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Becoming anonymous: how strict COVID-19 isolation protocols impacted ICU patients

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Abstract

In this article, I provide phenomenological reflections on patients' experiences of undergoing extreme isolation protocols while admitted to Intensive Care Units [ICU] during the first wave of COVID-19. Based on observation studies from within the patient isolation rooms and retrospective, in-depth phenomenological interviews with patients, I characterize this exceptional experience as one of becoming anonymous. To illustrate this, I start by establishing a perspective on embodied existence as constituted on a scale between anonymous embodiment and being enrooted into a *personal niche*. Against the backdrop of this framework, I illustrate how being admitted to the ICU under strict isolation protocols produced extraordinary experiences of becoming anonymous. Sources of the anonymization were: (1) Mechanical expropriation, pacification and disownership of the visceral-kinaesthetic body; (2) Objectification; (3) Spatial and intercorporeal anonymity (4) Surrealism: the intermingling of objective impressions and dream-like interpretations. Finally, I illustrate how anonymization induced an experience of embodiment as raw materiality, confronting the patient with what Martin Heidegger called the facticity of naked existence. This experience is discussed against Levinas' critique of Heidegger, while I propose that insights from this exceptional case may substantiate Heidegger's account.

Keywords Isolation · Phenomenology · Embodiment · Personal niche · Niche Construction · ICU · COVID · Sense of self

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1 Introduction

If COVID-19 showed us anything, it is the tangible experience of how being socially isolated profoundly disturbs the structure of our lives. Despite local differences in strategies for containing the spread of the virus, most of us have experienced some degree of social isolation. Not surprisingly, this has caused an upsurge in studies on the impact of social distancing on the mental health of the general population. Amid this precarious social situation, however, the experiences of one group stand out as exceptional – COVID-positive patients admitted to intensive care units [ICU]. With the emergence of the pandemic, the ICU instantly became the most significant resource in reducing mortality rates among those patients already infected. To deal with the responsibilities of this situation, unprecedented strict isolation protocols were implemented in hospitals in Denmark (and elsewhere). These included confinement to isolation rooms with no visitors allowed and all medical staff covered in personal protective equipment [PPE]. Due to the specific complications and unknown nature of COVID-19, the admissions were also both open-ended and extraordinarily long (up to 90 days). Hence, patients were confined to a highly artificial, clinical environment with almost no contact with the outside world.

In what follows, I will provide phenomenological reflections on this experience based on observational studies from inside the isolated ICU rooms and in-depth phenomenological interviews with surviving patients and ICU nurses. Importantly, the aim of this article is not to simply recount the findings of a qualitative study. The findings have been reported in detail elsewhere (Køster, Forthcomming). My aim is to engage in phenomenological reflections on the meaning of the reported experiences. The study was conducted at an ICU at Bispebjerg hospital (part of the university hospitals in Copenhagen, Denmark), in close collaboration with intensivists and intensive care researchers. The ICU had one of the largest uptakes of COVID-positive patients in the greater Copenhagen area. The study consisted of (1) in-depth phenomenological interviews with all surviving patients (6 in total) from the first wave of COVID-19, (2) in-depth phenomenological interviews with 6 ICU nurses on their experiences during the first wave; and (3) fieldwork from the general ICU, including extensive observation from inside the isolated rooms. Observations were not possible during the very early phase of the pandemic and were done slightly later, so there is no overlap between observed patients and interviewed patients. Both interviews and observations were conducted based on the phenomenologically grounded qualitative research framework [PGQR] (Køster & Fernandez, 2021; Klinke & Fernandez, 2022). In keeping with the PGQR framework, all aspects of the research process were guided by concepts developed in philosophical phenomenology (Køster & Fernandez, 2021). Specifically, PGQR advocates a focus on modal alterations in basic experiential structures and places an emphasis on exploring tacit and embodied aspects of experience. This makes PGQR ideal for investigations of experiences like ICU admission, since such experiences are profoundly visceral in nature and often display little reflective or narrative structure. The material was analyzed using a general six-phase process of thematic analysis and data triangulation (Braun & Clarke, 2006; Carter et al., 2014) while adhering to the principles of PGQR.

My reflections are based on the premise that isolation in the ICU constitutes an *exceptional case* that is not only interesting *per se*, but also in what it may tell us about human existence in general. Specifically, I will argue that the ICU experience shows us a case of radical deprivation from what I will term *the personal niche*, i.e. a disconnection from all constituents of the environment that daily serve to bring me to my habituated sense of self. As an effect of this extraordinary situation, patients described experiences of a profound loss of sense of self and feelings of becoming anonymous. This feeling of becoming anonymous, should be understood as an affective phenomenon. It is an affective response to a comprehensive loss of the scaffold that supports my sense of self. In the phenomenological literature it has been argued in detail how our environment may profoundly influence our affective lives (e.g. A. Saarinen, 2020; Køster, 2020; Colombetti & Krueger, 2015). However, due to the rarity of experiences of becoming anonymous, this type of affective phenomenon is seldom acknowledged and has therefore not previously been explored in detail.

I will proceed as follows: In the first section, I present an embodied account of personal existence specifying that it is an achieved structure based on the anonymous, functioning body. Specifically, I suggest that we understand our basic sense of self as enrooted in a *personal niche* meaning that it is a distributed phenomenon dependent on daily confirmations from interactions with our habituated environment. Second, I turn to a description of the peculiar scene that the ICU constitutes within the hospital and how it was altered by strict isolation protocols during the first wave of COVID-19. Third, I present an analysis how the ICU isolation deprived the patient of a sense of self. In the last section, I argue that experiences of anonymity differ in kind and that the type of anonymity experienced in the ICU confronts the patients with what Heidegger termed "facticity" or "naked existence"; i.e. an experience of "the pure that it is and has to be". I discuss this against Levinas' critique of this notion and propose that the exceptional case presented offers insights mediating this debate.

2 The personal niche: from anonymous experience to personal existence

As embodied creatures, we are not born into the world as subjects already imbued with an individualized sense of self. At the roots of embodied existence is a mode of presence that is predominantly impersonal and anonymous. Although only noticed at the margins of experience, it is this *functioning body* which continuously carries us forth and conditions the subject as it gradually achieves and maintains a sense of personal existence. Specifically, I want to propose that my sense of self, as an expression of *personal* existence, is an achieved structure, dependent on daily confirmations, and constituted along a scale from anonymous or impersonal existence to a developed and established personal niche. By introducing the concept of a personal niche, I am suggesting that the sense of self is a distributed phenomenon which is dependent on the particular things, places, practices and persons that I am habitually integrated with and daily use to recollect myself (Jacobson, 2015; Køster, 2020).

Let me specify this claim in detail: First, when referring to an impersonal or anonymous level of experience, it should not be understood as if embodied exis-

tence may be self-less. As argued extensively in the contemporary debate, minimal selfhood seems to be a structural feature of embodied experience (Zahavi, 1999). However, the concept of minimal selfhood is a strictly formal notion that commits to no more than that subjectivity is 'a built-in feature of experiential life' (Zahavi, 2017). Hence, referring to experiences as impersonal or anonymous does not imply that they are subject-less (Heinämaa, 2015). That embodiment nevertheless entails a mode of experience that is impersonal or anonymous is a well-traversed topic in the work of particularly Merleau-Ponty. According to Merleau-Ponty (2012), the fact that we are embodied implies a 'pre-personal adhesion to the general form of the world' (86). This means that before any personal act or self-acquisition, I am always already tacitly conditioned and carried forth by the fundamental functioning of my body. Merleau-Ponty refers to this dimension as an 'innate complex beneath the level of my personal life' (86). As an "innate complex" the body has its own basic movements, rhythms and pulses rooted in, inter alia, physiological processes such as heartbeat, respiration, digestion, circadian rhythms and hormonal cycles, energy balances, instinct-driven needs, and interplay between exhaustion and regeneration (Fuchs, 2021, p. 218). These are not the result of any act of the self, but rather aspects of a functioning body that carry the self forth as a constant and tacit undercurrent. We are therefore never only subjects *of* our bodies but equally subjects *to* a living body that grounds us and which both precedes and exceeds any personal act[1]. It is this fact of human existence, that I am always also the experiential subject of a living body, an organism, that is the basis for experiences of anonymity. Impersonal or anonymous experience occurs when the subject is somehow confronted with facts of embodiment in its raw materiality and the passive experience of being a subject integrated with a general form of the world.

Second, although the anonymous body precedes identity and is the basis for the development of personal existence, it belongs at the margins of lived experience, only manifesting in matters of degree or in exceptional events. This is due to the immense role of *habituation* in embodied experience. We have always already begun familiarizing ourselves with our bodily being and our environment. It is through this process that we appropriate a fundamental sense of ourselves. Thus, my sense of self as a concretely individuated person is not a self-reliant structure but a distributed phenomenon that is dependent on the broader self-world entanglement. To capture this structure conceptually, I propose we speak of the development of a *personal niche*. By employing the term "niche" I am drawing on the notion of "niche construction" which has travelled from biology to the cognitive sciences and phenomenology in recent years (e.g. Bertolotti & Magnani, 2016; Colombetti & Krueger, 2015; Sterelny, 2010). Niche construction refers to how an organism integrates with a specific environment and creates an adaptive fit using anything from physical spaces and materials to symbols and other people as significant resources. When I suggest the term *personal* niche, I am borrowing the term niche to make a phenomenological claim, specifying that my sense of self is achieved through habituation to a specific environment. It is an ecosystem of the personal that continuously carries and con-

[1] Merleau-Ponty (2012) maintains that both birth and death belong to anonymous experiences in so far as there is no awareness hereof (223).

firms my sense of self, you might say. The constituents of the personal niche are wide-ranging and involve, but are by no means exhausted by the following:

- *Visceral-kinesthetics body*: We are embodied creatures, and as such the personal niche resides in a fundamental acquaintance with the visceral and proprioceptive body. *Viscerally*, I am habituated to the steady background pulse of my heartbeat, the flow of my breath as the abdomen expands and contracts rhythmically, the feel of various regions of my body that only really manifest as salient when disrupted (e.g. I feel my stomach when hungry or in pain). *Kinetically*, we are familiar with the enaction of a repertoire of movements and how our body responds in these, such as getting out of bed, *picking up* forks and plates, *handling* our laptops, *pushing* the door open, *pulling* the kitchen drawer open. Sheets-Johnstone (2013) has referred to this as 'thinking in movement', however we do not only think through such movements, we also *feel* ourselves. These habituated patterns of movement – however insignificant and minute they may seem – are stylistically individualized in ways that are recognizable to others and give us a feel for ourselves. Hence, although the rhythms, pulses and melodies of movement of my body might intuitively appear as being outside of the realm of the personal, they are in fact imbued with a distinct personal feel acquired through habituation. Reflexes end up having a "personal style", Merleau-Ponty (2012) argued, and William James (1904) even proposed that our most intimate self-acquaintance is, in fact, not rooted in the cognitive "I think", but in the bodily "I breathe" (491). While James certainly pushes the argument,[2] it does point to the centrality of basic bodily rhythms to our sense of self. To see this clearer, consider events where these are brought out of sync with the habitual: If the heartbeat is unusually fast for longer periods (as in anxiety); if respiration becomes constricted and short; if the circadian rhythm is disturbed affecting digestion and sleep; if the rhythms of my movements are suddenly staccato or offbeat. (as experienced in degenerative MS). In all such cases, we feel off and not quite like ourselves. We feel distanced and somewhat alienated from our bodies.
- *Sensory-spatial environment*: Naturally, the personal niche extends beyond the visceral-kinaesthetic body into our sensory and spatial environment. We habituate to the familiarity of particular soundscapes, smells, lights, atmospheres, forms, textures and a sense of touch with the places we inhabit. All of this is paradigmatically displayed in our appropriation of a specific place as home. Home is, Bachelard (1994) tells us, "the non-I that protects the I" (5). Home renders, Levinas (1979) tells us, 'inner life possible' (132). It is a vital space that daily enroots me with a sense of familiarity, and I know this space in a profoundly sensory manner. Jacobson (2009) argues along similar lines and emphasizes the function of home as a sort of "outer skin" that protects our intimate lives; it is an extension of the body that provides a space of 'initial stability and foundation for the self' making

[2] It is for instance the case that we still breathe while unconscious, and we do not become unconscious when holding our breath. Furthermore, it is clinically possible to keep a patient conscious and alert without breathing in an ECMO. In an ECMO your blood circulates through a machine to exchange carbon dioxide and deliver oxygen. Being awake in an ECMO is nevertheless a very strange experience.

'the experience of being at home and the bodily sense of self are inseparable' (361). However, this kind of sensory-spatial familiarization with our environment extends beyond the intimacy of the home and includes the broader habituation of the local world we inhabit. Hence, the personal niche generally integrates wider arenas such as schools, work-places, and the local environment such as streets, neighbourhoods, grocery stores. In the broadest sense, the personal niche may include one's native country, as a kind of *Heimat* or homeland – like the relief upon hearing one's mother tongue after staying abroad.

- *Things* also play a vital function in constituting the personal niche. This is richly illustrated in empirical research such as Belk's (1988) famous study on the role of possession in our sense of self and identity. Consider, for example, the importance clothes have to our sense of self: the oddly alienating feeling of wearing clothes that are either not ours or which feel stylistically out of character. Or how certain things gets incorporated into the daily routine of bringing me to a sense of myself: a coffee cup, a wristwatch, my laptop, books, music instruments. Lacking these may cause a (however mild) disruption of the flow of retrieving my daily sense of self. In this sense, things are never mere ready-to-hand objects that serve a function in what Heidegger called a "referential whole of significance" [Bewandtnisganzheit]. Rather, they stick to my sense of self by being imbued with a distinct kind of ownership that express an extension of the self. Arguably, this explains why violations of ownership are not only a legal concern but experienced as a transgression of the intimacy of the self (Hood, 2020).
- *Intercorporeality*: One of the most important constituents of the personal niche is, ordinarily, the integration with specific other persons. Those with whom we form attachments may even become so integral to the personal niche, that it becomes a cohabitated environment whose integrity rests on the presence of that person. I find myself intercorporeally habituated to a person's embrace, how she is integrated as part of our shared bed, the soundscape she creates and the scent she leaves behind. (Køster, 2020, 2021). Significant others can be as integral to the function of a sense of home as that of a living space. Home may be an atmosphere that only exists as emanating her presence. Yet, the role of significant others in the personal niche expands beyond the mere physical presence and the traces they leave behind. I may, for instance, find myself through the particular conversations I can only have with a certain person. Our shared sense of humour, practices, memories or dreams for a shared life. As I have argued elsewhere, being bereaved of such significant others often leaves profound feelings of emptiness exactly because I lose such an integral element in my personal niche (Køster, 2020).
- *Practices*: The practices I engage in also play significant roles in my self-acquaintance. This may range from the minute habituated practices I engage in daily, such as my morning ritual of enjoying a cup of coffee at a local café. How I travel to work by bike and find my place at my desk. It could also be the practices that are more organized such as religious practices like praying, doing morning yoga, or rock climbing with friends. Notably, it also includes broader more abstract identification with what Korsgaard (2009) calls "practical identity". How I identify with being a mother, a nurse, a Muslim etc. In this respect, I find myself in practising motherhood, nursing, or specific Muslim rituals. Hence, practices

both refer to an overarching frame for activities and a basic temporal structuring of everyday life that cuts across and integrates things, persons and spaces, and through which I daily confirm my sense of self as enrooted in a personal niche.

- *Narrative*: Lastly, while most of the elements of the personal niche emphasised so far are embodied and practical, there is much to be said on how all of these are integrated into a coherent cognitive framework. That narrative plays a fundamental role in this kind of process is widely agreed upon and rightly so (e.g. Bruner 2000; Carr, 1991; Heersmink, 2020). However, as I have argued in detail elsewhere it is important to emphasize that our sense of self is not as such constituted by narrative configuration (Køster, 2017). Narrative may play vital roles in strengthening an integrated sense of self and, vice versa, narrative disintegration may lead to degrees of loss of sense of self (Køster, 2017; Dings & Bruin, 2022). Narrative is an attribute that may be used to shape embodied experience and that admits of degrees, meaning that experience can exhibit or be attributed more or less narrativity (Køster, 2017). In this respect, narrative may serve a variety of functions and purposes in organising and integrating aspects of the personal niche.[3]

Hence, my sense of self is a habituated structure – I create a *habitat* of the self. This means that my sense of self is precariously dependent on the personalised environment that sustains it. I collect myself on a daily basis through various constituents of my personal niche. One of the strengths of this perspective is that it can account for the commonplace (yet obscure) experience of "not feeling like ourselves". That such feelings may fluctuate on a daily basis is well-documented in the literature[4] and they may be associated with anything from homesickness to major life-events, mental illnesses, or even to losing a prized possession (Belk, 1988). In such cases, the loss of a sense of self reflects the loss of contact with some aspect of the personal niche. Importantly, this should not be understood in a binary manner, as if a sense of self is something that is either there or not. Rather, it is always a matter of degree ranging from minute feelings of being slightly off to more encompassing experiences of feeling alienated or even anonymous found in, for instance, traumatic, psychopathological and critical states (Køster, 2022, 2017; Dings & Bruin, 2022). In this respect, alienation and feeling anonymous should be distinguished. Alienation refers to situations where an element that was previously experienced as part of the personal niche with some degree of familiarity now appears as strangely unrelatable or unfamiliar (Køster, 2022). Consequently, Rahel Jaeggi (2016) has fittingly referred to such experiences as a 'relation of relationlessness'. The relation persists, but now evokes a sense of estrangement. Contrary to this, experiences of anonymity refer to situations where the entire structure of relational familiarity temporarily loses its valence. In experiences of anonymity, I am disconnected from the personal niche to some degree and do not feel like somebody in particular. Hence, one way to construe of the dif-

[3] Heersmink (2020) has recently proposed the concept of a "narrative niche", to account for how our memory ecologies scaffold our narrative identity. Much more could be said of the interplay of our personal niche and narrative, but it would exceed the scope and purpose of this article.

[4] For an overview see (Dings & Bruin, 2022; Lenton et al., 2013).

ference between feelings of alienation and anonymity, is that while alienation is an experience of discrepancy, anonymity is one of disconnection.

Lastly, it should be noted that the dynamics of my sense of self I have proposed here involve both passivity and activity. This differs from prominent ethical accounts of personal existence. Korsgaard (2009), for instance, argues that personal existence begins to develop the moment 'some movement of my mind or body is regarded as my action and not just something acting on me' (18). While the importance of agency and activity in the constitution of personal existence should not be neglected, I believe it misses the fundamental role of passive habituation in establishing and maintaining a sense of self. Examples of this is basic familiarity with all that which I do not initiate myself in the personal niche, such as fundamental bodily rhythms, spatial atmospheres.

3 The scene

3.1 The ICU experience in general

The ICU is a rather new construction in biomedical practice. The first ICU was established in Copenhagen, Denmark in 1953 as a response to the polio epidemic by anaesthetist Bjørn Ibsen (Berthelsen & Cronqvist, 2003). The objective in the ICU is exclusively to stabilize or keep the patient alive by attending to, monitoring and treating the basic functioning of all vital organs. Hence, only the most critical patients end up in the ICU, and usually for very short time intervals with a median ranging from 2 to 3 days at the particular ICU. To the patient, being admitted to the ICU is an extraordinary event and, by any standard, an extreme experience that the general population have very little acquaintance with. Even within hospital settings, the ICU is often considered an isolated entity, a kind of closed-off country, in the vast hospital machinery that outside staff only enter if specific competencies are needed.

To the patient, entering the ICU implies a radically altered status. As an antonym to "agent" one is nowhere more "patient" than in the ICU, in so far as the patient becomes a passive worksite for biomedical engineering stripped of autonomy. First, the patient is not admitted of her own will and is not considered competent to refuse treatment or discharge herself. Hence, she is stripped of autonomy in a very unusual and fundamental sense. Second, once admitted, the patient often undergoes several highly invasive procedures that transgress the intimacy of the body. One example is intubation (having a tube inserted in the trachea), that not only causes intense feelings such as pain and suffocation, but also a strong sense of being helpless, deserted, voiceless and restricted (e.g. Karlsson & Forsberg, 2008). When intubated the patient loses the ability to speak unless it is performed through a tracheotomy (a tube inserted directly in the trachea through an incision). Another example is dialysis, which restricts the patient's ability to move freely and accompanies the patient with a constant, intrusive soundscape of buzzes and alarms that stresses and disrupts the patient's ability to sleep (e.g. Pisani et al., 2015). Third, the patient is stripped of almost all basic agency which is taken over by instruments and health care personnel: A machine breathes for the patient. A machine provides the patient with sustenance.

A machine relieves the patient of urine (if not in dialysis). A machine cleans the patient's blood. Nurses turn the patient over when she needs to be moved. Nurses relieve the patient from stools, sputum or saliva. Fourth, since the patient is completely dependent on the health care staff, she is subsumed to the work rhythm and structures of the ICU. This is intrusive in so far as the patient is not able to decide basic processes such as when to sleep and wake up (Korompeli et al., 2017), or having saliva removed from the chin.

In essence, in the ICU the patient is stripped of all basic agency. Her body becomes an object of medical manipulation and a worksite for biomedical engineering. In response to the intrusive and overwhelming nature of this experience, patients are usually sedated when admitted (particularly if placed on respirators which is approx. 50% of all patients at Bispebjerg Hospital). That is, patients are sedated to cope with the *treatment situation*, not only to reduce their pain. The degree of sedation is adapted to the patient. The aim is, on the one hand, to keep the patient calm enough to tolerate the various treatments, e.g., being compliant when having a tube inserted in the throat and not trying to pull it out and flee the room. On the other hand, the aim is, when possible, to keep the patient adequately awake to remain responsive in the situation; as a minimum, be able to give a press of hand when prompted or answer verbally when not intubated. The intention is to maintain the function of both the central nervous system and muscle function[5]. Finding this balance between sedation and responsiveness is important to ensure that the patient is eventually able to regain control of their body (e.g., breathing for themselves again, basic movement) and to reduce loss of muscle mass. To sedate the patient, several drugs are used from anxiety inhibiting agents[6] to sleep-inducing drugs[7].

3.2 ICU during first wave of COVID-19

With the emergence of the COVID-19 pandemic, the ICU instantly became the most significant resource in reducing mortality rates among those patients already infected. This was due to an acute need for respirator treatment to ensure adequate oxygen levels in COVID-positive patients. To address this task, in midst of the uncertainty of the situation, unprecedented, strict isolation protocols were implemented for COVID-positive patients at the ICU ward that framed the study. Patients were placed in isolated rooms holding 1–4 patients. All staff wore extensive personal protective equipment [PPE] covering the entire body and consequently making staff indistinguishable from each other. All visitors were prohibited from entering the rooms except when the patient was moribund. This was combined with extraordinarily long and open-ended admissions where patients were confined to the isolation room for up to 90 days with no prognostic specification of when they could be expected to be

[5] It should be noted that practices differ across various countries. In Denmark there is a specific commitment to keep the patient as awake as possible. Importantly, this practice was significant in making retrospective interviews with patients possible since it probably made them able to recall the experience to a higher degree.

[6] Benzodiazepines, e.g., midazolam, anxiolytics.

[7] Hypnotics e.g. Propofol or opioids such as remifentanil, fentanyl.

discharged. Notably, the patient is never alone since the rule in ICU's in Denmark is that the nurse never leaves the patient.

Entering the ICU during the first wave of COVID at Bispebjerg ICU was like entering another world. It felt like stepping into a vacuum or being submerged under water. The atmosphere in the room is condensed around a particular purpose and everything in the room points to this purpose – it's all about keeping the patient alive. The patients are spread out like little secluded islands partitioned by walls and instruments. The staff look like astronauts and cannot be told apart visually. Apart from the steady mechanical pulse of the respirators and occasional beeping sounds and alarms, the room is quiet and calm. It is utterly colourless and uninspiring to the eye, with a distinct hospital odour of disinfectant. Nothing in the room is personalized; there are no objects apart from those designated for a specific biomedical purpose. In some rare cases, when a patient was adequately alert, they did have a phone present to text their relatives. Hence, where admission to the ICU in general constitutes an extraordinary experience of being objectified and anonymised, the COVID isolation protocols significantly intensified the experience.

Isolation of patients in hospitals is not unique to COVID. Other examples are various infections and states of immunodeficiencies (Barratt et al., 2011; Skyman et al., 2010). However, what distinguished isolation during the COVID pandemic from previous experiences was not only the sheer quantity of isolated patients, which impacted the logistics of entire departments, but also the level of anti-spread measures such as completely isolated rooms/departments and extensive use of high-level PPEs. Furthermore, the exclusion of relatives from entire hospitals, due to a general fear of spread of COVID to society at large, combined with open-ended admissions, were specific factors that contributed to this unique situation. Despite these important differences, studies of other types of isolation do reportt a similar loss of social connectivity, a loss of sense of self and a loss of body ownership (e.g. Egerod et al., 2015; Vottero & Rittenmeyer, 2012).

4 The experience: sources of anonymity

As mentioned, the most consistent experience expressed by patients admitted to the ICU during the first wave was a profound sense of becoming anonymous. Importantly, not all patients experienced feelings of anonymity to the same degree. The intensity of the experience differed according to types of invasive procedures, degrees of alertness and particularly the length of the admission. However, all patients expressed feelings of becoming anonymous and feeling so estranged from their admission that, although they know it happened to them, it feels like it happened to somebody else.

In the following, I analyse the sources of this feeling of anonymity. I do so from the premise that admission to the ICU under strict isolation protocols constitute an extraordinary case of personal niche deprivation. While some of these experiences reflect the general conditions of the ICU, it is safe to say that the isolation protocols intensified the experience in a distinct way. I will analyse the experience by focusing on four structures emphasized by the patients in the retrospective interviews and drawing on my observational studies from inside the isolated rooms.

4.1 Mechanization expropriation, pacification and disownership of the visceral-kinaesthetic body

Undergoing the treatment regimen of the ICU was experienced as a profound intrusion and disruption of the most intimate familiarity with the visceral-kinaesthetic body. Specifically, it was experienced as a kind of mechanical expropriation and pacification of the body that resulted in a loss of a sense of ownership. Most salient is the mechanization of the familiar visceral body caused by the use of mechanical ventilation. Contrary to the organic rhythm of breath, organized by the inhalation of air through a contraction of the diaphragm, mechanical ventilation functions through creating a gauge pressure by blowing air into the diaphragm. This not only causes an inversion in the organic rhythm of breath but, more importantly, the rhythm of breath is now expropriated to a machine which dictates the rhythm of breath through a numerical frequency[8]. However, the disruption of the visceral body is far more encompassing. The patient's circadian rhythm is also expropriated to machines or nurses. This is not only the case in respect to digestive functions (feeding, urinating, stool). It also pertains to the regulation of sleep patterns which is not dictated by the rhythms and needs of the body but by the effects of medicine and the rhythm of the ICU work order (change of shifts etc.). Furthermore, the patient's body was severely restricted from engaging in basic self-initiated movement and, in most cases, there was a complete pacification of the body. This included basic self-expressions such as talking, choosing on which side to sleep, being turned over to have the diaper changed. All this was expropriated to the nurses. The lack of a sense of bodily autonomy was a source of frustration and suffering. A patient expressed this experience in the following way: 'I remember lying there, passively, with my chin covered in my own saliva. It was so frustrating. I was unable to remove it and I could not disregard it. I remember begging the nurse to help me, but she was occupied elsewhere and would not help. I felt so undignified, like an inconvenient object, just lying there'. The inability to engage in self-initiated movements was caused by both lack of energy in the patients and constraints imposed by mechanical extensions such as ventilation, catheter and dialysis, but also by medical needs defined by the medical staff. An example of the latter was how COVID-19 patients were prescribed placement on their abdomen to ensure sufficient oxygen levels. In effect, the patient was severely inhibited from expressing a basic spectrum of self-initiated movements. There was a fundamental disruption of the rhythmic-dynamic structure of the lived body, both viscerally and kinaesthetically, which contributed to anonymization of the body through expropriation and disownership[9]: 'In the ICU my body stopped being *my* body. It became part of the biomedical machinery', a patient noted. Another patient said, 'I became a passive lump of meat'. In a contrasting experience, a patient described

[8] It should be noted that in patients who are lucid and awake, the mechanical ventilation is gradually more sensitive to the natural rhythm of the body.

[9] Another aspect of this experience was a profound temporal disorientation where patients reported losing a realistic sense of temporal duration. This is consistent with experimental studies reporting that 'the precision of the estimation of time depends on the capacity for perceiving rhythmic bodily signals' and how 'subjective experience of duration of time varies depending on the motivation, arousal and relaxation of the body' (Fuchs, 2021, p. 220).

how training with the physiotherapist was the most uplifting experience during her entire admission, even if all she managed to do was reaching for a cup. As the patient reported: 'although I hated it when I had to train with the physiotherapists because they demanded something from me, it ended up being the best thing. It gave me a sense of being alive, of returning to being a person again'. It felt uplifting because engaging in self-initiated movements returned her to a basic sense of agency and in effect to a basic sense of self.

4.2 Objectification

Having your body addressed as not only the site of subjectivity but also an object of manipulation, is, arguably, a precondition of biomedical intervention in general and the ICU in particular. Nevertheless, the strict isolation protocols and fear of contagion of the first stages of COVID-19 intensified this into a qualitatively distinct experience. One patient noted: 'upon entering the ICU, I stopped being a person and became a number on a spreadsheet'. There were several reasons for this intensification: First, because the dynamics of COVID-19 were unknown and the patient's bodies didn't react predictably, there was an unusual preoccupation with the patient's numerical values – oxygen saturation in particular. This caused medical staff to address the patient monitors next to the patient, rather than the patient herself. This practice was so pronounced that even the patients themselves started to direct their attention to the monitors in interacting with the medical staff (Køster, Forthcomming). A patient noted: 'all I focused on was the numbers, I even stopped registering how my body felt. I just tried to make sense of the damn numbers. Second, nurses, in particular, expressed a pronounced fear of contagion in interacting with the patients and how they would avoid getting close to the patient's face. Several nurses reported an inclination to distance themselves from the patients and relate to them as anonymous bodies to such a degree that the interaction rather resembled 'taking care of pigs at a research facility' (Køster, Forthcomming). Patients internalized this mode of relationality and started to experience themselves as an object-like presence: 'I became a thing, just lying there' and 'I was this thing the doctors and nurses worked on'. Some patients even referred to their bodies during admission in the third-person pronoun; as in '*it* (the body) did not want to lie on the front' or '*it* simply would not move'.

In reflecting on social anonymity, Rosenzweig (1985) writes: 'With the proper name, the rigid wall of objectness has been breached. That which has a name of its own can no longer be a thing, no longer an everyman's affair. It is incapable of utter absorption into the category for there can be no category for it to belong; it is its own category' (186). True as this may be in most ordinary conditions of social life, this was not the case in the extraordinary circumstance defined by the ICU isolation protocols. Rather, patients exactly experienced becoming thing-like and stripped of a sense of a personal self. One patient illustrated this through reference to a situation where a doctor, rather unusually, asked the patient about his professional occupation and learned that he was a musician. To this, the doctor responded by suggesting that they would bring in the patient's double bass. Ridiculous as this suggestion was, the patient expressed how this instantly returned him to a sense of self: 'It was weird, I remember this doctor suggesting that they would bring in my double bass. Obvi-

ously, that was a ridiculous suggestion, but it made me feel like he saw me as the real person I was. It reminded me of the fact that I had a life outside the ICU and that I was not just this thing with tubes and wires, lying there. I made me want to listen to music again, which I used to enjoy so much and had given up on. This gave me a lot of comfort'.

4.3 Spatial and intercorporeal anonymity

When confined to the isolated rooms at the ICU, patients were deprived of all spatial and social aspects of their personal niche and placed in an anonymous environment. Due to hygienic standards, there were no personal items or anything representing life outside the ICU, such as pictures, that could connect to the patient's personal niche. Rather, the only delimitation of a personal space in the isolated rooms was the specific workstation designated to the patient, i.e., biomedical equipment and machines. In effect, the patient was confined to a room that was spatially anonymous and completely deprived of anything that could scaffold a personal sense of self. This is particularly significant when considering that patients were admitted for up to 90 days in this setting.

This spatial anonymity was accompanied by unprecedented social anonymity. Most obvious was the physical absence of close relatives and intimate others – those who play a significant role in our daily confirmation of a sense of self. However, the social anonymity of the situation was not only related to the absence of familiar others, but also the anonymous presence of health care personnel. Although the patients were never left alone in the isolation room, the presence of the medical staff was made anonymous thorough the all-encompassing use of PPE. The anonymity of the nurses was so pronounced that patients reported not being able to tell the nurses apart visually. Some of the patients even explained how they would shift away from a visual focus to other aspects of their physical presence. One patient described this in the following way: 'I could not tell the nurses apart visually. So, I started trying to identify them in other way, like focussing on their voice. But that did not work either because the mask muffled their voice. Instead, I focused on the way they moved; there was the short and slightly round nurse who walked a bit like a duck, and another nurse who was tall and swift in her movements. This gave the nurses some sort of distinctness'. In effect, there was a manifest shift in emphasis in which aspects of the sensorium of the person that was foregrounded by patients (Køster, 2021). This was taxing and often the PPE would also disguise most modalities of the sensorium. A patient described this struggle in the following way: 'I remembered begging a nurse to show herself without her mask and gown, just for a second, just to get a sense of who she was. She did that briefly while preparing for a lunch break, and it was so nice. However, afterwards there was a change of shifts and I was back with another anonymous nurse. It was so disappointing. At the end, I gave up and did not care'. Hence, the relation between nurses and patients was bidirectionally anonymous: while the patients became anonymous to the nurses through objectification, nurses became anonymous to the patients through lack of sensory differentiation.

This social anonymity had an immense impact on the patient's sense of self: not only were patients separated from all those with whom they normally shared an inter-

corporeal integration but they were also exposed to an overall intercorporeal deprivation in so far as contact with the nurses was predominantly objectifying and mediated through PPE (gloves, gowns, masks). When framing this state as an intercorporeal deprivation, I am not alluding to the more common case of "touch starvation" or difficulties in reading emotions through face masks as a general condition of social distancing during COVID-19 (Carbon, 2020). Rather, it is an exceptional existential phenomenon: When exposed to intercorporeal deprivation, all kinds of fundamental bodily and sensory interactions, such as touch, felt presence, facial mimicking, expressivity and affective attunement are either severely inhibited or distorted for a significant period. Such an experience is by all standards extreme and exceptional. It starts to resemble the detrimental impact found in solitary confinement where both psychosis and an overall sense of disappearing from the world is well-documented (Gallagher, 2014; Guenther, 2013; Harlow et al., 1965). To the patients, this led to feelings of being disconnected from their significant others. Some reported being so distressed that they tried to escape the room during the first period of admission, while others reported gradually sinking into a state of anonymous passivity where they stopped longing for and feeling connected to relatives (Køster, Forthcomming).

4.4 Surrealism: intermingling of objective impressions and dream-like interpretations

Overall, patients characterised their admission to the ICU as a *surreal experience*. This surrealism not only refers to the extraordinary state of being untethered from all that which habitually anchors and organizes the self. Rather, surrealism also refers to the fact that the patient lived in a dream-like state with a pronounced breakdown in the ability to distinguish between dream and reality. A patient noted: 'I simply could not tell what was a dream and what was reality. It was all the same weird surrealistic experience to me'. Specifically, the experiential flow of the patient would manifest as a continuous intermingling of objective impressions and dreamlike interpretations. Examples of this were a patient who suffered from severe dyspnoea (shortness of breath) while having recurring dreams of being caught underwater, constantly struggling to reach the surface; another patient, unable to move for weeks, explained how she had recurring dreams of being attached to a strong magnet that made her unable to move in the slightest; and a patient reported how he experienced the ICU as a nightclub scene where nurses and doctors drugged the patients to keep them passive to continue their party undisturbed. In these cases, the objective somatic state of the patient was filtered through the distorting filter of a dream-like state of consciousness. This kind of reciprocal feedback loop between objective impressions and dreams was also present in patients who would typically be characterized as too sedated to be aware of their surroundings. Importantly, since there was no clear distinction between dream and reality, this was the experiential world of the patient for the majority of the time in the ICU.

That patients undergo delusions in the ICU is not extraordinary, and is referred to as "delirium". Delirium is registered in in approx. 50% of ICU admission and increases with greater severity of illness and with mechanical ventilation (Kotfis et al., 2020; Krewulak et al., 2018). Nevertheless, research indicates a higher preva-

lence of delirium in COVID-patients. There are presumably several somatic factors such as a higher degree of use of mechanical respiration and that COVID-19 targeted the central nervous system in a way that is consistent with an increase in delirium (Matschke et al., 2020; Køster, Forthcomming; Vardan Nersesjan et al., 2021). However, the encompassing state of surrealism described by the patients is also consistent with known effects of social isolation and being separated from of one's personal niche. That such isolation in and of itself can cause a delusional state of mind is, for instance, well documented already in Harry Harlow's (1965) famous studies on primates. However, a more relevant example is solitary confinement where inmates experience both social isolation and being deprived of most of their personal niche. In solitary confinement, inmates commonly report abnormal experiential states such as self-harm and delusional states (Guenther, 2013). Not only that, they also exhibit similar feelings of becoming anonymous. As Smith states in his review of the literature (2006), 'The person subjected to solitary confinement risks losing her self and disappearing into non-existence' (497). That hallucinations, at least to some degree, are related to isolation, is also consistent with recent research showing how states of delirium were reduced significantly when relatives were allowed to enter the isolation rooms (Pun et al., 2021).

Notwithstanding the specific causes of surrealism, patients experienced it as a profound defamiliarization with their thoughts that further exacerbated anonymity and disconnected them from a sense of themselves.

5 Anonymity, facticity and the burden of existence

The experience of being admitted to the ICU during the first wave of COVID-19 constitutes an exceptional case in so far as patients experienced an almost global disconnection from all elements of their personal niche. In fact, it is hard to imagine a more encompassing scenario where a subject is deprived of so many constituents of the personalised environment. The patient becomes defamiliarized with her visceral-kinaesthetic body through passivity, materialization and mechanical expropriation. The isolated rooms are deprived of any personal habituation and all objects in the room exist only according to their utility in a biomedical context. The patient is cut off from physical contact with relatives and all human interaction in the room is bidirectionally anonymous. Moreover, all of this was stretched out over exceedingly long and open admissions. In response to this situation, patients experienced feelings of becoming anonymous. They started relating to themselves as anonymous objects, feeling disconnected from the outside world and being in a state of surrealism.

Importantly, experiences of anonymity not only come in degree; they also differ in kind. The specific type of anonymity experienced by the ICU patients was characterized by the state of becoming a passive object of manipulation and being expropriated to an overarching biomechanical purpose. Patients even reported that whatever agency they could momentarily attain was predominantly directed towards being a pliable patient: that is, towards cooperating by being an easy object of manipulation for treatment with attention directed towards numerical values. In essence, it was anonymity specified as becoming a contextless, solitary and mechanized object.

This differs from other types of experiences of anonymity. An example is the kind of anonymity reported by women undergoing labour. Here the experience is rather one of being absorbed in the rhythms of the natural body in such a way that the I 'is stripped of its personal attributes and swept up in the primacy of the anonymous body' (Trigg, 2021, p. 628). Hence, rather than becoming anonymous through mechanical expropriation, labouring women experience becoming anonymous through being overtaken by the innate natural physical energy of a primordial body. This may be experienced as 'a marvel of the female body', and a 'work of creation' (Kitzinger, 1984, p. 201; Trigg, 2021). In the ICU, there is no such marvel or wonder of the physical body. Rather than being "a work of creation", patients experience becoming "work stations" – pliable, passive object in the mechanical workings of biomedicine. Not surprisingly, a returning issue in the ICU, in general, is transitioning patients back to a basic sense of agency and responsibility for their own life, such as breathing for themselves again (ventilation weaning) or even leaving the ICU (e.g. Chen et al., 2017).

Interestingly, several patients emphasised the experience of becoming anonymous during ICU isolation in a way that tracks with Martin Heidegger (2007) description of the existential confrontation with the "facticity" of existence. To see this, a few basic concepts need to be outlined:

In Heidegger, we are confronted with our existence through basic affective attunement [*Befindlichkeit*] (126) and we always find ourselves through some modality of affective attunement. To illustrate this, Heidegger points to the fact that even in 'the pallid, evenly balanced lack of mood' [*Die fahle Ungestimmtheit*], we do not experience our being as neutral, but we find ourselves feeling a certain *way*. In fact, in this state of lack of differentiation, existence is disclosed in its fundamental character as a "burden" [*Lastcharakter*] (127). We are confronted with what Heidegger calls the 'naked that it is and has to be' of existence (127) and the facticity of being 'delivered over to ourselves' [Faktizität der Überantwortung] (127). Heidegger also refers to this existential structure as "thrownness", stating that human existence begins from the fact that we always already find ourselves as existing and having to project ourselves. It is the sheer, naked fact that 'I exist and have to be'. This is the basis for the prominent role of "care" [*Sorge*] in Heidegger. As existing we are delivered [Überantwortet] to our own existence, having to "care" for ourselves. In everyday life, however, we try to avoid confrontation with the experience of facticity at all costs. The primary mode of doing so is by immersing ourselves in the world and distracting ourselves through worldly engagements (Heidegger, 2007). This is no mean feat since world engagement is a constitutive structural feature of human existence as being in the world. We relate to ourselves and understand ourselves through worldly engagements.

In becoming anonymous by disconnecting from the personal niche, patients were stripped of all everyday structures that usually shield them from confrontation with facticity. In response to this, they reported being in a continuous state of being faced with the naked fact of existence – of simply having to be. There were two reasons for this: First, during isolation, there were no avenues for distraction. Patients reported simply lying there, in an open-ended admission, with no personalised environment or futurity to project towards. The nights were particularly difficult. Some patients

recalled lying awake for 6–7 hours straight with absolutely no means of escape or distraction from their situation. There was no worldly engagement of any sort to disperse to since the patient's world was reduced to a baren clinical environment. Hence, there was no means of turning away from the sheer fact of having to exist. Second, the profound disconnection from the personal niche equally entailed a disconnection from structures of care. Patients recalled experiencing how nothing mattered and how they no longer felt connected to the outside world (Køster, Forthcomming). They reported entering a state of *carelessness* or "acedia". The notion of acedia, in its Christian reception as a state of *listlessness* and not caring about one's position in the world, is, arguably, the historical background for Heidegger's articulation of existence as a burden (Theunissen, 1996)[10]. One patient referred to this experience by describing how he became obsessed with a passage from Bob Dylan's *Murder most foul* stating: 'For the last fifty years they've been searchin' for that freedom, oh freedom, freedom over me, *I hate to tell you, mister, but only dead men are free*. On the significance of this passage to the ICU experience, the patient noted:

> I had this haunting voice in my ear where Dylan told me that I am going to die. Yet, it was said in this context where it was not something bad, but a liberation. It was not a punishment, nor a torment, but a relief. Here we are, fighting with everything we have not to die. And the hospital is the best place to be if you don't want to die. Then suddenly, he tells me, right into my ear, that it is not until you die that you are free. That realization was important to me.

In response to this description, it may be noted that Levinas (1979) famously critiqued Heidegger's framing of naked existence as a burden. To Levinas, there is no experience of a "naked" or "bare fact of existence". The reason is that 'Life's relation with the very conditions of its life, becomes the nourishment and content of that life' (112). To Levinas this means that "enjoyment" is as fundamental to human existence as Heidegger's notion of the burden of "Care" [Sorge], and that the conditions of life cannot be extricated from the enjoyment of that which we "live from" – i.e. 'we live from good soup, air, light, spectacles, work, ideas, sleep etc.' (110) Furthermore, the absence of that which sustains us merely reaffirms enjoyment by implicitly pointing to the relief of regaining it; e.g., being unable to breath is inseparable from the pleasure of regaining breath, hunger is inseparable from the anticipation of enjoying food etc. Similarly, Levinas emphasizes how the things we are surrounded by do not primarily refer to their utility in upholding existence, as Heidegger emphasized, but first

[10] It should be noted, that the confrontation with facticity through anxiety also serves as a principle of individuation in Heidegger; i.e. as an escape from the anonymity of "the they" (Heidegger, 2007§ 40). Hence, the experience of facticity is exactly what draws Dasein out of anonymity. While this I true, it should be noted that when Heidegger speaks of the individuating function of anxiety, it is specifically rooted in an analysis of the dialectics of authenticity and inauthenticity. The kind of anonymity discussed is the anonymity of being absorbed in "the they". Importantly, in being called out of "the They" by anxiety, Dasein is not altogether bereft of a world nor deprived of her personal niche. She is not placed in an enduring confrontation with facticity or naked existence as in the ICU. The experience Heidegger targets is an "existential modification" in her relation towards the pre-structured world she already inhabits (122). In contrast, the confrontation with facticity during ICU isolation is an enduring confrontation with facticity as a fundamental character of being of Dasein [Seinscharacter des Daseins].

and foremost point to enjoyment. Levinas states: 'As material or gear, the objects of everyday use are subordinate to enjoyment – the lighter to the cigarette one smokes, the fork to the food, the cup to the lips' (133).

Right as Levinas is in nuancing Heidegger's disconsolate account of existence as a burden by pointing to the important dynamics of "enjoyment" and "living off", I think the exceptional circumstances of the ICU offer examples of experiences that bypass Levinas' analysis. Being the exceptionally artificial environment that it was, nothing in the ICU pointed to enjoyment. "Living off" is expropriated to machines, leaving the patient in a state of passivity. This is evident across a range of dimensions: Most patients did not breathe for themselves, yet they did not lack oxygen. Patients rarely felt hunger, and since food was often given intravenously, they were deprived of sensory stimuli when given sustenance. When the patients were gradually re-exposed to food and liquids, this was not experienced as a relief, but rather overwhelming. The following passage illustrates this:

> I remember how I got the oxygen mask pressed against my nose and mouth. It was like a violent storm blew into my face. The oxygen dried out my mouth and I imagined that my tongue, the roof of my mouth and my cheeks were made of splinters of glass. They no longer felt like part of my body. Water was supposed to be the only thing that could provide some kind of relief, but it didn't, it hurt to drink too. I could only take in a drop at the time, so I never drank anything. When I eventually started having cravings for orange juice this was excruciatingly painful to drink.

Furthermore, no objects in the isolated rooms afforded any expectation of, or reference to, potential pleasure but solely to their utility in biomedical engineering. In effect, the basic dynamics of Levinas' "living off" were temporally and artificially overwritten, leaving the patients with the experience of simply existing and having to be.

6 Conclusion

In this article, I have presented an analysis of patient's experiences of being admitted to the ICU during the strict isolation protocols implemented in the first wave of COVID-19. I emphasised this as an exceptional case in which patients experienced an almost global disconnection from the personal niche for a significant period. This resulted in pronounced experiences of feeling anonymous. Experiences of anonymity differ in degrees and kind. The kind of anonymity experienced by the patients in the ICU was specified as defamiliarization with visceral-kinaesthetic body through mechanical expropriation and pacification, objectification, pronounced anonymity of the physical environment and lack of intercorporeal contact. This was accompanied by the defamiliarization of the patient's own mind through being in a state of surrealism. Hence, it was a kind of anonymity produced by placing the lived body in a highly artificial environment. Lastly, I argued that this mode of experience confronted the patients with the raw material fact of existence framed by Heidegger as "facticity".

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Declarations

Ethical statement Local hospital approval was obtained before study initiation: Journal-number 20063113. Ethical approval was not needed according to Danish law. All patients provided written informed consent prior to enrollment in the study."

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