Constructing the Not-So-New Normal

Ambiguity and Familiarity in Governmental Regulations of Intimacies during the Pandemic

Dmitry Kurnosov and Anna Varfolomeeva

Abstract: This article examines the early evidence for the emergence of new governmental regulations of intimacies during the COVID-19 pandemic based on the authors' experience of hospital treatment in Russia. It discusses the increasingly used notion of 'the new normal' and its potential implications for citizen–state relations. Approaching these emerging regulations from both legal and anthropological perspectives, the authors propose the alternative concept of 'the not-so-new normal', which combines discursive ambiguity with familiar patterns of control. The notion of lawscape is used to systematise the bodily control practices inside and outside a Russian hospital and to place them in a wider context. Applying the concept of rupture, the authors claim that 'the not-so-new normal' obfuscates the break with pre–COVID-19 reality to reinforce existing hierarchies and inequalities.

Keywords: COVID-19, governance, intimacies, lawscape, new normal, Russia

The term 'the new normal' is fast becoming a nearly ubiquitous description[1] of the realities shaped by the rules and routines emerging in the wake of COVID-19. However, its exact meaning is still contested. Some have argued that 'the new normal' allows for integration of quintessential human experiences such as pain, difficulty and struggle into dominating perceptions of 'normality' (Maisel 2013). During the pandemic, such a 'new normal' can become a liberating force by giving voice to those affected and challenging the established narratives. On the other hand, 'normalisation' has historically been a tool for reinforcing hierarchies and inequalities through rules and routines (Foucault 1995). Therefore, it is possible that the pandemic will also produce a situation that we define in this article as 'the not-so-new normal', where the existing power relations between the state and its subjects are reinforced. This article combines anthropological and legal approaches to analyse the construction and perception of 'the not-so-new-normal' during the first months of the COVID-19 pandemic. We focus on law's spatially grounded aspects, or what some scholars have called the 'lawscape' (Philippopoulos-Mihalopoulos 2015), during the coronavirus outbreak in order to bring attention to the material and embodied manifestations of changing legal regimes.

Today, it might still be too early to say whether the post–COVID-19 'new normal' state will realise its liberating potential or, conversely, turn into a 'not-so-new normal'. However, we can examine governmental practices (Foucault 2008) that emerged at the moment of rupture with the pre–COVID-19 realities. Rupture – understood as a profound and radical break of the existing condition – can be conceptualised in a complex way as including negative connotations (tearing things apart) as well as affirmative ones such as breaking the established structures of power (Holbraad et al. 2019). At the same time, rapid societal changes may revitalise pre-existing discussions or reinforce familiar configurations (Højer et al. 2018). In such cases, although the rules and rou-

Anthropology in Action, 27, no. 2 (Summer 2020): 28–32 © Berghahn Books and the Association for Anthropology in Action
ISSN 0967-201X (Print) ISSN 1752-2285 (Online)
doi:10.3167/aia.2020.270204

tines change, the underlying power relations often remain the same. We argue that the 'not-so-new normal' of COVID-19 is constructed by combining the conditions of familiarity and ambiguity. In this combination, the familiar hierarchies and inequalities are reinforced through the deliberate ambiguity of decision-making. Although this article is mostly based on Russian material, we believe that its conclusions can potentially be applied to other contexts of citizen–state relations.

In March 2020, both of us were amongst the first dozen confirmed COVID-19 cases in a large Siberian region. We were also the first people in our city infected through community spread rather than foreign travel. Subsequently, we were hospitalised according to the policy existing at the time, spending 13 days (in the case of Dmitry) and 20 days (in the case of Anna) at the Regional Infectious Disease Hospital.[2] This article is primarily based on our auto-ethnographic narratives as COVID-19 patients witnessing shifts of policies and practices governing our treatment. During the period of hospitalisation, we experienced a set of changing measures and practices defined by the hospital administration. Many of these measures combined the familiar concepts of care and surveillance, which were both seen as corporeal experiences (McCorkel 2003; Vaittinen 2015). As patients with a little-known and supposedly highly contagious disease, we were simultaneously perceived by the medical staff as vulnerable individuals who needed protection and as potential sources of danger for society – 'abnormal' individuals requiring isolation and control. This latter perception bears a resemblance to the Foucauldian notion of the 'human monster' as the 'fundamental figure around which bodies of power and domains of knowledge are disturbed and reorganized' (Foucault 2003: 62). Through hospitalisation, we were placed into the domain of monstrosity in order to be healed and ultimately reintegrated into society. Based on reflections on this process of hospitalisation, treatment and return to the outside world, we argue that the emerging rules of the pandemic – couched as they are in legal ambiguity – are reminiscent of previous familiar patterns of bodily control.

In Russia, the COVID-19 pandemic decidedly broke with two decades of increasingly centralised governance. The federal authorities assigned the responsibility for disease control and prevention to the regional governments. Consequently, instead of a nationwide state of emergency being issued from Moscow (although there is a relevant law explicitly covering epidemics), a panoply of heightened alert regimes were adopted across the country.[3] In practice, this resulted in a nationwide state of increased ambiguity with particular competences and responsibilities becoming increasingly blurred (Karaseva 2020).

Shortly after the introduction of the regime, and following an international event held at our university in early March, we, alongside our colleagues, were tested for coronavirus. While our blood tests and nasal swabs were being checked, the university administration announced that one of the foreign participants in the recent event tested positive for COVID-19 upon returning to their home country. The next morning, we were informed that both of us had also provisionally tested positive. In March 2020 in our region, a provisionally positive coronavirus test meant immediate hospitalisation regardless of symptoms. Back in January, the Russian government added COVID-19 to the list of infections 'that are a danger to others' along with plague, cholera, tuberculosis, HIV and anthrax. With very limited knowledge about the virus, this was primarily an exercise of biopower in the legal realm. Consequently, suspected COVID-19 carriers could be hospitalised against their will by a court order (Meduza 2020a). As such, we were left in the rare – and unenviable – position of being subject to near absolute state discretion, a position usually reserved for marginalised groups.

The hospitalisation procedure underscored both the ambiguity of the situation and our perceived 'otherness' as 'human monsters'. We were told to proceed to the ambulance car where one of us was dramatically put into a biocontainment unit for the two-minute ride to the hospital, despite only having mild cold-like symptoms and no breathing issues. After we arrived at the hospital and were placed in isolated rooms, the nurses communicated with us through windows and asked us to write answers on provided pieces of paper. We were asked to close our rooms from the inside and to return the key to the nurse. All these stages emblematised the symbolic borders built between us as potentially dangerous subjects and the rest of society. In the meantime, the state of ambiguity remained present. Both of us were told that our provisionally positive tests did not count for the hospital: new samples were taken, but their results took days to arrive and even then proved 'inconclusive'. Due to this indefinite uncertainty, we were left to wonder whether we were, in fact, infected and whether our isolation was necessary.

The construction of our new docile 'patient' identities was managed through several interrelated technologies of care and control, going in line with Foucauldian concepts of hierarchical observation

and normalising judgement (Foucault 1995). The isolated hospital rooms were constructed according to the principle of the 'panopticon', with a window facing the corridor (Figure 1). Through this window, each of the patients could be monitored at any time of the day or night. At times, the surveillance could be predicted. For example, we were checked every three hours for mandatory temperature measurements. However, we could also be observed at any given moment without prior knowledge. This near total visibility was presented to us as a sign of care: it meant that the staff could easily reach us and see whether anything was wrong. At the same time, such surveillance symbolised the hospital's control over our daily routines and behaviours. As Michel Foucault (1995: 187) notes, 'disciplinary power . . . is exercised through its invisibility; at the same time, it imposes on those whom it subjects a principle of compulsory visibility'. In our cases, this familiar invisibility of power was reinforced under the new conditions. While as patients we remained almost always visible, the ones caring for us were unseeable or unrecognisable. Due to the highly contagious nature of COVID-19, medical staff needed to use protective gear such as masks and goggles, and it was impossible for us to recognise their faces. They all merged into the vague unifying figures of doctor or nurse. Such a difference between patients' visibility and staff's invisibility reinforced the hierarchies existing in the hospital. It also contributed to the construction of the patients' abnormality as 'human monsters' that their caretakers simultaneously needed to be protected and hidden from. As our health stabilised and slowly returned to 'normal', these protective measures were gradually lifted. In the evening before our release from the hospital, our doctor started approaching us without any protective gear, telling us that we were 'not dangerous' now.[4]

Figure 1. Inside the isolated hospital room. Photo is courtesy of the authors.

In addition to hierarchised observation, our treatment was marked by an ever-present ambiguity that dictated the changing constructions of normalisation. Whereas the 'norm' seemed clear – the absence of coronavirus in one's body – the paths towards normality were constantly reassessed by the hospital's administration. Due to limited knowledge of the disease, there was no consensus regarding the prescribed treatment, and the recommendations were in constant flux. However, while at the hospital we were never directly informed about the deliberations and uncertainties surrounding COVID-19 treatment. Conversely, the doctors and nurses assured us that the medication we were taking was essential 'to feel better', and that additional testing was needed 'to make sure you are not contagious'. Even during this time of ambiguity, the hierarchies between the hospital administrators as 'producers of truth' and the patients as docile subjects were maintained.

As we slowly grew accustomed to the newly established realities, our release from the hospital became a new rupture of its own. The tightly controlled hospital routine, which provided us with a sense of security and dependence, was abruptly replaced by one in which we had to monitor our own health. We still knew little about the disease and its consequences, and therefore although we escaped hospital supervision we were simultaneously deprived of the care provided by the medical staff. Our hospital experience suggests that the notions of care and

surveillance are ubiquitously entangled in state responses to COVID-19. This confirms the theoretical work of others who have recently argued that the pandemic has resulted in the reconceptualisation of the vague boundary between care and surveillance (Miller 2020).

After our release, we joined those outside the hospital experiencing the escalation as 'change of change' (Højer et al. 2018: 37) while local authorities effectively put the city on full lockdown. However, the new restrictions often lacked clarity and were enforced only selectively. Soon some of the measures were lifted. Along with our fellow citizens, we had to negotiate the constantly morphing lawscape of the city as well as the often contradictory information about the virus. During our hospital treatment, both of us received leaflets entitled 'Between Carelessness and Panic' which provided some brief information about COVID-19. After our release in April 2020, it felt as if the whole city found itself between these two extremes.

A degree of ambiguity is inherent when humans encounter a new fast-spreading disease. This ambiguity reminds us of the limitations of our knowledge. By recognising these limitations, we can potentially challenge the established notions of normalcy. However, our experience during the rupture of pre–COVID-19 normalcy reflects a different kind of ambiguity. The governing practices we found ourselves in obfuscated the limitations of knowledge and denied the need to justify the measures that were undertaken. In our case, we had little understanding and no control over the measures directly affecting us. Outside of the hospital, Russian authorities employed cryptic language with terms such as 'heightened alert regime' instead of 'state of emergency' and 'holidays' instead of 'lockdown' (Cherkaev 2020). Individuals, on the other hand, were subject to hefty fines for violating new rules and to criminal responsibility for 'spreading misinformation' during an epidemic (Meduza 2020b). Thus, the authorities tried to construct the 'not-so-new normal', further extending their powers vis-à-vis their subjects and extending control over their movements and daily routines.

Our experience could also illustrate the 'familiarity' aspect of the Russian state's pandemic policies. In the absence of clear guidance for the prevention and treatment of COVID-19, Russian authorities resorted to the time-honed practices of bodily supervision in the health-care system. Although treated with care and attention, we were, in many cases, deprived of essential information about our tests, health condition or planned treatment. The medical staff, in turn, often had little control over the situation, as the hospitals were heavily supervised by the federal authorities. This multi-level governance strengthened the general state of ambiguity while at the same time embedding us in the established practices of state control.

Lawscape can be viewed as a continuum reproducing itself; however, as Andreas Philippopoulos-Mihalopoulos (2015: 192) notes, 'there is always room for surprises, for ruptures in the continuum'. The coronavirus pandemic has largely been viewed as such a rupture, which breaks familiar practices and introduces new ways of coping with reality: the 'new normal'. However, just as the corridor glass in our hospital rooms looked like a window to the outside world but in fact represented an extension and intensification of the surveillance mode, the 'new normal' is not always what it seems. We argue that it often turns into the 'not-so-new normal' by juxtaposing the states of ambiguity and familiarity. Ambiguity allows rule-makers to shroud the rupture brought by the disease in mundane language and practices. Yet, the state of familiarity reminds us that the emerging regulation of intimacies reinforces existing hierarchies and inequalities. In this way, our intimate and corporeal experience of COVID-19 treatment in a Siberian hospital reflects large-scale processes of citizen–state relations in the time of a pandemic.

Dmitry Kurnosov is a Research Assistant at the University of Copenhagen and a Visiting Lecturer at the School of Advanced Studies, Tyumen State University. He has published on the resolution of electoral disputes by courts and the European Convention of Human Rights. E-mail: bpd348@alumni.ku.dk

Anna Varfolomeeva is a Postdoctoral Researcher at the University of Helsinki. In 2019-2020, she was an Assistant Professor at the School of Advanced Studies, Tyumen State University. She is the co-editor of the volume *Multispecies Households in the Saian Mountains: Ecology at the Russia–Mongolia Border* (with Alex Oehler, 2019), and has also published on indigeneity in Russia and the symbolism of stone extraction. E-mail: anna.varfolomeeva@helsinki.fi

Notes

1. For example, the Spanish and Philippine authorities use the term to denote the goal of phased transitions of their countries in the wake of the pandemic.

2. Shorthand for the State Budgetary Medical Establishment of the N Region (*Oblast*) 'Regional Infectious Disease Clinical Hospital'
3. Hitherto, this was a rather obscure legal regime in the *Law on Human and Territorial Protection from the Emergencies* that formally bound only the authorities.
4. In Russian, the doctor used the word *strashnyi*, which has a double meaning as 'dangerous' and 'frightful'. We considered this linguistic juxtaposition an interesting addition to our 'human monsters' conceptualisation.

References

Cherkaev, X. (2020), 'They Sow the Wind and Reap the Whirlwind (Covid Doubt in St. Petersburg)', *Society for Cultural Anthropology*, 23 April, https://culanth.org/fieldsights/they-sow-the-wind-and-reap-the-whirlwind-covid-doubt-in-st-petersburg.

Foucault, M. (1995), *Discipline and Punish: The Birth of the Prison* (New York: Vintage Books).

Foucault, M. (2003), *Abnormal: Lectures at the Collège de France, 1974–1975* (London: Verso).

Foucault, M. (2008), *The Birth of Biopolitics: Lectures at the Collège de France, 1978–1979* (Basingstoke, UK: Palgrave Macmillan).

Højer, L., A. Kublitz, S. S. Puri and A. Bandak (2018), 'Escalations: Theorizing Sudden Accelerating Change', *Anthropological Theory* 18, no. 1: 36–58, doi:10.1177/1463499617744142.

Holbraad, M., B. Kapferer and J. Sauma (2019), 'Introduction: Critical Ruptures', in *Ruptures: Anthropologies of Discontinuity in Times of Turmoil*, (ed.) M. Holbraad, B. Kapferer and J. Sauma (London: UCL Press), 1–26.

Karaseva, A. (2020), 'The Legal Void and COVID-19 Governance', *Social Anthropology/Anthropologie Sociale* 28, no. 2: 294–295, doi:10.1111/1469-8676.12825.

Maisel, E. R. (2013), 'The New Normal: Mental Health in the Context of Inevitable Struggle', *Psychology Today* 13, https://www.psychologytoday.com/us/blog/rethinking-mental-health/201302/the-new-normal.

McCorkel, J. (2003), 'Embodied Surveillance and the Gendering of Punishment', *Journal of Contemporary Ethnography* 32, no. 1: 41–76, doi:10.1177/0891241602238938.

Meduza (2020a), 'A Total of Four Suspected Coronavirus Patients Escaped Quarantine in St. Petersburg: Two Have Been Returned to the Hospital', *Meduza*, 14 February, https://meduza.io/en/news/2020/02/14/a-total-of-four-coronavirus-patients-escaped-quarantine-in-st-petersburg-two-have-been-returned-to-the-hospital.

Meduza (2020b), 'Russian Authorities Launch nearly 200 Prosecutions for 'Fake News' during Coronavirus Pandemic', *Meduza*, 15 June, https://meduza.io/en/news/2020/06/15/russian-authorities-launch-nearly-200-prosecutions-for-fake-news-during-coronavirus-pandemic.

Miller, D. (2020), 'There Is a Fine Line between Care and Surveillance', *Anthropology of Smartphones and Smart Ageing Blog*, 31 March, https://blogs.ucl.ac.uk/assa/2020/03/31/there-is-a-fine-line-between-care-and-surveillance.

Philippopoulos-Mihalopoulos, A. (2015), *Spatial Justice: Body, Lawscape, Atmosphere* (London: Routledge).

Vaittinen, T. (2015), 'The Power of the Vulnerable Body', *International Feminist Journal of Politics* 17, no. 1: 100–118, doi:10.1080/14616742.2013.876301.