# The medical student response to the COVID-19 pandemic

## Introduction

In this essay I will reflect on my first shift working in an ICU as a Healthcare Assistant, during the COVID-19 pandemic. Due to a second surge of infected cases in January 2021, the NHS workforce, already under significant pressure, needed more help. Thus, hospitals contacted local medical students for work.

The night shift I am going to talk about had a multidisciplinary team (MDT) consisting of respiratory consultants, foundation doctors, nurses, and healthcare assistants (HCAs). My main purpose was to support anyone in the MDT to provide the best care possible to the patients on the ward.

The COVID-19 outbreak has had a negative impact globally and has affected everyone. One of the main repercussions is the loss of so many lives. As of 26th February 2021, there has been a total of 123,282 deaths in the UK.[1] Such data demonstrates the overwhelming nature of the pandemic that resulted in: collective bereavement and grief, worsened individuals' mental health and has led to a new set of challenges. I will be focusing on the standard of care provided, withdrawing treatment and the effects of moral distress in healthcare professionals.

## Significant clinical encounters

Throughout my first shift in the ICU, I have seen the devastating consequences of COVID-19. All patients were in a critical state and I have contributed to delivering the necessary care by restocking the trolleys, cleaning and finding equipment. Interacting with two different patients has specifically affected me, personally and professionally. The two clinical encounters are connected to one another, as they occur chronologically; they had an emotional domino effect on me.

All I knew about Patient A was that he had been on a ventilator for about three weeks, had COPD and renal failure, which resulted in constant treatment on a dialysis machine. Over the night, his oxygen saturation dropped frequently, and he required regular suctioning. Seeing no improvements for the past couple of months, the MDT reached the decision that withdrawing treatment would be in the patient's best interests. As a result, the patient's

relatives were contacted. Amidst the pain that would irrevocably cause to the family, the potential loss of this patient's life made me feel helpless. I remember thinking about all the other thousands of people that must have gone through similar circumstances in this pandemic and an immense wave of sadness washed over me.

As I left Patient A's bedside, heading to another bay, one of the nurses suggested that I speak to Patient B, the only conscious patient in the ward. After talking about how much he missed home, he asked me if I could hold his hand. Considering I was already upset from the previous patient encounter, my eyes teared up even more and I would have started crying if I held his hand. Since I did not want Patient B to be burdened with my feelings, I explained that I would have visited him again later, as I had to finish restocking the trolleys. In hindsight, I am not sure how convincing I sounded, and I am extremely mortified for my lack of courage at the time. Why have I allowed my emotions to affect my professionalism? I still ponder over this question and it was further distressing to learn that later in the night, Patient B had deteriorated. He had to be sedated and put on a ventilator.

**The ethical guidelines and my perspective on Patient A**

The implications of the clinical decision for Patient A to having treatment withdrawn are based on the pillars of medical ethics. Prolonging a patient's life (which would be of a lower quality of life) goes against the principles of Beneficence and Non- Maleficence. [2] This is because the former is about doing good and the latter about doing no harm. Therefore, since the present treatment for Patient A is not working and hence it is only extending his suffering, the next approach to implement an End-of-life care plan is appropriate, as indicated in NICE guidelines. [3]

Looking at BMA guidelines, such decision is lawful, as the same principles of the allocation of organs for transplantation upheld by the Court of Appeal are followed. [4] Furthermore, according to the Doctrine of Double Effects, balancing the benefits and the burdens of a treatment are at the basis of best practice, which has been applied in this case, due to Patient A's signs of unresponsiveness to treatment and lack of recovery. [5]

However, how would we react if we knew that this decision was partially influenced by the lack of spare ventilators on the ward? This would cause a conflict with the principle of distributive justice and resource allocation when at full capacity. The issue lies in finding a compromise between the utilitarian perspective of benefitting for the greatest number of people, with the risk of affecting the quality, and the equity for any given treatment, whilst providing a high standard of care. [6] Ultimately, the idea of maximising ventilators involves Scanlon principles, which evolve around relative sacrifice and gain. This explains the MDT's decision in further depth, as at the time, I was troubled to learn that Patient A would no longer receive treatment.

## The ethical guidelines and my perspective on Patient B

In terms of Patient B, the ethical challenge arose between my professional obligation and my emotions. According to the GMC, the Duty of Care is about making the care of patients our first concern. Thinking back about my inability to hold the patient's hand, especially when the patient needed some human connection, I understand that my fear of being seen vulnerable stems from an assumption deeply ingrained in our society. The ordeal of 'rescuer and rescued' in the dynamic between doctor and patient has been associated in the medieval past, yet I could not realise that at the time. Therefore, this clinical encounter has influenced my personal growth. Dealing with the guilt and shame that followed has been a tumultuous journey, in which I gained some relief, only by discovering that Patient B's request was eventually carried out. This is because I was made aware at the handover in the morning that my fellow medical student and HCA co-worker held Patient B's hand before the doctors decided to sedate and ventilate him.

## Long term considerations and conclusion

Overall, this clinical experience has highlighted to me areas of improvement in terms of my interactions in a healthcare setting, influenced my development as a person and future doctor and questioned my implicit values about the doctor-patient relationship. There has been a mixture of emotions throughout the shift, ranging from utter worry and despair to hope and gratitude.

At the start of my shift, I felt anxious as I was expecting the situation in the ward to be critical. My apprehension was reinforced as I felt distant wearing PPE and I kept thinking about being safe with its correct donning and doffing, plus monitoring the other MDT members' PPE. My interactions with all patients were limited and I had a passive role in contributing to their care, given my lack of knowledge in the technical procedures and operating the required machines. The uneasiness could only get worse, as some staff members assumed I knew certain things, simply because I am a medical student. This made me feel under further scrutiny and I could not help feeling that my presence there was undeserved. Therefore, I think for next clinical experiences, I am planning to be more open about what I know and do not, sharing my thoughts about a task I have been allocated and not being wary of getting judged to be 'too sensitive'.

Another learning point for the future is trying to repress my underlying tendency to assume making upsetting decisions (e.g., withdrawing treatment) and breaking bad news should not affect healthcare staff's professionalism. I realised that there should be a balance between displaying empathy and upholding professionalism. Yet, a fear of becoming insensitive and dehumanised to such scenarios is instilled in me and I think this is why I could not hold Patient B's hand when asked to. In addition, the importance of recognising the emotional impact of being involved in critical clinical decisions is also acknowledged by the Royal College of Physicians, stating that clinicians will undergo moral distress. [7] Therefore, I think that as much as doctors have a Duty of Care to patients, there is also a duty of self-care towards themselves. This led me to see why the emotional pain is inevitable and as a result, I believe being exposed to it now, will help me to better deal with it in the future.

Furthermore, I am also grateful to have had this experience. Sharing such vulnerable moments with the patients on the ward, assisting the highly skilled staff to deliver the best care possible and recognising the efficiency of communication alongside cooperation within the staff members was inspiring. I realise that it would have been even better if I shared my worries with the MDT more freely. In the morning, a couple of nurses and doctors asked me how I found my first shift and wondered if there was anything I wished to talk about: it was clear that the events taking place had a toll on me. Thinking about it now, I wish I did not hold back and talked about my feelings with them and explored their perspective on the situation. They could have advised me ways to cope emotionally as well.

Finally, I believe my experience as a HCA will have a positive impact on my clinical practice as I have gained a deeper insight into the MDT and patient relationship as well as discovering my own biases and weaknesses when working in a clinical setting.

**References**

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