

Very, very mild: Covid-19 symptoms and illness classification

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By

Mild

'[A] large portion won't notice that they have it'. 'Another substantial portion will have very, very mild symptoms'. 'A small portion will have a very significant reaction'. So runs UK's Home Officer Deputy Science Advisor Rupert Shute's assessment, in April 2020, of what the 80% of the UK public he says are predicted to get Covid-19 will experience (Ahmed, 2020).^[1] For Shute, Covid-19 will barely, if at all, scratch the surface of most people's subjective experience. His assessment went along with his exhortation that 'we can't hide away' from the virus 'forever, but we can manage the way in which we are exposed'. While Shute's adverbial intensification is distinctive, his characterisation is similar to others close to the UK's governmental apparatus: Patrick Vallance, the UK Government's Chief Scientific Advisor, [stated](#) on 13 March 2020 that 'the vast majority of people get a mild illness'. Shute's phrase 'very, very mild symptoms' has, since, I first read it, been rolling around my head. It is a head still frequently [fuzzy](#) in the seventh week since the start of suspected Covid-19. I have found myself chafing as a patient against the descriptor mild. The adjective can end up both revealing and hiding various logics at a moment in which thousands continue to die every day, world-wide, of a new and brutal disease.

The use of the term mild derives from the original descriptive report from China – which, in February 2020, characterised confirmed cases, describing 80.9% as mild. The mild included non-pneumonia and mild pneumonia (The Novel Coronavirus Pneumonia Emergency Response Epidemiology Team, 2020; see also Wu and McGoogan, 2020). The World Health Organization (WHO) subsequently reported (World Health Organization, 2020b), also in February, that 80% of laboratory confirmed patients had 'mild to moderate disease, which includes non-pneumonia and pneumonia cases' – a category which included both those treated in isolation and in hospital. The report further noted that the median time from onset to clinical recovery for mild cases was approximately two weeks. On 6 March 2020, the WHO stated that 'data to date suggest that 80% of infections are mild or asymptomatic, 15% are severe infection, requiring oxygen and 5% are critical infections, requiring

ventilation' (World Health Organization, 2020a). It is these data, I am guessing, that Shute has interpreted, and which Vallance has in mind when he refers to the 'vast majority' getting a 'mild illness'.

Use of the term mild by actors such as Vallance and Shute achieves several aims. It supports effective health service delivery and triage procedures, which need to maintain the limited number of inpatient (and Intensive Care Unit [ICU]) beds free for those with severe and critical Covid-19, and which therefore require people with less severe symptoms to be reassured that they should be able to deal with the experience at home. (One newspaper columnist who suffered with Covid-19 in the USA sardonically put it, the phrase *mild or moderate* 'reflects the blithe taxonomy of pandemic triage — whatever doesn't kill you must be mild or moderate' (Von Drehle, 2020).) It also combats panic by reassuring what is imagined to be a febrile population about the general mildness of a new illness that will be life-threatening only for a very small proportion. And it establishes a framework in which 'not hiding' from the disease looks a manageable and sensible undertaking for the majority of the population. This establishment of the terms on which the mild is to be thought in relation to Covid-19 pushes a great deal out of view.

Illness experiences

Right now, many of those who have had – or suspect they have had – Covid-19 in mild or moderate form are keen to make visible something rather different. 'I am thankful for my mild to moderate symptoms. I'm not sure I could survive anything worse', writes one columnist (Von Drehle, 2020). Another laments:

Moderate sounds light and easy. Moderate winds are what make walks bracing. A moderate case of the flu is nasty but bearable. A moderate Covid-19 experience ... [would] come close only if you souped it up with nuclear waste and mamba venom. (Moore, 2020)

A third states: 'I have had 14 surgeries. I have had two children. And honestly, my mild case (of COVID-19), I would do any of those over. I can't imagine being any worse than I was' ("I can't imagine being any worse", 2020).

What accounts for the insistence in many of these early illness narratives on making visible the intensity of suffering? And what might we learn from the tussle over metrological adjudications over the mild? While for many mild Covid-19 has been experienced as mild, others have undergone significant suffering. For many, physical symptoms have been awful and have lasted much longer than two weeks (Davis, 2020). But it's also

important to make clear that no matter how mild (or not) an individual's experience of Covid-19 illness is judged to be, many have found it affectively and psychologically intense to manifest symptoms of a new disease without knowing what might unfold in the course of illness. There are no narrative anchors yet in place – and as medical humanities scholarship has demonstrated across many decades, narratives have been central to how many have understood and experienced (Woods, 2011).^[2] There is, therefore, no easy calibration and reassurance available, yet, over whether one's own (or one's carer's) assessment of the severity of a symptom one is experiencing at home is more or less medically appropriate, or commonly accepted as an expected symptom. Many of the symptoms – feeling as though one's lungs are in a vice, severe gastrointestinal discomfort across many days, confusion, extreme and sudden fatigue – are frightening and diminishing. And, even worse, one does not know, at the time, where they might lead: 'mild symptoms' may rapidly worsen after several days. The mild is always potentially or not-yet severe. For many, the present in which the Covid-19 illness experience unfolds is overshadowed by the horror of a potential, imminent, unknown and frightening future. This has made it more difficult to construe the experience undergone as a mild one, even if that imminent, more frightening future did not come to pass in actuality.

Accounts by patients of those who experienced mild Covid-19 without finding it mild also make evident the significant disparity between scientific studies and the everyday, common comparators that people use to understand the experience of illness. Many scientific studies currently describe Covid-19 cases as mild as long as the patient did not develop Acute Respiratory Distress Syndrome (ARDS), or have organ failure, or have an ICU admission (Michelen et al., 2020). Sick people's metrological comparisons, in contrast, tend to come from other life events or everyday phenomena – earlier surgeries they've had, a previous bout of flu, a 'bracing' wind: it is in relation to those that the descriptors mild or moderate have felt, to some, nonsensical when applied to their experience of Covid-19. The clinicians and scientists focusing on Wuhan had, in contrast, understandably, a very different focus. Their attention in January and February 2020 was on cases requiring urgent treatment in hospital. The disease of Covid-19 was construed at that point as manifesting largely as respiratory illness; any Covid-19 cases that did not require intense medical intervention could reasonably be classified as mild.

The mild in one context is, then, not the mild in another. And in the United Kingdom at least, the exemplary mild illness has been, up till now, the common cold ('a mild viral infection' – as one [NHS website](#) defines it). Media reports continue to make an equivalence between mild Covid-19 and the common cold: 'About 80% of people who get Covid-19 experience a mild case – about as serious as a regular cold' (Boseley et

al., 2020). The mild is commonly construed as that which does not significantly impair one's existential equanimity. Indeed, the philosopher and medical humanities scholar Havi Carel, in her monograph on the phenomenology of illness, makes explicit that her use of the term illness 'denote[s] serious and life-altering conditions, rather than mild ones, such as the common cold' (Carel, 2018, p.14). Elsewhere, she writes that 'minor ailments' are those which 'fit within, and hence do not disrupt, one's being in the world' (Carel, 2018, p.59).

That has been overturned with Covid-19 in the United Kingdom – at least for now. For many in the first, non-hospitalized Covid-19 cohort, our usual sense of agency and phenomenological fit with the world *has been* significantly disrupted. Whether on account of the work of the virus; or the affective intensity of experiencing symptoms of a new disease – alone or with informal carers – whilst often cast adrift, in lock down, from structures of NHS care to which many have been accustomed; or an experience of a rocky and long recovery process; or concern over potential longer-term bodily (and potentially neuropsychiatric (Troyer et al., 2020)) effects – many people's experience of, and memories of, Covid-19 illness in the first phase of the pandemic are unlikely to be analogous with those associated with the common cold. 'Mild symptoms', 'mild illness', 'reaction', 'a recovery of 14 days'; these phrases point to an imagined punctual event with a fixed duration and a clear end. As I write, I am in communication with many who have had 'mild'/'moderate' Covid-19 who have been feeling ill for multiple weeks – some feeling largely abandoned, at home, by healthcare services; some wondering if, not when, they will recover from the virus; some gravely concerned that their employers will not recognize they are still ill. For those who feel they have gone through something phenomenologically intense with no tight closure in sight, such phrases can be received a denial or refusal of the duration and affective potency of suffering. The descriptor mild can feel a kind of affront: it needs to be thrown off, challenged. The ongoing physical and psychic work, both of those ill and those caring, needs to be brought to light. Even as, especially as, the potential for survivor guilt is there too. *Your illness was mild: you, unlike many others, survived.*

Ontology of the disease

Mild, then, as it is used by different actors, in different locations, in different contexts, experiences profound shifts in meaning. I am particularly interested in the effects of the slippage between its application to both symptoms and illness (compare Shute's 'symptoms' and Vallance's 'illness', above). Because having mild symptoms does not necessarily equate to having a 'mild illness': the variable, and as yet not fully understood, durational trajectory of Covid-19 – which appears to tip some people around day eight into much more severe illness – is central

in understanding the complex relationship between the ontology of the disease alongside the subjective experience. Consider three scenarios associated with Covid-19: (i) Symptoms that are experienced subjectively as relatively mild can transform, over time, into symptoms – and illness(es) – that are experienced subjectively as severe. (ii) Symptoms that are experienced subjectively as ‘mild’ may hide critical and contemporaneous danger to the human organism. For example, there is growing concern that Covid-19 may be causing strokes in young ‘patients with mild symptoms’ (Hamilton, 2020).^[3] (iii) Coronavirus infection that leads to illness that is currently characterized as ‘mild’ or ‘moderate’ might potentially lead to long(er)-term damage to the body (Healy, 2020). There are also concerns that the virus might precipitate post-infective fatigue syndrome, which would complicate the notion and imagined length of recovery from illness (Wilson, 2020).

People’s differential, and racialized, abilities to access healthcare and other services in relation to Covid-19; other on-going illnesses, or disabilities, or experiences of mental distress; situations of precarity and exclusion – these will also influence how forms of ‘mild’ Covid-19 are lived and experienced. There will also be pressures exerted by employers to return those who have experienced mild Covid-19 to work as quickly as possible – as an example of an ICU nurse in the USA already makes clear (Leckie, 2020). This will play out across a racialized terrain in which people’s bodies and their suffering are both marked by – and will be interpreted through – racist practices that unequally dispose some to greater illness and to less care, both prior to, and in relation to, the Covid-19 pandemic (Bécares and Nazroo, 2020).

The ontology of the disease is unstable, complex, and multiple: ‘The disease arises from a combination of the virus and the person it infects, and the society that person belongs to’ (Yong, 2020). The variability of the mild will likewise emerge both from how virus, immune system, bodily history, and sociocultural forces intertwine in Covid-19 cases, and crucially, how these contributions to how the disease is lived are interpreted and acknowledged. Some are beginning to conceive of Covid-19 as a ‘systemic disease’ (Marini and Gattinoni, 2020)– very different from what was imagined to be, at the start, a predominantly pulmonary illness. Indeed, rather than one ‘illness’, the virus may precipitate many illnesses across multiple organs. It is said to be ‘[acting] like no pathogen humanity has ever seen’ (Wadman et al., 2020), such that Covid-19 has been said to have ‘joined the ranks of other “great imitators” – diseases that can look like almost any condition’ (Pathak, 2020). What if what we currently call the disease Covid-19 does not, in fact, exhaust the pathological capacity of the virus SARS-CoV-2?^[4] Much is currently unknown about biological mechanisms; potential long-term effects, damage, or post-viral sequelae; and whether

damage in various organs results from the direct attack of the virus or the response of the immune system. So much is still unclear about what exactly ‘mild symptoms’ or ‘mild illness’ might mean for the sick person – both at the moment of designation and in relation to the sick person’s unknown future. The emollient connotations of the word mild serve to occlude all of this.

Metrology

The mild will likely continue to be used for multiple Covid-19 purposes – whether adjudicating clinical symptoms, assessing the virus’s impact on the body, determining the need for formal healthcare services, or judging the likely time of return to functional normality, whether inside and outside the labour market. I therefore predict on-going epistemological, ontological and political contestation over the scope and definition of the mild.^[5] Historians’ and interpretive social scientists’ analyses of the ‘mild’ as a classificatory tool reveal instances of dispute and deliberation. When do other actors – as opposed to medical practitioners – come to determine the boundaries of the ill and the well?^[6] How much concern should publics have in relation to particular bodily markers that might indicate health or disease?^[7] When does a broad category of the ‘mild’ break down into more phenomenologically meaningful categories?^[8] Analogous examples are likely to emerge in relation to tussles over the specification and interpretation of mild Covid-19.

Governmentality

The disease of sickle cell anaemia has been lived as ‘the mild’ in Senegal, Duana Fullwiley has argued, both because the ‘construct of mildness’ emerged in relation to geneticists’ ideas about Senegalese people’s biological capacities to ‘weather the worst symptoms of the disease’, and because of patients’ turn to informal care economies in the context of searing austerity and the prioritisation of other public health measures (Fullwiley, 2017). Fullwiley makes visible how the disease was able to be lived as mild through the production of stoic phenomenological realities, which required the enlarging of relations of care. Sickle cell anaemia, an inherited disease, is clearly different from Covid-19, an infectious disease. Nonetheless, Fullwiley’s arguments open up ways of thinking about how ‘mild’ Covid-19 in the UK might be governed through the intertwinement of political, and political-economic, rationalities together with epidemiological and public health logics. For a start, let us observe how mild Covid-19, for many in the UK, has been held in place as mild on account of very significant physical and psychic labour happening outside of formally designated spaces of medical care. While many have been able to weather mild Covid-19 outside of hospital, the significant suffering and labour that has been unfolding in people’s homes, often at some

distance from the support of NHS services, remain, to date, largely invisible (not least because of the focus rightly being on the terrible deaths that are ongoing in hospitals, care homes – and, indeed, in private homes). There are already indications that the access of those with mild/moderate symptoms to formal care will be subtended by racialized logics – as in the case of Kayla Williams, a 36-year old black woman who died at home from Covid-19. She was not admitted to hospital with Covid-19 symptoms since, her husband reported, the paramedic said ‘the hospital won’t take her, she is not a priority’ (Laville, 2020). There is also the potential for the mild to be wrapped in moralizing (and again racializing) discourses and injunctions, whereby those who are seen to have looked after their own health might be expected to experience no more than mild Covid-19. (‘Because he lives a healthy lifestyle and gets plenty of exercise’, one journalist wrote in relation to a white doctor’s recovery from Covid-19, ‘his immune system had no real trouble defeating the virus’ (Blech, 2020).)

Mild is useful in all sorts of ways for classifying and interpreting what particular bodies experience and endure. I can’t help but think that for those determining the UK’s epidemiological and governmental response to Covid-19 in the absence of a vaccine, there must be ballast, if not comfort (whether consciously acknowledged or not), in working with a calculus in which one can continue to tell oneself that four in every five people will experience an illness that is (physiologically, subjectively, durationally) mild – perhaps no worse than a winter cold.^[9] And I also can’t help but wonder about both the broad political and intimate psychosocial consequences that might accrue from substantial numbers of people experiencing what they regard as significant illness and distress at the same time as they, along with the rest of a country’s citizens, are told that those experiences are (very) ‘mild’. We do not know what those effects might be: they aren’t currently visible; they aren’t generally acknowledged; and we have no idea how many or few people might be affected.

The suffering that can attach to ‘mild’ Covid-19 will then be made variably (in)visible. Governmental actors, clinicians, epidemiologists, health service planners, patients, informal carers – and also academic commentators on the pandemic – are likely to become increasingly invested in particular, and divergent, models of the mild. As the pandemic continues, unlikely alliances regarding ‘the mild’ are possible. The use of heterogeneous means of representation (illness narratives, visualizations, figures, the use of social media) will continue. Forms of activism may well bubble up. Cases of mild Covid-19 might well be used in efforts to firm up a stoic nation, recalibrate citizens’ understanding of suffering, and moralize further over the healthy and unhealthy body. Such efforts will occlude the suffering and labour –unequally societally apportioned – of patients and

informal carers, as well as what it might take to live with Covid-19's potential long(er)-term effects. For the UK economy and those who govern it need this pandemic to be largely mild. Many are ill-equipped not simply to address but even to see a situation that might turn out, in multiple ways, to be other than the mild. The appellation 'mild' hypertension was abandoned at one point, because it was thought not to do a good enough job in encouraging citizens to show enough concern for their health (Dumit, 2012, p.235). With the opposite impetus, and in the context of UK's current governmental and political-economic regime, citizens are likely to be encouraged to manifest an appropriately low level of concern in relation to a form of illness that is to be lived as the mild.

Postscript

This essay insists that what is currently termed mild Covid-19 can comprise, and should be recognized as, a significant – and for some – lengthy illness. At the same time I am aware the essay risks being read as a manifestation of productive labour and evidence of a certain kind of functional normality. I have written this in snatches of time as I navigate the aftermath of suspected infection with SARS-CoV-2. I remain uncertain about how possible it is securely to separate writing used to navigate illness from writing that constitutes one form of academic labour. That I have been able to write at all is further evidence of all that enables my own living of the mild – which includes, most prominently, the ongoing labour of the one who has cared for me since the first day I started feeling ill.

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Notes

^[1] These words were reported as spoken by Rupert Shute during a confidential, leaked Home Office conference call on 7 April 2020 (Ahmed, 2020).

^[2] My thanks to Angela Woods for this insight.

^[3] There are also reports of ‘hypoxic pneumonia’. One doctor writes with alarm of how Covid pneumonia patients can arrive at the hospital still able to use their cell phones – i.e. they are interpreted as not being ‘critically’ ill either by themselves or by others – even as their oxygen saturation levels, when tested, seem ‘incompatible with life’ (Levitan, 2020). The symptoms have not alerted either the one experiencing them or those witnessing them to the profound danger of the situation, since Covid-19 is not behaving in ways currently legible to those familiar with other diseases.

^[4] My thanks to Des Fitzgerald for this and other insights, which have

helped shape this essay.

[5] Difficulties over the use of the term mild bubble under the surface in relation to various clinical and scientific phenomena and classifications – including ‘mild stroke’ (Carlsson et al., 2003), mild Traumatic Brain Injury (TBI) (Yamamoto et al., 2018), and the way in which patients with rheumatoid arthritis receive the term mild ambivalently when used by clinicians in an attempt to reassure (Donovan and Blake, 2000).

[6] See Benjamin Zajicek (2014) on ‘mild schizophrenia’ in the Soviet Union.

[7] See Joseph Dumit on how a new classification scheme for hypertension was introduced, since the staging of ‘mild’ hypertension was not seen as eliciting appropriate levels of concern by patients or providers (Dumit, 2012, p.235).

[8] See Geoffrey Bowker and Susan Leigh Star, who take up the work of Julius Roth on the ordering of time in the tuberculosis hospital (Roth, 1976) and quote Roth noticing how after patients have ‘been in hospital for some time, they find that “mild” and “bad” are not very meaningful categories’. ‘Much more detailed matching categories’, Star and Bowker summarize, then develop (Bowker and Star, 2008). Indeed, I have already glimpsed those who are sick developing ‘more detailed matching categories’ for Covid-19.

[9] There is more to be said in relation to how suffering is envisaged and governed in relation to how it is apportioned across a population. How might the planning and response to Covid-19 have looked different in and beyond the UK, for example, if children were one of those groups most likely to experience moderate, severe or critical Covid-19?

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Somatosphere. (accessed May 11, 2020).

Harvard citation

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