Reflections on being a Covid 19 patient  (version 15.3.20)

I am a Covid 19, swab positive, sixty year old general practitioner in the early cohort of infections in England. My symptom onset was 8th March 2020. These are observations of my own symptoms and of the processes in place to support me and others in the community with Covid 19 infections. It is intended to be a basic factual account with suggestions and no criticism. Indeed I am full of praise for all the services and committed people involved so far.

1 Symptoms recognition

There is a pattern of symptoms for most viruses and as swab confirmation outside hospitals is ending (verbal report Public Health England Health Protection nurse) GPs will have to make a diagnosis on probability of symptoms alone.

For me the symptoms were distinct from other virus infection and immediately raised the possibility of Covid 19.

The first symptom (Day 1 Sunday 8th March) was a soreness in the throat which was noticeably at the back and lower down. The position was unusual and similar to having shouted more loudly to speak at a party, which I had indeed done. Unlike post party shouting it settled then recurred later in the day before resolving inside 24hrs. Others in our family have not mentioned a sore throat as being significant.

The second distinct symptom was a dry upper airways cough which occurred at frequent intervals overnight. Around every half hour or so then settled between. Then sensation was that the sore throat had extended then moved to the trachea. As if it was a lower pharyngitis and had extended to a tracheitis.

Other symptoms were non-specific, but temperature has been a fluctuating and significant feature throughout (all in degree centigrade). Initially 38.4 on Day 2 and then fluctuating around 37 to 37.8 until the present day (Day 7).

Myalgia was noticeable and generalised muscular, but not usually in the joints.

Some features will depend on the individual’s medical history and age for example: Tiredness and lack of energy has been significant for me. Productive cough with white/light brown phlegm is usual for me post virus.

1a Detailed pattern symptom recognition is likely to be crucial for GPs. Collation of evidence on the character of the “diagnostic symptoms” and dissemination of this will help GPs be more confident in labelling and managing patients. Eg is the lower/back throat and upper chest location of symptoms key?

1b Clearer Information on major criteria (eg upper dry cough and fever 37-37.8?) and minor criteria (eg myalgia?) for diagnosis will help the clinical management in the community.

I had spent the week prior in Austria with no significant symptoms and left there 3am Sat 7th March. My room-mate developed very similar symptoms over the same time period and was Covid 19 swab positive.

I was in contact with my wife and family at our adult son’s party from Saturday afternoon to Sunday afternoon before self-isolation Sunday evening. Those who developed symptoms did so around day
3 or 4 after contact with myself. Upper airway dry cough and time to onset after contact was a guide to symptom diagnosis in these people, but they were not swabbed due to the policy change nationally on the 12th March.

**1c Timing between contact and onset of symptoms is a key guide for symptom diagnosis by GPs. Better delineation and dissemination of this information will help GPs**

**2 NHS 111 advice**

The online NHS 111 advice route was readily accessible (Day 2, 9th March) and made it clear only contacts with Covid 19 or those returning from at risk areas would be tested. There appeared to be little information if you were not in these groups. This has changed since and is now clearer with 7 day isolation advice (accessed 14.3.20 NHS 111 coronavirus).

NHS 111 phone advice was protocol led by what appeared to be non-medical advisers as a triage. The second level of triage was nurse led later the same day and introduced a more pragmatic approach, which, for me, led to the third stage next day of arranging the swab.

Advice to other doctors who were in contact with me varied. One was advised to attend work and completed an operating list. Another was advised to self-isolate.

**2a NHS 111 advice is understandably protocol driven and does change its advice rapidly with national policy change. More tailored advice for healthcare workers with access to the next triage level of a clinician for pragmatic advice would help.**

**3 Occupational health advice**

Occupational health access for swab testing was mentioned when I was told about the positive swab result by a consultant microbiologist. I passed this information onto those in contact with me who were medical. The response varied across different trusts. One symptom free medical contact was told to leave immediately and had their room deep cleaned with a review of patients seen. They were not informed of this but heard about it from a secretary.

**3a Occupational health contact could be mentioned by NHS 111 especially for healthcare workers**

**3b Occupational health could be encouraged to request permission to breach confidentiality before taking action on patient records and deep cleaning**

**4 Confidentiality**

The staff and patients at my GP surgery were not informed of my diagnosis in the first week as I had not had any contact with the surgery so I did not pose a risk to them. This planned to limit inappropriate media attention. I was told my own registered GP surgery would not be informed.

Occupational health advised other doctors to avoid telling people about the situation in case it raised undue concern.

**4a Confidentiality is best openly discussed at each contact.**

**4b Confidentiality is likely to lead to underreporting of the number of Covid 19 cases.**
4c A policy on whether to inform the registered GP and asking permission to do so is likely to be needed.

4d Guidance on how to share records and where covid 19 consultations and diagnosis should be recorded is likely to be needed.

4e There is a risk that the patients usual GP is excluded from Covid 19 information as a parallel service has developed

5 Swabbing

The policy on swabbing has now changed nationally but on Day 3 10th March it was notable that the approach varied from swabbing in the car (television reports) to use of an isolation pod (myself and two contacts) to home visits (two contacts).

I attended an isolation pod and observed very good infection control measures. Staff appeared relatively inexperienced and anxious, but this was very understandable. Plans for access and egress were more ad hoc. We attended at short notice, and shared a coned off parking bay with one other car. I probably stayed for longer than needed (40mins) and doors were wedged open so I could leave without contact.

5a Nurse teams may need advice on organisational logistics for swabbing high numbers of patients if this resumes or continues eg the most efficient processing

6) Result

I was contacted with the result on my mobile on Day 5 Thursday 12th March by a consultant microbiologist who was very helpful and provided contact numbers in case of problems. I knew the result was positive as soon as he explained his role and it fitted with what I expected. Relief that I was one of the few who actually knew they had it. Relief that I was half way through. But sadness about my contacts.

The consultant also raised my awareness of the risk of a seventh day respiratory decline and how to access services. I was reminded of the value of the access to expert advice.

6a Disclosure of a positive result by a clinician was particularly helpful to be able to answer questions openly and off protocol

6b Back up contact phone numbers are important to patients

6c Information about respiratory decline and when it might happen should be disseminated to GPs, if it is consistent with evidence

6d A 7 day self-isolation policy should probably include advice to self-isolate for longer if specific warning symptoms still persist and to get further advice if specific symptoms persist after seven days

7) Public Health England
I was contacted within a few hours of the swab result on Day 5 15th March. We had a one and half hour consultation with the Health Protection Nurse looking at contacts and places. There was a follow up call about the policy change next day. By that next day the policy on both swabbing and contact tracing had ended so only one family in the neighbouring county were contact traced. This family were actively helped to get swabs as deemed higher risk to school and hospital (results awaited, assumed positive).

My wife and I phoned all our contacts, noted their symptoms and advised them of the latest NHS policy. Subsequently we contacted them to update on the change of policy and advise on symptoms.

In future I assume there will be no community swab results to trigger involvement by Public Health England and their support or contact advice. Diagnosis will be based on GP advice on symptoms alone.

7a Consideration could be given to contact tracing and advice by the affected individual or family member. This is likely to be low cost and effective as the individual is motivated to help friends and family.

7b Emails were the quickest route to disseminate information to contacts and a suitable advice sheet or online web address for such a “contact advice sheet” would help.

8) Covid 19 Home management service

I was unaware of this service until a triage call by a member of the Home management service on day 6, 13th March. I had spent most of this day dozing or asleep after a night with much less cough. I had felt briefly better, then disappointed about my lethargy symptoms, which was raising concerns in the family. After a confused discussion about confidential access to my summary care records and the realisation I was a GP, with symptoms still, I was put on the list for a GP call by the Home management service the next day. I had noted a livedo reticularis rash on my thighs.

This GP call the next day was a check call, planned to be daily and run centrally for England for all proven Covid 19 cases. The GP was able to answer questions openly and acknowledged the variation in guidance from 7 to 14 days isolation to 5 days symptom free and swab before return to work. At this stage each service call gave different advice and said it would be changing in the next 1-2 days.

8a It would be worthwhile making GPs aware of the Covid 19 Home management service and outlining its role and limitations.

8b The Covid 19 home management service and registered GP may need to be linked to support each other and prevent duplication or omission.

8c The patients usual GP is likely to have more complete records and a better understanding of patients with complex illness. Linking the GP with the home management service is likely to help.

8d Access to advice such as microbiology, Public Health England and the Home Management Service was triggered by a positive swab. In the absence of swabbing other routes to access such services need to be defined including a diagnosis based on symptoms.
9) Self isolation for students

On this 6th day of my own symptoms, my daughter and her boyfriend moved to our house after self-isolating in shared student accommodation. They had symptoms of upper airways cough 4 days after contact with me so we assumed this was Covid 19.

If it was not Covid 19 then the risk was that they would get Covid 19 on top of their other virus and we were at risk of getting their virus on top of our Covid 19. My wife had similar symptoms to them also on 4 days after contact with me. This is an example of decisions being made by families alone based on a symptom diagnosis.

Both the university and other flatmates had been keen for them to leave and return home, but did not take into account risks to the relatives. There was fear and concern expressed about the situation in the shared flat. The university was otherwise supportive and informed. The NHS 111 advisor suggested self-isolation, but said it was their first shared accommodation situation. As a couple they had stayed in the one room together for two days using the toilet in the same corridor, which no one else used. Flatmates had delivered each meal to the bedroom door and old plates had been left in a pile outside the bedroom door. On leaving they disinfected the bathroom, took all their bedding, medicines and tissues then walked, on their own, out to their car. They did not stop on the drive back and had plans to use gloves and clean touchpoints if they stopped for petrol.

Options were to stay in the room, to find other accommodation, to return to our house with Covid 19 or to return to his parents and risk their infection.

9a Families will be making decisions on where to stay or move to based on limited information. Case scenarios could help to guide them.

9b Students advised to return home are a risk for dissemination both in transit and to their family, especially if there are older family members with co-morbidities.

9c Services should consider checking about older relatives with co-morbidities before finalising advice to people with symptoms

10) Self isolation

My wife and I self-isolated from onset of symptoms as we had a high index of suspicion after travel. As a result I did not attend any meeting and could be certain I had not put my GP surgery and patients at increased risk of infection. Self-isolation based on symptoms from the evening of day 1 worked better than swab results as these came back on day 5. Waiting for the swab result delayed informing contacts, which may have put patients seen by three medical members of the family at risk.

10a Diagnosis based on symptoms, self-isolation with patient led contact tracing may reduce spread more than awaiting for a swab result and public health contact tracing if either were available

11) Infection control measures

With two people in the house I was able to use a separate bedroom and bathroom which may have limited the viral load for my wife. The bathroom became a cough room using tissues and
handwashing after each episode. Tissues were flushed away or put into plastic bags for double bag disposal later.

Cleaning wipes were used for surfaces, door handles, light switches. We cleaned glass milk bottles for collection and tops of dustbins. However this was limited by symptoms and energy levels when we were unwell.

Mobile phones were used and exchanged often, but we initially omitted to clean these or the fridge and microwaves handles.

Many neighbours offered help with shopping and the temptation was to talk to them through open windows. Talking on mobile phoned across closed windows appeared less risk of transmission and equally as good.

There was debate about washing up. If a dishwasher machine was enough. If the affected person washed their own cutlery with soap and hot water first.

With four people in the house it became harder to live separately and the focus moved to the interface between the house and those visiting to assist shopping, milk, rubbish or dog care.

11a A “cough into tissue then wash hands each time” routine appeared best

11b Talking to outside house visitors on a mobile phone and through closed windows appeared best. If no mobile number then from a window furthest away vertically and horizontally.

11c It is easy to forget cleaning of mobile phones (Mouse and keyboard) fridge and microwave door handles.

11d Practical advice on cleaning helps and could cover questions like, who does what (symptomatic or asymptomatic) and how to handle cutlery, plates etc

12) Contacts and Spread

I identified 4 close contacts I had travelled with and three had self-isolated already. Two had no symptoms, one had non-specific symptoms and one had very similar symptoms with full family swabbing.

I was asked to identify face to face talking contacts and contacts within 2metres for more than 15mins at the party. This led to twenty names.

Out of this group my daughter and her boyfriend had similar symptoms on day 3-4 post contact.

My siblings along with families had no symptoms. My other daughter and son had no symptoms. Three family friends had different upper airways cold symptoms the day after contact that were assumed not to be Covid 19, but they self-isolated

Overall I and my roommate, had Covid 19 symptoms starting on the same day. We may have met a common source given the timing. My roommate is likely to have passed Covid 19 to his wife. I am likely to have passed it to my wife, daughter, and her boyfriend.

12a Out of two likely Covid 19 sources of infection entering the country. Four subsequent infections were recognised to have occurred. Both included spouses sharing the same household. Two were a close relative. Twenty people self-isolated overall.
13 Coconing

I have concerns about those people I believe are at risk in the local community. At this stage the stated plan is to self-isolate those with infection. As the numbers increase an emphasis on isolation of those with health risks and older age is likely to be needed. Coconing has been one term used for this.

As a working example, for local counsellors over age 65yrs, my advice has included pre-screening their clients for symptoms and contacts as well as moving to phone / skype consultations. For those not working and over 75yrs it is at what point they cocoon and how long for.

13a Guidance on how to advise older at risk individuals with chronic health problems would be valuable

14 Self-monitoring

For those isolated at home it is a challenge for the services and, in future, GPs to assess them. Useful self-monitoring information includes temperature and oxygen saturation. Blood pressure is also a guide to severity. These objective measures guide on persistence of infection or deterioration.

As a GP my biggest concern about older people on their own is the ability to self-care and adequate hydration. No services I was in contact with mentioned hydration.

14a Guidance on patient self-purchase of equipment such as thermometer, oxygen saturation monitor and blood pressure will assist clinical supervision. An equivalent home monitoring pack could be considered for distribution if needed.

14b A plan on how to provide social care to older symptomatic people who are not managing on their own is required. Failure to self-care is likely to be one of the common triggers for admission.

14c Fluids and hydration could be mentioned by all services when in contact with patients

15 Current situation:

All four of us, in our shared isolation, have ongoing coughs and get tired in the afternoons.

It is now day 8, 15th March, my cough appears slightly less and is now dryer, I have some energy in the morning but sleep most afternoons and evening. Myalgia is worse when tired. Temperature fluctuates up to 37.7 Episodes of coldness occur when livido reticularis on the thighs is more evident.

16 Greeting

Hand shaking has stopped so alternatives have been elbow touching (> <), bum bounce (UU) or Namaste (AA) in the mornings. Namaste being clashed hands in front with a bow. Livens the day anyway. Namaste Khush Raho (Be happy).