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Commentary: COVID-19 pandemic from medical students' perspective in Nigeria

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Memoirs of a medical student

The novel coronavirus disease (COVID-19) pandemic is present in nearly every country in the world. As of May 26, 2020, there were 8,063 cases in Nigeria and 5, 652,116 cases worldwide. These numbers attracted the attention of people more than other international news. In Nigeria, schools were closed and students were asked to study at home. Likewise, pre-clinical medical students were asked to do the same. However, medical students who are in their clinical years like myself though not qualified as healthcare professionals neither are they regarded as laypersons (Neto, *et al.*, 2020). Therefore for these groups of medical students who were required to stay in the hospitals, things became complicated. This is because conventional medical knowledge, clinical care, and personal protective skills of these set of medical students have not been saturated, not to mention the unclear pathophysiology of the COVID-19 virus. Also, there was this issue of getting infected. This is because the dividing line that dichotomizes the global population into medical staff who provide care and patients who receive care has never been this thin. It has been noted that healthcare providers have more likelihood of not only getting infected but also spreading the virus (Chirico et al., 2020; Gallagher & Schleyer, 2020). This was a big source of fear for medical students.

There was a 55-year-old male presented with dyspnea on exertion for one day. Despite no obvious respiratory symptoms, his oxygen saturation was about 91-92%. Electrocardiogram showed sinus tachycardia with partial right bundle branch block and a chest x-ray was within normal limits. However, peripheral infiltration of both lower lungs compatible with COVID-19 was revealed. The patient was immediately moved to an airborne infection isolation room at the hospital where a nasopharyngeal swab was obtained for test and the patient was indeed positive. Performing an echocardiogram on this patient to rule out structural heart disease added up exposure time.

However, we were taught that a good medical student is required to undertake history-taking and physical examination intensively— approximately 45 minutes per patient on average, in my own experience. Nigerian medical students have been taught to take care of patients as if we were looking after our family members. It was partially acceptable to make an inconclusive diagnosis or treatment plan but unacceptable for a medical student to show inadequate compassionate care, especially in the Nigerian

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context. Unfortunately, the longer time we spend with an infected patient, the higher the chances of getting infected ourselves. This posed a big dilemma for medical students.

The moment I knew that the patient was COVID-19 positive; I started asking myself so many questions, including about the reliability of the personal protective equipment that I wore that day. Did I wear it correctly? Did I clean my hand adequately afterward? There was real anxiety and stress while waiting for the result from laboratory investigations of hospital staff who had contact with the patient, I did not feel discouraged from taking care of patients. I believe in remaining calm and finding a way to learn and practice skills through this situation. Although physical protection is essential, I learned that the ability to remain focused was crucial during the pandemic. There have been several atypical presentations of COVID-19 cases; abdominal and testicular pains, sudden loss of smell, shortness of breath without fever or respiratory symptoms. Patients come to the hospital without a clue of COVID-19 so it was very difficult to indicate which patient is 'high risk'. Hence, the medical school policy to limit exposures or procedures in high-risk patients for medical students in Nigeria was quite difficult to adhere to.

COVID-19 has a potentially significant impact on medical students and medical schools in Nigeria. For instance one of my classmates became ill while at school but tested negative for COVID-19. After returning to his home he was still ill and was taken to the emergency room of a hospital where he tested positive for COVID-19 and had to be admitted to the intensive care unit for weeks. After he got better, he became depressed because he didn't know how he got infected.

Medical students in preclinical years in Nigeria are now being taught online in other to decrease the gathering of students into the crowded classrooms and also reduced physical interactions. However, those in clinical years like myself are in their questionable roles and responsibilities. While I hope that a different approach has been taken as necessary tools for other countries, I am still not sure if I prefer a clear and legitimate role and responsibility as a doctor to being an in-training medical student with unclear safety skills in Nigeria.

Conclusion

I believe the skills and training gained regarding infection control in the medical curriculum in Nigeria have been minimal to none. The COVID-19 pandemic introduced a unique opportunity for medical students and a majority of medical staff to learn about personal protective equipment (PPE) for the first time. This is an outstanding starting point of a new norm in our medical society, along with the other emerging social norms such as wearing a mask and washing hands.

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