Hearing the Call of Duty: What We Must Do to Allow Medical Students to Respond to the COVID-19 Pandemic

Adina L. Kalet, MD, MPH; Fabrice Jotterand, PhD, MA; Martin Muntz, MD; Bipin Thapa, MD, MS; Bruce Campbell, MD

In the coming weeks, the needs of critically ill patients will likely stretch Wisconsin's hospitals beyond their resource and personnel capacities as the COVID-19 pandemic rolls across the nation. New York City and other regions have been – or will soon be – forced to adopt crisis standards of care (CSC),[1] where health care systems are so overwhelmed that they find it impossible to provide the "standard" level of care to patients, thus confronting health care workers with choices never-before seen in their lifetimes. *In this context of emergency and scarcity, should students be "deployed" to care for patients?* These issues must be addressed now, before this rapidly evolving crisis – and the next one – reaches us.

A week ago, when the discussions were mostly theoretical, our conversations turned on pragmatic concerns around the ethics of least harm: removing students from all patient-contact clinical settings was necessary because (1) they deplete precious personal protective equipment (PPE) that other health care workers desperately need, and (2) as students, medical students are neither adequately prepared nor obligated – as they will be after graduation – to accept personal risk or contribute meaningfully to patient care under extraordinary circumstances.

Medical Education Disrupted

Over the past few days, most US medical students, sidelined in response to bans on group gatherings and the American Association of Medical Colleges (AAMC) recommendations to dial back all clinical education,[2] have predictably displayed a surge of volunteerism. Although welcome, this phenomenon exposes a third reason to consider prohibiting students from clinical care: if given the option to volunteer, some students might feel coerced to serve, worrying that their absence would trigger reprisal, such as lower grades or being excluded from future opportunities for training or research.

What Others Are Doing

In New York, and other states, senior students are being given the choice to graduate early and begin their residencies in mid-April instead of in early July.[3] Medical educators everywhere are scrambling to connect medical students with meaningful opportunities to serve patients, communities, and health care workers, while linking these activities with course and clerkship objectives. Patient and community education, virtual COVID-19 journal clubs, and telehealth for acute and chronic health issues are a few examples of activities implemented to match community needs, medical student skills, and learning objectives, while still limiting spread of the virus.

Adult Learners Capable of Making Their Own Judgements

Society views adults as being capable of making their own judgements and acknowledges that adults possess and can exercise freedom of choice without undue coercion. Several professions require participants to work in high-risk settings dedicated to the preservation of the lives of other individuals and the protection of society. Much as other young adults right out of high school or college seek out risk-inherent careers as fire fighters, police officers, nurses, first responders, and members of the military, medical students enter their chosen field with a social contract that includes possible hazardous duty.

Adult Learners Ready to Participate

Of course, under usual circumstances, society offers thorough training and requires certification prior to working in risk-exposed profes-

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Author Affiliations: Director of the Robert D. and Patrica E. Kern Institute for the Transformation of Medical Education, holder of the Stephen and Shelagh Roell Endowed Chair, Medical College of Wisconsin, Milwaukee, Wis (MCW) (Kalet); Associate Professor and Director of the Graduate Program in Bioethics, Center for Bioethics and Medical Humanities of the Institute for Health and Equity, MCW (Jotterand), Professor and Vice Chair, Department of Medicine, MCW (Muntz); Associate Professor of Medicine, Assistant Dean of Clinical Curriculum, MCW (Thapa); Professor of Otolaryngology and Communication Sciences, MCW (Campbell).

Corresponding Author: Adina L. Kalet, MD, MPH, Kern Institute for the Transformation of Medical Education, Medical College of Wisconsin, 8701 Waterplank Road, Wauwatosa, WI, 53226; phone 917.913.6010; email akalet@mcw.org; ORCID ID 0000-0003-4855-0223.

sions. Society also makes contingencies, under extraordinary circumstances, to allow individuals who are incompletely trained to serve.[4] Although all medical students have gaps in their clinical preparedness, they should, at this stage of education, be adept at "learning how to learn." Preclinical medical students should be capable of adopting skill sets allowing them to provide supervised medical care. Clinically experienced senior medical students, having already worked in interprofessional teams with practicing clinicians, should be proficient at learning how to screen, monitor, triage, and provide basic, urgent care for patients with symptoms of COVID-19 and other patients with a host of acute or chronic concerns. Moreover, their skills can readily be augmented with focused, succinct training; our duty is to develop and deliver this training.

Professionalism, Moral Agency, and Professional Identity Formation

Medical students participate in ceremonies during orientation to medical school where they receive their first white coats and usually recite a professional oath that they will reiterate at the time of graduation. As medical students, they enter as novices into a profession that has a clear and unambiguous commitment to moral fidelity, justice, and service.

We believe that enabling the safe and effective deployment of our students back into the clinical arena is the responsibility of medical educators; it is our civic, moral, and educational duty to quickly and creatively enable our students to act on their altruism, courage, and sense of duty.

Fundamentally, a particular student's response to a "call to duty" is a combination of their sense of professional obligation, moral agency, ability to tolerate moral ambiguity, level of emotional resilience, and maturity of their professional identity. Professional Identity Formation (PIF), a critical goal of medical education, is defined as "the process of internalizing the medical profession's core values and beliefs," so that one begins to "think, act, and feel like a physician."[5] Medical students develop their medical PIF at different points in their education.[6] On entry to medical school, some have already internalized this identity. Others – even as they near graduation – have yet to do so; but most are already thinking, acting, and feeling ready to act as physicians.

We believe that frustrating the altruism of our novices is paternalistic, disingenuous, and detrimental to their future careers in medicine. Even while preserving PPE, most medical students can be deployed to procure, produce (with a sewing machine!), and distribute this equipment. And although there are risks to students re-entering the clinical arenas, medical education leaders must collaborate with health systems to develop meaningful roles for students to fill identified needs, effectively and efficiently train them and other health care workers to collaboratively care for patients in our transforming work and learning environment, and study the impact of student re-entry. We need to understand and tolerate the reality that some students, as is the case with other health care workers, will not be able to safely participate in all activities due to underlying health conditions, personal exigencies, and other risk factors. As the situation evolves, the needs to care for our community will change and, in response, students will nimbly adapt.

Avoiding Coercion

Clerkships will be transformed and students will have multiple options. Those that choose to volunteer to participate under supervision should undergo interviews that screen for students enlisting for the wrong reasons (eg, a sense of coercion, a "hero-type" approach, worrisome psychological conditions, etc), and make certain that they understand the implications and unknowable risks of their service.

As an institution dedicated to training the next generation of physicians according to the triple aim of medical education – character, caring, and competence – we have an obligation to create the conditions for these students to demonstrate their altruism, courage, vulnerability, and dedication to be present to ease suffering. Ultimately, however, this effort will require a commitment of the whole education community and the world beyond to support, nurture and help those rising to the call.

In Summary...

A few times each generation, there are crises. This is ours to seize.

Because we are health care professionals, we seek opportunities to help patients and colleagues, even though it is safer to stay home. The instinct to run toward terrifying, uncertain situations rather than away is a result of our character, education, and training. We watched our role models do the same. Our students are already showing that they, too, have this instinct, and it is up to us to develop safe, meaningful, and life-affirming opportunities for them to serve.

Our goal is to work together, finding ways to – as safely as possible – integrate students into the fold. As medical educators we will use the pandemic as a teaching moment while everyone strives to provide compassionate, character-driven, competent care and healing for as many of our fellow human beings as we possibly can.

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REFERENCES

1. Emanuel EJ, Persad G, Upshur R, et al. Fair allocation of scarce medical resources in the time of Covid-19. *New Engl J Med.* Published online March 23, 2020. doi: 10.1056/NEJMsb2005114

2. Interim Guidance on Medical Students' Participation in Direct Patient Contact Activities: Principles and Guidelines. American Association of Medical Colleges. March 30, 2020. https://www.aamc.org/system/files/2020-03/meded-March-30-Interim-Guidance-on-Medical-Students-Clinical-Participation_0.pdf. Accessed March 31, 2020.

3. Ducharme J. NYU med school will graduate students early to help New York fight coronavirus. *Time Magazine*. March 25, 2020. Accessed March 29, 2020. https://time.com/5809630/nyu-medical-school-early-graduation/.

4. Sunshine G, Thompson K, Menon AN, Anderson N, Penn M, Koonin L. An assessment of state laws providing gubernatorial authority to remove legal barriers to emergency response. *Health Security.* 2019;17(2):1-6. doi:10.1089/hs.2018.0126

5. Cruess RL, Cruess SR, Boudreau JD, Snell L, Steinert Y Y. Reframing medical education to support professional identity formation. *Acad Med.* 2014;89(11): 1446-1451. doi:10.1097/ACM.0000000000000427

6. Kalet A, Buckvar-Keltz L, Harnik V, et al. Measuring professional identity formation early in medical school. *Med Teach.* 2017;39(3):255-261. doi: 10.1080/0142159X.2017.1270437.

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