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Broken Silence

By Jonathan Davidow

I.
Through the phone, I could almost hear the tears welling up in her eyes.

"How often do you feel that way?"

"Oh. Every day."

I heard the tears begin to fall.

"I'm sorry to hear you've been struggling with this, but I'm so glad you told me."

It was almost two months ago when she returned home from the hospital. At that time, the CDC was recommending discontinuation of in-home isolation on a case-by-case basis, in general three days after resolution of symptoms and a minimum of 10 days after symptoms first appeared. Since she left the hospital, she had been feeling weak, anorexic, a little dizzy from time to time, but she had no fever, no respiratory symptoms. She even had a telehealth appointment with her primary care doctor and received a clean bill of, well, telehealth. But since she had not been formally re-tested, she'd decided to continue her isolation.

And now she felt like she would be better off dead.

I asked if she had been feeling down, depressed, hopeless, low energy, low appetite, all the characteristics that describe clinical depression: an affirmative answer to all the questions on our standardized depression screening. I checked the boxes leading up to her suicidality, scared of what I knew her answer would be.

Or was I actually scared of the tears I knew would come?

I activated the Psychiatric social work cascade we've established for this exact scenario. She said she was open to getting the help she needs but only if the therapist spoke Spanish. Her English was fluent, but she was comfortable in Spanish.

I so often wish my Spanish was fluent.

This wasn't a primary care screening. This was a woman recuperating at home from COVID-19. She had been in the hospital only for a few days, and she wasn't intubated. I asked if there was anything about her hospitalization she would consider particularly traumatic. She said no. It was a fairly peaceful course and she was very thankful for the care she received.

But when she was discharged from the hospital, she came home to an empty apartment. Her daughter and granddaughter had moved out. For their safety, she said. For the first time she could remember, she walked into her home and was met with silence.

Now that I spend my days on the wards, I crave any silence I walk into once home. But COVID-19 was a different type of silence that descended upon us all.

My third year of medical school will always be marked by that silence.

But in this moment, I had to ensure my patient's life wouldn't be completely shrouded by it.

II.

Treat the patient, not the symptom.

Great and gracious doctors who have shared their wisdom with me say I'll spend the rest of my life working through this simple concept. How do our social disorders interface with our biological ones? How did our patient get to this point and where will life take her from here? How can our understanding of her life impact the way she experiences her illness and the ways we can help return her to health?

Her depression could simply be due to her isolation, though it could also be a symptom of a post-viral syndrome. Oh, how we long for neuroimmunology to neatly explain the changes of our minds. We work so hard to understand the virus. Are we working hard enough to understand our lives?

How often do we overlook human simplicities for biomedical complexities?

Virtually none of the patients I've spoken with while providing follow-up calls for a large health system in an extremely hard-hit area of the US know how they got the virus. Even the people who have had multiple neighbors come down with the same symptoms within the same timeframe wonder if they could've gotten it from that time they had to take the train into a neighborhood not their own. We all disconnect the social from the biological.

An older couple self-isolating in their apartment for a full month suddenly developed symptoms and ended up in the hospital with respiratory failure. How could they be expected to place any blame on their nephew who so generously delivered food to their doorstep every week? He came down with the same symptoms as they did just a week prior.

Another patient I spoke with, after being discharged from a particularly difficult clinical course, had been taking his over-clothes and shoes off outside his apartment for weeks before he got sick. Now that he's home from the hospital, unable to pay rent or provide food for his family, he wears his mask even in the house. How could he see this virus as a Trojan Horse carried out by his grocer or his wife's nail lady or, God forbid, his own children whom he's now struggling to feed?

I could hear some hope slowly return to him when I offered him the phone number to the USDA Hunger Hotline. A bit more surged when I told him to push two to speak with someone in Spanish.

Our patient with thoughts of suicide relies on her neighbor for social support. She gladly takes the number for the 24/7 Helpline. She agrees to have someone from the hospital call her to talk about her feelings. She knows this can be hard, but she can't shake it.

I, on the other hand, did not know this would be so hard. Before I went back to school to study medicine, I spent 10 years honing my abilities to build and sustain business relationships. I pride myself on how quickly people open up to me, and I greatly respect that trusting relationship. But those people were colleagues, and those relationships were forged on marketing and strategy.

This relationship built so quickly and to such great depth over the course of a 45-minute phone call now leaves me feeling as though I've offered to share a weight I was not prepared to carry.

I wonder if I'll always feel this way or if calm comes with experience. Will she call the Helpline? Will she be able to wait until tomorrow for follow-up from the psychiatric social worker? Someone will call her, but will they speak Spanish? Will she have to wait until next week to get the help she needs? Can she wait that long?

What I'd like to do is to bring her food. Maybe she could tell me her favorite Puerto Rican restaurant, I've been looking for a good one anyway. Or I could sit on the phone with her for an hour and let her tell me her story. I could call her back in the morning and see how she's doing.

One thing we don't learn in medical school is where the line is drawn.

III.
If we focus too hard on social justice, can we miss how it plays out?

The impacts of housing on health, the connection between policing and chronic stress, the social determinants that have defined this pandemic: These are injustices. This is health inequity.

But does understanding inequity mean I'm prepared for my patients' stories?

We marched through the streets this summer for both the inequities and those who experience them. Black Lives Matter doesn't only refer to the aggregate Black lives that society so skillfully hides behind its luxury condos and ultramodern skyscrapers. It refers also to each and every individual Black life. What was George Floyd's course with COVID-19 like? When the post-mortem nasal swab confirmed he was positive for the virus as the police held his body against the ground, his words "I can't breathe" carried even heavier weight. Had Breonna Taylor,

before being shot to death by police in her Louisville apartment on March 13th, worried yet about contracting the virus on her EMT runs?

We focus on systemic problems because we can measure those. We can talk about them at conferences and come up with solutions, timelines, and budgets. But what if we could prioritize time to reflect on what our patients' evenings are like? Who do they say goodnight to? What is their favorite food? What pressures do we lay so heavily on their necks that they come to the hospital unable to breathe?

On top of the daily pressures of living in an under-resourced community, what pressures had COVID-19 added to my suicidal patient's life? Society may have been able to prevent a virus from overtaking her lungs, but can we expect her to fully catch her breath?

If I were to bring her dinner, what would be her favorite food?

We can hide behind our white coats. We can look at the aggregates—the comorbidities, diagnoses, the labs—and we say we understand. But when we come face-to-face with the person behind the patient, we sometimes don't know how to make eye contact.

While tears ran down my patient's face, I attempted to employ my training: a barrier is important, stay confident, lead the discussion toward a resolution, ask if the patient agrees with the plan. We did all that. She said she was fine. She said she'd be fine.

I hung up the phone, and I said into the silence, "thank you."

I was still speaking to her. I was speaking to my future patients. "Despite any barriers between us, I'm so thankful I got to see you."

Jonathan Davidow is a third-year medical student, experiencing clinical medicine for the first time against the backdrop of the pandemic. He began his medical education after 10 years in non-profits and health technology, driven to connect deeper with the patient and their experience. Davidow is passionate about using both data and story to change how we see, understand, and ultimately deliver health and healthcare in society.