Exhausting care: On the collateral realities of caring in the early days of the Covid-19 pandemic

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A R T I C L E   I N F O

A B S T R A C T

We explore care as a site of multiplicity and tension. Working with the qualitative interview accounts of nineteen health care workers in Colombia, we trace a narrative of 'exhausting care' in the early days of the Covid-19 pandemic. Accounts relate exhausting care to working without break in response to extraordinary demand, heightened contagion concern, the pressures of caring in the face of anticipated death, and efforts to carry on caring in the face of constraint. We bring together the work of John Law (2010, 2011) on 'collateral realities' with Lauren Berlant's (2011) thesis of 'cruel optimism' to explore care as a site of practice in which the promise of the good can also become materialised as harm, given structural conditions. Through the reflexive narrative of 'carrying on' in the face of being 'worn down' by care, a narrative which runs through health care worker accounts, we draw attention to the collateral realities of exhausting care as personal and political, at once a practice of endurance and extraction. We argue that the exhausting care that relates to the extraordinariness of the Covid-19 pandemic also resides in the ordinariness, and slower violence, of the everyday. The cruel optimism of care is a relation in which the labour of care reproduces a harmful situation.

1. Introduction

An emergent body of qualitative research accentuates the lived experiences of Covid health care as physically and emotionally demanding, given contagion concerns, competing care demands, resource constraints, the challenges of caring in the face of anticipated death, and working in an atmosphere of crisis and uncertainty (Hoernke et al., 2021; Podgorica et al., 2023; Shah et al., 2022; Smeltzer et al., 2022; James et al., 2023; Sherman and Klinenberg, 2024). A diminishing of agency, sometimes depicted as 'helplessness' and 'powerlessness', features in many such accounts, especially of 'frontline' care, linked to experiences of stress, emotional overload, anxiety, depression, and burnout (Galehdar et al., 2020; Shreffler et al., 2020; Ness et al., 2021; Franklin and Gkiouleka, 2021; Smeltzer et al., 2022; Shah et al., 2022). The following is not untypical:

"Because of the high expectation of health care workers and first responders during the COVID-19 pandemic, high mortality rates of patients, and perceived lack of support, study participants reported stress, anxiety, depression, inability to sleep, and symptoms associated with PTSD [post-traumatic stress disorder], including flashbacks, panic attacks and nightmares. Others reported fatigue and exhaustion." (Smeltzer et al., 2022: 12)

The collateral harms of Covid care in the early phases of the pandemic have thus been largely understood as an internalisation of psychological harm (Shreffler et al., 2020; Sirois and Owens, 2021; Hanna et al., 2021; Billings et al., 2021; Scott et al., 2023). While accounts of embodied stress have emphasised the uneven distribution of workplace 'stressors' (Shah et al., 2022; Arcadi et al., 2021; Shreffler et al., 2020), as well as community and organisational responses experienced as devaluing or stigmatising (Smeltzer et al., 2022), there is a relative lack of research investigating the exhaustions of Covid care as embodied effects of material conditions. Sociological research investigating Covid health care draws attention to agency and care as co-constituted effects of the unfolding entanglements of people,

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materials, practices and environments (Williams Veazey et al., 2021, 2022; Dowrick et al., 2021; Montgomery et al., 2021, 2023; Harrison et al., 2022, 2023; Sherman and Klinenberg, 2024). Montgomery et al. for instance, draw attention to how the affectual flows of Covid care transcend individual experiences as well as time-space and work-home boundaries in a "carry-over of emotional body work" that is located in a "total system of relations" (2023: 13–14). Describing Covid care in the early days of the pandemic as "extraordinary labour" which was "as dangerous as it was demanding" and which "took a physical and psychological toll", Sherman and Klinenberg draw attention to the limits of many accounts of 'burnout' to emphasise how efforts to care were lived as a form of "moral suffering" shaped by structural relations, including by health care systems in crisis (2004: 1). Sociological work thus traces the competing multiplicities, including unforeseen harms, of care as effects of social practices and structures (Mol, 2008; Mol et al., 2010; Moser, 2005; Law, 2010; Lindén and Lydahl, 2021). Human-centred agency, and capacities to care, can be envisaged as always entangled – 'becoming with' – their material situations (Duff, 2016; Buse et al., 2018; Latimer, 2018).

Our focus in this paper is 'exhausting care' as narrated by health care workers in the early phases of the Covid-19 pandemic. We seek to explore how exhausting care is enacted as an altered agency which locates not only to matters of psychological concern but to social and material conditions. Our fieldwork concentrated on Covid hospital care in Colombia, a country hard hit by the pandemic (Prada et al., 2022). Colombian studies have reported high levels of psychological stress, anxiety and fatigue among frontline health care workers (Gonzalez-Delgado et al., 2023; Fernándes-Miranda et al., 2023; Peñaranda et al., 2022; Campo-Arias et al., 2021). Studies have also noted precarity in the organization of 'managed competition' in the health care system, generating financial instability in payment flows to hospitals, insecurity in relation to working conditions, interruptions in equipment supply, and some incapacity to manage emergency care demand (Abadía-Barrero, 2022; Giovanella et al., 2021; Vargas et al., 2016; Lamprea and García, 2016; Camargo Plazas, 2018). Epidemic waves of Covid-19 have coincided with the country's worst economic recession, itself exacerbated by six months of stringent lockdown in 2020, as well as with fiercely debated Government proposals for tax and health care reforms affecting job insecurity and working conditions (Prada et al., 2022; Taylor, 2022). We explore the altered agency of exhausting care as at once personal and political; an effect that resides in the slow and ordinary violence of everyday practices shaped by structural contingencies, and not only in the spectacular moments of crisis (Berlant, 2011; Anderson et al., 2020). Our analysis of exhausting care draws on two intersecting ideas: 'collateral realities' (Law, 2011), and 'cruel optimism' (Berlant, 2011).

1.1. The collateral realities of care

Informed by social studies investigating the social materialities and multiplicities of care (Mol et al., 2010; Law, 2010; Puig de la Bellacasa, 2017; Latimer, 2018; Buse et al., 2018; Lindén and Lydahl, 2021), we treat agency, and care, as capacities of their material situations. This accentuates practices of care as neither singular nor fixed but as malleable and adaptive. Care is a practice of tinkering and negotiation, wherein care is 'made to work' given the limits, potentials and tensions of the unfolding situation (Mol et al., 2010). In this way, care is always a matter of 'becoming' (Duff, 2016; Rhodes et al., 2019). As Mol reminds us, "caring is complex and erratic" (Mol, 2009: 1757); a set of practices that are "not only demanding" but "rarely do what is promised", because instead, "they do more, or less, or something entirely different". Because care is open to multiple interpretation and enactment, practices of care, and constitutions of 'good care', can also become conflicted (Law, 2010; Van Dooren, 2014; Pols, 2015). This accentuates care as potentially harm producing and reducing (Law, 2010), in which practices of care enact "darker sides" (Martin et al., 2015) as well as "destructive"

potentials (Varfolomeeva, 2021).

Our focus then, becomes tracing some of the 'collateral realities' of care in relation to Covid-19, as they are enacted in health care worker narratives, including care that becomes conflictual and sometimes damaging or destructive. John Law imagines collateral realities as those "that get done incidentally and along the way" and that "may be obnoxious" (2011: 156). Law's invitation to trace the collateral realities of care accentuates caring as a practice that can involve negotiating "multiple cares" in tension in "chronically problematic" ways. His case study is the UK's foot and mouth outbreak in 2001, wherein care for the animal, the farmer, the scientist and the public are held "in the air" together in tension yet "without letting them collapse into collision". Here, the art of navigating the collateral realities of care is to prevent collapse, a theme we shall explore below in the context of exhausting Covid care.

The "darker sides" of care thus emphasise that practices of care unavoidably enact a "selective mode of attention", which can value some versions of care over others, as well as exclude or silence the violence that can be produced in the name of care (Martin et al., 2015: 627). Care practices may also constrain what is possible by reproducing rather than transforming the distribution of agency in a given situation (Giraud, 2019). Drawing attention to the collateral realities of care – the harms and sufferings potentiated by different versions of care held in tension as well as absented from attention – accentuates care as an ethico-political concern (Van Dooren, 2014; Puig de la Bellacasa, 2017; Law, 2010). In her exploration of "destructive care", Varfolomeeva (2021) focuses on miners' narratives of their lived experiences of extracting rare ornamental stones in Karelia, Northwestern Russia, as a process of caring which generates an alienation from the bodily harms that such care work requires. In this account, miners are said to "take risks for the sake of productivity, neglect safety rules, and feel emotionally estranged towards their bodies" (2021: 14). Their "self-sacrifice for the sake of the industry", which is promoting of "productivity over self-care", is enabled through miners' "affective entanglements" with the stones, which are highly valued and cared for, and with the work, which requires skill, graft, as well as risk management. In caring for the potentials afforded by their labour, workers are said to "appear distanced from their bodily needs, from their tiredness, or possible harm to their health" (2021: 19). Here then, we see the destructive potentials of care materialised in affective-industry relations.

1.2. The cruel optimism of care

In tracing the collateral realities of care, we also draw on Laurant Berlant's account of 'cruel optimism' (2011). Berlant draws attention to the 'crisis ordinariness' of events enacted as crises, such as epidemics, to accentuate their hinterland and endemicity. In Berlant's analysis of crisis events – like obesity and HIV – there are ongoing and slower processes of attrition embedded in everyday hardships linked to structural conditions. This means that the extraordinariness of crises, with their sudden and heightened care demands, are at once also *ordinary* and *ongoing*, that is, forms of 'slow catastrophe' (Povinelli, 2011), 'slow emergency' (Anderson et al., 2020), and 'ordinary affect' (Stewart, 2007). Importantly, Berlant's thesis of 'cruel optimism' extends beyond the particularities of epidemics and pandemics to the wider crisis ordinariness of unrealised promise linked to the imaginary of living the 'good life' as materialised in late capitalist systems of consumption and extraction:

> "A relation to cruel optimism exists when something you desire is actually an obstacle to your flourishing. […] These kinds of optimistic relation are not inherently cruel. They become cruel only when the object that draws your attachment actively impedes the aim that brought you to it initially." (Berlant, 2011: 1)

Berlant's notion of cruel optimism, like Law's attention to the

collateral realities of care (Law, 2010, 2011), emphasises the messy, multiple and potentially harmful effects linked to the promise, and tensions, of the 'good', in this case efforts to care. Cruel optimism is a relation in which attachments do not produce difference for the better but reproduce the attritional situation. Recent work by Farrugia and colleagues (Farrugia et al., 2024), for example, begin to apply Berlant's ideas of cruel optimism to the field of health care. They trace the cruel optimism of new treatments promising cure from hepatitis C, which in their situations of implementation reproduce inequities in relation to value, worth, and entitlement among those affected. Despite discourses of great promise and possibility, the constraints of entitlement to care and citizenship that are reproduced in the promise of hepatitis C's treatment, and even hopeful elimination, are ordinary and familiar, and reside in an ongoing pattern of marginalisation (Rhodes et al., 2010; Harris and Rhodes, 2018; Seear et al., 2021; Fraser et al., 2022).

In patterns of sustained structural constraint, where there is ongoing unrealised promise of the 'good', and thus an emphasis on surviving rather than thriving, there is what Berlant calls 'slow death' (Berlant, 2007, Berlant, 2011). Slow death is envisaged as a constraining of agency in which the experience of efforts to flourish in the face of perpetual constraint become exhausting; an attritional harm itself; so much so that, over time, these attritional harms become ordinary, uneventful, even unnoticeable (Berlant, 2007). We shift then, from an account of attrition as psychological harm and existential crisis to one that envisages exhaustion as an altering of agency that is embodied in the hinterland of material conditions (Povinelli, 2011; Hitchen, 2016; Anderson et al., 2023; Fraser et al., 2022; Rhodes and Lancaster, 2023). Living in crisis ordinariness does not engender the heroic or sovereign agency that enactments of crisis usually call for, but a 'practical sovereignty' of 'lateral agency'; a "mode of coasting consciousness within the ordinary that helps people survive the stress of their sensorium that comes from the difficulty of reproducing contemporary life" (Berlant, 2011: 18). This is an agency of "getting by"; a "condition of being worn out by the activity of reproducing life":

> "Working life exhausts practical sovereignty, the exercise of the will as one faces the scene of the contingencies of survival. At the same time that one builds a life the pressures of its reproduction can be exhausting." (Berlant, 2011: 116)

Can we think of health care, including in times of crisis, as a form cruel optimism? To do so, invites tracing the collateral realities of care that are materialised in crisis, moving care from its enactments as a promise, a hope, a flourishing, a good, to an object also made contingent and multiple, as well as harmful and potentially cruel. To do so moreover, invites us to locate how enactments of care entangle with the crisis ordinariness of health care work. We therefore consider the 'crisis ordinariness' of exhaustions made visible in the early days of Covid health care in Colombia as sites of struggle in which the political incentive is less to encourage the weary "to get beyond their fatigue" but to "listen more carefully to the voice of the weary" (Wilkinson and Ortega-Alcázar, 2019: 164).

2. Case study methods

Our case draws on the qualitative interview accounts of health care workers engaged in hospital-based Covid care in Colombia in 2020 and 2021. A purposive interview sample was recruited from five hospitals (in Medellín, Bogotá, Cali, Rionegro, and Apartadó) linked to a national cohort investigating the mental health impacts of Covid care among 767 clinical and non-clinical health care workers in the first waves of the pandemic (PAHO, 2022). This national survey was itself linked to a global initiative mapping the distribution of mental health impacts of Covid health care in 26 countries (Mascayano et al., 2022). Whereas this survey work sought to generate standardised quantifiable measures of psychological distress, depression and post-trauma alongside workplace and pandemic stressors, our quaitative study engages sociologically to

situate Covid care and its lived impacts as embodied effects of social and material relations.

Among those in the national survey expressing interest in our qualitative study, we generated a purposive sample based on diversity of expertise across five hospital settings. The sample comprised: general physicians (5); specialized physicians (4); resident physicians (2); headnurses (3); auxiliary nurses (4); and psychologists (1). The majority of participants (10) were involved in 'frontline' care, defined as direct in-person care with people diagnosed with Covid-19, with others involved in general hospital-based care (4), virtual care, both specific to Covid (1) and general (1), and care administration (3). Most (12) participants were women (7 were men), and particpants were relatively evenly spread in relation to age. Our sample, with participant numbers and pseudonyms, are summarised in Fig. 1. The study received ethics approval from the London School of Hygiene and Tropical Medicine Observational Ethics Committee (UK) and the Research Bioethics Committee of the National School of Public Health, University of Antioquia (Colombia).

We undertook 19 interviews, conducted by MPRO, remotely via Zoom, between August 2021 and September 2022. Interviews lasted between 50 and 90 min and adopted a conversational approach. All 19 interviews were transcribed verbatim, translated into English, coded initially for emerging descriptive content, with coding further refined in an iterative process of data coding, charting and interpretation (Charmaz, 2006). Our key areas of conversation, also coded as analytical themes, included accounts of care, stress, risk/harm, pandemic, Covid, power/agency, responsibility, systems/environment, and lessons learnt. Our overarching analytical focus here is how accounts enact agency in relation to care. Our analytical approach is not oriented to representing the accuracy of 'truth claims' but their performance. We are interested in 'enactments' that come into being in interview accounts (Bacchi and Goodwin, 2006). We therefore approach accounts as storied performances (Riessman, 1993; Mattingly, 1994; Law and Singleton, 2000). In the analysis we present below, we first describe how 'exhausting care' is enacted in accounts before then looking at examples of how the exhaustions of care are materialised in practices. This leads us to trace a narrative of 'carrying on' as a reflexive practice of holding out in the situation of exhausting care. In doing so, we note how interviews invite a 'looking back' (Rhodes and Bivol, 2012; Rhodes et al., 2010) in which narratives work as a site in which altered agency is navigated as well as performed. In the analysis which follows, all participant direct quotes are indicated by the use of double-inverted commas.

3. Exhausting care

Care, in its multiple demands and tensions, can become exhausting. As we shall see, being worn down by the collateral realities of care in the early days of the pandemic is an entanglement of the extraordinary and ordinary, emotional and material, as well as personal and political. We will also see how accounts in response to the exhaustions of care emphasise a narrative of *carrying on*.

3.1. No break

In the early phases of the pandemic, hospitals and care units were said to be "bursting at the seams" [14]. On her arrival for work as a senior nurse at the intensive care unit, Laura, for instance, remarks that "the auxiliary team was already worn out". She says that the "whole protocol was exhausting" and there was "no break". Looking back at this time, Maria comments: "We were thinking all day long about care, care, care". And Isabel: "The shifts we've had to do, so long, so tiring". Matías sums up this period: "Stress, fatigue, people are exhausted". There was no let-up: "When you hadn't finished seeing one patient, they were already bringing up the next one, who was dying after 6 hours" [15]. The urgency and intensity of care demand, mixed with contagion concern and working in the face of anticipated death, created an "emotional

#	Pseudonym	Age	Location	Role
1	Jose	50+	Medellín	Physician
2	Juan	38	Medellín	Nursing assistant
3	Daniel	50+	Medellín	Physician
4	Ana	29	Medellín	Physician
5	Sara	30	Medellín	Nursing assistant
6	Eva	35	Rionegro	Nursing assistant
7	Lucía	31	Bogotá	Nursing assistant
8	Isabel	50+	Bogotá	Psychologist
9	Lucas	50+	Apartadó	Physician (ER)
10	Martín	33	Cali	Physician (ICU)
11	Matías	50+	Cali	Physician
12	Alicia	45	Cali	Head nurse (COVID unit)
13	Nicolás	37	Cali	Physician (resident, geriatrics)
14	Susana	27	Cali	Head nurse (ICU paediatrics)
15	Laura	47	Bogotá	Head nurse (COVID ICU)
16	Emma	35	Bogotá	Physician (ER)
17	Elena	30	Bogotá	Physician
18	María	33	Bogotá	Physician
19	Catalina	30	Medellín	Physician (COVID unit)

Fig. 1. Study participants.

burden" that you "can't imagine" [9]. Care was colonising: "You didn't have a social life, you didn't meet anyone, and we hardly had the time and strength to talk" [15]. Accounts fuse together a loss of time-space as a marker of care's attrition (Berlant, 2011; Williams Veazey et al., 2022; Montgomery et al., 2023).

In this crisis situation, exhausting care reproduces its own attritional energy. As remarked by a hospital emergency doctor: "The atmosphere was very tense from the moment you arrived at the hospital, because everyone came with all that emotional baggage from previous shifts" [16]. Care staff "lived with [their] adrenaline pumping, from the moment [they] started" [19]. Exhausting care is *passed on*, extended, from shift to shift, becoming an *ongoing* effect of the crisis situation:

"Shifts are very stressful because, well, the person leaving is very tired and the person arriving has a certain disposition as to what she expects to find. So the person who is leaving, the one who is handing off the shift and wants to go, is already tired and is exhausted from the shift, whether it was 6 or 12 hours. And the new co-worker arrives like, 'Um, this is still pending, that other thing is still pending'. And you're like, 'Man, just look at everything that needs to be done'." [3]

The extraordinary demand was described as at once physical and emotional, and in the early phases of the pandemic "got out of hand". It was "very tough". Exhausting care was described as a suffocation and an entrapment, "like being tied up, like being against a wall", "locked-up" [19]. No break potentiates the risk of *break-down*. As Laura describes:

"I joined a Covid intensive care unit, and well, that was the last straw, I collapsed. I mean, the burden was brutal. [...] I was diagnosed with burn-out syndrome due to work-related stress. [...] I developed a very strong depression, issues with anxiety. 'Quick, run, get on with it, quick, go on', all of the time. Not eating, not sleeping." [15]

3.2. Caring at the end of care

One element of Covid care demand felt to be especially wearing was caring in the face of anticipated death. The frequency and intensity of such care in the early days of the pandemic is presented as extraordinary. Lucas, a general practitioner, described the atmosphere at work in the first waves of epidemic "like everyone was at a funeral"; a "stress" that "was overshadowing our daily life". He talks of the attritional effects of the "darkening of everyone's mood":

"You notice that everyone's spirits are low, and that one week one person is feeling low, the next week another, and the next week another. So that keeps you in a state of worry, of sadness, and that's how you are." [9]

Catalina remarks that caring for the critically ill was "like trying to swim against the tide", with patients "like time bombs, who at any moment would have respiratory failure" [19]. Death was an anticipation of care: "We knew that sooner or later they were all going to end up intubated". Death was omnipresent. Lucas says that: "Every week patients were coming in, and one or two would die"; and that "I'd go to bed at night and think about the patient, dream about doing intubations, dream about doing thousands of things" [9]. There is no easy break from the extending affects of caring in the face of anticipated death. Like Lucas, Catalina comments: "I would get home and I would dream, literally, that I couldn't intubate the patient, that I had lost their airway, and that the patient was dying" [19]. Others talked of the exhausting toll of 'death dreams'. With Covid-19 hitting the workforce hard (Malagón-Rojas et al., 2022), death was also feared as a collateral reality of care:

"Another of our doctors died, a neonatologist died too. Then another one of our doctors died, and a nurse died too. Then, of course, it becomes 'We really are doing to die'" [8].

Other studies have traced the 'cruelties' and 'moral injuries' of caring for those critically ill in the early days of the pandemic, including in light of extraordinary protocol (Driessen et al., 2021; Montgomery et al., 2023; Rodriguez, 2023; Sherman and Klinenberg, 2024). Here, we accentuate the attritional effects of caring in the face of anticipated death as an extinguishing of care itself. Lucas described efforts to carry on caring as an endurance of "working with patients without losing

hope", of "managing to not see a dead patient, but to see potential", of "gritting your teeth" to get through, "knowing that people are dying and there is nothing you can do". He asks of himself "What am I doing?". Despite the urgency, need and sense of duty, he says he "even thought about taking some time off". This situation of attritional agency, of care at the end of care, gives Lucas's reflexive question of "what am I doing?" existential resonance. Here, there is a sense of care, and carers, having lost their course. Care extinguished of generative potential becomes extractive: "It takes it out of you"; "You feel bad saying, 'I can't do anything else'. It hits you emotionally" [19]. The capacity to carry on caring reduces: "My mind and my heart can't take it anymore. I can't watch people dying as if they were nothing" [15]. As Laura remarks of caring at the end of care, "It is a grief marked by death": "We were all overwhelmed. We were all burnt out. We all had problems." [15].

3.3. Contagion concern

Accounts of Covid care in the early days of the pandemic are infused with extraordinary concerns about contagion. Such concerns were described as a "terror and a "purgatory" in their pervasiveness and intensity: "You always had that fear" [18], even a "constant fear of death" [4]. While made ordinary over time through experience and the routinisation of protocols, the collateral contagion risks of caring created tensions in the balancing of care for patients, self and others. Work and home conjoin in accounts of contagion concern (Montgomery et al., 2023), with "bringing it back home" a prime concern of collateral harm: "You had the emotional burden that you could bring a disease into your home that could kill your family" [14]. The yearning to finish long exhausting shifts at work became infused with trepidation about potentiating harm elsewhere and among others: "I've been on shift for 12 h, I want to get home, [but] God, what if I get home and infect them [children]?" [15]. Laura describes this as "something I wouldn't forgive myself for", precisely because *she cares*:

> "And I infected them all, my whole family, with Covid, and that was very difficult. To see me with Covid, and to see my children with Covid. And me being the nurse who cares, who protects. It was very, very hard." [15]

In response, attention to hygiene became intense ("I would get home and undress at the entrance. I washed everything"; "I would stay at the door, in my underwear, and I would go upstairs and bathe my skin with Isodine [Iodine]"). Many avoided the home ("I was terrified about spreading the disease. I didn't even go home"; I stopped seeing my family for a year, only by phone, only on Zoom"). Some avoided work, finding it difficult to carry on caring. As Susana, a head nurse, recounts of the risk collateral felt among her nursing staff: "She was saying 'I can't take it anymore. I'm tired. I'm thinking of quitting. I'd better stay at home. We can't take the risk'" [16]. Enabling care to continue at work, by minimising time at home, created its own conflicts in care relations, for instance, workers feeling "disconnected" from children and family, with some talking of "anxiety attacks" about being "absent" while doing long shifts at work.

With covid infection transmuting across space, family become 'patients', with covid care entangling "the burden of work and the burden of home" [14]. Elena, for instance, is "the only doctor" in the family network. She advises her uncle in his Covid care as best she can. This becomes difficult, linked to "the anxiety of not being able to help him, not being with him, being a doctor and not being able to help him". He "was in the ICU for eight days and that is where he stayed", leaving behind his five year old adopted daughter who "he had fought so hard to have". Her uncle's death was compounded by her mother's illness. She also got Covid. As did her brother. This juggling of covid care across home and work became too much: "I couldn't sleep. I couldn't eat. I had nightmares. I raised my hand at work and said, 'No more, I feel like I can't take it anymore'." [17]

4. The matrialisation of exhausting care

The exhaustions of care are embodied not simply in people but in materials, practices and environments (Law, 2010; Mol et al., 2010). Here, we accentuate how caring practices are materialised in work relations (Varfolomeeva, 2021), in this case, the equipment and infrastructures of health care. We draw specific attention to protective materials and the social organisation of frontline health care responsibilities. These examples accentuate the structural politics of exhausting care.

4.1. Protection materials

Protective clothing materials were described, literally, as a wearing down (See also: Williams Veazey et al., 2022; Montgomery et al., 2023). Care was made physically exhausting by materials: "All those protocols were very exhausting. All those long workdays wearing all those things which you could never take off, it was terrible" [4]. This was an exhaustion at once also emotional: "Stuck here day and night, with a gown, gloves, a mask, visor" that "made you feel anguished, uneasy" [15]. Caring became an endurance: "They got tired of having all the equipment on them. They wanted to eat but couldn't. They needed to pee and would have to take everything off. So they just put up with it" [16]. The wearing effects of heightened contagion concern in the early days of the pandemic are not only incorporated personally – as "emotional burden", "worry", "stress", "anguish" and so on – but in the materials of infection control. The uneven supply of protection equipment was a prime source of tension: "We fought over masks because they only gave us a few" [12]; "You would arrive and find the masks broken and it was a real drama" [12]. In times of "supply failure", workers purchased or created their own material protections. The absence of protection at work, for some, accentuated the labour of care as conflicted, with the care of care workers coming into tension with the interests of caring institutions and the care industry. Laura, for instance, describes situations where the "same gown lasted for a week", where "it had to be stained with blood or secretions before we could change it", and that this was ultimately a question of "money" [15]. Alicia, a head nurse in the peadiatric Covid unit, characterises personal protections as a public "show", with the undoing of supply over time linked to weakening institutional protections for workers: "When there are no supplies, and now that they are no longer available, it's like they tell people that they don't need it anymore" [12].

At the same time, infection control materials and protocols enact a sense of risk surveillance, especially in the early days of pandemic, which were not only felt as "tiring" but as a "judgement", a sense that "everyone is on top of you", "watching what you say, what you do, how you move" [16]. As Emma, an emergency doctor, describes: "Everyone was on edge, so everyone was always looking around to see who was breaking the rules about wearing a mask, or who was not wearing all the bits they should" [16]. Mundane surveillance is here enacted as a cruelty of extraordinary protocol. Emma gives an everyday example. Her colleagues are having breakfast, and they have removed their masks to eat, taking momentarily release from the pressures of having worked their shift. This attempt to make a break from the exhaustions of care results in them being photographed by "people from general services" for contravening safety protocol. The collateral realities of exhausting care reside in materials, human and otherwise.

4.2. Care responsibilities

A second example concerns the materialisation of care's collateral harms in the social relations of care responsibility. Nurses, for instance, describe themselves as a frontline in relation to risk, as "facing-up", even "abandoned" to contagion, in ways that doctors and specialists are not [12]. The difference here is presented as the power to choose, for instance, in the doctor electing not to deliver face-to-face care to patients

in the face of heightened contagion concern: "Nurse, send me a photo, because I'm not going in" [12]. For the nurses concerned, the power to choose not to face up to patients is electing *not to care*, a "stumbling block" to care: "The doctor comes to the door, asks three questions, leaves". Nurses become abandoned to care: "The nurses are left, and that is it". Nurses in Colombia are mostly women and face disproportionate contagion risk (Malagón-Rojas et al., 2022). The contagion concerns of care-giving in these early days of pandemic reproduce a familiarity of power differential. Doing care, being the carer, carries with it the perverse effect of discipline and harm potential, at the same time as a sense of *not being cared for*: "Going in with my mobile phone to record a video for a doctor who earns ten times what I am earning. I am also at risk, and I also have a family, and I have to send him a video so he can write his notes" [12].

The capacity to make a break, to enact interruption from exhausting care, is shaped structurally. There is a voiced hinterland and politics to exhaustion, especially among frontline staff. Nurses providing intensive care would ordinarily be desperate for breaks: "Give us something as simple as a space for having lunch". Breaks in the time-space of care were felt unequally distributed: "There were rest rooms for doctors, but never a rest room for a nurse" [15]. The extraordinariness of pandemic intensifies the ordinary crisis of working conditions. As Laura elaborates:

"Do doctors get more tired than nurses or auxiliaries, or is it that the doctor works more than the nurse, or the therapist, or the auxiliary? No, we work on a par. You are not more important than I am because you are a doctor. [...] I, in the same way, wear myself out and get tired, because I am made of the same material as the doctor, a fragile and vulnerable human being. [...] I'm not saying it wasn't well deserved, but when did the nursing staff ever get a rest room? [...] Yes, an area where you can take everything off, have a glass of water, or have a coffee to get your energy back, and carry on." [15]

Agency and contract-based staff are particularly vulnerable to the uneven structuration of exhausting care. Maria, a paediatrician, emphasises the need to "feel secure in your work". The insecurities of care work intensify when working under extraordinary pressure. She wants to "feel sure that they are not going to fire me". There is a conflict between not abandoning a duty to care and being abandoned that is materialised in the trouble and struggle of making a break from exhausting care:

"We can never rest. If one of us gets ill, if someone can't come in, someone else has to come, and you feel the need to do it because how can you abandon the service? [...] And always thinking [...] if you don't comply, they will kick you out, and you'll be left adrift." [18]

The labour of care, without escape, at its extremes, was presented by some as "nothing more than a type of slavery" [12]. Care is understood here as an extraction, itself in a process of exhaustion. There is a hinterland of vulnerability in the frontline of care work, voiced as "complaints" about "bad conditions", "very poor pay", "cancelled holidays", and being "worked to the bone". Alicia, for instance, entangles her own "uncertain future" with that of Colombia's and being "at the mercy of delinquency, bad jobs, bad salaries, and the corrupt politics we have" [12]. The pandemic is felt as an extension of the ordinariness of inequity, for instance, with health insurance and provider institutions felt to be "getting big bucks" at the cost of "inhumane" treatment. In Alicia's case, she has "worked for two years doing more than 240 hours a month". She says that "you don't even have the right to rest for five days". And if a rest day is taken "they deduct it from [what] we earned". There is a bifurcated reality to caring in the early days of the pandemic between the presentation of health care workers as "heroes" on "social media and on the news" which is "not reflected financially" or in material terms [12]. Care is extracted without care.

5. Carrying on

'Carrying on' is an overarching reflexive narrative in the face being 'worn down'. Carrying on is a practice of holding out in the situation of exhausting care. It is close to what Berlant articulates as a 'latent agency', which focuses on getting-by, which is itself exhausting (Berlant, 2007, 2011).

5.1. Maintaining care

With there being "no break" from the omnipresence of care demand, making a break in time and space becomes a site of trouble and struggle in the maintenance of exhausting care. The 'trouble' is often articulated in mundane terms, perhaps to accentuate its unreasonableness: "And when do you go to the bathroom? Never. It would be 10 hours without going to the toilet, then hours without taking a sip of water" [15]. The 'struggle' at work resides in efforts to "create real active breaks" and "rest spaces", yet in practice, these were often short-lived: "In the ICU we have 15 minutes for lunch" [14]; "We have chosen to eat in the bathroom: close the toilet door, get organized, and have lunch in 10 minutes" [12]; "If you have a cup of coffee, it's on the run" [18]. Here, attempts to create small breaks from care, no matter how fleeting, enable caring to carry on within constraints. As Sara describes, "I stop what I'm doing for a moment, breathe, concentrate, and say, 'Well, I have to do this". The "need to hurry" is handled pragmatically: "fine, let's go out and do it". It means that there is little time-space for emotional release when navigating overloaded care demand: "If you are going to cry, do so for a moment, but then you have to calm down, because crying isn't going to solve anything" [5]; "You have your emotions [...] but you have to keep going" [5]. There are parallels here to the 'destructive care' which results from "emotionally estranged action" which "sacrifices" the self-care and bodies of workers as part of the duty of care in work and industry (Varfolomeeva, 2021: 19). Breaks then, were generally seen as not "real" enough to actualise a *break*: "If you have 12 patients, when are you going to rest, or when are you going to take a break? A *real* break. If there is no one to cover you, you can't" [15].

There is a pressure to carry on in the face of overwhelming care demand: "You just have to keep going" [14]; "You carry on, keep going, to the max" [5]; "We just carried on coping with things" [4]. Carrying on is a constitutive element of care itself, an "ethics" [15] and "responsibility" [17]. Carrying on is also an effect of structural arrangements: "It's just that your colleague hasn't arrived yet, you have to keep going" [14]; "People carried on even when they were unfit for work" [15]. Paradoxically, carrying on is presented in accounts as a *reasoned action* which seeks to side-step an *awareness* of the collateral damage of exhausting care, to enable caring to endure, for as long as possible. As noted above, a key strategy said to enable carrying on were efforts to detach the 'emotional self' from the situation. For Susana, a senior nurse, carrying on "was like smearing Vaseline on your face so that everything slid off". Carrying on required consciously bracketing-off emotion: "My strategy was to keep it all inside, I kept it all in" [5]; "Come on, come on, get on with it, come on, don't think, don't *feel*" [14]. Carrying on is distinct from being carried away:

"You have to learn to manage your emotions. Because if you let yourself be carried away by your emotions, you wouldn't do your job in the best way. People say, 'Oh, doctors are all cold, nurses are cold'. No, you do feel. But you can't let yourself be carried away." [5]

Carrying on presents, to self and others, as if conditions are ordinary and controllable. There is recognition of the 'presentation work' involved here, as said of the risk management of emotions: "I didn't talk to anyone" [4]; "I would lock myself in the bathroom [...] so that my wife wouldn't see me and realise" [9]; "You shouldn't show those things'" [17]. Such was the care demand, as we have seen above, that carrying on encouraged an abandonment to care which, on looking back, felt "dehumanised", wherein people likened themselves to

"things", for instance, "robots" in the reflex response of emergency: "We were no longer treated as human beings, but as things" [17]; "In reality, we were just things, machines" [15]. Care becomes paradoxically 'less-than-human' and 'all-too-human' at the same time (Wilkinson and Ortega-Alcázar, 2019).

In Varfolomeeva's (2021) account of miners' bodies becoming emotionally estranged to harm as they function as machines of industry, work-related illnesses (such as breathing and back problems) are presented as "unavoidable side-effects" of "self-sacrifice" made worthwhile in an affective relation of pride linked to the capacity to carry on as well as produce. In looking back on the early days of caring in the Covid-19 pandemic, the reflexive narrative of 'carrying on' is unsettled as reasoned action of care. Accounts emphasise that a situation of time-crunched care did not allow for themselves to see, reflect on, or resist the harms that were accumulating until the 'crisis' of personal "breakdown". Attritions of the 'crisis ordinary' become unnoticeable (Berlant, 2011). A common remark, for instance, was that it took others – usually friends and family – to make it visible to carers how they had become abandoned to care. In Catalina's case, it was her sister and father who impressed upon her that she "had to see someone" because she "couldn't take anymore". In Laura's case, it was her daughter, who made a call for help on her behalf. She notes that she had "lost about 12 kilos", that she had "developed a very strong depression", that she would "come home crying everyday", but at work, "here at the clinic, I did not realise". She says that "without that call", without her daughter saying "'No, mum you look really bad, let's go to A&E [accident and emergency]'" that she "could have carried on".

5.2. Cruel learning

Carrying on is, therefore, a cruel learning of exhausting care. As Lucas says of his attempts to elide the harms to himself of carrying on: "Ignoring it is the worst thing you could do", because "in reality, that made the situation worse and worse, until there came a time when I ran out of strategies" [9]. We can see the narrative of carrying on as a reflexive moment which negotiates through the bifurcated realities of imagined and materialised care. The narrative of carrying on *realises* what was not said and bracketed-off at the time: "No one was talking about it. We all knew we were overwhelmed. We all knew we were tired. But *no one realised it*" [19]. Looking back is a making 'after' of crisis that reveals the limits of surviving collateral damage at the end of care: "Now I think about it, we didn't used to take care of ourselves at all" [12]. Looking back temporalises, and makes present, the paradox of exhausting care, that "we are the most incoherent professionals" when doing care "for ourselves": "We tell the patient, 'You have to sleep, you have to eat, you have to rest, you have to do things', but we are not capable of doing it ourselves" [15]. One lesson here is to take better care of carers. But even here, accounts tend to emphasise not being able to carry on as a failing of care linked to the incapacity to work:

"Self-care is never promoted. It is always, 'You are here to take care of the patient'. But if I don't care take of myself, I can't care for anyone. I think we have to work a lot on the ethics of care". [8]

Attritional care is extractive in its extremes when it takes *break-down* or *collapse* to realise the collateral damage wrought to human agency. For Elena, the fundamental learning is "you are human": "I realised that yes, you can do it, that you don't have to have a happy face all of the time, or say that you are always fine, but that you also have your downfalls. You are human. You are not made of stone." [17]. At the end of care is a crisis realisation, a cruel learning, that brings, in part through narration, the 'human' back in, that *re-makes* the self, that re-capacitates the self to *care for itself*:

"I think this is going to make us evolve little by little, like little grains of sand, towards a humane practice, not only towards the patient, but also towards ourselves. Recognizing ourselves as vulnerable beings

too, with the power to do good to a patient, but with the capacity to do a lot of harm to ourselves as professionals". [15]

Ana, a doctor, similarly suggests exhausted care as a crisis learning that is cruel but humanising. Reflecting on the break-down in agency among her colleagues, Ana gestures toward learning that extends beyond the care of the exhausted self:

"I saw my intensive care professors—who are the fiercest, roughest, most self-centred, most conceited—defeated. Defeated in front of a PC, looking at a monitor because they didn't know what more to do. Desperate because there wasn't room for even one more Covid patient, and doing what they already knew how to do, but without results. It was like 'I'm tired', 'Tired, bored, I want to leave now'. Like recognizing the humanity that they don't show to anyone, that they can't show to anyone normally, but on those days of exhaustion, there was no other option. It gives us many lessons". [4]

5.3. Cruel optimism

We see then, that caring in the early days of pandemic can embody care as a 'cruel optimism', a care that is not without conflict or attritional harm (Berlant, 2011). For Laura, "Covid did not bring out the best in us" but "brought out the worst". The extraordinariness of pandemic reproduces the crisis ordinary. In Laura's case, "the pain of working in a Covid ward was so great that [she] took the decision not to go back to work in intensive care". The narrative of carrying on realises its end: "I moved away from care"; "I did not want to work in care anymore". Others pondered if they might no longer carry on. Catalina, for instance, says [she] has an "existential crisis". She says "I don't know what to do". She says that "I am very tired. I'm extremely tired. I'm exhausted". She feels "like throwing it all away".

For Laura, the overload of exhausting care was perhaps not even a surprise but an expectation: "At the end of the day, it was all the overload, all the inequity, that ended up affecting my mental health". While one story of many, Laura's narrative can be read as a lesson on the cruel optimism of extracted care:

"I learned that you are not valuable to any institution, that no institution is worth giving your life to. And I say that as a nurse. I loved the institution where I worked during the pandemic. It had been my dream to work with that institution. […] And to realise that we were just another thing. When they didn't need us, they threw us out." [15]

An important question then, is how the personal connects with the political; that is, how the cruel learnings of exhausting care narrated by carers make structural differences. This is at once a question of how the ordinary might be remade. Here, there is some doubt:

"There was no learning. A real, structured, learning should already have made changes in the care system … For me, there was no change at all, absolutely no improvement at all. In any sense. They didn't improve in terms of availability of beds for patient care, there are always patients in the corridors. Having the opportunity to look at that process, and say 'We have to change'. And there was no change. In no way. In no way was there change. The working conditions have not improved. […] It's the same. It's the same story. We carry on the same." [18]

The exhaustions of care reside in the normal. As said of exhaustion: "We have normalised it" as a repeated condition of "no staff", having to "double up shifts", having "to work exhausted", getting "overloaded". Laura remarks that "every year […] there is overload". Crisis and collapse are not unfamiliar: "The emergency services are not like they were during Covid, but they are always collapsing, always". There is familiarity also, as we have seen, in the sense of abandonment to care that is embodied in the everyday materiality of care's labour; from

uncertain access to protection materials, to the uneven opportunity to make a break from care, to the reduced capacity to carry on caring. Alicia says of nursing at the frontline that "we carry on like that":

> "I don't think they [the hospital administration] have learnt anything, because we have been abandoned. […] I really don't know what they have learned. They have never come to see how we work, they never acknowledged that we are there on a daily basis. They have all gone into hiding". [12]

While the crisis of Covid care in the early days of pandemic is also narrated away, in retrospect, as an event of the past that has since been lived through, as something that has become "routine" and even "forgotten", we find that exhausting care is also narrated as an ongoing 'crisis ordinariness'. Care is made exhausting in the repetition and extension of crisis: it is "repeated", it "keeps happening", "we live through it all the same". Indeed, "we carry on like that" [12].

6. Conclusion

Bringing together ideas on 'collateral realities' (Law, 2010, 2011) and 'cruel optimism' (Berlant, 2011), we have explored 'exhausting care' in the early days of the Covid-19 pandemic as a form of altered agency in the materialisation of competing care demand, potentials and harms. The collateral realities which flow from the exhaustions of Covid care, we have suggested, are enacted in a narrative of being 'worn down' while 'carrying on'. Exhausting care is a relation in which the promise of care as a 'good' comes into tension with care as a form of harmful attachment. As we have argued here, while the cruel optimism of exhausting care becomes especially noticeable in situations of extraordinary care demand, such as in the early days and crisis of pandemic, these collateral realities also reside in a hinterland of 'crisis ordinariness' and ongoing constraint.

Lauren Berlant notes how the rhetoric of 'crisis' can "distort something structural and ongoing within ordinariness into something that seems shocking and exceptional" (Berlant, 2011: 7). As the accounts of health care workers in our study emphasise, the exhaustions of care in the early days of the Covid pandemic are not only materialised as spectacular ruptures but reside in the slower temporality of personal and institutional struggles in the face of structural constraints. Exhaustions are here reproduced in the impasse of the everyday (Stewart, 2007; Berlant, 2011); from the uneven distribution of personal protection equipment, to the differential capacities of frontline workers to avoid contagion, to the unequal opportunities to make breaks from the relentless pressures of care demand. A cruel lesson of exhausting care is the *lack of learning* epitomised in the habituated reflex to carry on – to repeat as well extend the 'crisis ordinariness' – without seizing the opportunity for adaptation or fundamental change going forwards.

Crucially, the narrative of 'carrying on' speaks at once of personal endurance and the structuration of care's attritions. Personal accounts of the collateral harms of exhausting care are made political through their narration as a 'carrying on' that is at once personally internalised and situationally habituated. This upscales accounts of exhausting care from a short-lived problem of extraordinary personal crisis to the precarity of care itself as a chronic problem of systems and structures (Law, 2010; Varfolomeeva, 2021; Lancaster and Rhodes, 2023). Accounts emphasised exhausting care as an effect not only of the pandemic situation but of the unrealised promise and destructive potentials of care work systems shaped by inequality and competition. The Colombian case study we have presented here accentuates how the collateral realities of health care that are lived day to day reflect the longer-term and dispersed effects of competition and precarity, in which systems of care and work themselves are in 'crisis', for instance, from a mix of recession, marketisation and structural reform (Abadía-Barrero, 2022; Prada et al., 2022). An immediate lesson here is a need to care well, and better, for carers given the systemic collateral harms they endure (Willis et al., 2021; Williams Veazey et al., 2022; Sherman and Klinenberg, 2024). But

there is a wider question here of how we might 'make good' of a crisis in care (Wright, 2022). Exhausting care, as we have shown, is reproduced in practices of 'carrying on' until break-down. Rather than perpetuating a reflex of crisis and emergency response in care, we need to pause (Wright, 2022), to invite a 'slower' and 'perpetual' care (Williams Veazey et al., 2022; Lancaster and Rhodes, 2023), that helps foster a care for care itself through social and material change (Puig de la Bellacasa, 2017). A care for care does not detract from acting in emergency but it resists reproducing the uneven destructive potentials of care when doing so. For this to become possible, making visible and undoing the crisis ordinariness of care work is critical.

Though extractive, wearing, and ultimately uncaring, exhausting care is a form of agency. Exhaustion, in our account, is not simply a closing-down or loss of agency but "a messy paradoxical state" which incorporates endurance, the capacity to survive, as well as possibility (Wilkinson and Ortega-Alcázar, 2019: 158). It is through accounts of impasse, of survival time, of being 'worn down' while 'carrying on', that the relative agency of exhausting care becomes visible (Berlant, 2011). The narrative of 'carrying on', as we have seen, is a site at once of trouble and struggle. Care felt as a form of risk or entrapment, for instance, tends to alter rather than extinguish the desire to care. Even while the structuration of exhausting care repeats and reproduces the uneven familiar – in everyday work shift practices, to protection materials, to working conditions, to care environments – there is bounded agency in the cruel learnings of exhausting care. We saw this, for instance, in how the materials of care are tinkered with in the effort to create breaks in the time-space of care. We can see this also, in how narratives bearing witness to the harms and constraints of care give shape to alternatives. Even narratives of break-down, which tell stories of the collateral damage of carrying on to the point of personal crisis or system collapse (Law, 2010), redistribute agency as a site of possibility, induced by the crisis situation (Berlant, 2011).

Wilkinson and Ortega-Alcázar suggest that "weary withdrawal may be a way in which to survive", and that "the quiet murmur of the weary should be heard as a political demand in itself" (2019: 164). Berlant (2011) reminds us that the crisis ordinariness habituates a situation in which the power to enact an intentional or heroic break from trouble is itself in trouble, a form of cruel optimism. In narratives of the cruel optimism of exhausting care, and of the paradoxes of 'carrying on' while being 'worn down', there is not only endurance and survival but possibility, an invitation to do care differently, not only in times of pandemic but in ordinary times.

Ethics approval

London School of Hygiene and Tropical Medicine Observational Ethics Committee (UK), and the Research Bioethics Committee of the National School of Public Health, University of Antioquia (Colombia).

CRediT authorship contribution statement

Tim Rhodes: Writing – review & editing, Writing – original draft, Methodology, Formal analysis, Conceptualization. **Maria Paula Ruiz Osorio:** Writing – review & editing, Investigation, Data curation. **Adriana Maldonado Martinez:** Writing – review & editing, Methodology, Investigation, Formal analysis, Data curation. **Alexandra Restrepo Henao:** Writing – review & editing, Investigation, Data curation, Conceptualization. **Kari Lancaster:** Writing – review & editing.

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References

Abadía-Barrero, C.E., 2022. Health in Ruins: the Capitalist Destruction of Medical Care at a Colombian Maternity Hospital. Duke University Press, London.

Anderson, B., Grove, K., Rickards, L., Kearnes, M., 2020. Slow emergencies: temporality and the racialized biopolitics of emergency governance. Prog. Hum. Geogr. 44, 621–639.

Anderson, B., Awal, A., Cockayne, D., Greenhough, B., Linz, J., Mazumdar, A., et al., 2023. Encountering Berlant part two: cruel and other optimisms. Geogr. J. 189, 143–160.

Arcadi, P., Simonetti, V., Ambrosca, R., Cicolini, G., Simeone, S., Pucciarelli, G., Alvaro, R., Vellone, E., Durante, A., 2021. Nursing during the COVID-19 outbreak: a phenomenological study. J. Nurs. Manag. 29, 1111–1117.

Bacchi, C., Goodwin, S., 2006. Poststructural Policy Analysis. Palgrave, New York.

Berlant, L., 2007. Slow death (sovereignty, obesity, lateral agency). Crit. Inq. 33, 754–780.

Berlant, L., 2011. Cruel Optimism. Duke University Press, London.

Billings, J., Ching, B.C.F., Gkofa, V., Greene, T., Bloomfield, M., 2021. Experiences of frontline healthcare workers and their views about support during COVID-19 and previous pandemics: a systematic review and qualitative meta-synthesis. BMC Health Serv. Res. 21, 923.

Buse, C., Martin, D., Nettleton, S., 2018. Conceptualising 'materialities of care': making visible mundane material culture in health and social care contexts. Sociol. Health Illness 40, 243–255.

Camargo Plazas, P., 2018. Understanding the space of nursing practice in Colombia: a critical reflection on the effects of health system reform. Nurs. Inq. 25, e12242.

Campo-Arias, A., Jiménez-Villamizar, M.P., Caballero-Domínguez, C.C., 2021. Healthcare workers' distress and perceived discrimination related to COVID-19 in Colombia. Nurs. Health Sci. 23, 763–767.

Charmaz, C., 2006. Constructing Grounded Theory. Sage, London.

Dowrick, A., Mitchinson, L., Hoernke, K., Mulcahy Symmons, S., Cooper, S., Martin, S., Vanderslott, S., Vera San Juan, N., Vindrola-Padros, C., 2021. Re-ordering connections: UK healthcare workers' experiences of emotion management during the COVID-19 pandemic. Sociol. Health Illness 43, 2156–2177.

Driessen, A., Borgstrom, E., Cohn, S., 2021. Ways of 'being with': caring for dying patients at the height of the COVID-19 pandemic. Anthropol. Action 28, 16–20.

Duff, C., 2016. Atmospheres of recovery: assemblages of health. Environ. Plann.: Econ. Space 48, 58–74.

Farrugia, A., Lenton, E., Seear, K., Kagan, D., valentine, k., Fraser, S., et al., 2024. 'We've got a present for you': hepatitis c elimination, compromised healthcare subjects and treatment as a gift. Soc. Sci. Med. 340, 116416.

Fernández-Miranda, G., Urriago-Rayo, J., Akle, V., Noguera, E., Mejía, N., Amaya, S., Jimenez-Leal, W., 2023. Compassion and decision fatigue among healthcare workers during COVID-19 pandemic in a Colombian sample. PLoS One 18, e0282949.

Franklin, P., Gkiouleka, A., 2021. A scoping review of psychosocial risks to health workers during the Covid-19 pandemic. Int. J. Environ. Res. Publ. Health 18, 2453.

Fraser, S., Moore, D., Farrugia, A., Fomiatti, R., Edwards, M., et al., 2022. Exhausted practical sovereignty and lateral agency: non-uptake of treatment for hepatitis C in the antiviral era. Int. J. Drug Pol. 107, 103771.

Galehdar, N., Toulabi, T., Kamran, A., Heydari, H., 2021. Exploring nurses' perception of taking care of patients with coronavirus disease (COVID-19): a qualitative study. Nursing Open 8, 171–179.

Giovanella, L., Vega, R., Tejerina-Silva, H., et al., 2021. Es la atención primaria de salud integral parte de la respuesta a la pandemia de Covid-19 en Latinoamérica. Trabalho, Educação E Saúde 19, e00310142.

Giraud, E.H., 2019. What Comes after Entanglement? Duke University Press.

Gonzalez Delgado, M., Cortes Gil, J.D., Rodríguez Araujo, D.L., Mira Solves, J.J., Rodriguez Gallo, E.B., Salcedo Monsalve, A., et al., 2023. Acute stress in health workers in Colombia 2017–2021. Int. J. Publ. Health 68, 1606274.

Hanna, A.B., Rapa, E., Dalton, L., Hughes, R., Quamby, L., et al., 2021. Health and social care professionals experiences of providing end of life care during the COVID-19 pandemic: a qualitative study. Palliat. Med. 35, 1249–1257.

Harris, M., Rhodes, T., 2018. Caring and curing: considering the effects of hepatitis C pharmaceuticalisation in relation to non-clinical treatment outcomes. Int. J. Drug Pol. 60, 24–32.

Harrison, M., Rhodes, T., Lancaster, K., 2022. How do care environments shape healthcare? A synthesis of qualitative studies among healthcare workers during the COVID-19 pandemic. BMJ Open 12, e063867.

Harrison, M., Lancaster, K., Rhodes, T., 2023. The fluid hospital: on the making of care environments in COVID-19. Health Place 83, 103107.

Hitchen, E., 2016. Living and feeling the austere. New Form. 87, 102–118.

Hoernke, K., Djellouli, N., Andrews, L., Lewis-Jackson, J., Manby, L., Martin, S., et al., 2021. Frontline healthcare workers' experiences with personal protective equipment during the COVID-19 pandemic in the UK. BMJ Open 11, e046199.

James, M., Mansaray, A., Omega Thige, F., Mafinda, M., Kambale Kasonia, K., Kahehero Paluku, J., et al., 2023. Continuity and rupture in crisis: from ebola to COVID-19 in Sierra Leone and the eastern democratic republic of the Congo. Global Publ. Health 18, 1. https://doi.org/10.1080/17441692.2023.2259959.

Lamprea, E., García, J., 2016. Closing the gap between formal and material health care coverage in Colombia. Health and Human Rights 18, 49–65.

Lancaster, K., Rhodes, T., 2023. Problematising the emergence of outbreak in the governance of global health: making time for slow dis-ease. Crit. Publ. Health. https://doi.org/10.1080/09581596.2023.2232523.

Latimer, J., 2018. Afterword: materialities, care, 'ordinary affects', power and politics. Sociol. Health Illness 40, 379–391.

Law, J., 2010. Care and killing: tensions in veterinary practice. In: Mol, A., Moser, I., Pols, J. (Eds.), Care in Practice, pp. 57–69. Bielefeld: Transcript.

Law, J., 2011. Collateral realities. In: Dominguez Rubio, F., Baert, P. (Eds.), The Politics of Knowledge. Routledge, London, pp. 156–178.

Law, J., Singleton, V., 2000. Performing technology's stories. Sociology 41, 765–775.

Lindén, L., Lydahl, D., 2021. Care in science and technology studies. Nordic J. Sci. Technol. Stud. 9, 3–12.

Malagón-Rojas, J.N., Mercado-Reyes, M., Toloza-Pérez, Y.G., Interinstitutional Support Group, 2022. Seroprevalence of the SARS-CoV-2 antibody in healthcare workers: a multicentre cross-sectional study in 10 Colombian cities. Occup. Environ. Med. 79, 388–395.

Martin, A., Viseu, A., Myers, N., 2015. The politics of care in technoscience. Soc. Stud. Sci. 45, 625–641.

Mattingly, C., 1994. The concept of therapeutic 'emplotment'. Soc. Sci. Med. 38, 811–822.

Mascayano, F., van der Ven, E., Moro, M.F., et al., 2022. The impact of the COVID-19 pandemic on the mental health of healthcare workers: study protocol for the COVID-19 HEalth caRe wOrkErS (HEROES) study. Soc. Psychiatr. Psychiatr. Epidemiol. 57, 633–645.

Mol, A., 2008. The Logic of Care. Routledge, London.

Mol, A., 2009. Living with diabetes: care beyond choice and control. Lancet 373, 1756–1757.

Mol, A., Moser, I., Pols, J., 2010. Care: putting practice into theory. In: Mol, A., Moser, I., Pols, J. (Eds.), Care in Practice. Transcript Verlag.

Montgomery, C.M., Humphreys, S., McCulloch, C., Docherty, A.B., Sturdy, S., Pattison, N., 2021. Critical care work during COVID-19: a qualitative study of staff experiences in the UK. BMJ Open 11, e048124.

Montgomery, C.M., Docherty, A.B., Humphreys, S., McCulloch, C., Pattison, N., Sturdy, S., 2023. Remaking critical care: place, body work and the materialities of care in the COVID intensive care unit. Sociol. Health Illness. https://doi.org/10.1111/1467-9566.13708.

Moser, I., 2005. On becoming disabled and articulating alternatives: the multiple modes of ordering disability and their interferences. Cult. Stud. 19, 667–700.

Ness, M.M., Saylor, J., Di Fusco, L.A., Evans, K., 2021. Healthcare providers' challenges during the coronavirus disease (COVID-19) pandemic: a qualitative approach. Nurs. Health Sci. 23, 389–397.

Pan American Health Organization (PAHO), 2022. The Covid-19 Health Care Workers Study: Regional Report from the Americas. PAHO, Washington.

Peñaranda, A., Moreno-López, S., Peñaranda, D., Pérez-Herrera, L.C., 2022. Effect of the COVID-19 pandemic on the mental health, daily and occupational activities of pediatric otolarngologists in Latin American. Front. Public Health 10, 735073.

Podgorica, N., Rungg, C., Bertini, B., Perkhofer, S., Zenzmaier, C., 2023. End of life care during the COVID-19 pandemic: a qualitative study on the perspectives of nurses and nurse assistants. Nursing Open 10, 3881–3891.

Pols, J., 2015. Towards an empirical ethics in care: relations with technologies in health care. Med. Health Care Philos. 18, 81–90.

Povinelli, E.A., 2011. Economies of Abandonment. Duke University Press, Durham, NC.

Prada, S.I., Gacria-Garcia, M.P., Guzman, J., 2022. COVID-19 response in Colombia: hits and misses. Health Pol. Technol. 11, 1000621.

Puig de la Bellacasa, M., 2017. Matters of Care. University of Minnesota Press, Minneapolis.

Riessman, C., 1993. Narrative Analysis. Sage, London.

Rhodes, T., Bernayss, S., Houmoller, K., 2010. Parents who use drugs: accounting for damage and its limitation. Soc. Sci. Med. 71, 1489–1497.

Rhodes, T., Bivol, S., 2012. "Back then" and "nowadays": social transition narratives in accounts of injecting drug use in an East European setting. Soc. Sci. Med. 74, 425–433.

Rhodes, T., Egede, S., Grenfell, P., Paparini, S., Duff, C., 2019. The social life of HIV care: on the making of 'care beyond the virus'. BioSocieties 14, 321–344.

Rhodes, T., Lancaster, K., 2023. Early warnings and slow deaths: a sociology of outbreak and overdose. Int. J. Drug Pol. 117, 104065.

Rodriquez, J., 2023. Reconfiguring the social organization of work in the intensive care unit: changed relationships and new roles during COVID-19. Soc. Sci. Med. 317, 115600.

Scott, H.R., Stevelink, S.A.M., Garoor, R., et al., 2023. Prevalence of post-traumatic stress disorder and common mental disorders in health-care workers in England during the COVID-19 pandemic. Lancet Psychiatr. 10, 40–49.

Shah, A.H., Becene, I.A., Nguyen, K.T.N., Stuart, J.J., West, M.G., Berrill, J.E.S., et al., 2022. A qualitative analysis of psychosocial stressors and health impacts of the COVD-19 pandemic on frontline healthcare personnel in the United States. SSM – Qual. Res. Health 2, 100130.

Sherman, M., Klinenberg, E., 2024. Beyond burnout: moral suffering among healthcare workers in the first COVID-19 surge. Soc. Sci. Med. 340, 116471.

Shreffler, J., Petrey, J., Huecker, M., 2020. The impact of COVID-19 on healthcare worker wellness: a scoping review. West. J. Emerg. Med. 21, 1058–1066.

Sirois, F.M., Owens, J., 2021. Factors associated with psychological distress in health care workers during an infectious disease outbreak. Front. Psychiatr. 28 (11), 589545.

Smeltzer, S.C., Copel, L.C., Bradley, P.K., Maldonado, L.T., Byrne, C., Durning, J.D., et al., 2022. Vulnerability, loss, and coping experiences of health care workers and first responders during the covid-19 pandemic: a qualitative study. Int. J. Qual. Stud. Health Well-Being 17, 2066254.

Stewart, K., 2007. Ordinary Affects. Duke University Press, Durham, NC.

Taylor, L., 2022. Colombia's truth commission reveals the devastating health impact of half a century of conflict. Br. Med. J. 378, o2023.

Van Dooren, T., 2014. Care, vol. 5. Environmental Humanities, pp. 291–294.

Varfolomeeva, A., 2021. Destructive care: emotional engagements in mining narratives. Nordic J. Sci. Technol. Stud. 9, 13–25.

Vargas, I., Mogollón-Pérez, I.M., De Paepe, P., Ferreira da Silva, M.R., Unger, J.-P., Vázquez, M., 2016. Barriers to healthcare coordination in market-based and decentralized public health systems: a qualitative study in healthcare networks of Colombia and Brazil. Health Pol. Plann. 31, 736–748.

Wilkinson, E., Ortega-Alcázar, I., 2019. The right to be weary? Endurance and exhaustion in austere times. Trans. Inst. Br. Geogr. 44, 155–167.

Williams Veazey, L., Broom, A., Kenny, K., Degeling, C., Hor, S., Broom, J., Wyer, M., Burns, P., Gilbert, G.L., 2021. Entanglements of affect, space, and evidence in pandemic healthcare: an analysis of Australian healthcare workers' experiences of COVID-19. Health Place 72, 102693.

Williams Veazey, L., Broom, A., Kenny, K., Degeling, C., Wyer, M., Hor, S., et al., 2022. Paradoxes of pandemic infection control: proximity, pace and care within and beyond SARS-CoV-2. SSM Qual. Res. Health 2, 100110.

Willis, K., Ezer, P., Lewis, S., Bismark, M., Smallwood, N., 2021. "Covid just amplified the cracks of the system": working as a frontline health worker during the COVID-19 pandemic. Int. J. Environ. Res. Publ. Health 18, 10178.

Wright, F., 2022. Making good of crisis: temporalities of care in UK mental health services. Med. Anthropol. https://doi.org/10.1080/01459740.2021.2018686.