

A nurse academic's lived experience with COVID-19: a reflective narrative and literature review

Abstract

COVID-19 as a phenomenon is incomparable in terms of its impact and reach across the globe. Every corner of the World has been affected by this virus in one way or another. The impact of Covid-19 poses an existential and physical threat to us all. It does not take a psychologist to tell us about widespread mental health impact from Covid-19, in part driven by the state of fear and panic of catching this novel coronavirus, and even worse still, experiencing symptoms (whether these are mild or severe). The upheaval this situation has created in our lives will be spoken about for many years to come; the lockdowns and widespread restrictions are a threat to our civil liberties and the wider economy, with financial hardships now pervasive across society, brought on by countless job losses and business' collapses. This reflective narrative discusses my own experience having caught the virus and examines the impact that living with the disease has had and continues to have on my life. Battling distressing symptoms and having had to face this life-threatening illness, evoked fear and panic within me, despite my usual level-headed, calm and easy-going personality. I ruminated whether I would be among the statistics of those who eventually recover from the disease or those who sadly do not. Therein was my mental anguish and self-torment; and I very much doubt if I am alone in this.

Key words: *Covid-19, SARS-COV-2, Mental health, Long Covid, National Health Service*

Introduction

Globally, as of the 16 December 2020, there were approximately 71,919,725 confirmed cases of COVID-19, and worldwide mortality due to Covid-19 now stands at 1,623,064 deaths as reported by World Health Organisation (WHO 2020a). The World Health Organisation has claimed that this Covid-19 pandemic situation caused by SARS-COV-2 coronavirus could become endemic (i.e., a constant presence) like HIV; a stark reminder of the gravity and wider implications of past and now current global health challenges the world population faces. In his talk during an online briefing, WHO emergencies expert Mike Ryan lamented that, "It is important to put this on the table: this virus may become just another endemic virus in our communities, and this virus may never go away". Perhaps some may consider these remarks as naïve and premature, especially as the evidence suggests that this virus has only manifested and reared its ugly head since December 2019. But what if this reality that Mike references is not so farfetched, that we may have to adapt

life as we know it in order to live securely (but can we?) with this horrible catastrophe! Whatever your views are on this issue, it is clear that we need to get into the mindset that it will take some time to emerge out of this pandemic, likely along with a 'new normal' for all of us.

Across the world, the coronavirus pandemic has disrupted economies, health systems and resulted in massive job losses, and government debts spiralling out of control (World Bank 2020). The unforeseen reality of this situation has presented significant challenges for public and private businesses, where variable and ever-changing lockdown measures adopted in different countries to stem the spread of the virus, has made it a struggle and often a logistical nightmare for governments to ably provide a clear strategy for reopening economies while still containing the deadly virus. For developing countries, where many face daunting vulnerabilities and dysfunctional public sector services including poorly resourced health services, the impact of this current situation has been critical. Maladaptive public health systems have been adversely affected; where addressing challenges posed by this pandemic in these locations continues to encounter systemic bottlenecks that existed pre-Covid (Henstridge 2020). Although it is well documented that actual Covid-19 cases and death rates in low- and middle-income countries (LMIC) have been much lower compared to the situation we have seen in many developed countries, some have argued that in LMIC in particular, the direct health impact of Covid-19 is actually outweighed by the huge economic cost of the indirect impact of the lockdowns. This is not difficult to imagine, considering that country-wide furlough schemes and government business loans or support payments in these LMIC would be completely unheard of. Rather unsurprisingly in both LMIC and developed economies, the impact of both the virus and lockdown combined on people from low social economic disadvantage (e.g., those from poor neighbourhoods and households) has had disproportionately greater economic, health and social adverse effects on these individuals compared to those from higher socio-economic standing.

In the United Kingdom, there has been significantly higher death rates recorded in people from Black, Asian and Minority Ethnic (BAME) groups, compared to other races (Davis 2020). Various perspectives of complexities driving this association have been offered to explain this phenomenon in this sub-population group; these include genetics, medical comorbidities, vitamin D levels, socio-economic status including occupation, behaviour, cultural practices, health beliefs and environment. The Office for National Statistics (ONS) and others support this probable interaction and further emphasise that higher death rates in BAME population groups is largely due to life circumstances brought on by social-economic disadvantage in these groups (Russell 2020; ONS 2020a). Sir Professor Michael Marmot has investigated determinants that maintain health inequalities across various population groups and has led numerous research groups over the last twenty years on the national and global stage. Findings from many of his works, including 'Status Syndrome' (Marmot 2004), 'The Health Gap' (Marmot 2015), 'Healthy Equity in England'

(Marmot et al. 2020a) and 'Build Back Fairer: The COVID-19 Marmot Review' (Marmot et al. 2020b), substantiate why initiating strategies early that address root causes of health inequalities are critical to sustainable population growth and productivity. The evidence he has presented in most of his work, some dating back more than a decade, peels freshly before us when evaluating the impact of Covid-19 across socially and economically disadvantaged population groups. The notion that we all do better when every member of our community is given the same opportunities (jobs, housing, education etc.) and has equitable healthcare access is very often taunted by capitalists and right-wing commentators. However, snail-paced action as we have seen over the last 8 months of the pandemic situation can result in catastrophic and life-changing effects, not only on those at the lower socio-economic end, but evenly felt across all social economic groups (Williams et al. 2020).

In the rest of this article, I share with the reader my personal experience having contracted coronavirus, reflecting briefly on my life before the virus through to symptom/disease stage and challenges encountered during the recovery stage. A core value necessary for healthcare professionals is possessing a healthy ability and appetite to engage in regular reflection (NMC 2015), often achieved by the individual through activities he/she experiences in the context of both personal and professional perspectives. As a nurse lecturer, I have delivered lectures on the process and benefits of reflective practice to undergraduate and postgraduate health students during my time in higher education; therefore, the reflective process is not an alien concept to me. I will examine my Covid-19 experience using Gibbs reflective model (Johns 2017; Gibbs 1988) towards uncovering a personal and honest exploration of the realities of this experience; referencing fears, anxieties, doubts, and giving recognition to any positives arising from this undesired experience.

My Covid-19 experience.

I work in higher education. The reality of the University experience for most is that universities and colleges are settings where students live, study, mix and play; forging social connections, many of which are lifelong. The student experience, for thousands joining undergraduate and postgraduate programmes is largely positive, with reports of late-night parties, bar/pub crawls, nightclubs, buzzing social activities, sports clubs, and numerous interest groups expected as standard. Ultimately, universities are places of community and belonging, where students cultivate connections with people from all different walks of life. Some have even gone to the extent of comparing university social scenes, including endless weekend parties and freshers' week events, to a weekend spent on Fremont Street in downtown Las Vegas! However, all of this rather sadly changed for students and for professional staff since March 2020. The usual vibrant ambience in higher education institutions (HEIs) has been impacted significantly by the rapid

contagion of the coronavirus outbreak, with an uncanny uncertainty regarding effects on business in higher education (Universities UK 2020).

For the majority of pre-registration nurses and other healthcare students, the availability of rich, varied clinical environments in which to undertake clinical learning has been significantly impacted upon by Covid-19. This means that HEIs and health providers have had to ration the already scarce number of clinical learning placements; most students stayed home, while a few have still been able to access clinical placements, albeit within a completely different atmosphere. Feedback from several students who have remained engaged with clinical placement and learning during the first lockdown and subsequently other mini-lockdowns reported various challenges with clinical learning experiences- in part due to lack of staff to offer good quality student learning supervision and training. For some, as they opted to lose their supernumerary status, and were added to the over-stretched NHS workforce, the difficulty of this quick transition from student to a new demarcation of their practitioner roles, was understandably confusing and challenging (Swift et al., 2020). In particular, the mental health impact of working and learning in a clinical environment whilst also facing a new, invisible, potentially lethal threat, is profound. Usually, healthcare professionals tend not to be vividly scared of their patients, but this Covid-19 pandemic has brought with it a real sense of fear and anxiety for one's own safety whilst working and caring for patients on the front line.

The impact of Covid-19 on HEIs has manifested numerous challenges including speedy conversion of normally in-class face-to-face taught programmes to fit in with digital pedagogies in a very short space of time. The stress that this has generated has been further exacerbated by a tsunami of emails, zoom meetings, and new policies and guidelines developed over the past few months as a direct consequence of the pandemic. The lack of time and resources available for most academics has meant that we have had to give much more to the job, with unsurprisingly direct negative effects on the psychic of education professionals in these institutions. A recent report by the national charity Education Support (2020) shows that 50% of all education professionals felt their mental health and wellbeing had deteriorated either significantly or a little during the pandemic situation.

For nursing education, the pragmatic underpinnings that inform traditional pedagogies when planning the delivery of courses often require physical presence and direct interpersonal engagement in a classroom environment. Particularly, mental health nurse education draws on good quality interpersonal skills, including effective communication and delivery of cognitive-motor skills mapped in teaching activities within a class environment. However, the new norm of using digital pedagogies to deliver learning and teaching for healthcare students means that these important constants may not be as easily replicable. Having now personally delivered several

online lectures, I submit to you that this is not the same as being in a classroom environment, which affords that extra socialisation of learning and cognitive engagement. But will this be the new norm for nurse education? Perhaps so, but the reality of the situation is that the pandemic situation has completely overhauled the lenses in which nurse education has traditionally been planned and delivered across HEIs. Could we see the gradual erosion of the 'person-centred and contact-led' approach from nurse education through a more digitalised curriculum? The concept of the 'person-centred approach' is interwoven in healthcare and health education, therefore it would be unthinkable if the new norm impacts this, however small this might be.

Like most nurse academics across the country, I have worked from home since March 2020 and tried to avoid going into my place of work, as advised by the government. However, the challenges of home working, added to issues already discussed, are a much undesired distraction for everyone in this position. I have had to fight for working space in my study room with the big, noisy gas boiler standing over me and the blaring hum and vibration of the washing machine behind me. In addition to family pressures of screaming babies, hormonal teenagers, elderly relatives who are shielding and commitments which for many have been heightened by lockdown and stuck realities of this pandemic situation. However, all of these home issues may seem insignificant if one considers the increased risk of contracting the virus from daily commutes on public transport to my place of work and the higher chances of human contact with many people outside of my family bubble.

Contracting the virus

The decision to reopen schools after the first national full lockdown was much welcomed, especially for public sector key workers, along with millions of parents across the country. Proponents in favour of the government's decision to reopen schools and colleges argued that prolonged lockdowns would negatively affect the economy as well as the significant educational and mental health impact on children if these institutions remained closed. UK Prime Minister Boris Johnson when interviewed by the BBC commented that the coronavirus risk to children is very, very low, adding that benefit of education is so huge (Johnson 2020). Publicly, cabinet ministers have supported this and asserted that opening schools has clinical benefits in that this would enhance and promote the welfare and morale of young people. On the other hand, some have repeatedly questioned the competency of the government and the decision to reopen schools, particularly at the beginning of the winter flu/cold period which traditionally places the NHS under huge pressures and strain, even without the added coronavirus burden. Nevertheless, the government released a policy paper providing guidance and direction to schools on how to safely reopen, and stated that schools would be supported to put in place 'well-controlled school

environments', which would be relatively safe and stem the rapid spread of the virus (Department for Education 2020a).

The lifting of lockdown during the summer period and the government's 'Eat out to help out' scheme, were a huge boost to a population which had spent 4-5 months in full lockdown; although with the subsequent spikes in viral cases in the autumn, it seems this may have come at a high cost to the nation. Anecdotally, media commentators went as far as accusing the government of harbouring an agenda to enforce herd immunity in the hope that if it worked, there would not be further need for prolonged lockdowns- some perceived this as purely for political and economic reasons. However, none could have anticipated the rapid spread of a new highly transmissible strain of the virus, as the numbers of people infected spiralled out of control (Wise 2020).

The months leading up to Christmas revealed a stark reality of what the country was about to face. Figures from the Department for Education (DfE) showed that the number of children attending secondary schools in England dropped to as low as 80% in the first two weeks of December 2020 and the preceding months before the Christmas break (DfE 2020b). Government figures also indicated that roughly 700,000 children did not attend school for Covid-related reasons on December 10th (DfE 2020b). December rates of coronavirus infection as reported by Office for National Statistics showed that these were rising highest in the secondary school (10-19 years) age group (ONS 2020b).

While evidence suggests that children with Covid-19 infection usually experience mild or no symptoms more frequently than adults, the risk of cross-infection and transmission from this population group to other groups, particularly their immediate family, often including older adults who are more vulnerable, and others, remains high (Davies et al., 2020). On this background, my 12-year-old son who attended secondary school from September 2020, started complaining of Covid-19 symptoms in late November, and shortly after his symptoms started, we received a notification from his school stating that he needed to self-isolate because he had been in contact with a known positive case of coronavirus at the school.

The cycle of infection begins.

By the end of November 2020, myself, my wife, and our 1-year-old baby, having been exposed to the virus, started to also self-report on classic symptoms including fevers, fatigue, dry cough, headache, loss of taste and smell. Naturally, I started to worry, initially mainly for the baby, given an immature immune system and the thought of a severe respiratory pathology and possible risk of further complications at a such a tender age. My anxiety and anticipatory fear soon turned to anger and resentment towards the government over what I considered to be a cavalier and ineffective approach to managing this crisis situation across the country. While self-isolating in a

household where all of us were displaying Covid-19 symptoms, I contemplated that the risk of exposure to us during the first lockdown had been minimised because all of the teaching and learning for schools was conducted online. The risk to me had been further reduced as I had been working from home from March 2020 and my wife was at home on maternity leave. Was I angry about my situation? Yes! I ruminated that perhaps if we had continued to home-school my son as we had done during the first lockdown, we probably would not have been exposed to this dreadful virus.

Though I was aware that upon opening schools in June 2020, as noted by the politicians, children were returning to what the Government and Department for Education referred to as 'socially distanced places of learning', where the risk of cross-infection would be reduced because of the phased return and other measures (increased cleaning budgets, staggered start and finish times, year group bubbles etc.) implemented in schools (DfE 2020c). However, it is unclear whether these measures had a significant effect on reducing the cross-infection rates in schools, particularly since November-December 2020 saw the secondary school age group record the highest numbers of positive cases. On reflection, I suspect that trying to consistently implement new, restrictive, and stringent safety measures amongst a large group of autonomous teenagers must be an almost-impossible feat!

Acute disease phase

By 1st December 2020, my symptoms became bothersome, yet I was still active around the house and continued to virtually attend work meetings and deliver teaching online, but I did not feel right. I recall struggling to remain alert and focused in one of the meetings due to a thundering headache. I recorded daily high temperatures of around 38-39°C, and symptoms were worse during the evenings and overnight, with extremely debilitating aches and pains, palpitations, night sweats, and chest pains. From 3rd December, I became noticeably more breathless and issues with cognitive deficits were evident, as I struggled sometimes to think clearly and complete sentences. After testing positive with Covid-19, and over the following 5-10-day period, my condition became critical. I was so determined to beat the virus that I underestimated both the seriousness of acute phase of the disease, and I foolishly took unnecessary risks to my health.

I had a pre-planned teaching/supervisory meeting with first year mental health nursing students on the evening of the 8th of December, which I considered cancelling in view of my health situation, but I was determined not to let the students down and thought I was well enough to conduct the meeting. Incidentally, I had struggled through another online meeting on the evening of the 7th of December; during which I developed severe chest pains and palpitations with intermittent episodes of breathless and dizziness, but because I had somehow managed to recover and finish the meeting, I considered that the teaching on the 8th would be just fine! Rather, it turned out that

I had to end the meeting with my students early as I felt the same symptoms as the day before, but this time they were more intense and did not resolve. I climbed the stairs to get some pain killers and felt like I was about to faint. I assessed my oxygen saturations using a pulse oximeter and was shocked to see a reading of 87% (normal oxygen saturations are 95% and above). Within 2 hours of ending the meeting with my students, I was gasping for air and falling to my knees pleading with my wife to call the ambulance! My wife is a medical doctor, which for most would be reassuring when facing the claws of death; and although I received the most careful attention from the Mrs, in that dreadful moment, all my worries and fears about death were amplified by my professional knowledge and experience as a healthcare practitioner. I teach anatomy and pathophysiology, and when facing my own health crisis, instead of exercising positive imagery, I rather strangely started to visualise severe Covid pneumonia in my lungs, heart attacks, cognitive decline, multi-systemic failure. In all fairness in the moment, I regretted having read about all these potential covid effects on the body in the media as all of it felt too close to home. You could argue that this knowledge of the biosciences in my brain turned against me, and perhaps I had only myself to blame for the irrational thoughts but as mental health professional, I couldn't deny that this reality was everywhere around me, one I couldn't just brush under the carpet. Normalising my fears and worries in view of the pandemic situation seemed the appropriate thing to do, but was it? Did this help to alleviate my strife, probably not!

Journey to the hospital and stay

Fortunately, the ambulance crew arrived in less than 5 minutes to evaluate my situation; I was taken into hospital due to inconsistencies on my ECG report associated with breathlessness and chest pain. On the way to the hospital, the paramedics tried their best to keep me alert and talking, although every breath and word spoken felt like climbing Mount Everest. The anxiety that comes with going into hospital with Covid and fearing whether I would be coming home to loved ones, only became too real in those 20 minutes to the hospital. My Christian faith sustained me in moments where one may feel like all hope is lost, then a glimmer of hope and a ray of sunshine lifts you from within. One of the paramedics shared his own personal experience of Covid-19 with me, explaining how he still feels guilty for infecting his wife with coronavirus during the first wave of the pandemic, after being exposed through his work. He lamented that even though many months had passed since his wife has suffered with severe Covid-19, she was still not back to her pre-covid self and had been forced to significantly reduce her working hours as a result. Hearing his story and the sacrifice that he and the countless other NHS workers on the frontline have made and continue to make, putting themselves in harm's way in order to deliver vital care to the many people affected by this pandemic situation, strengthened my resolve to fight on.

Hospitals, especially accident and emergency departments, are often associated with pain and suffering. My time in accident and emergency went by quickly but what was evident was the complete dedication to their work emergency healthcare staff showed, amidst a desperate situation caused by the influx of back-to-back ambulance crews, carrying most if not all, patients with covid symptoms. As I lay on the hospital bed, I overheard paramedics discussing amongst themselves that nearby local health services were re-routing ambulances out of their catchment areas due to pressures brought on by increased demand on services by covid and non-covid cases. In some cases, ambulances crew had been re-routed 15-20 miles from local areas where they usually operate to ferry patients to alternative facilities. This desperate situation, heightened by the increased demand on resources, and perpetual fear and anxiety from both healthcare staff and service users, was often played out too well within the emergency room. I considered that this was now the norm, as we were over 9 months into the pandemic situation, and that it was inevitable therefore to see psychological ill effects manifesting in these situations. These observations and reflections helped to keep my mind off my systolic blood pressure (SBP) which on periodic monitoring was considerably low ranging between 90-96 mmHg (normal SBP is around 120 mmHg). Added to this was the venepuncture challenge encountered by emergency nurses and doctors who struggled to obtain a blood sample to measure my blood gases and to check for any serological evidence of serious infection. After eight attempts peripherally, followed by a femoral stab, a blood sample was finally obtained!

A cross-sectional, descriptive study conducted in a tertiary hospital during the outbreak of Covid-19 between February and March 2020 in Wuhan, China found that 60% of healthcare staff reported moderate to severe stress levels; caring for Covid-19 patients was cited as the main source of stress among frontline healthcare workers (Hwang et al., 2020). This stress and worry stemmed from the fear of being infected or being responsible for family members being infected as a result of the direct contact healthcare staff had with seriously ill Covid-19 patients. Nine months into the pandemic, and this reality remains intact for most healthcare professionals, especially those I had the privilege of meeting and engaging with during my time in hospital. The genuine fear of contracting coronavirus and becoming seriously unwell whilst in service was a regular topic of conversation among healthcare colleagues. Alongside discussions around concerns of fatigue, exhaustion, and burnout, driven by the seriousness and escalating pandemic situation and the relentless, pressurised work environment that clinical settings have experienced since this global crisis began. For some, grief and loss were much closer to home as they had either lost a family member or colleague to this horrible disease; one nurse acknowledged that she now lives with a fear of death continually but stated that she had made peace with 'her Maker' about this. I also considered that perhaps the personal protective equipment (PPE) worn by staff for 8-12 hours daily might possibly be a further source of anxiety- a constant visual reminder of these

unprecedented times, as well as the physical discomfort, and worry of potential low PPE stock levels, a particular concern during the first wave.

Recovery Journey

The majority of people who test positive for Covid-19 experience a mild illness; some are completely asymptomatic; however, others develop severe symptoms- fever, chills, breathlessness, chest pain, muscle/body aches, diarrhoea, headache, nausea/vomiting (Jacqui 2020). In the most critical acute cases, people require oxygen intervention and/or mechanical ventilation for breathing support. The World Health Organisation COVID-19 situation report (WHO 2020b) states that for Covid-19, data suggest that 80% of infections are mild or asymptomatic and 15% are severe infections. Yet, the million-dollar question is, what accounts for such a wide spectrum in severity of clinical presentation in different individuals exposed to the same virus?

Perhaps the main confounding factor proposed to explain this phenomenon is age. An evaluation study of Chinese data by Verity et al. (2020), estimated 13% increased mortality due to Covid-19 for patients 80 years and older, compared to those aged under 60. UK research has revealed similar findings: those with Covid-19 aged 80 or older were seventy times more likely to die compared to those under 40 years old (Public Health England 2020). Possibly this could be due to the fact that as we get older, our immune system is not as efficient at fighting viral infections or any other pathogens for that matter. Also, underlying health conditions, especially long-term medical comorbidities, can impact on normal physiological processes and can weaken the body, thereby reducing one's reserve and interfering with the effective functioning of the immune system to fight off infections. Gender disparities for Covid-19 mortality have also been reported, with males making up 54% of diagnosis cases, 60% of mortality cases and 70% of admissions to intensive care due to Covid-19 in England (Public Health England 2020). Additionally, people from Black, Asian and minority ethnic (BAME) groups are at greater risk of possibly contracting the virus and at even further increased risk of dying from Covid-19 (Veena 2020). As discussed earlier, socioeconomic factors, such as poverty, access to healthcare, keyworker occupations and housing issues prevalent in this sub-population are likely to play a role. Other possible confounders to explain the noted differences in symptoms severity and mortality rates in different individuals include genetic vulnerabilities and viral dose (dose of exposure to infectious agent), but there are still many unknowns about the SARS-CoV-2 novel coronavirus, and only time will permit health researchers to fully evaluate the impact of this virus and its effect across populations.

During my experience with Covid-19, I have reflected on much of the issues discussed above, as being a BAME male, my risk of severe disease symptoms and poor outcome were increased. Naturally, knowing this attracted a level of anxiety, such that this reality was further compounded

by having to worry about my own recovery and that of my immediate family. More than 4 weeks since testing positive, I am yet to return to my full pre-Covid health status. While I am gradually getting better, I am still bothered by body aches, constant tiredness, episodic breathlessness, light-headedness, and palpitations. 'Long Covid' (also known as post-COVID-19-syndrome) has been defined as not fully recovering for several weeks or months after the start of symptoms that were suggestive of Covid-19 (Nabavi 2020). I have wondered if the long Covid symptoms are heightened due to genetics, race, or age, although I am aware that the condition in itself, being even more novel than its causative agent, is shrouded in mystery and uncertainty. The National Institute for Health and Care Excellence (NICE 2020) recently released rapid guidance for long Covid, identifying 28 of the most common symptoms, including breathlessness, dizziness, fatigue, and chest pain. This is a useful resource to help identify those with Covid-related long-term issues and complaints, which have now become common reports in primary care, and are often regularly posted by individuals on social media platforms. In particular, long Covid sufferers plead to be believed and for the condition to be rightfully acknowledged, as too often they feel their complaints of ongoing symptoms are dismissed or minimised (Long Covid Support 2020). There is also a Facebook support forum for individuals with long Covid syndrome (www.facebook.com/groups/longcovid/). This group has just over 32,000 members, and the growing membership provides evidence of the potential seriousness of the condition, causing morbidity and thus affecting the quality of life of so many people.

Although I find myself in the 4-12 weeks' timeframe, following the start of my acute symptoms, and not yet beyond the 12-week threshold for long Covid as set by NICE (2020), I cannot help but feel perturbed by my lack of full recovery thus far. The intermittent breathlessness and the challenges I still encounter when I talk for prolonged periods, are a major concern for me, particularly since my day-to-day job as a nurse academic requires, among other things, the energy and ability for me to speak, deliver lectures, conduct meetings etc. Support from friends and family have helped me greatly to regain confidence, and as my relative often said, "It is not benefitting you to fill your mind with constant worries and anxieties, in fact this makes a difficult situation even more challenging". As a mental health professional, I know too well how easy it is for one to gradually lose their locus of control in the presence of environmental and external disruptors. For now, I live each day as best as I can, filling my mind with positive thoughts of full recovery from this awful virus, keeping up my energy, eating healthily, getting plenty of sleep and taking outdoor walks.

On the other hand, it is vitally important to speak up when worried and concerned about things—given the current challenging times that we are all experiencing, it is unsurprising to see increased reports of mental health problems across the population (Pierce et al. 2020). Widespread psychological trauma has been reported due to fear of contracting the virus, the experience of

suffering with the disease, and exacerbated by the numerous consequences of the pandemic-social isolation, job losses, difficult family/household dynamics etc. (Brooks et al. 2020). This added to the increased rates of grieving experiences for countless individuals who have lost loved ones due to coronavirus, can negatively impact on mental wellbeing. During 2020, I lost one of my first-year undergraduate students to Covid-19, an experience I am yet to recover from. Sadly, the reality of Covid has robbed us all of the normalities of life, and in many cases due to Covid restrictions, individuals have not had the opportunity to attend funerals for their loved ones, and many have not been able to hold the hand of their dying relative/friend in their final moments. Yet another part of life that we perhaps took for granted in the pre-Covid era.

As I recover from this disease, I am hopeful that now with the roll-out of the approved vaccines alongside the individual's willingness to practice good hygiene, face coverings, social distancing and planned lockdowns (provided the Government can maintain a clear message on this), we will overcome this horrible virus and take back control. For now, as I am sure most of you are, I will continue observing all the necessary precautions to avoid catching this the second time round. I definitely do not want a second edition to this article!

Final reflections

- The National Health Service (NHS) is a first-class health service; it is not perfect, but I have unwavering confidence in the quality of care it provides at the point of one's need. Every member of the public, politicians, NHS workers, and policy makers must do all they can to fiercely fight for the survival of and protect the integrity and values upon which this great institution was founded. As a healthcare professional who has worked in the NHS, benefited from the NHS as a service user, and also been involved in teaching future healthcare workers, I am confident the pandemic situation will not break the resolve of this great institution and the dedicated staff working within it.
- The discussions I had with ambulance crew and hospital staff demonstrated their professional devotion, commitment, and altruism to their jobs in very difficult and challenging times for the NHS workforce. However, I am also aware that as a country, we need to do more to ensure structures and systems are properly implemented and evaluated to safeguard the welfare of NHS staff, as not to do so is counterproductive.
- My professional experience as a healthcare professional nurse academic helped me, to a degree, to manage the coronavirus illness when I became symptomatic. I conducted my pulse, blood pressure, oxygen saturations, temperature, and respirations regularly in order to pick up any sudden changes. However, in doing so, I have reflected on whether possession of prior clinical knowledge and experience was of benefit to me or a hindrance

when facing such a serious health challenge. Given the heightened anxiety and fear of the unknown I experienced when severely ill with the disease, I have concluded that the duality of the two realities, i.e., a sick healthcare professional (HCP) was for me, partly a blessing but mostly a curse. Whilst it might have added benefits of inside knowledge/skills for the HCP suffering with an illness, in my experience I actually found this ability to afford myself a clinical examination rather perpetuated my fears and worries about mortality and morbidity from this disease.

- It is true that HCPs are not detached from the social environments, which are very often connected to their roles or specialities. The angst and somewhat impending doom Covid-19 appears to have imposed over the UK public and the global population, has generated a range of psychological problems including anger, frustration, worry, grief, depression, fear and anxiety. HCPs with a lived experience of Covid are not immune to this reality, where the psychological impact of the pandemic situation remains fresh and apparent across the population, irrespective of race, gender, social class or professional status. A close associate of mine, on learning about my situation, outrightly dismissed my mental anguish, and went as far as suggesting that I needed to “Stop feeling sorry for myself and toughen up to beat the virus”. Alas, in that moment, I did not share his sentiments, and would not advocate this response. Providing non-judgemental care, compassion and support during such difficult times may provide us all, whether affected by this virus or not, reassurance and help to normalise phenomena, as I am sure there have been many complexities and adjustments, we have all had to deal with in our personal, family, work and social lives since March 2020.
- As the discovery and approval of vaccines is much welcomed news for the global community, one must remember that vaccine approval does not equate to vaccination rates. As the infection rates are going up across the country, particularly of this new strain of SARS-COV-2, many more people will need to be vaccinated at a faster rate. However, several challenges remain, especially as we have seen anti-vaccine misinformation circulated across social media, which hinders the right information about the benefits of these vaccines from reaching the lay person and instead breeds confusion and cynicism. More needs to be done by policy makers and politicians to ensure that correct and factual-based messages about the use and the safety of the Covid-19 vaccines is communicated in a timely fashion to all sects of the general public.

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