‘The medical student response to the Covid-19 Pandemic’

On the 29th of January 2020[1] the first case of the SARS-Covid-2[1] (Covid-19) was reported in the UK- a figure that, at the time of writing, now stands at 3.93 million[1] with 112,092[1] deaths recorded with a positive Covid-19 test in the previous 28 days. With this, a year of disruption ensued with schools, businesses and workplaces being shut by law to help stem further spread. *As a first-year medical student this meant that my summer 2020 term was condensed and moved online, along with the end of year exams.* The return to in-person teaching in September entailed increased safety measures but reduced hands-on experience, which contradicts expectations of medical school. As per the General Medical Council’ guidance on achieving good medical practice[2] it is important to ‘engage fully in the learning process’[2] in order to gain essential skills and knowledge that form the foundation of our medical careers however the past year of disruption has altered the ability of students nationwide to do so.

Whilst attending a General practice placement in early January 2021, a 30-year-old patient presented with dysuria and polyuria for the previous 3 days. They had a diagnosed urethral diverticulum after a 4-year history of recurrent urinary tract infections, and were halfway through a course of 10 Hyoscine injections when the pandemic started. Along with many other services, non-urgent urological interventions were paused for the foreseeable- meaning the patient was not able to finish their course of treatment. In response to the 2009 Swine flu pandemic the British Medical Association[3] published guidance that stated the forefront priority of healthcare services should be to ‘minimise the harm of a pandemic’[3] by halting non-essential services, and respectively this reinforces the third pillar of medical ethics- non-maleficence[4]. However, this is protecting a theoretical patient by intending to stop further spread of the virus rather than treating the actual patient with a health complaint, and indeed contradicts the second pillar of medical ethics- beneficence. From a consequentialist perspective the patient has been denied their right to treatment, with the consequences including further discomfort and disruption to their home life, all without any physical or measurable gain. *I find this difficult to comprehend. To stop treatment mid-course only means the treatment must be started from the beginning once procedures can recommence- wasting time and money for the health service- and frustrating the patient who lost all benefit they had gained. In a profession that most join in order to ‘help others’ it can feel demoralising that even best efforts derive no return for the patient*. By reducing services and redistributing medical professionals across the Trust patients are being denied treatment, and figures state that due to the effects of the pandemic 1 in 6[1] of the British population is on an NHS waiting list for a procedure with more than 48%[1] having waited more than the 18-week standard[1].

During the same placement a 34-year-old patient was consulted by phone for new depressive and suicidal thoughts. The patient worked as a pharmacist and had planned several ways to end their life using the pharmaceutical products they could access. There was great urgency to ensure the patient was safe, and that help was provided immediately to prevent them coming to harm. Research shows that more than 50%[3] of GP consultations were conducted by phone from March 2020 onwards, compared to just 14% in February[3]. To conduct such an emotive consultation by phone to someone in such a desperate crisis seems wrong. As doctors we are taught the primary objective must be to act in the best interests of the patient, as well as the second pillar of medical ethics (beneficence), including to work to keep them from harm. However, this has been hindered by the imposition of restrictions and changes. *I have learnt that to consult with someone in crisis is extremely difficult even without the*

barriers imposed by Covid. Considered with a deontologist perspective, while we are intending to help this patient and theoretically that should provide a positive outcome, the circumstances in which we are acting are volatile as to prevent any kind of conclusion certainty. *Furthermore, the doctor whom I was shadowing did not inform the patient that I was present and party to the conversation.* This is a direct violation of the confidentiality codes that all medical students and professionals must abide by, and indeed of the fourth pillar of medical ethics- autonomy[4]. It is sometimes necessary to break the conventions of confidentiality if there is concern around the safety of the patient, and it could be considered an important case for a medical student to hear. Yet, *I found it to be a situation where I felt uncomfortable questioning the doctor's choices. The pandemic has increased job pressures and stresses, and hence I felt it inappropriate to ask them to make the patient aware I was attending the call, which I will endeavor to do in the future.* While phone consultations continue outside of the pandemic, it would be less likely for this situation to occur. Issues around the conduction of consultations are not the only ethical dilemmas to afflict the health service.

Nationwide shortages and poor-quality PPE have been some of the logistical issues that have blighted health trusts during the pandemic. Yet, the government permitted the return of medical students to in-person teaching, to ensure they achieve the desirable quality of education, with additional safety measures in place. *A recent teaching session of mine required 4 pieces of disposable PPE per student; a surgical mask, apron, visor and gloves- all to learn how to carry out a peripheral nerve examination.* Entirely online learning and reduced contact time with professionals of the field did compromise the quality of teaching, so the decision to return is understandable. Nonetheless, it is difficult to see why we should be using these resources for non-essential teaching sessions, which could be repeated or retaught, and the PPE used within healthcare settings to ensure the continuation of safety to those working with virus patients. Environmentally, the additional items of disposable PPE that the teaching of medical students will contribute will add to the volume of un-biodegradable plastic in landfill. This does bring into question the role of medical students within the wider healthcare setting.

The advent of the pandemic brought requests for medical students to assume positions such as Healthcare assistants (HCA), or later vaccinators. *At my medical school we received many invitations to train to work as HCAs from Trusts and specific hospitals in the area.* While appropriate training would be given, the role of the medical student begins to change; from student to employee and the emphasis is removed from learning. Indeed, it has been suggested that medical students who act solely as learners introduce 'unnecessary risks'[5] to both patients and clinicians but simultaneously students should not be seen as a 'principal team member'[6] responsible for patient safety. Under beneficence it could be deemed that medical students should take up work in healthcare settings, as they have a greater clinical knowledge and experience that could be useful. Contrastingly, non-maleficence means that the students must 'recognise the limits of their own competence'[2] to prevent patient harm, but this may be overlooked in a stressful environment. *Initially I felt obliged to help relieve the burdens on the healthcare system, but realized that my priority must be to focus on my studies.* Similarly, the first lockdown heralded requests for medical students to assist in the childcare of medical professionals who struggled with school closures. This role holds no similarities to that of a medical student and perhaps can be interpreted as an exploitation of

the good nature- a trait common within those undertaking such training- of the students. This also reinforces the medical culture that dictates the profession to be rigorous and demanding, where students are expected to balance many commitments alongside their studies- *something many find challenging.* Indeed, through the course of the pandemic the role of the medical student has transitioned from learner to willing volunteer- perhaps not completely by our own volition. This can designate a level of responsibility that not all students care to assume.

Despite restrictions, some students have continued to socialise without regard for the wider effects of their actions. *A housemate of mine attended a gathering- numbers exceeding that permitted by restrictions at the time- along with another student who was experiencing Covid symptoms. They had felt unwell enough to get a test, which came back positive the next day. Consequently, my housemate become unwell, and the entire house entered a period of isolation.* Not only was this breaking the law, but it also subverted the social role of the healthcare professional- one that is assumed involuntarily upon the initiation of medical training. Socially, such professionals are usually deemed to be of high moral status and hence their behaviour to be of example to others. The question then arises around the point at which a student bears the same social responsibilities as a qualified professional. Similarly, from a utilitarian perspective the students may have personally gained from this gathering- the enjoyment from socialization is something many miss- but there is no wider gain to be had. University education primarily provides academic tuition but part of the learning process for a vocational course is around the assumption of the professional role- rather than that of a student. This transition may, however, have been accelerated by the pandemic and the circumstances it has created.

Much in line with the understated work of the NHS, the medical student experience of the Covid-19 pandemic is not one of triumph but quiet observation and progression towards a career in a field visibly struggling under pressure. To try to learn a profession during a time when most services are either reduced or paused all together means to learn a profession with little solid foundation from which to base to rest of knowledge and skill upon. It will, however, enable students to foster flexibility and the ability to adapt to a changing environment. The response to the requests for students to assist during the pandemic exhibit the good nature of the next generation of doctors and their willingness to assume responsibility in fairly adverse conditions. *My own experience has been more of that of a witness to the pandemic, others will have had different experiences, but I have learnt more than I could have outside of these circumstances.*

References:

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