

STAGING THE COVID-19 PANDEMIC:
REVISITING ROSENBERG'S DRAMATURGICAL FORM OF EPIDEMICS

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Epidemics are biosocial events. However diverse their biology may be, they share a common dramaturgical form (Rosenberg 1992); each epidemic has a beginning, follows a plot of increasing and revelatory tension, approaches a climax of crisis, and eventually fades to an end. Rosenberg described this dramaturgical form of the epidemic in response to the AIDS crisis in the USA, an epidemic that served as a stark reminder that the Global North was also susceptible to the perils of infectious disease. Now the COVID-19 pandemic has again reminded us of our collective vulnerability. The emergence of and responses to SARS-CoV-2 have differed greatly between countries. Some, such as China, have carried out well-coordinated responses to coronavirus, minimizing excess deaths and successfully containing transmission after the initial outbreak. Others, in contrast, have seen high rates of excess mortality due to incoherent and poorly directed response strategies; the UK should be placed among the latter. This essay will argue that the diversity in local responses to SARS-CoV-2 can be meaningfully examined through the lens of Rosenberg's dramaturgical model of the epidemic by comparing the emergence of and responses

to COVID-19 in China and the UK respectively. In so doing, it will reveal the pandemic as at once a localized and a globalized biosocial phenomenon.

Act I. Emergence of an epidemic

According to Rosenberg's model, in Act I of an epidemic, suspicious cases start to arise, but the aetiology of the illness remains unclear. During this act, experts may suppress their anxieties or be silenced by the authorities, who remain unwilling to acknowledge the looming threat publicly. Public acknowledgement inevitably threatens the institutional and economic interests of the authorities, as well as the emotional assurance of ordinary people and the maintenance of public order. Nevertheless, the public is not necessarily naïve to the mounting risks, especially as increasing fatalities occur. It is often not until deaths and suffering have patently accumulated that a threat is officially recognized. With this recognition, the act ends (Rosenberg 1992).

COVID-19 first emerged in Wuhan, China, as the story goes, in December 2019. A patient with a pneumonia of unknown aetiology was identified on 8 December, and soon a cluster of patients with this diagnosis emerged (He et al. 2020). By 31 December the cluster had grown to 27 cases, and the WHO China Country Office was alerted to the existence of this unknown disease. These cases were all traced to a wet market in Wuhan. On 1 January 2020 the market was closed (Altakarli 2020). This, however, did not mark an official acknowledgement of the pandemic-to-be, as no further measures were implemented. On 9 January the causative agent of the patient clusters was identified: SARS-CoV-2 (ibid.). Despite warnings from whistle-blowers, no measures to curtail the spread of coronavirus were implemented until 10 January, and even then they were insufficient (Pan et al. 2020). The imposition of COVID-19-specific measures can be considered to mark official recognition of the threat from the disease in China.

SARS-CoV-2 has now created a global pandemic, or an epidemic impacting on the global community. However, the dramaturgical form of COVID-19 has played itself out differently in different countries, with each epidemic progressing through its dramaturgical course in its own way. For example, the emergence and acknowledgement of COVID-19 in China did not prompt acknowledgement of the epidemic threat in the UK. Globalized information networks allowed the UK government to follow the spread of the pandemic and anticipate its arrival but did not prompt it to take significant action. In fact, while the first UK local transmission of SARS-CoV-2 appeared on 28 February 2020, the UK government did not raise its threat level to high until 12 March or give official advice on social distancing until 16 March (Drury et al. 2020). The bar for action that would constitute recognition of COVID-19 in the UK is admittedly higher than that previously described for China. However, I believe that this is a reasonable distinction to make, given that the

UK had witnessed the severity of countless COVID-19 epidemics in other countries, providing the government with insights into what policies would constitute genuine action.

Act II. Conceptualization of arbitrariness

Following acknowledgement that there is an epidemic, a framework for understanding its arbitrariness must be established. These frameworks of understanding help people rationalize their susceptibility through risk factors such as behaviour, lifestyle and the environment. For example, by conceptualizing the mode of transmission of a disease, a measure of understanding and a sense of control is acquired (Rosenberg 1992).

During the COVID-19 pandemic, many conceptualizations of the disease have emerged. This essay focuses on the scientific frameworks that were developed to understand COVID-19 due to their relevance to the national responses seen in China and the UK. The events in Act II that are most significant to policy decisions were the confirmation of human-to-human transmission of the SARS-CoV-2 virus in China and the recognition of its transmission through aerosol droplets (He et al. 2020; Lupton 2020). In this understanding of COVID-19, people of all social groups and geographical regions are at risk of infection if they leave their homes or interact with potentially infected persons (Lupton 2020). Nevertheless, the risk of severe illness and mortality from the disease is not equally distributed: the risk is much higher for people aged sixty and over and for those with pre-existing conditions (Liu et al. 2020; Aveyard et al. 2021).

While frameworks of understanding COVID-19 are based predominantly on scientific research and advice, conceptualizations do differ between countries. For example, in the UK the government initially conceptualized COVID-19 as posing a limited local risk. This conceptualization of COVID-19, like all frameworks developed to understand it, has had significant effects on the public response (Drury et al., 2020).

Act III. Response

In Act III, the sense of crisis produced by the epidemic elicits moral and political pressure for a decisive and visible community response. The response is predominantly guided by the conceptualizations of the epidemic developed in Act II, but significantly the public health responses that were adopted also reflect cultural attitudes (Rosenberg 1992).

While the COVID-19 pandemic has undeniably unfolded on a global stage, the differences in its local forms can be seen most clearly through national response strategies. Strategies have varied significantly between countries, as can be seen below through the examples of China and the UK (Hale et al. 2020).

China

COVID-19-specific restrictions were first put in place in China on 10 January 2020, the first day of the Spring Festival travel season, or *Chunyun*. During *Chunyun*, millions of people were expected to travel around the country for holidays and to visit their families for the Chinese New Year. Nevertheless, restrictions implemented during *Chunyun* were limited and did not restrict movement within or between cities (Pan et al. 2020). Following confirmation of human-to-human transmission, and facing medical shortages and patient crowding in hospitals, more forceful response policies were put in place (ibid.). On 24 January, Wuhan and the whole of Hubei province went into lockdown, with airports, public transportation and non-essential shops closing (Altakarli 2020). It may now seem that China delayed responding to the emergence of COVID-19; considerable controversy has emerged on this point and the lack of initial transparency in the response (He et al. 2020). Nevertheless, while hindsight may confirm that stricter measures should have been introduced sooner, China was dealing with a new, unknown disease. Any intrusive response such as a lockdown carries a high burden of proof, and responses must be proportionate and evidence-based (Nuffield Council on Bioethics 2020).

A suite of responses to COVID-19 were implemented in China with great success; focusing on those implemented in Hubei allows them to be described at greater depth. The introduction of a cordon sanitaire in Hubei on 23 January was accompanied by compulsory mask-wearing in public places and a ban on all social gatherings. From 2 February a universal and compulsory stay-at-home policy was implemented throughout Hubei (Pan et al. 2020). These policies were enforced by half a million Chinese Communist Party volunteer community enforcers, who also provided material support to vulnerable groups such as the elderly and disabled (He et al. 2020). Lockdown measures in Hubei included a centrally enforced quarantine policy, with treatment of all presumed and confirmed cases and their close contacts in designated hospitals and facilities. Further, from 16 to 18 February the government initiated door-to-door symptom-screening of all Hubei residents, allowing it to identify any additional cases (Pan et al. 2020). The components of the COVID-19 response in Hubei described here illustrate the comprehensive, well-enforced responses implemented in China. These measures were successful in curtailing the local spread of the virus, with large-scale domestic SARS-CoV-2 transmission coming to an end on 31 March and Wuhan's lockdown being eased on 8 April. SARS-CoV-2 cases in China have remained remarkably low since then (He et al. 2020).

United Kingdom

The first transmission of COVID-19 within the UK was documented on 28 February 2020. By this time, the devastating effects of COVID-19 in China were clear, and the outbreak had been classed as a Public Health Event of International Concern by the WHO for almost a month. Nevertheless, meaningful official action was not taken in the UK until mid-March (Drury et al. 2020). The initial response to the COVID-19 pandemic in the UK, and arguably the response throughout, has been characterized by underestimates of the risk and an unenthusiastic response, resulting in a mortality rate that was disproportionately higher in the UK than in most other European countries (Drury et al. 2020). In the UK, health is a devolved matter, and the four nations' responses have to the COVID-19 pandemic have consequently differed. However, in the initial response to the pandemic that is discussed in this essay, only minor differences arose (Sargeant and Nice, 2021). As such, this essay considers the overall UK approach.

The UK response to COVID-19 began with public-health messaging encouraging better hygiene practices, including hand-washing. Nevertheless, the national response did not begin in earnest until mid-March, after COVID-19 had been declared a global pandemic. The public was *requested* (not *compelled*) to avoid all unnecessary social contact and travel, to work from home if possible and to avoid pubs, restaurants and other venues (Nuffield Council on Bioethics 2020). Following this limited response, cases continued to rise, prompting a national lockdown that began on 23 March (Drury et al. 2020). Legislation was introduced to allow the authorities to isolate or quarantine people infected with SARS-CoV-2 forcibly, though very limited enforcement was carried out, and instead the response focused on voluntary action (Nuffield Council on Bioethics 2020). A successful response was also hindered by unclear public-health messaging that initially failed to communicate in collectivist terms (Drury et al. 2020). In contrast to China, the UK has not managed to control SARS-CoV-2 transmission (Pollock et al. 2020). Following the first nationwide lockdown, public-health messaging remained confusing, and contact-tracing efforts were beset by failures. To date (July 2021), implementation of new measures has continued to be characterized by delay. Over a year since the emergence of SARS-CoV-2, the UK is nowhere near the end of Act III. While the country is slowly emerging from its third national lockdown with the support of a successful vaccination campaign, it faces continued threats from new variants of the SARS-CoV-2 virus at home and abroad.

Act IV. The End

According to Rosenberg (1992), Act IV sees the inevitable end to the epidemic; it fades away with a whimper as the biosocial incidence gradually declines. Unfortunately, the global community is

currently (July 2021) stalled in Act III, with no end to this crisis in sight. Although cases of SARS-CoV-2 remain low in China and have rapidly declined in the UK, we will not see Act IV of this pandemic until cases decline in every country. In recent months, this has been laid bare by the massive global inequalities in vaccine distribution and the emergence of new SARS-CoV-2 variants with the potential to evade vaccine-acquired immunity. According to the WHO, the best way to end this pandemic and stop the emergence of new variants is to limit the spread of the virus through vaccinating quickly and equitably. Nevertheless, as rich countries hoard vaccines, many low- and middle-income countries continue in crisis and without access to any vaccines (WHO, 2021). Such inequalities create the conditions for the emergence of additional SARS-CoV-2 variants, posing a continued threat to all, even the vaccinated. Due to the globalized, interconnected nature of our world, every country is put at risk by the persistence of SARS-CoV-2 elsewhere.

Conclusion

Rosenberg's model of the dramaturgical form of epidemics provides a useful lens for comparing the emergence of COVID-19 and the response to it of different countries. It has been applied in this essay to the examples of China and the UK. In Act I, recognition of the epidemic in China eventually became inevitable, followed by a much-delayed recognition in the UK months later. Act II saw the conceptualization of COVID-19, where the common belief in scientific frameworks brought countries onstage together, albeit briefly. In Act III, China and the UK diverged even more significantly than before: China's forceful response efficiently addressed the epidemic and has maintained low case numbers ever since, while the UK has managed its response poorly, resulting in very high case numbers more than a year after the emergence of COVID-19. In accordance with Rosenberg's model (1992), the comparison of China and the UK presented in this essay has demonstrated that even global epidemics are experienced and responded to locally. Nevertheless, due to the global character of this crisis, we will not reach Act IV, the end, until cases are controlled everywhere. The persistence of SARS-CoV-2 in any country poses an enduring threat to the rest of the world.

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