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INSIGHTS

THE CLINICAL TEACHER

Bedside teaching during the COVID-19 pandemic

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The impact of the SARS-CoV-2 (COVID-19) pandemic on medical education is well described.[1] Here, we describe an aspect that has received little attention so far, namely the ethical implications of continued bedside teaching. As a team of clinical educators supported by one of our students and an ethicist, we describe this unexpected challenge and how we navigated it in an already existing sea of COVID-induced issues and uncertainty.

Our organisation provides clinical placements to just under 300 medical students from the University of Manchester. On 4 August 2020 we received communication from clinicians raising concerns over the continued presence of students on surgical wards and in theatre. As part of the new admission pathway, elective patients are required to self-isolate and complete a COVID-19 swab before they are admitted to a "super-green" ward, where entry is limited to small numbers of staff and to essential interactions. Our colleagues, concerned that student presence is not essential and increases the risk of COVID-19 transmission, referred the case to the local ethics committee. The subsequent ethics analysis was framed by the four biomedical ethics principles of non-maleficence, beneficence, justice and autonomy.

Compliance with the principle of non-maleficence demands that positive steps are taken to avoid harm and minimise risks; stopping bedside teaching would indicate compliance because it reduces the risk of COVID-19 exposure to both patients and students alike. It might also help to preserve protective equipment[2] and avoid exacerbation of (already high) anxiety for patients. Furthermore, it should be noted that bedside teaching in COVID-19-positive patients would be at odds with specialty guidance such as the British Thoracic Society's guidelines which require that contact between COVID-19 patients and health care professionals is minimised.[3]

The principle of beneficence demands that health care professionals take steps to act in the patient's best interests. If steps are taken to stop bedside teaching, this decreases the risk of patient exposure to COVID-19. It also releases staff and reduces the workload for teams who may be working under great pressure. However, the presence of medical students can also have positive effects. For example, during the first wave students volunteered to work as health care assistants. They also provided inpatients with welcomed interactions that were otherwise sparse during times of strict social distancing and isolation.

It is quite normal for ethics analysis to involve the weighing-up of harms and benefits in order to decide upon the 'best' course of action. For the individual patients who are exposed to students via bedside teaching, it appears likely that the harms could outweigh the benefits. However, the principle of justice demands that equal consideration is given to the interests of *all* patients. While the stopping of bedside teaching might maximise the benefits for these patients, how will it affect the interests of other and future patients?

Stopping all bedside teaching would have lasting implications for the wider health economy and it could result in a temporary stop in the "supply chain" for a variety of health care professions. The benefits of continued bedside teaching are obvious when the effects on future generations of patients are considered. In keeping with this reasoning, government and medical schools in the UK have classified medical students as 'essential members' of the workforce.[4] Another

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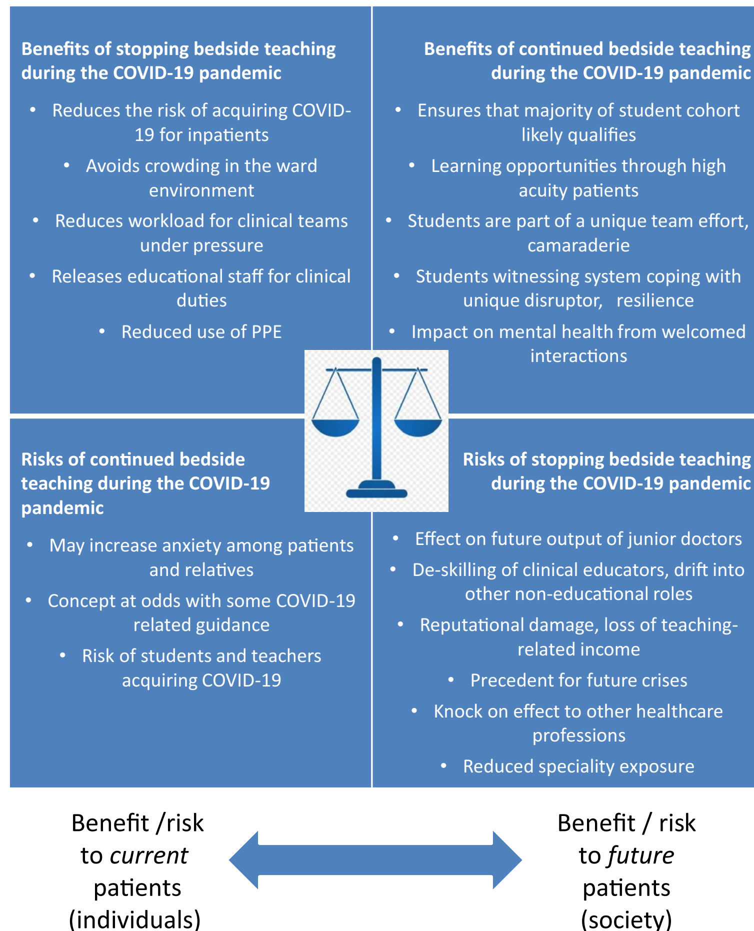

FIGURE 1 Four-quadrant decision matrix of risks and benefits of continuing and stopping bedside teaching during the COVID-19 pandemic.

potential longer-term implication of pausing bedside teaching is that clinical educators may become de-skilled.

When, in keeping with the principle of justice, the interests of other and future patients are represented in the balancing of risks and benefits, it becomes clear that the benefits of continued bedside teaching are likely to outweigh the harms (Figure 1). Nevertheless, the deliberate exposure of a patient to increased risks without consent would be unethical. For this reason, respect for patient autonomy is an essential ingredient for ethical bedside teaching in the COVID-19 era. Patients must be informed of any additional risks and made aware that they can refuse participation. In this sense, patient participation in bedside teaching is akin to participation in a clinical study because consent is provided for altruistic reasons, for the greater good.

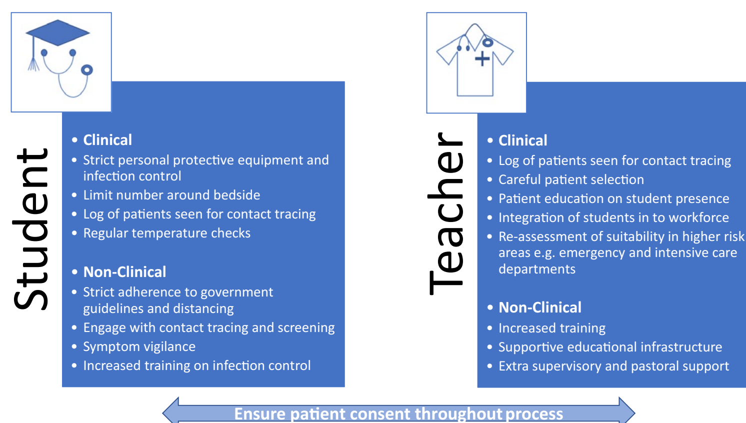

FIGURE 2 Suggested strategies to minimise risk of asymptomatic exposure to COVID-19 during bedside teaching and medical student presence in clinical areas.

In our experience patients are, if anything, more willing to participate in teaching than before; we speculate that they, too, have balanced risks and benefits and come to a similar assessment. Nonetheless, regardless of their willingness, when people take on risks every effort is needed to minimise the potential for harm (Figure 2).

On 7.9.2020 the clinical ethics committee agreed with our assessment and allowed us to continue bedside teaching. Osler stated, 'to study the phenomena of disease without books is to sail an uncharted sea, whilst to study books without patients is not to go to sea at all'.[5] We found ourselves out at sea when faced with this challenge. In hindsight, we are grateful to our colleagues for raising a concern that we had overlooked. This gave us the opportunity to explore clinical ethics and find a route back to safe harbour.

ETHICS APPROVAL

Ethics approval for this work was not required at our institution.

AUTHORS' INFORMATION AND CONTRIBUTIONS

Madelena Stauss is a specialist trainee in Nephrology and senior education teaching fellow at Lancashire Teaching Hospitals NHS Foundation Trust. She contributed the clinician perspective and wrote much of the manuscript. Hetty Breed is a medical student with the University of Manchester and previous year 3 student representative at Lancashire Teaching Hospitals NHS Foundation Trust in Preston, UK. She is currently intercalating as an Anaesthetics and Critical Care Student at Imperial College London, London, United Kingdom. She contributed the student perspective to our manuscript. Kate Chatfield is Deputy Director of the Centre for Professional Ethics at the University of Central Lancashire. She sits on the Lancashire ICP Clinical Ethics Committee who reviewed the original concerns and contributed ethics oversight to the manuscript. Prof Madhavi Paladugu is Hospital Dean at Lancashire Teaching Hospitals NHS Foundation Trust in Preston, UK. She contributed to the manuscript. Bachar Zelhof is a Consultant Urologist at Lancashire Teaching Hospitals NHS Foundation Trust in Preston, UK. He submitted the original query to the clinical ethics committee and contributed to the manuscript. Alexander Woywodt is Associate Undergraduate Dean at Lancashire Teaching Hospitals NHS Foundation Trust. He wrote the submission to the ethics committee, came up with the idea for the manuscript and contributed to writing.

CONFLICT OF INTEREST

None.

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