

HOW MILD IS ‘MILD’ COVID-19?

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The term ‘mild’ COVID-19 first emerged in China’s original descriptive report of February 2020, which defined ‘mild’ cases as those without pneumonia or with only mild pneumonia (Epidemiology Working Group for NCIP Epidemic Response, Chinese Center for Disease Control and Prevention 2020). Since then, the clinical characteristics, biomarkers and treatment pathways for ‘mild’ COVID-19 have been further elaborated in clinical research, guidelines and international health reports. As of 27 May 2020, the World Health Organization officially defines a case of ‘mild’ COVID-19 as any ‘symptomatic patient meeting the case definition for COVID-19 without evidence of viral pneumonia or hypoxia’ (WHO 2020: 13). This disease classification obscures the lived severity of ‘mild’ COVID-19. Its semantics have been co-opted by nation states in their rushed attempts to craft expedient pandemic responses. States eager to maintain legitimacy against the pathogenic anarchy of COVID-19 have privileged biological definitions of ‘mild’ COVID-19 as an individually manageable disease, thereby un-making ‘mild’ COVID-19 as sickness and removing it from the realm of social concern and governance. The result of this has been the effective social abandonment of many ‘mild’ COVID-19 patients, who are being left to manage their ‘mild’ COVID-19 with minimal health or welfare support.

In the case of ‘mild’ COVID-19, definitions of biomedical disease have been privileged in the socializing process, with clinical and diagnostic characteristics becoming socially accepted symptoms for understanding the condition. As the following section of this paper shows, such disease definitions of ‘mild’ COVID-19 tend to place it at the bottom of a universal hierarchy of severity based primarily on the clinically visible and physical aspects of the experience.

‘Mild’ COVID-19 as disease

Kim et al. (2020) produce a detailed tally of the various physical symptoms experienced by ‘mild’ COVID-19 patients in a South Korean community facility. They come to the conclusion that patients with ‘mild’ COVID-19 primarily suffer from coughing, followed by hyposmia and sputum, and suggest that these symptoms are useful markers of disease stratification (ibid.: 948.e2). Velavan and Meyer (2020) similarly identify key biomarkers predictive of disease severity based on the cumulative clinical data of COVID-19 patients across China. In addition to peripheral oxygen saturation and the presence of concurrent comorbidities (the most common risk

factors), they suggest ‘low lymphocyte count as well as the serum levels of CRP, D-dimers, ferritin, cardiac troponin and IL-6’ as parameters for triage (ibid.: 304).

The image of ‘mild’ COVID-19 that emerges from these articles is a decidedly pathological one, focused on the physical abnormalities that characterize the condition. This disease definition of ‘mild’ COVID-19 privileges not only the physical aspects of ‘mild’ COVID-19, but more narrowly the physical aspects that can be seen and reported by clinicians. Physical signs are reduced to what practitioners glean from patients verbally or through questionnaires, as in the symptom-taking conducted by Kim et al. (2020). Physical markers are also limited to biological measures that can be obtained in laboratory procedures, as in Velavan and Meyer (2020). Most commonly, physical signs are limited to what can be visualized using imaging tools, as in the common use of computerized tomography (CT) scans to confirm the absence of viral pneumonia – a widely-accepted standard for classifying a case as ‘mild’ COVID-19. Disease definitions of ‘mild’ COVID-19, rooted in a biomedical prism of understanding, thus take on the same disadvantages of medicine’s epistemological approach, namely its overwhelming focus on the physical body and its reliance on ‘objective’ instruments for measurement. While this approach undoubtedly allows for quick and uniform treatment, it inadvertently ignores the significant diversity in physiological manifestations of COVID-19, as well as the varied affective and psychological aspects of patients’ conditions and their own subjective accounts of the experience.

By focusing only on clinically observed physical markers, it is easy to think of ‘mild’ COVID-19 as truly mild and manageable since its physical symptoms point to common and seemingly benign signs such as coughing, sputum and the absence of blood inflammation markers or viral pneumonia. ‘Mild’ COVID-19 as a disease is characterized by the absence of clinically worrying markers and the presence of clinically common ones. Disease definitions of ‘mild’ COVID-19 as presented in clinical articles hence firmly implant ‘mild’ COVID-19 at the bottom of a universal hierarchy of severity, rendering it less deserving of concern and attention.

‘Mild’ COVID-19 as illness

While Kim et al. (2020) and Velavan and Meyer (2020) seek to establish ‘mild’ COVID-19 as manageable and benign, this is contradicted by contrasting patient accounts. The anthropologist Callard’s (2020) article ‘Very, very mild: COVID-19 symptoms and illness classification’ effectively illustrates this disconnect by discussing a range of ‘mild COVID-19’ illness experiences. Callard notes that, while physical suffering is experienced and recognized as being mild by many ‘mild’ patients, many others have also reported long-term, debilitating physical symptoms, such as ‘feeling as though one’s lungs are in a vice, severe gastrointestinal discomfort

across many days, confusion, extreme and sudden fatigue' (ibid.: 2). Beyond the physical, Callard emphasizes the emotional distress produced by the spectre of severe COVID-19 and the anxiety surrounding the lack of institutional support. She writes that many 'mild' patients with whom she had been communicating felt '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' (Callard ibid.: 3-4). This intense affective suffering contrasts with the descriptor 'mild' and the relatively benign physical characteristics attached to it by Kim et al. (2020) and Velavan and Meyer (2020). Indeed, Callard notes the seeming insistence with which early 'mild' COVID-19 patients recount their experiences, perhaps as a pushback to the misleading notion of 'mildness' that is foisted upon them by disease classifications. One patient lamented:

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. (Lang 2020: 1)

Physician Paul Garner's (2020) personal account of 'mild' COVID-19 provides us with a more intimate look into this illness experience. He recounts a 'roller coaster of ill health, extreme emotions, and utter exhaustion ... frightening and long', which stretched far beyond the median two-week recovery window for mild cases described by an early WHO report (ibid.: 1). Although he noted that he 'had not had severe disease', his experience reveals markedly different psychological and affective suffering:

I was mortified that I might have infected the staff I had worked with for over 20 years. I imagined their vulnerable relatives dying and never forgiving myself. My mind was a mess. My condition deteriorated. One afternoon I suddenly developed a tachycardia, tightness in the chest, and felt so unwell I thought I was dying. My mind became foggy. I tried to google fulminating myocarditis, but couldn't navigate the screen properly. There was nothing to do. I thought, if this is it so be it. (ibid.: 1)

In a highly visceral way, Garner's (2020) words demonstrate the gulf between chest tightness as experience and chest tightness as biological descriptor. In Garner's experience of tachycardia, intense feelings of chest tightness become intertwined with guilt, fear, disorientation and an overwhelming sense of mortality, of 'dying'. The lived physiological experience cannot be separated from its affective and psychological dimensions, which layer upon each other in the constitution of a severely felt illness. His account of his personal illness therefore makes clear the

subjectively felt severity of ‘mild’ COVID-19 in a way that disease definitions, with their focus on biomedical detachment, mind-body distinctions and objectivity, do not.

Moreover, Garner’s account reveals the deep sense of alienation that he and fellow COVID-19 sufferers felt in having their experiences questioned. He recounts that ‘the least helpful comments were from people who explained to me that I had post viral fatigue. I knew this was wrong’ (ibid.: 2). Garner also spoke to others ‘experiencing weird symptoms, which were often discounted by those around them as anxiety, making them doubt themselves’ (ibid.). Indeed, self-doubt, alterity and isolation are equally felt aspects of the illness, which official disease definitions of mild COVID-19 both create and obscure. In privileging a specific set of common symptoms and median duration, ‘mild’ COVID-19 as disease erases diverse experiences of physical, psychological and affective severity, instead projecting an image of ‘mild’ COVID-19 as truly mild and manageable.

‘Mild’ COVID-19 as a sickness, pushed back to a biological disease

In advanced capitalist societies, as Frankenberg notes, ‘making conflicts social is too threatening. Sickness is therefore pushed back through psychological illness to biological disease’ (Frankenberg 1980: 200). This individualizing process is precisely observed in the reactions to ‘mild’ COVID-19 noted by Callard (2020) and Garner (2020).

Garner (2020: 2) describes how he encountered fellow sufferers of prolonged ‘mild’ COVID-19 whose illness experiences were met with disbelief by family members, employers and physicians:

I joined a Facebook page (COVID-19 Support Group (have it/had it)) full of people with these stories, some from the UK, some from the US. People suffering from the disease, but not believing their symptoms were real; their families thinking the symptoms were anxiety; employers telling people they had to return to work, as the two weeks for the illness was up. And the posts reflect this: ‘I thought I was going crazy for not getting better in their time frame’ ... ‘the doctor said there is zero reason to believe it lasts this long’.

We thus see how normative definitions of ‘mild’ COVID-19 in the UK and US are rooted in biomedical conceptions of COVID-19, which set boundaries to the kinds of symptoms and duration that can legitimately be accepted. Experiences that fall outside this strict category are labelled ‘crazy’ or regarded as manifestations of ‘anxiety’. The use of mental health terminology reveals how the fault is placed squarely in the minds of individual sufferers, pathologizing them rather than socializing with them. ‘Mild’ COVID-19 as sickness therefore appears to map on to

‘mild’ COVID-19 as disease, with the attendant individualizing effect of erasing illness experiences and denying sufferers access to adequate support. Callard’s (2020) account of ‘mild’ patients in the UK corroborates this, many of them finding themselves largely abandoned by healthcare services and left to nurse themselves at home.

In Callard’s (2020) article, the UK healthcare system is described as being faced with insufficient beds, necessitating stringent triage and the sidelining of ‘mild’ cases in favour of the survival of public health. This underlying social conflict, of an unmanageable pandemic characterized by severe public health inadequacies and poor government responses, reflects the ‘perfect’ threatening situation to which Frankenberg (1980: 200) referred – a situation ripe for individualization and the unmaking of ‘mild’ COVID-19 as sickness.

Indeed, Callard (2020) notes how this national exigency explains comments from the UK’s Home Officer Deputy Science Advisor and Chief Scientific Advisor, which stressed the ‘very, very mild symptoms’ faced by most cases. The context of public-health failures and the related desire to minimize their social and political effects necessitated interpreting mild COVID-19 as a ‘very, very mild’ biological disease. The related effect of this is that COVID-19 as a pandemic whole is rendered more palatable, manageable and governable.

At the beginning of this unmaking of ‘mild’ COVID-19 stands China, which first coined the term ‘mild’ in its original February 2020 epidemic report (Epidemiology Working Group for NCIP Epidemic Response, Chinese Center for Disease Control and Prevention, 2020). While this terminology seems to serve purely practical purposes, China’s subsequent reporting standards reveal clear political interests in the shaping of ‘mild’ COVID-19. Xie (2020) reports on this in a news article highlighting the Chinese government’s failure to include ‘mild’ and asymptomatic patients in the official tally of confirmed COVID-19 cases. According to the National Health Commission’s infection guidelines in March, mild and asymptomatic patients were classified as ‘positive cases’. Although ‘positive cases’ were isolated, only confirmed cases were included in the Commission’s official daily reports. This under-reporting reflects the Chinese government’s attempts to erase ‘mild’ COVID-19 from the public consciousness and unmake ‘mild’ COVID-19 as sickness. In many ways, this benefits the current Chinese government, which has faced significant public criticism over COVID-19’s catastrophic proliferation and what is seen as its failure to prevent it.

Therefore, in both Callard’s (2020) spotlight on the UK and Xie’s (2020) article on China, we see how nation states endorse disease classifications of ‘mild’ COVID-19 and accentuate it by attaching a greater sense of ‘mildness’ to it or obscuring the category altogether. According to Hobbes’s (1985) theory of sovereign authority, political legitimacy depends on a government’s

ability to protect the consenting governed from brutish anarchy. Epidemics such as COVID-19 present an extreme anarchy in that pathogens defy easy governance – they are rapidly evolving, elusive, multiple and highly international. The state’s abject inability to order this pathogenic anarchy must therefore be minimized through the unmaking of ‘mild’ COVID-19 as sickness and making COVID-19 a governable disease and an individually manageable illness as its corollary. In this flurried exercise of governance, however, individual experiences of ‘mild’ COVID-19 are swept under the carpet, and the individuals suffering them are denied legitimate care.

Re-making ‘mild’ COVID-19

To resist the marginalizing process by which ‘mild’ COVID-19 is unmade, more illness experiences must be shared so that their diversity is not labelled anecdotal and insignificant but is treated as worthy of medical consideration, as it speaks loudly against the limiting confines of ‘mild’ biological symptoms. While ground-up collections are one way of achieving this, media coverage can also play an important role in focusing public and political attention on more inclusive and embodied configurations of COVID-19 as sickness. Here, medical anthropologists can also play a role in uncovering the variety of illness experiences across localities and the social relations that make or unmake ‘mild’ COVID-19 in oppressive and othering ways. More importantly, by placing a spotlight on the range of psychological and affective experiences, as well as the everyday concerns of ‘mild’ COVID-19 patients, medical anthropologists can aid in the remaking of ‘mild’ COVID-19 as an intense, jolting, perhaps life-changing and often ongoing sickness deserving collective and especially institutional attention.

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