The medical student response to the Covid-19 pandemic

In February 2020 I was a first-year medical student, just finding my feet on a demanding course, nervous for the first set of exams looming at the end of the semester. Fast forward a couple of months and life could not have looked more different. I was now a healthcare assistant working in the red zone of a busy Emergency Department in the grip of a global viral pandemic.

To Volunteer or Not to Volunteer?

My decision to respond to the call for medical students to help on the frontline in hospitals was initially instinctive and based on the same foundation that drew me into medicine in the first place; the inherent desire to help those most in need. This ethical principle of beneficence was joined by the pragmatic realisation that if I wanted to continue to gain clinical experience in the light of the suspension of clinical teaching, I needed to volunteer. I hoped that I could be a useful resource in a situation where clearly existing resources would be stretched to the limit. Weighing against this was my personal vulnerability and the potential to be a carrier and infect family and friends. In that early stage of the pandemic very little was known about the virus and initial data was indicating that healthcare workers were being disproportionately impacted (1). Consequently, my decision had to encompass risk to myself and the prospect of losing contact with my own support network at the same time.

A determining ethical consideration for me was the need to ‘do no harm’ or non - maleficence. I was personally clear from the outset that given my very limited training at this point, I would not work outside of my competency (2). Helpfully the healthcare assistant role I was assigned was therefore appropriate. I am aware that maintaining this boundary was probably more straight forward for me as a pre-clinical medical student, than for qualified clinicians, many of whom were redeployed from their usual work settings into emergency settings, where balancing the acute needs of very unwell patients, in a resource restricted context potentially made the choice of whether to work outside of their competency more difficult.

In the UK, clinicians have had the benefit of working in a national health service which indemnifies their work. Additionally, they had the additional legal support from the Coronavirus Act (2020), extending indemnification to cover emergency situations where they might be asked to work outside of their usual zone of competence. This has helpfully reduced the risk that fears of litigation might shift medical decision-making in the direction of non-treatment.

Once I started working, I realised the privilege I had of having a choice about whether to work on the frontline or not. Whilst I experienced some subtle pressure to ‘do my bit’, unlike NHS employees, I was not contractually bound to work, thus I largely retained my own autonomy over this decision. I was, however, working alongside substantive members of staff who were expected to expose themselves to a dangerous environment on a daily basis. Covid has presented a unique challenge in terms of risk assessment, as the outcomes of infection vary from an asymptomatic carrier status to overwhelming multi-organ failure, and whilst there are some clear vulnerability factors which led to some staff shielding or leaving the front line, those who were left were still facing a very unpredictable enemy.

Moral Injury

The concept of moral injury has gained increasing recognition over recent years. Arising from studies of war veterans with chronic symptoms of PTSD who were not responding to standard treatments, moral injury has been defined as the impact of being forced to act (or to witness) actions that conflict with an individual's own moral code (3). Even prior to the pandemic there was growing recognition that healthcare workers were vulnerable to moral injury, given the need to work in a system that rations limited health resources on a daily basis. The pandemic clearly intensified this rationing greatly, with clinicians having to grapple with thresholds for use of ventilators or ICU beds.

Personally, I had to come to terms with seeing choices being made in this context, but my experience was that the choices were made with sound ethical foundations, based on quality-of-life decisions with appropriate use of the health resources available. I am grateful that I do not work in a system where access to healthcare is determined by a patients bank balance or the terms of their health insurance, situations where upholding the principles of social justice is much more problematic.

From the institutional betrayal of working with inadequate PPE, to enforcing draconian visitor restrictions, to facemasks limiting the empathy able to be offered to scared patients, there were countless times during the pandemic when I, and many of my peers, experienced a degree of moral harm. It is well documented that medical students in emergency medicine can suffer moral injury caused by the trauma of witnessed events (4). Support and debrief are just two methods by which such injury can be alleviated, if not avoided. As students were 'bank' (temporary) staff during the pandemic, the opportunities for this were negligible. Many of us came back to empty university houses at the end of a shift, unable to see friends or family due to the lockdown. I remember thinking after one particularly difficult shift how I had not hugged anyone in two months.

The most difficult situations to deal with in my own experience were having to enforce infection control restrictions which meant that patients could not have relatives and friends accompanying them in hospital. Witnessing the emotional distress of both patient and relatives was heart-breaking and whilst I understood the rationale, it felt very cruel and dehumanising at times, challenging the principle of non-maleficence. This was a situation where the best interests of the individual had to be sacrificed for the greater good of the nation. When visiting restrictions did not align with national Covid guidance, however, they felt disproportionate, potentially infringing on an individual's human rights. Personally, I dealt with this in the work setting by trying to spend as much time as I could with unaccompanied patients, chatting, reassuring and being a (albeit gloved) hand to hold.

Support Available

Managing the personal impact of working on the frontline during the pandemic was difficult. As per my bank contract, I was not a regular member of a team, and as such did not have access to the support of consistent colleagues or the formal support mechanisms in place in such departments. My shift patterns were unpredictable and myself and my peers could often find ourselves moved to unknown wards at the last minute.

This is an area where medical schools could have played a more prominent role. Having issued the call for action to medical students, there was a moral duty to minimise the chance of students being damaged either physically or emotionally in the process. A recent study has found that empathy declines the further through medical school an individual is (5).

Consequently, students very early on in their training are at a heightened risk of compassion fatigue and emotional burnout. Early-year medical students, unlike their seniors, have not had the chance to develop robust coping skills to manage the impact of moral injury, or even the skills to manage the more pedestrian stresses of working irregular shift patterns in busy clinical settings. Whilst the Medical Schools Council issued advise that pre-clinical students should not be in clinical roles and that students should stay in one department and have 'buddies' to support if they were to move, it was clear that much of their guidance was not heeded once students were placed in their roles at local hospitals (2). It is unsurprising to me that rates of mental health crises have risen dramatically over past months given that I was one of many that were left to deal with their own emotional difficulties largely alone.

The Risks

Although guidance from the Medical School Council explicitly emphasised the importance of ensuring appropriate access to and training in the use of PPE (2), this was an unrealistic aim in the early weeks of the pandemic. One week we found ourselves using bin bags instead of aprons. When asked to look after a Covid positive patient with dementia who was distressed and behaving unpredictably, I remember being told to wear an FFP3 despite not being 'mask fit trained' to ensure it adequately protected me. I remember feeling fearful as I spent several hours in a small cubicle with this patient, as they waited for transport. 'I didn't sign up for *this*' I thought at the time, but with the pressure of the department at the time, I also did not feel able to say no. For days afterwards I isolated myself, fearing that I might be infected and could pass on infection to someone more vulnerable than myself. I finally received mask fit training six months after I had started working.

Final Reflections

The Covid global pandemic has changed the world. It has put health systems under enormous pressure and altered almost every aspect of human life in some way. It has also thrown up a huge range of ethical challenges in health care, from public health decisions about vaccination strategies, and when to lockdown a whole country to protect the vulnerable, to my individual decision, as a medical student, to work on the frontline.

On a personal level, the time I have spent working over the last 18 months has no doubt accelerated and enhanced my learning, built my resilience, and eased my transition to clinical placements and ultimately to life as a qualified doctor. I realise that have been one of the lucky ones – I have continued to work, to stay connected with people and I have stayed well. Others have not been so fortunate.

This experience has made me value the training in professionalism and ethics that I had already received, and I hope that it spurs medical schools to consider extending these courses and perhaps also introducing training specifically for pandemics. At times of extreme pressure, doctors and health workers need their professional values more than ever. Being guided by principals of Good Medical Practice (6) has helped me personally to navigate my experiences ethically and professionally.

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References:

1. Nguyen L, Drew D, Graham M, Joshi A, Guo C, Ma W et al. Risk of COVID-19 among front-line health-care workers and the general community: a prospective cohort study. The Lancet Public Health. 2020;5(9):e475-e483.
2. STATEMENT OF EXPECTATION: Medical Student Volunteers in the NHS [Internet]. Medical Schools Council; 2020 [cited 4 July 2021]. Available from: https://www.medschools.ac.uk/media/2641/updated-volunteering-guidance-020420.pdf
3. Shay J. Moral injury. Psychoanalytic Psychology. 2014;31(2):182-191.
4. Murray E, Krahé C, Goodsman D. Are medical students in prehospital care at risk of moral injury?. Emergency Medicine Journal. 2018;35(10):590-594.
5. Hojat M, Shannon S, DeSantis J, Speicher M, Bragan L, Calabrese L. Does Empathy Decline in the Clinical Phase of Medical Education? A Nationwide, Multi-Institutional, Cross-Sectional Study of Students at DO-Granting Medical Schools. Academic Medicine. 2020;95(6):911-918.
6. Good Medical Practice. General Medical Council; 2013 [cited 4 July 2021]. Available from: https://www.gmc-uk.org/-/media/documents/good-medical-practice---english-20200128_pdf-51527435.pdf