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# Uncertainty, Fear and Action. A Critical Commentary on Patrik Aspers' Book

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**Abstract**

In this critical commentary of Patrik Aspers' book, I consider some of his assumptions that uncertainty is a universal human challenge that can be addressed through systems of mutual adjustments. I argue that a broad approach to risk that acknowledges both its rational knowledge and non-rational elements such as emotion, and combines future orientation with interrogation of the past, provides a way of understanding strategies for managing uncertainty. I consider the ways such an approach can be applied to a real-world case-study, the COVID-19 pandemic.

**Keywords**: Uncertainty; fear; trust; COVID-19 pandemic.

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# 1 Uncertainty in Contemporary Society

## 1.1 Some Underpinning Assumptions

Aspers (2024) argues that main challenge which individuals have to deal with in contemporary society is uncertainty and his analysis is designed to minimize this challenge (p. vii).

Aspers links uncertainty to negative emotions, especially to fear. Citing Bauman, he postulates that uncertainty is a universal human challenge: "Uncertainty in a broad sense is a problem that plagues people, and some call it fear — 'uncertainty under a different name' (Bauman, 2006, pp. 99–101)" (Aspers, 2024, p. 4). Aspers sees uncertainty in terms of predicting and managing the future through the improved use of knowledge: "*Uncertainty* here means that we cannot know the 'future consequences of present actions' [...] Uncertainty is caused by the lack of knowledge" (p. 5, emphasis in the original).

## 1.2 Is Uncertainty a Universal Problem?

While Aspers' focus is on late modern societies, he does make some references to studies from other cultures. He did not refer to Evans-Pritchard's study of the Azande. For the Azande uncertainty is not a problem as they have mechanisms, various forms of divination, for gaining knowledge about the future relevant to the success of their actions. Indeed, this system works so well for the Azande that they could use it to change the future to suit their proposed actions. Before undertaking an action, a Zande would consult an oracle to ensure that the proposed action was not threatened by witchcraft. However, if the divination revealed a negative future the Azande could change this future:

> Azande envisage a future, an individual's future that is to say, dependent on mystical forces. Hence when the oracle paints a black horizon for a man he is glad to have been warned because now that he knows the dispositions of witchcraft, he can get in touch with it and have the future changed to be more favorable to him [...] The future depends on the disposition of mystical forces that can be tackled here and now (Evans-Pritchard, 1937, pp. 161–162).

While such mechanisms for neutralizing uncertainty are not available in contemporary late modern societies, there are psychological mechanisms that perform much the same function. Giddens (1991) has argued that in everyday life individuals use a psychological device, "bracketing out", to disregard uncertainty. The normality of everyday routines means that actions can take place without the need to consider uncertainties, a psychological auto-pilot: "Since anxiety, trust and everyday routines of social interactions are so closely bound up with one another, we can readily understand the ritual of day-to-day life as coping mechanisms" (Giddens, 1991, p. 47). Such disregard of uncertainty is grounded in trust, which Giddens sees as the underpinning of the protective cocoon of everyday life that "filters out potential dangers impinging from the external world" (p. 244).

The use of such mechanisms can be seen in actions such as choosing foods. In their focus group study of how consumers in the UK discussed making food choices, Green, Draper and Dowler (2003) found that participants disregarded the uncertainties and complex evidence and characterized such choices as routine using "common-sense" rule of the thumb devices to routinize the process:

> Rather than being made anxious by the overload of information on food risks, the consumers who participated in these focus groups were adept at creating strategies of confidence in food. Undercutting these rules of thumb was the taken-for-grantedness of food safety, most of the time. As many participants noted, food safety was not something that concerned them in their day-to-day activities of shopping and cooking, and the act of participating in a focus group had sensitized them to issues that would not otherwise have been of interest [...] The "taken-for-grantedness" of food safety was only punctured in temporary ways by information about food risks (Green et al., 2003, p. 51).

### 1.3 Is Uncertainty Always a Problem?

Aspers assumes that uncertainty is essentially problematic and that it is necessary and beneficial to minimize it. As Zinn (2016) has demonstrated when faced with the knowledge that their course of action will lead to undesirable outcomes, individuals exploit or create uncertainty.

Brown and de Graf (2015) considered the situation in which individuals have a terminal prognosis of cancer and therefore a certainty that they were going to die in the foreseeable future. They found that individuals used uncertainty to disrupt this time frame and create hope. While doctors encouraged patients to remain realistic about the future, there was always a degree of uncertainty about the outcome, such as the possibility of new treatments or an unexpected remission. Brown and de Graf observed that patients could use this uncertainty to maintain hope and to imagine and plan for a future, albeit one that was unlikely to happen (2015, p. 222).

### 1.4 Is Uncertainty the Same as Fear?

While uncertainty can act as an impediment to action, fear can both focus attention on a specific threat or danger and act as a stimulus for action. As Zinn (2008) has argued, emotions such as fear are usually considered an inferior basis for action compared to cognitive rationality as they "tend to be viewed as both too personal and too unstable to form the basis for stable social institutions" (p. 7). However, as an emotion, fear can overcome some of the limitations of cognitive rationality, which requires both time, effort and knowledge. Zinn has argued that "the advantage of emotional judgements is their speed, which makes them useful in high risk and overly-complex situations, where cognitive reflections cannot, or can only partly inform decision-making" (*ibidem*, p. 7).

In her study of women's responses to being at-risk of hereditary cancer, Hallowell explored the key role of emotion, especially fear, and how it shaped women's responses to the knowledge that they were at risk of ovarian cancer. BRCA1/2 genetic mutation increase the risk of ovarian cancer from 1 to 5 per cent for the general population to between 28 per cent and 60 per cent and may increase the risk of breast cancer to as high as 80 per cent (Hallowell, 2006, p. 12). Hallowell noted that being at-risk from ovarian cancer had consequences for the lives of the women in her study, as 26 of the 49 women in her study had had prophylactic surgery to remove their ovaries and the remainder had regular screening.

While statistical knowledge was important, it was emotions that focused women's attention on the danger and triggered their response to it. The women in the study had close female relatives, in some cases their mothers, who had already died of cancer. Witnessing their deaths made women conscious of their own vulnerability and their probable future suffering: "As Sally said: 'I don't want to die. I don't want to go through what my mother went through. I couldn't bear it. The illness, the pain, the pain and the agony, for what?' " (Hallowell, 2006, p. 16).

Institutions also use emotions to try and shape and direct action. Public health campaigns are designed to make the public aware of specific dangers and to change collective behavior in order to minimize those dangers. These campaigns often use emotions, to foreground and attract public attention to the specific danger and the associated collective behavioral change needed to mitigate it. This approach has underpinned campaigns such as the UK's regular "don't drink and drive" campaigns (The Telegraph, 2020). In Australia, in July 2021, the federal government was criticized for using scare tactics when it released a COVID-19 awareness advert that showed a young woman in a hospital bed fighting for breath (Wahliquist, 2021).

Institutions not only exploit emotions such as fear to shape individual actions, they also in certain circumstances use it to shape their own decision making and actions when they use the precautionary principle. The precautionary approach does not use evidence from past events to predict the future rather it is based on fear of an (imagined) catastrophic future. As Alaszewski and Burgess (2007) have argued, it is a better safe than sorry approach:

> The precautionary approach focuses on uncertainty rather than risk, and uncertainty is often an openly posed condition rather than the bounded and specific challenge common to the more technical conception of risk. Within the context of radical new technologies, the past is no longer a good or acceptable guide to the future. It also focuses on the less clearly determined aspects of risk, notably the perception rather than its more objectively given dimensions. The emphasis is on the emotional response to challenges, especially fear and anxiety. It is in this respect that the perception of risk from mobile phones or power lines is considered sufficient to invoke a precautionary approach, irrespective of scientific evidence. One critic of precaution describes it as a "law of fear" (Sunstein, 2005) (Alaszewski & Burgess, 2007, p. 356).

The use of the precautionary principle is evident when fateful events are involved. While childbirth is a relatively safe event, the high value attached to the safety of the birthing mother and the baby means that it has become the focus for the application of the precautionary principle. At the start of the pandemic, there was no evidence that COVID-19 infection presented a particular threat to pregnant women and their unborn babies. In high income countries such as the UK, Canada and the US, public health experts included them in a high or at-risk category as a precautionary measure (Alaszewski, 2020; 2023, pp. 37–41). In the UK the Chief Medical Officer Chris Whitty justified this action stating: "Infections and pregnancy are not a good combination in general and that is why we have taken the very precautionary measure, whilst we find out more" (REV, 2020).

In the UK, this use of precautionary principle had some advantages, it did reduce the exposure of pregnant women and their unborn babies to SARS-CoV-2 and as the pandemic developed it became clear that coronavirus infection did increase birth complications (Wei et al., 2021). However, the benefits were somewhat limited as pregnant women continued to work as key workers who were exposed to the virus. Furthermore, there were disadvantages: being categorized as high-risk increased social isolation, reduced social support, and reduced access to services including, for a time, vaccination (Alaszewski, 2023, pp. 37–41).

### 1.5 Is Uncertainty Only a Problem in Relationship to Future Actions?

While trying to predict the future is important, understanding and learning from past misfortunes can be equally important. In the case of the Azande, Evans-Pritchard observed that when

individuals experienced misfortunes, they saw it as a malevolent act: "[A] Zande in misfortune at once considers who is likely to hate him. He is well aware that others take pleasure in his troubles and pain and are displeased at his good fortune" (1937, p. 100). Using divination, a Zande could identify the individual who was to blame for the misfortune and take (usually peaceful) action to rectify the situation.

Douglas (1990) refers to this interrogation of the past as the forensic use of risk. It is evident in contemporary society in various public inquiries into public disasters. In the UK, there have been recent Inquiries into the contaminated blood scandal, the death of 72 adults and children in the Grenfell Tower block and the on-going Inquiry into the COVID-19 pandemic. The aims of these inquiries include:

- Providing compensation or closure for victims and survivors;
- Allocating blame for the disaster;
- Learning lessons (to prevent future disasters) (Alaszewski, 2023, p. 136).

The first two aims are concerned with making amends for past failures. The third is future oriented. Most public and media responses tend to focus on the first two aims and allocation of blame features prominently in media reactions to Inquiry reports (Alaszewski, 2024). The third aim depends on the response of organizations and individuals with the power to implement change. Where there is a political will, Inquiry reports can effect major change in systems. The Bristol Royal Infirmary Inquiry (BRII, 2001), for example, was a public inquiry appointed to investigate the failure to protect babies and young children undergoing cardiac surgery from avoidable harm (Alaszewski, 2024). The Inquiry found that the problems in the unit were well known in the wider health service, but because of a policy of professional self-regulation no action was taken. The Bristol Inquiry provided a rationale and stimulus for the Labour government to implement major changes in the meta-governance of public health. Clinical governance in particular shifted from a traditional emphasis on professional self-regulation to an independent regulatory framework. In his response to the final report, the Secretary of State at the time (Alan Milburn) stressed that it was a critique of the failures of the organization and culture of the NHS and that reforms should create a service in which the "safety for patients always comes first" (Learning from Bristol, 2002, p. ii).

### 1.6 Comment

Aspers (2024) sees risk as a limited response to uncertainty and argues that market like mechanisms of mutual adjustment, combined with making decision for others, provides a more fruitful approach to uncertainty and ambiguity. His critique of a narrow definition and use of risk is valid. However, risk research is not limited to a narrow knowledge-based future orientation, but includes other elements that shape human action, including emotions, trust, blame and learning. In some ways it is difficult to assess whether Aspers' focus provides a more effective way of managing uncertainty as it is not applied to real-world challenges. In the second part of this article, I will consider the case of the COVID-19 pandemic to consider how factoring in wider elements provides insight into the different responses to a real-world situation.

## 2 Managing Risk in the COVID-19 Pandemic

In early 2020, countries round the globe faced the challenge of a new disease of uncertain origins, transmission and impact. High income countries had similar resources to draw on but responded to this challenge in different ways and there were markedly different outcomes. A group of countries mainly on the Western Pacific rim, that were close to the source of the outbreak in China, had relatively low infection and death rates while countries in Europe and the Americas had far higher infection and death rates (see Table 1). In this section, I will consider the choices made and the role which fear and distrust played in these choices. I will focus on decision making in five countries, the UK and US with high infection and mortality rates, and Taiwan, Mongolia and Japan with lower infection and mortality rates. As the Independent Panel appointed by the WHO observed: "The emergence of COVID-19 was characterized by a mix of some early and rapid action, but also by delay, hesitation, and denial, with the net result that an outbreak became an epidemic and an epidemic spread to pandemic proportions" (The Independent Panel, 2021, p. 21).

**Table 1 Cases and Mortality Rates**
(Data from official sources published by John Hopkins University (2023) up to 3 October 2023)

| | Recorded cases | Deaths | Death rate per 100,000 |
|---|---|---|---|
| **High rate countries** | | | |
| US | 103,802,702 | 1,123,836 | 341.11 |
| UK | 24,658,705 | 220,721 | 325.13 |
| **Low rate counters** | | | |
| Taiwan | 9,970,937 | 17,672 | 74.20 |
| Mongolia | 1,007,900 | 2,136 | 65.16 |
| Japan | 33,320,438 | 72,997 | 57.72 |

### 2.1 Knowledge in Early 2020

On 30 December 2019, the head of the Emergency Department in Wuhan Dental Hospital received some test results marked "SARS CORONAVIRUS". She highlighted it in red and passed it to the Chinese messaging site WeChat, which posted it online. This posting was picked up by a local doctor, Li Wenliang, who shared the posting with his university class group, and it rapidly spread. Dr. Marjorie Pollack, deputy editor of ProMed, a program monitoring the internet for information about disease outbreaks, was alerted to this chatter by a contact in Taiwan. Pollack issued an emergency post on the ProMed network asking for more information, and received confirmations. On the basis of this evidence, Pollack issued a warning just before midnight on 31 December 2019, to the ProMed global community — 80,000 doctors, epidemiologists and public — alerting the world to a new infectious disease (McMullen, 2020; Honigsbaum, 2020).

Within a month, many of the key features of the SARS-CoV-2 were evident. It was a highly infectious disease that was passed from person to person causing serious illness and death especially amongst older people and those with preexisting diseases. On 12 January 2020 the genetic sequence of the new virus was published making it clear it was a coronavirus similar to the highly lethal and infectious SARS (Enserink, 2023). It was evident that when there was sustained community transmission there was major pressure on health services. On 23 January

2020, hospitals in Wuhan, China, were being overwhelmed by COVID-19 cases and the Chinese authorities announced lockdown measures to restrict the spread of the virus (Kuo, 2020).

There were important aspects of the disease that were uncertain, i.e. precisely how it was transmitted and how rapidly it spread from person to person, but the key information was available by the start of February. As the Independent Panel appointed by WHO to review responses to the pandemic found in many countries, there was a slow response to the new virus (Editors, 2021). The Panel referred to February 2020 as the lost month, as most countries failed to "appreciate the threat" and adopted a "wait and see" policy (The Independent Panel, 2021, p. 29). However, there were countries such as Taiwan and Mongolia that took a more rapid proactive approach. In the remainder of this section, I will examine why countries adopted different approaches to the new virus.

### 2.2 Adopting a Wait and See Approach

Countries which adopted a wait and see policy used the uncertainty of the new virus as a reason for waiting for more evidence. They downplayed and denied the threat.

#### 2.2.1 *The World Health Organization*

The WHO was slow to acknowledge the dangers of COVID-19 and issue warnings. Despite being alerted by Chinese authority to a new virus in early January and visiting Wuhan on 20–21 January, the WHO did not issue a Public Health Emergency of International Concern warning until 30 January, and only upgraded it to a global pandemic warning on 11 March. The Independent Panel was critical of the WHO delays in issuing warnings and excess caution:

> The Panel's conclusion is that the alert system does not operate with sufficient speed when faced with a fast-moving respiratory pathogen, that the legally binding IHR (International Health Regulations) [...] are a conservative instrument as currently constructed and serve to constrain rather than facilitate rapid action and that the precautionary principle was not applied to the early alert evidence when it should have been (The Independent Panel, 2021, p. 26).

In addition to bureaucratic impediments to fast action, there were two factors which contributed to the slow response:

- *Hierarchy of evidence*
  The WHO is dominated by medically trained public health experts who valued evidence from clinical trials and epidemiology (from past events) and tended not to attach much credence to contemporary accounts, such as journalists' accounts of panic and lockdown. Given the absence of valued evidence, this uncertainty justified delay.

- *Trust in the Chinese*
  The WHO is a multinational agency and China engagement in its work was important especially at the time when another major funder, the US, was threatening to withdraw funding. The WHO therefore sought to work in partnership with Chinese authorities accepting their information. This was problematic at the start of the pandemic as the Chinese authorities initially downplayed the significance of infections in Wuhan. From 1 January to 19 January, the official Communist Party line was that the new disease did not pose a particular danger and was controllable, and this was reflected in Chinese media reporting (Alaszewski, 2023, p. 14).

#### 2.2.2 *Wait and See in the US*

In the US, President Trump initially downplayed the threat of COVID-19. In his State of the Union Address on 4 February 2020, he observed that the US was working with the Chinese government, and that "my administration will take all necessary steps to safeguard our citizens from this threat" (Trump, 2020a). In his press briefing on 26 February, Trump responded to evidence of community transmission in New York and California and to panic on the stock market by stressing the small numbers of confirmed cases and their good outcome (The White House, 2020). On 16 March, Trump accepted the need for lockdown as evidence of community transmission and pressure on hospital beds was emerging (Shuster, 2020). This was the first in repeated cycles of "delay, lockdown, premature reopening", that were characteristic of most of the countries that adopted a wait and see approach.

There were a number of factors in the US's slow response:

- *Politics*
  2020 was an election year and, as a populist politician, Trump was keen to present an optimistic upbeat picture of his own presidency and its impact on the US. A lethal pandemic was a threat to this image. He was willing to endorse conspiracy theories that denied the reality of the pandemic and the effectiveness of public health measures to reduce its impact, such as mask wearing.

- *Hostility to experts*
  Trump was reluctant to accept advice from experts and publicly criticized them. In October 2020, Trump commented: "People are tired of COVID. People are saying: 'Whatever, just leave us alone'. People are tired of hearing Fauci and all these idiots" (Graham, 2020, p. 1).

- *Deflecting the blame*
  Trump sought to deflect the blame for the pandemic onto experts and outsiders. In his White House press briefing on 14 April 2020, he attacked and blamed international experts (the WHO) and the Chinese for allowing COVID-19 to become a pandemic, saying:

  > Today I'm instructing my administration to halt funding of the World Health Organization [...] Everybody knows what's going on there. [...] Had the WHO done its job to get medical experts into China to objectively assess the situation on the ground and to call out China's lack of transparency, the outbreak could have been contained at its source, with very little death [...] (Trump, 2020b, p. 1).

#### 2.2.3 *Wait and See in the UK*

The pattern in the UK was very similar to that in the US. In late February, it was clear that there was community transmission in Northern Italy. In Italy localized lockdowns started on 21 February (Lowen, 2020a) and became national on 9 March (Lowen, 2020b). By mid-March it had become clear that there were community transmissions in the UK, that hospital admissions were rising rapidly, and modelers at Imperial College, London, predicted that 250,000 people would die in the UK. Key UK policy makers met on 13 March to review the government strategy and agreed that if policy was not changed, there would be 4,000 deaths a day and the health

service might collapse. They agreed a new lockdown policy in which everyone except essential workers would stay at home (Cummings, 2021). The lockdown was delayed until 23 March (Calvert & Arbuthnott, 2021, pp. 194–220).

Boris Johnson, the UK Prime Minister, like Donald Trump drew on populist politics and was keen to avoid blame. However, there was no impeding political pressure in the UK as Johnson had just won a general election. In the UK politicians:

- *Claimed to be following the science*
  In contrast to the US, there was a close alignment between ministers and their expert advisers, which was evident in regular joint press conferences. This unity created what Dame Sally Davies described in her evidence to a Parliamentary Inquiry into the pandemic as "group think" which downplayed the threat of COVID-19 framing it as "seasonal flu" (House of Commons, Science and Technology Committee, Health and Social Care Committee, 2020, Q716). This is a contagious but relatively mild infection which is a threat to vulnerable individuals who can be warned to protect themselves, but the rest of the population can be exposed leading to herd immunity. In early March, Jenny Harries, at the time Deputy CMO, justified the decision not to reduce social interactions by closing schools and cancelling sports events, arguing that these measures were not supported by science (BBC, 2020). In the US, Deborah Birx, the White House COVID coordinator, using European data reached exactly the opposite conclusion.

- *Justified delays in taking action*
  Chris Witty, the Chief Medical Office, on 9 March used the term "behavioral fatigue" to delaying lockdown: "If we go too early, people will understandably get fatigued and it will be difficult to sustain this over time" (COVID-19 Public Inquiry, 2024, p. 42). This position was not supported by the wider community of behavioral scientists (*ibidem*, p. 41).

- *Disregarded evidence from other countries*
  Given the evidence of rapid community spread in both Wuhan and parts of Europe, there appeared to be an overconfidence in the UK and a failure to recognize the danger. Helen MacNamara, a senior civil servant in central government, described her response to this overconfidence:

  > But the jovial tone, the view that in implementing containment measures and suspending work and schooling, the Italians were overreacting, and the breezy confidence that we would do better than others, had jarred with me (MacNamara, cited in Weaver, 2023).

- *Failed to learn*
  In 2016, a parliamentary committee investigated the UK's response in 2015 to Ebola (the UK set up a team led by Chris Witty to support the Sierra Leone government). The committee noted: "The biggest lesson that must be learnt from this outbreak of Ebola is that even minor delays in responding cost lives. Rapid reaction is essential for any hope of success in containing an outbreak. Yet delays were evident at every stage of our response [...]" (House of Commons, Science and Technology Committee, 2016, p. 3).

### 2.3 Comment

In the US and UK the initial response to the new coronavirus was delayed. As a result, policy makers lost control of the situation and had to resort to panicked emergency lockdown measures to prevent health services being overwhelmed. Populist politicians were reluctant to introduce unpopular measures and sought to calm fears (Alaszewski, 2023, p. xviii).

### 2.4 A Rapid Precautionary Response

In Taiwan and Mongolia there was a rapid response.

#### 2.4.1 *Rapid response in Taiwan*

On 31 December 2019, Taiwanese officials were alerted to SARS-like disease in Wuhan, China. Officials took immediate action. They boarded all flights from Wuhan and checked passengers for symptoms of respiratory infection, isolating those with symptoms. By 5 January, surveillance was extended to include all passengers who had travelled from Wuhan in the previous 14 days. Anyone with symptoms was tested for 26 viruses including SARS, and was quarantined at home or in hospital. Using the national database, the Taiwanese authorities rapidly developed a sophisticated system that could provide immigration clearance for those travelers who presented minimal risk and keep track of and prevent the spread of the virus (Wang et al., 2020).

This rapid response was based on a number of factors:

- *Learning from Past Errors*
  In 2003 SARS outbreak in Taiwan there had been delays in testing and the virus was allowed to rapidly spread, creating a near panic state (Hseih et al., 2004). The Taiwanese government established a National Health Command Center (Taiwan CDC, 2018). The centre had the legal authority to access data from the National Health Insurance Administration (NHIA) and the immigration agency (Cheng, 2021).

- *Distrust of China*
  Taiwan has close economic links to China but is aware of the existential threat of China and is therefore sensitive to any new danger from its powerful neighbor. It mistrusted initial Chinese reassurances that the new virus did not present a major threat (Armitage & Stein, 2020).

#### 2.4.2 *Rapid response in Mongolia*

Mongolia did not have the sophisticated technologies and database of Taiwan. It was a rather cruder response with both external and internal travel controls plus quarantining described by Erkhembayar et al. (2020) as "extreme precautionary measures". On 6 January the Mongolian government activated its emergency plans, using the 2017 emergency preparedness law to set up the State Emergency Committee. In January, before there were any COVID-19 cases, in Mongolia all education institutions were shut (Erkhembayar et al., 2020).

The rapid response in Mongolia was based both on learning and fear:

- *Learning*
  In Mongolia there are endemic infectious diseases, including the plague. During the Soviet era, Mongolia developed a public health system to rapidly isolate and treat plague

outbreaks. In response to the 2003 SARS epidemic, Mongolia had created and empowered a State Emergency Committee.

- *Fear of health service collapsing*
  Mongolia is a low to middle income country and one of the legacies of the communist era is a universal health service. However, given limited resources, it was feared that this health system would be rapidly overwhelmed if there was community transmission of the virus. Thus, early action was a way of protecting the system.

- *Fear of China*
  Mongolia is a landlocked country with long borders with two powerful neighbors, Russia and China. It has natural resources like coal, copper and uranium and is economically dependent on China, which has taken actions against Mongolia when displeased (Roy, 2020).

### 2.5 Comment

Although Taiwan and Mongolia are different in geopolitical and economic settings, they both have reasons to fear and distrust China. Having learnt from previous epidemics, especially the SARS outbreak, they both adopted a precautionary approach and reacted quickly to evidence of a new disease in China.

### 2.6 Japan: A Special Case

Japan's response to the danger of the new virus was slower and more hesitant than that in Taiwan and Mongolia. In January 2020, despite evidence that individuals infected by the virus had travelled from the Wuhan to Japan, the Japanese government did not impose travel restrictions until the end of the month, indeed it arranged for charter flights to repatriate its citizens from Wuhan (Prime Minister's Office of Japan, 2020). At the end of January, the Prime Minister Shinzo Abe announced that COVID-19 was to be legally categorized as a Designated Infectious Disease and there would be border controls to deny entry to potentially infected travelers (Prime Minister's Office of Japan, 2020). The Japanese approach was not based on legally enforceable rules. There were occasional local lockdowns, but these were voluntary. Prefect governors had the authority to ask citizens to avoid social contacts but could not impose fines for non-compliance (Kodoma et al., 2022). This initial reluctance to take action was linked to the Olympics. Japan was scheduled to host the Summer Olympic in Tokyo in 2020. The government wanted to avoid cancelling or postponing these games and therefore sought to minimize the threat and maintain as much normality as possible.

Given this "soft" approach, how did Japan do so well in the pandemic? There are a number of factors that provide an explanation:

- *An unexpected learning opportunity*
  The Diamond Princess, a cruise ship, sailed from Yokohama on 20 January. A 80-year-old passenger disembarked in Hong Kong on 25 January and tested positive for COVID-19 on 1 February. When the ship returned to Yokohama on 3 February, there were 10 further cases and the ship was then quarantined (Nakazawa et al., 2020). Japanese researchers were able to study the transmission of COVID-19 on the ship (Kakimoto et al., 2020). Researchers also used retrospective contact tracing to examine other Japanese super spreading events and concluded that contact within crowded confined spaces played

an important role in transmission. These data, combined with computer simulations of people breathing, sneezing and coughing (Greenhalgh et al., 2021), highlighted the role which aerosol spray played in the transmission and the importance of air circulation and (well-fitted) masks (Craft, 2020). In early March the national coordinating Expert Group highlighted the "3 Cs" and issued guidance highlighting the importance of avoiding crowded spaces with poor ventilation (Government of Japan, 2020).

- *Pollution and fear*
  The anthropologist Mary Douglas (1966) argued that some cultures are sensitive and fearful of pollution and create boundaries to control it. Such sensitivity is built into Japanese culture and can be traced back over a millennium (Alaszewska & Alaszewski, 2015). It is evident at national level, with a fear of foreigners, at household level, with rituals highlighting thresholds, and at individual level, with protection for the mouth and throat. In 2009, Japanese public health officials and doctors responded to the danger of the swine flu pandemic (H1N1) of 2009 by advocating gargling with disinfectant and wearing masks (Armstrong-Hough, 2015). The Ministry of Health undertook large public health campaigns encouraging the Japanese to *ugai* (gargle) and *masku* (wear protective masks) (*ibidem*, p. 287). Armstrong-Hough noted that while many doctors did not believe there was scientific evidence that gargling was effective, they still practiced gargling and commended it to others. Such sensitivities meant that during the pandemic individual Japanese were both fearful of foreigners and sought to protect themselves by mask wearing and gargling. Yamagata, Teraguchi and Miura (2023) undertook a study of Japanese citizens early in pandemic (February 2020). In early February before there was extensive media coverage of dangers of COVID-19, 68 per cent of respondents in their survey said they were wearing masks and 69 per cent were gargling. In May 2023, the Japanese Government downgraded COVID-19 to a Grade 5 danger, the same as seasonal flu. However, the majority of Japanese continued to wear masks. A survey in May 2023 found that over 70 per cent of respondents wore masks at a hospital, on crowded public transport or when shopping and less than 5 per cent said they never wore a mask (Nippon.com, 2023).

The unique Japanese situation — a relative slow policy response to threat of the new virus with a relative successful outcome — can be explained by the combination of factors: an open and flexible scientific community that identified the importance of aerosol with rapid uptake by policy makers combined with culture, which made individuals sensitive to threats of pollution and willing to minimize such threats by minimizing social contacts and wearing masks.

### 2.7 Comment

As Flinders, Degerman and Johnson have pointed out in their commentary on the pandemic (2024), fear could and did play a positive role in stimulating responses to the pandemic and argued that: "Influential critiques of fear as anti-political, irrational, and borne of ignorance, were contradicted by examples of collective action, effective responses to real and concrete threats, and the central role of scientific information in framing the pandemic as a fearful threat" (p. 1).

## 3 Conclusion

It is not clear that an analysis of the response to the COVID-19 pandemic provides evidence to support Aspers' central thesis that mutual adjustment provides the most effective way of minimizing uncertainty. In the US there was conflict between politicians and their expert advisers, while in the UK there was mutual adjustment, but it made no major difference to the outcomes. The problem in both countries was a failure to be fearful. The imagined future in February 2020 was made to fit the desired inaction. When reality broke through and with it the prospect of blame for a disaster, there was a panicked reaction. In all the countries, key policy makers took decision on behalf of their populations, and sought to communicate the dangers and the actions needed to minimize them. The response of populations was shaped by cultural factors. In Japan, given cultural sensitivities to pollution, it required only minimal signals for major changes in behavior, whereas in countries such as UK and US, distrust of public health messages provided fertile grounds for conspiracy theories and resistance to such measures.

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