Purposeful Inaction in COVID-19

A Medical Student Perspective

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In the first week of medical school, our class recited our adaptation of the Hippocratic oath, promising to "consecrate our lives to the alleviation of human suffering" (1). Thus, when asked to step back from clinical rotations to curb the spread of coronavirus disease (COVID-19), many of us grappled with the feeling that staying at home was not helpful enough (2). In this piece, we describe our experience with such feelings and how we continued to advance our professional development and service of humanity virtually during the pandemic.

CHANGES TO THE MEDICAL STUDENT ROLE IN THE COVID-19 CRISIS

In March 2020, medical students were temporarily withdrawn from in-person clinical activities to protect patients, ourselves, and the community as a whole. At the time, we were in the middle of subinternships essential for making our ultimate specialty selections and completing our residency applications, our junior classmates were pulled from core rotations, and our graduating classmates were unable to complete their final clinical experiences prior to intern year. Though we were concerned about our ability to prepare for the next stage of training, we understood that the limitation of medical student involvement in direct patient contact was necessary to reduce viral transmission and preserve personal protective equipment (3). At the same time, our identities as healers and helpers were challenged by our inability to contribute clinically in an unprecedented pandemic.

Today, although the hospital and outpatient environments have adapted to facilitate the safe inclusion of trainees in the clinical setting, our roles continue to evolve. Our colleagues in their first year of medical school are learning fundamental physical exam skills remotely. Meanwhile, didactics on clinical rotations remain virtual, and many clinical electives are still unable to accommodate students. No aspect of medical education remains untouched by the pandemic; as fourth year medical students, we are currently applying to residency virtually. The ongoing surge of COVID-19 across the country creates further uncertainty about our future clinical involvement.

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ALTRUISM AND PROFESSIONAL IDENTITY

Seeing our residents and attendings caring for patients with COVID-19 on the wards and intensive care units during the initial phase of the pandemic, we felt it was our professional obligation to do the same. We sought guidance from professional guidelines such as the *American Medical Association Code of Ethics*, which states that physicians are obligated to provide medical care in times of "epidemic, disaster, or terrorism," including "even in the face of greater than usual risk to physicians' own safety, health, or life" (4). This obligation to provide care despite personal risk reflects altruism, which forms the core of physicians' professional identities (5, 6).

This altruism was a major factor that drove our decision to enter the medical profession. We are excited to use our careers as physicians to relieve suffering through service. However, this self-identity was called into question when our mentors were valiantly fighting the pandemic on the frontlines while we were safely at home watching virtual lectures. Physical distancing felt passive, conflicting with the desire to serve our community.

The rhetoric regarding the role of healthcare workers further contributed to this internal conflict. We heard repeated encouragement to "step up to the challenge" and take immediate action in the face of the ongoing crisis. Moved by these calls to action, we wondered what the utility of our clinical training was if we were not able to apply it in an unprecedented time of need. We were not alone in this internal struggle. Some argued that medical students could be helpful in the hospital (7), whereas others worried about their personal safety and being a burden to already overwhelmed clinical teams. We most struggled balancing the efforts to limit viral transmission with the need for more in-person help at the hospital, particularly as rates of staff burnout and COVID-19 infection rose. We sought a resolution to these internal conflicts to help us and our fellow medical students avoid a sense of ineffectiveness, worthlessness, and burnout.

PURPOSEFUL INACTION IN MEDICINE

Limiting time in the hospital with patients during the initial acute phase of the COVID-19 crisis was in our patients' best interests. Thus, we frame this decision as in alignment with our desire to serve. These same principles can be applied to future surges that may again require limited clinical interaction if other infection control measures are not adequate. We use the term "purposeful inaction" to define instances in which inaction (i.e., staying home) may be more beneficial than action (i.e., participating in clinical care with direct patient contact), if done deliberately and to achieve a specific goal.

We can look to our medical training to identify other instances in which carefully considered, meaningful inaction constitutes better treatment than engaging in potentially harmful actions. For example, a patient who receives unwarranted antibiotics for a viral respiratory infection and then develops *Clostridium difficile* colitis experiences harm because of action. Additionally, "zentensivist" practice calls for a "less is more" approach to intensive care medicine (8). At the end of life, "do not resuscitate" orders that actively prevent cardiopulmonary resuscitation result in goal-concordant medical care. In these cases, doing less, in the appropriate clinical context, improves patient care.

We view similarly the act of staying out of the hospital as medical students during acute exacerbations of this pandemic.

Although it takes incredible courage to volunteer in the hospital during COVID-19 surges, it is equally powerful to set aside one's desire to be physically present in a crisis to contribute to a collective effort to slow the spread of this deadly virus. We can then look for innovative ways to contribute to care while maintaining physical distancing.

ALTERNATIVE CONTRIBUTIONS TO THE COVID-19 RESPONSE AS ALTRUISM

Purposeful inaction necessitates alternative contributions to the overall healthcare mission to maintain our sense of altruism and professional duty. Students quickly organized to virtually address new and unprecedented needs (9). At our institution, we worked with our classmates to create a COVID-19 educational curriculum to help trainees and healthcare professionals learn about this global pandemic (10). We aspired to help clinicians who might not have time to sort through the literature while treating patients directly. Seeing our materials reach numerous medical schools and countries around the globe solidified our sense of purposeful physical distancing and a collective, rather than individual, professional identity.

In addition, teams of students and faculty translated and distributed COVID-19 educational pamphlets on prevention and management of infection for the general public in over 30 languages (11). We also called patients who had visited local respiratory clinics to follow up on their symptoms, while other medical students engaged in grocery shopping, childcare, and collection of personal protective equipment for frontline workers. These efforts helped us appreciate that there are many ways to serve the community during these unprecedented times.

Although medical students are trained primarily to participate in the direct care of patients, professional identity development is a critical component of medical education. This includes being flexible and being a team player. During peaks of infection, the most pressing need for the healthcare system may be physical distancing and conservation of personal protective equipment. After carefully considering mixed priorities and viewpoints, we understand that taking an alternative role in the overall healthcare mission in place of in-person clinical care allows us to accomplish our goal of serving others to alleviate human suffering during the COVID-19 pandemic.

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