“The Voice on the Other Line”

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Since clinical clerkships were cancelled, it has been a struggle to connect meaningfully with this intensifying pandemic while remaining entirely outside the clinical sphere. It’s a special limbo to live in as a medical student: considered enough of a doctor to understand the science of the virus’s respiratory bedlam but not enough to remain in the clinical battlespace. The perspectives around us medical students are complex: viewed as another mask taken at best, a fomite or potential patient at worst, and maybe most practically someone who cannot write orders. So while I complete my Pandemic Medicine course online and get most of my “patient contact” at the grocery store, I face the same question everyone on Earth has asked during this unprecedented crisis: *what do I do now?* Still, the front lines appear no less devastating from the relative safety of my place many rounds of reinforcements back, the distance only further highlighting the *essential* differences between those trained and those still in training.

Like thousands of other motivated medical students, being relieved of clinical duties has offered me the freedom to contribute to the cause in other ways. I have spent much of this time conducting phone interviews with COVID-19 positive patients and employees, tracing their contacts and exposure sources for my local Department of Health, my institution’s medical center, and the neighboring university.

Despite some differences, these calls often resemble the patient interactions I had while still on clerkships, as they can vary wildly in tone and course. On the other line, some react warmly (“Oh, thanks for reaching out!”), others less so (“Actually, I *do* mind…”), and most simply do not even pick up (like those sleepy patients who just cannot stay awake long enough to answer my questions before rounds start, or started… three minutes ago.)

Before each call, I survey some basic information from the database: name, gender, date of birth, testing date, phone number. Even from these sparse details, it is difficult not to craft an imaginary picture of who this person could be. A birthday in the 1950's? *I worry about them*. A 931 area code? *Michigan, quite a hot spot.* It's that rapid-fire association cortex that makes these judgements, the same one that medical school nurtures and tortures with one-liners like "18-year old female with a butterfly rash and joint pain."

As the phone rings and a bit of anticipatory anxiety kicks in, I again find myself thinking to the uncanny similarities of being back in the hospital. With every call, I "knock on the door" and take another glance at the last name of a new patient for whom I will soon unearth and record the details of whichever powerful process suddenly evicted them from their "prior state of health" and sent them to live with us for a few days at our 864-bed Hotel.

My first call on behalf of the Department of Health went unanswered, then promptly was returned by a young man in his mid-20's. We walk through the basics – symptom onset and type, date of isolation, travel history – before starting the arduous task of retracing his steps, place by place, person by person, using emails and bank statements to triangulate events that happened nearly two weeks prior. The timeline started to take shape. He had never travelled to China. He was furloughed from his marketing job. He had been self-isolating for weeks now, he insisted.

Except a nearly overlooked four-day trip to the Gulf Coast with relatives from California.

A hard piece of history to forget, I think a bit harshly, remembering any number of patients on service who prided themselves on being "pretty healthy" and only mention their hypertension, MI, and gangrenous left pinky toe with the same tone of nonchalance one might use when remembering to add paprika to their grocery list – an afterthought's afterthought. Upon returning, he developed the symptoms we have all heard a thousand times: body aches, dyspnea, loss of taste and smell. A positive swab at a walk-in clinic the next day confirmed the diagnosis. As we traced the timeline of the trip, I felt my anxiety toward the responsibility of notifying each person exposed, each business frequented, transform into silent judgement.

Over two million cases of COVID-19 in the world. A stay-at-home order in our county. A contact list at least five people long across three states. All to go to the beach.

Was it worth it?

To err is human, yet only when we listen with grace instead of judgement can we focus on our humanity. Whether conscious or not, medicine can silently reinforce us to view people by their problems and mistakes (or *modifiable risk factors*, if you prefer…) with the unforgiving gaze of hindsight. We preach from the privilege of the present, thinking "if only he lost 30 pounds" without considering the millions of factors that influence a person's lifestyle. Our associations become simple and crude: if X, then Y. Remove X, and you avoid Y. And when Y occurs, we shake our heads. The emphasis of our profession should be caring for patients *despite* these ubiquitous, risky choices – from smoking to sharing needles to travelling during a global pandemic - and to offer them compassionate education without instinctively wielding the heavy hand of "I told you so!"

Another call to place, this time through my institution's internal database for COVID-19 positive employees. Among the snapshot of limited data: a 1999 date of birth. *A student,* I thought to myself. As the phone rings, the associations flow without trying: sparkling Florida beaches bustling with college students while leaders delayed issuing a unifying stay-at-home order, the governor of Kentucky's speech about a young adult becoming ill after attending a "coronavirus party," a group of 70 students from the University of Texas at Austin ignoring social distancing

rules to party during spring break, only for 44 of them to test positive for the vir--… *Hello, who is this?*

G. *is* a student, it turns out, but that is about the only correct assumption I made about him. Studying topics in the global health realm (online, of course), he knew what losing his taste and smell meant. At the walk-in-clinic, he was not worried when healthcare workers greeted him in full PPE. In fact, he thanked them, appreciating how they made him feel more comfortable by explaining the precautions while they worked. He had been isolating since developing symptoms, leaving student housing two days prior. And with my contact tracing completed, he had a question of his own: *Is it possible I can donate plasma to someone in the ICU?*

At best, heuristics can save lives. Quick judgements make up a large part of our ability to recognize seemingly unrelated points as a dangerous constellation of symptoms on which to intervene. However, just as constellations lack the true detail of the animals and people they were meant to depict, these voices on the other line remind me of the grave disservice we do unto our patients if we treat them solely as a one-liner of demographics and pathology without the nuance that brings out their humanity. And nowadays, a bit of humanity is what we all deserve.

Linked Articles:

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