pandemic.

Now the position of The Last Breath Society seems significant. How can we be together when we clearly cannot be together? The multitude of online options cannot replace touch, or closeness. Zombie time holds within its nature a cruel optimism. We are united through a temporal experience but cannot form important and necessary friendships, or communities. Our CF bodies, which are failing, are left to do so alone. The people we worry about as the virus spreads, are disembodied voices on the end of a phone. What we would give to hold the people we love now. What we would give to love the people that share our experience.

The zombie time of COVID-19, as well as CF, frames the other as danger, as carrier of your death. It also imposes upon you the responsibility of other people's lives. That is the impossibility of closeness in times of infection. The shattering of temporal experience means that zombie time is defined in relation to our own mortalities and the place of others in this. Inherent within the make-up of zombie time is the need for survival, to continue. The zombie is driven only by the desire to survive, both as an individual and a species. The zombie knows nothing but desire for human flesh; it bites in order to feed and this produces more zombies. Zombie time is living with death inside you, and that's what we are all doing now. So, welcome to The Last Breath Society, a place where we can decay together.

> *This used to be the most optimistic city in the world. Now it's full of darkness illuminated by the fading street lamps. Out of this darkness stumbles life quite different from us. The unwell negotiate this landscape in a way we could not. There is no war in this city, no poverty, no crime, nothing to fear. There is only sickness and this sickness is itself a form of existence, a way of seeing and being, a way of breathing and moving. This is life. They do not fear death because death is already behind them. They are not motivated by material things. To witness the unwell is to understand all of our fears but our fears mean nothing to them. This city used to be our future but now the future belongs to the unwell.*
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> Text from *The Unwell*, 2016

Data availability

All data underlying the results are available as part of the article and no additional source data are required.

Author information

Martin O'Brien is an artist, thinker, and zombie. He works across performance, writing and video art in order to examine what it means to be born with a life shortening disease. His writing also reflects on the experience of illness and the ways in which other artists have addressed it. A book of writings about Martin, *Survival of the Sickest: The Art of Martin O'Brien* was published in 2018 by the Live Art Development Agency. His performance work has been shown throughout the UK, Europe, US, and Canada. His writing has been published in books and journals on performance, art, and the medical humanities. Martin is currently lecturer in Performance at Queen Mary University of London.

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