

Lessons from the Covid-19 pandemic. A collective autoethnography of bioethics education

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Abstract

The Covid-19 pandemic disrupted academic life worldwide, for both students and teachers." Then the next sentence stating the purpose of study is highlighting that its specifically internal medical students and bioethics teachers. The purpose of this study is to shed light on the collective adversity experienced by international medical students and bioethics teachers amidst the Covid-19 pandemic in relation to both personal and academic life. The authors wrote subjective memoirs that were analyzed using a collective autoethnography method to find similarities and inconsistencies between their experiences. The results consist of three different sections; falling apart, bouncing back and bioethics. 'Falling apart' explores the breakdown of daily lives during the initial stages of the pandemic, shown through subjective quotes contextualized through the authors commentary. The consensus is that the journey home and the move to remote education, were the two main perpetrators for the breakdown 'Bounce back' focuses on the authors' rebirth after the initial breakdown, by acquiring new information about the virus, discovering substitute hobbies, like home workout or dancing, and the students learning to adjust their exam expectations. 'Bioethics' is about how it was to learn and teach this subject during the pandemic, and how you can apply bioethical knowledge to better understand and cope with some of the pandemic's moral dilemmas. The study presents how important bioethics is during a global pandemic, as well as the struggles of remote learning, from both the students' and the professors' point of view.

Background

Individual attitudes towards the restrictions on medical education related to the COVID-19 pandemic were tiding in time. In this collective autoethnographic study, we try to describe and understand how the public health interventions targeting the spread of the sars-cov-2 virus impacted the process of medical education of first year medicine students, and what the particular role of bioethics online classes was in understanding the social and cultural circumstances of the pandemic. The sudden change of the educational situation can reveal the hidden aspects of the biomedical curriculum,[1] which are not otherwise visible. Moreover, it can also help to understand, what the role of bioethics is, in medical socialization of first year students.

The Medical College of the university X arranges its medical program with a duration of 6 years in accordance to the X country legal requirements. The first-year tackles 'Ethics in medicine' as a 30-hour seminar together with anatomy, physiology, biochemistry, histology, history of medicine and genetics.[2] According to the formal curriculum, the aim of bioethics education ('Ethics in medicine') is to teach students three main goals. Firstly, giving students the ability to perceive the ethical dimension of medical practice. Secondly, familiarizing students with fundamental schools of moral thought, typical methods of ethical reasoning and argumentation. The last goal is to prepare the students for future moral dilemma problem-solving in their medical practice based on rational ethical argumentation. Topics that are taught are patients' rights, communication with the patient and their family in a trusting atmosphere and focus on the well-being of the patient.

COVID-19 is a new, human transmissible, coronavirus that introduced mass uncertainty around the world and still has ongoing questions surrounding it. At the time of the early stage of the pandemic, fever, cough, sore throat and headaches were reported as the only symptoms.[3] However now we recognize that there is a much larger range of symptoms, and it has been reported that scientists still do not know what the length of COVID-19 effects are, moreover, they are not able to explain individual differences between the severity of the illness.[4]

As COVID-19 transmissions spread globally, lockdowns became a standard response in many countries to control transmission and halt its unknown effects. The aim of lockdown was to keep the reproduction number (R) below 1, meaning, for each affected individual to transmit to less than one person. In order to achieve this, social interaction was limited, and movement restricted for only essential purposes, such as food shopping and exercise. There are a few countries that are now COVID-free, and one of the measures that resulted in their success was due to timely and locally limited lockdowns.[5]

However, though lockdowns were effective at reducing transmission rates, they did not come without burden. Pain and sacrifices endured include, but are not limited to, increased number of deaths from other diseases (Guardian 2020),[6] ongoing effects on mental health and suicides,[7] (Thakur 2020) and the tragedy of many loved ones dying alone (Nelson-Becker 2020).[8]

The outbreak of the Covid-19 pandemic was a challenge to the educational system around the world, forcing most universities to move their classes online in a very short period of time. This rapid digital transformation was accompanied by a lot of technological, organizational and socio-economic challenges. Many schools lacked technological infrastructure and digital competences among both the professionals and students.[9] Many studies report that the pandemic online education exposed, and further deepened, existing socioeconomical inequalities, since students from poorer socioeconomical backgrounds often lacked necessary technical equipment and decent working conditions.[10, 11] Other obstacles reported are heavy workload, difficulties to conduct exams online, and incompatibility of some subjects such as clinical medicine with an online mode.[9] Therefore, as Hodges et al. rightly clarify,[12] the accelerated digital transformation should be understood as an instance of 'macgyvered' (improvised) experiment of 'emergency remote teaching' rather than a proper online course. Preparation of such an online course usually takes months and is evaluated accordingly. Nevertheless, this 'emergency remote teaching' experiment brought some developments. Series of survey-based studies report some advantages of this experiment such as boosted confidence in the effectiveness of online medical education (Rajab et al. 2020),[13] research and technological innovations and socio-economical interventions,[9] as well as expressed teacher's readiness to transition to online teaching and necessity to incorporate such trainings into professional training.[14] Majority of existing studies, however, analyses teachers' perspective, and with limited reference to medical subjects and bioethics.

Our research endeavor was a form of collaborative autoethnography. In a collective autoethnography, a group of researchers tries to evocate their individual, personal perspective, and then in a more systematic manner, summarize and analyze their shared experience.[15, 16] A collective autoethnography can help to

avoid methodological and ethical pitfalls associated with a traditional ethnography, on the one hand, and an individual autoethnography, on the other.[15] A traditional, outsider perspective ethnography can be detached from individual and cultural understanding. This possible superficiality can entail exploitation of sensational information that is given without a proper cultural context, and in consequence it distorts others' experience, and shows a lack of respect, and in a symbolic way colonize other perspective.[15, 17] An autoethnography can be self-indulging, subjective and without scientific rigor. Moreover, an autoethnographer can exploit others, making them a part of their story without obtaining their informed consent.[16] As we describe further in more details, we have tried to do our due diligence to make the process of research and writing inclusive, multivocal and collaborative, with clear rules that were agreed upon a consensus.[16]

Autoethnography has already been successfully used to deal with the professional and personal experience of a teacher,[18] as well as several different areas where the boundaries between research and individual experience matters.[19] However, to our knowledge, there is no similar study focusing on the shared experience of students and teachers in a medical school during a pandemic, that is focused on the particular subject of bioethics education.

In the following sections we are going to describe our individual and group experience of studying and teaching bioethics as a part of medical curriculum. Our analysis will go beyond the description of individual perspective and will try to discern some common motifs or patterns. We think that the COVID-19 pandemic and the following changed circumstances taught us a certain lesson on how to study and teach bioethics, as well as what universities should teach their students in general. We also think that our experience can be a point of departure for future research that would deepen our understanding of becoming a better medical student, and then in consequence, a better physician.

Methods

We applied a collective ethnography method, that is supposed to capture individual experience and juxtapose it with others' individual perspective and common deliberation. On Sept. 19. 2020 J – a bioethics academic teacher - sent to his students who attended his online course 'Ethics in medicine' in spring semester 2020 and to O, who taught the same subject, an email with an announcement that he looks for co-authors of an autoethnographic paper on bioethics education during the pandemic. In a few hours the research team was composed. During the whole process of research and writing we used online communication (MS Teams) for online meetings, sharing documents, and writing different versions of the manuscript and we did not have an opportunity to meet in person.

In the first step of research, we decided through consensus how we want to tackle the problem of individual experience. We agreed that each of us would create a memoir of the spring semester 2020, focusing on the bioethics class and pandemic. We also discussed which aspect of the studying/teaching experience we wanted to specifically focus on our writing. During the online discussions, multiple areas of experience were suggested, but 3 were chosen after a round of voting and a discussion. These was

'Existential experience of COVID-19 pandemic', which focused on the personal experiences of the author during the pandemic. Second area of experience was 'Understanding the COVID-19 pandemic' which covered the underlying infodemic concerning COVID-19 from a social, cultural, political and scientific point of view. The final area of experience was 'Studying/teaching bioethics during the COVID-19 pandemic' which covered important experiences from the pandemic seen through the lens of bioethics. Further, each author was supposed to write a 2–10 pages memoir over 1,5 months that would cover her/his personal experience of the 2020 spring semester.

When the memoirs were ready, and after initial analysis of the memories, we focused on a limited number of overarching motifs. We worked in two pairs and one trio, and then compared our results in open forum online discussions. After agreeing on general motives and ideas, each sub-team (2 pairs and trio) of researchers was assigned to write a passage of the paper. All sub-teams contributed to the results and discussion sections.

During the project J held short online seminars on ethnographic research methods and writing research articles.

Results

Our autoethnographic efforts resulted in 7 memoirs written in English, different in length (from 1979 to 3850 word-count), writing style, and perspective. Some of us tried to keep a chronological order of events (H, J, K, M, O), whilst some of us divided our text into three parts that were supposed to cover pre-established topic-areas (A, R). All memoirs covered personal experiences of studying or teaching bioethics during the COVID-19 pandemic, however, we varied in the way we described our lives; some descriptions were focused chiefly on professional identity, describing private aspects of life merely as a background (J, O, A), some of us gave a more comprehensive picture of life, where private experiences were intertwined with studying. Moreover, some of us treated our memoirs as an opportunity to share more general reflections about studying and teaching bioethics (J), British response to the COVID-19 pandemic and public life (A), political and personal responsibility of world leaders (H, K), social and humanitarian situation in Ecuador (K), as well as role of social media and misinformation (K). Others shared their private ethical doubts and dilemmas associated with the COVID-19 pandemic (M, R). Despite many differences, there were also vivid common motifs and themes that could be expressed by two metaphors: *falling apart* and *bouncing back*. The metaphor of falling apart captures the manifold changes the outburst of the pandemic brought into our personal, professional and social lives, which for most of us, felt as a breakdown of normal life routines and a challenge to common patterns of understanding the world. The metaphor of bouncing back sums up our efforts to continue our life in the changed circumstances and our attempt to construct our personal and professional identity anew. We also devoted one section to focusing solely on the experience of studying and teaching bioethics, as it played an important role in understanding the pandemic and the attempted process of 'meaning-making' through it.

Falling apart

The pandemic started for all of us, when the university X and the X government introduced restrictions and then a full lockdown (March 10th-20th, Wikipedia). Until then, the Covid-19 pandemic seemed to be an abstract and faraway event. The restrictions made it seem real. And when the restrictions were imposed, we experienced disbelief, confusion, in some cases derealization, but finally we all accepted the reality of the new normal. As O recalls:

For me the Covid-19 pandemic began during bioethics class. (...) I noticed some unusual agitation in the room. «The suspended university from today on» – one of students read from his smartphone. «That sounds apocalyptic» – another commented. *Does it?* – I asked myself. For a moment I hesitated, still in a deep disbelief that it can ever affect us here, but the atmosphere was thickening by the second, and soon sucked me in. (...) I went home, confused and de-realized, as in the dream.

The shutdown of the university was not accompanied with a clear roadmap of further restrictions and instruction for students. Therefore, students' plans and expectations were shaken, as K noted:

Thoughts, fears, rushing my mind. What should we expect now... As international students and as young people in a world where information is overwhelming? What does a lockdown mean for me residing in X, for my dad and brother living in Austria and for my mom back in Ecuador?

All the students decided to go back to their homes. For international students (A, K, H), this transition was accompanied by a journey from X to their family countries. K poignantly depicts the atmosphere of this journey:

The airport is filled with angst, everyone walking defensively, waiting for anyone to screw up. What does "screw up" mean, I am not entirely sure myself, but I believe it has to do with sneezing too loud or forgetting to wear your mask the right way: over your nose and mouth. We are defending ourselves from what exactly? No one knows and yet we are so panicked.

The whole process was stressful to the point of showing somatic symptoms, as H confesses:

I was holding in obscene amounts of stress, and it was bound to overflow. My body ended up releasing all my stress the moment I got into my dad's car at the Norwegian airport and felt safe, which led to me puking in the car. I do not get stressed very easily, and rarely does it affect me physically. However, I ended up being very sick for a week.

Some of us also confessed that we were "terrified of [our] physical and mental health on top of being scared for the world and a virus without a cure". For those who recovered from mental health challenges, the pandemic and the stress it caused was not only another challenge, but also a reminder of past struggles and a threat that they might come back, if additional precautions are not undertaken:

Thankfully me and my parents do have a good relationship and generally communicate well. So, I told them how it was. I was struggling, I felt like shit and I was aware of it but wanted them to know. I told them to intervene if the situation escalated.[R]

All first-year medical students had just moved out and ‘spread their wings’. Now they were ‘forced’ to move back to their homes. Living with parents felt as a breach to a newly begun adulthood, as R noticed:

Not only how scared I felt about the pandemic, but also the fact that I would have to move back in with my parents (...) We were living on top of each other, having loud calls at all times of the day and few out of house outings. I felt like I was a child again, with the turmoil of teenage years. And when you’re in your mid 20’, that is not exactly a dream scenario.

Studying at ‘home-university’ was very demanding, especially for adepts of such a demanding faculty that medicine is. Most of the students felt a lack of motivation. It was difficult for them to find a balance between free time and studying. One of the main reasons of this was – as they report – the fact that both their free time and studying would be done in the same room or apartment. Home environment, as one student reports – was full of various distractions and temptations that made it difficult to focus. H recalls:

The biggest factor for me was not having my friends from my class around me. I get a lot of motivation from being around my class and working together to break down the difficult topics we are studying. Being alone makes this very hard. (...) This made some of the more difficult topics harder than they could have been, something that is not appreciated before and during exams.

The transition to entirely online learning and teaching was also not easy at first. The students felt that the first year of medical school abroad is exhausting and switching to online learning was perceived as another challenge. Students felt that they had to keep track of everything that was happening online. In addition, they felt stressed because of the uncertainty of not being able to plan more than a week ahead. The online infrastructure was especially challenging during the time of exams, as K reports:

The exam page lagging whenever moving on to the next question. Every test happening in a different format and a new platform. While taking the test, we need to turn our microphones; having to concentrate with the noise of 130 people is terrible.

Also for teachers, switching to online teaching was at first perceived as a challenge. O noticed that it was the first year of her work at a new faculty and:

The first class (which still took place at university in February) I was so stressed that I barely slept, and my voice almost broke down during the class. But it was good. (...) So, during the first month I was gaining some confidence, but then the pandemic broke out, and everything was new again.

We expressed our fears and worries for our families and close friends, we did not want them to get sick. The severity of COVID-19 for elderly people was the first and foremost concern, thus especially, if the

family lived in a faraway country. K decided to visit her grandparents in Ecuador as soon as the major restrictions were lifted, and after taking all precautions to avoid infecting her grandparents (quarantine and test):

I haven't seen my grandma in two years now, and the possibility of never doing it again is disheartening. I need to make sure I see her and hug her before anything bad happens to her.

Bouncing back

We went through a process of adaptation by using different coping strategies. Some of us started to avoid factors that could, in our opinion, affect wellbeing and mental health. For instance, some decided to cut off the news and social media. As R noticed "When reading the news, the first weeks of lockdown it became so overwhelming that I eventually stopped reading them".

As K pointily observed, expressing also the lesson of critical and autonomous thinking the pandemic (and the accompanying phenomenon of so-called infodemic) gave her:

We are dealing with a health crisis ruled in its entirety by information. (...) Information is at our fingertips, 24/7, but how we acquire it can be key in a situation like the one we are facing. Twitter, Facebook, Instagram vs Johns Hopkins University, the World Health Organization, National Institutes of Health. We need to be mindful of the power that we give to misinformation, a small click can make a difference.

Close relations with family and friends in the permitted capacity, and replacing sport activities by their temporary substitutes, for instance gym with home workouts or swing-dancing with running, could also be considered as coping strategies. Some students report that the key element that allowed them to cope with stress caused by studying and exams, was letting go of personal ambitions and (too) high self-expectations. R put it in that way:

I had my final exams of first year of medical school. I only failed one. Which I was very proud of myself for. Not for failing, but for the fact that it was only one. (...). I think not being so strict on myself to perform 100% in a troubling time was a smart move.

The resilience was also experienced at the institutional and community level. Some countries reacted quickly and achieved impressive outcomes. As K observed:

Austria applies a contingency plan almost immediately and the compliance is impressive. Everyone but frontline workers have to stay at home. To avoid high rates of unemployment, the ones who can work from home are given paychecks.

The X university also managed to resume its activities, as H reports: "online classes was getting better and we actually had a semi-consistent schedule". R agrees, however, she also admits that her expectations were lowered:

The university tried to communicate as good as possible with us students. They did well, at least in some cases. Since everything was changed to an online platform in a short time, I was not expecting much really, as long as clear messages were to be given.

Bioethics

The transition to online for learning, including bioethics, was challenging for all. The dynamics between learning online and offline are different and what was mainly missing was the element of discussion. As M mentioned, discussion is “fuel to the thinking” and R said “...discussions are much better when you can look everyone face to face and the threshold for asking questions and sorting out misunderstanding are much lower”.

Though the pandemic was challenging, we felt it opened opportunities to explore and apply bioethical learnings. Students were able to view the dilemmas that COVID-19 introduced through a bioethical lens, resulting in our critical questioning of institutions, the public’s response and our own individual navigation of the issues.

First of the unanimous challenges we faced was the heightened level of misinformation from many sources, affecting our ability to eliminate uncertainties regarding the new virus – its transmission, consequences and ethics behind following public health policy recommendations, including wearing face masks. Anti-maskers believe wearing a mask ‘infringes on their freedom,’ and as A realized, this conviction stems from “not believing in the dangers of COVID-19, disregarding scientific evidence and sharing misinformation via social media platforms.” However, due to bioethical education, the students understood the importance of wearing face masks. As H put it, “studying bioethics helped me understand that I was right, and that it is not okay to put your opinions before others well-being”.

The students felt it was their duty to adhere to the recommendations and because it is a public health dilemma, elimination of virus transmission is dependent on the collective efforts and behaviors of all.

The opposition to face mask use resulted not only from personal opinions but also the lack of guidance from governments. The students learned during bioethics classes that, as A put it “in order to effectively manage public health, the duties of healthcare leaders is to plan, safeguard and guide”. However, most of the students experienced a lack of leadership during this tumultuous period, and they realized the ethical dimension of political decisions. There was a delay in government response to wearing face masks. For example, in the UK, as A realized “Even with the knowledge that transmission is air-borne, face masks only became compulsory in shops from July 24 in the UK – 4 months after the lockdown”.

In Norway, as H puts it, the “unwillingness of the government to add stricter mask rules created an unsafe environment outside”. In addition to a lack of guidance, some students’ experiences highlighted the lack of government preparation and response to the pandemic. As a result, certain hometowns were faced with devastating outcomes. K wrote in her memoir:

The health system budget was cut by 20 percent in the last year. In my hometown, Cuenca, there are only 40 artificial respirators supposed to supply this emergency and the 331 000 people living in it. All of these aspects make Ecuador doomed to fail protecting their inhabitants.

As practicing medical students, many of the bioethical dilemmas raised by the pandemic, the students experienced on their own skin. R felt this at her clerkship:

When working at the nursing home I had to experience this inner conflict in person. (...) Feeling guilty every time we had to lock the door on people who just did not want to accept the fact that they could not visit their loved ones.

The management of public health differs to the individualized care that is more natural to our inner moral core of values. However, studying bioethics helped students to come to terms with these conflicting situations, as R mentioned:

I do think the fact that I studied bioethics simultaneously gave me an advantage. In a way I think I coped with these «lesser evil» situations.

In addition to restrictions, the problem of healthcare prioritization was discussed by the students in their memoirs. Decision making factors affecting prioritization included “maximizing benefits, treating people equally, promoting and rewarding instrumental value, and giving priority to the worst off” (A). The students learned that “an intervention is justifiable if the goal is to lessen mortality and morbidity, and the benefits and burdens are fairly balanced” (A). Therefore, they perceived that the intended result of prioritization was to maximize the number of lives saved. However, as students who had taken the Hippocratic Oath to do no harm, this was difficult to comprehend, with the reality being that if “[in Ecuador] a senior is plugged to a ventilator and a younger person comes, they are given priority and the elder is unplugged” (K).

The experiences teaching bioethics online differed. J found there to be a change in communication styles online compared with face-to-face interactions:

Tone of my voice, body language (I can even act a little bit, make gestures). All of this is gone during an online class. [as a result, teaching online felt cold] The course and the whole experience of studying becomes non-personal. I can say almost the same about teaching.

Though at first O felt “a strange feeling of detachment and disembodiment,” O found a positive shift from the offline to online learning experience. “Don’t we immerse in the discussion deeper in the hermetic headphones-bubble over our heads?” O said, as “In the virtual class our only bond is the pursuit of knowledge and the exchange of information.” Instead of feeling non-personal as J felt the experience was, O felt it retained personal relationships with her students:

I didn’t lose personal contact with my students. It shifted, changed, took new routes – as everything during the pandemic – but remained good, personal and often very rewarding.

O and J applied different online teaching techniques. While O held online seminars using Zoom video communication mainly, J relied on self-tutoring quizzes uploaded on the X university platform or using Microsoft Forms, only rarely communicating with students using online video communication (MS Teams).

There were some advantages to teaching bioethics during a pandemic. For both teachers, the pandemic was a real-time simulation of the ethical issues they try to explain to students, such as "How to share scarce resources, who should decide about it, and based on which criteria?" (O). Previously, this was only constricted to historical or theoretical case studies. The teachers believed real-life situations maintain the attention of students, as J said, they are "much more interesting than abstract principles and reasoning, they involve student's imagination and provoke them to think, what I would do in this or that situation".

This existential dimension revealed itself clearly during the pandemic, as J sums up:

Bioethics is about norms that regulate our behaviors in regard to very basic human needs, the need of being taken care of, the need of being respected, and the need of being part of a community. These needs are especially important, when one experiences one's vulnerability and existential limitations.

Discussion

Perception of the past, the present and the future

Our experience of the COVID-19 pandemic has been changing over time, and there were some discrepancies between our memoirs and how we felt later. Perception of past became blurred by the present experience. This epidemical fact has become clear during the discussions on the collected materials (7 memoirs). Some of us have a very strong feeling that during the period of spring semester 2020 they experienced something that could be captured by the metaphor of rebirth. This feeling had something to do with the fact of having the experience of being trapped in our own sense of normalcy and it was all falling apart, and what came after with the changing world, gave some of us a personal renaissance. However, the analysis of the memoirs did not find passages that would support this feeling. This discrepancy between memoirs and the current perspective also demonstrates the character of autoethnography: when one analyzes one's experience, it is almost impossible to clearly distinguish between the experience and its understanding. Understanding is not something that comes later, but it is a part of experience itself.

The process of self-reflection impacts also future experience. People who previously have experienced struggles with mental health could possibly foresee that the worst-case scenario were to happen. K thought that the world was going to end, and R thought she might need therapy again. Yet none of this did happen, proving that having a mental health problem can further increase unnecessary stress to an already stressful situation. The experience of the COVID-19 pandemic and a breakout from everyday life made us more mindful of what we were giving our attention to, realized the harm it was doing to our

mental health and thus redirected it towards something else. It seems that this was a kind of coping mechanism we collectively adopted to get through the uncertainty of the time.

Personal growth through adversaries

Some of us felt that the experience of mindfulness activates personal growth and heightened self-awareness in this regard. Some of us shared that having to start all over again after finally making it into medical school and settling, was particularly troubling and hard to accept. Medical students have had to change their outlook on life and adapt to a new lifestyle of constant change, sacrificing many aspects of social life to reach their goals. Considering this, one would believe that this curveball would be just another minor inconvenience in the road to becoming a physician. The challenges we faced with this new environment started as a disruption, but it was experienced with time as something unexpectedly great. Letting us develop into more organized and adaptive beings.

Adaptation was the main key to the bounce back, as the months of the pandemic passed everything became less and less new. We have learnt to coexist with it. Finding substitutes for pre pandemic activities was one form of adaptation. As medical students we are no strangers to hard work, but we also are very ambitious. Any form of personal development was desired, a possibility to be the better form of ourselves. Also, lack of a routine at the beginning of the pandemic made us lost, not as 'lost lambs', but rather lost in a sense that we did not have a plan. We feel that it is in our nature to have a plan of action, but at that moment nothing was certain enough to have one. Fortunately, over time as we found those substitutes, and the online classes began to have more of a solid structure and a fixed plan, we found our routine which we desperately needed. Pinpointing the breakdown in each memory is easy, but it is rather difficult to do the same for the rebirth. Medical students are very resilient and follow their educational plan down to the last detail, but because of the pandemic this was not an option. Suddenly their goals seemed unreachable and uncertain. This could have been the start of every medical students' nightmare, the fact that all their hard work could be for nothing. In contrast to the breakdown, the rebirth was more of a continuous adaption where everyone individually tried to conquer the pandemic.

A difference in how quick everyone turned their life around emerged, resulting in an unstable rebirth. An unstable rebirth is the same as a rebirth, although it is not definite. There are plenty of examples of people regressing back to their pre-rebirth way of thinking when they encountered excessive hardship.

Bioethics education

It seems that the principles and theories of bioethics helped students understand the reasoning behind lockdowns, which were implemented with devastating impact on societies. Initially, students were left shocked and did not have conceptual framework for the health, social and political situation in X and in the world. But bioethics classes, and in particular topics devoted to ethics of public health, justice distribution of health resources, as well as the role of bioethics in pluralistic democratic societies, provided students with concepts and skills that they could use in critical approach to the social crises triggered by the COVID-19 pandemic.

However, one can say that bioethics also played a role of justification for implemented restrictions on individual freedoms, and at the same time advertised itself as the only rational and moral approach. The public health ethics framework outlines the nature of public health interventions, that they will always have both benefits and burdens, but the key is to ensure that the chosen intervention tips the scale more towards chosen benefits. This is the utilitarian calculus that is rarely questioned during the time of emergency. Bioethical classes provided students and teachers with additional arguments for this approach.

For J. it was striking to see in one memoir explanations of public health and public health ethics taken almost directly from the reading materials. But it seemed not to be a lesson learned by rote, but a manifestation of how seriously these bioethics readings were taken by a student, who understood and internalized the concepts and principles of public health ethics. These bioethical principles became an important element of the student professional medical identity. In that sense, bioethics seems to provide a safe theoretical ground where the medical challenges, moral dilemmas and conflict of values experienced by doctors can be boldly faced and tackled. Students also felt that they were also better prepared for their practical clerkships, when they had to adopt some restrictive safety measures towards patients and experience the pandemic dilemmas in person.

Therefore, it seems that bioethics played two important roles during the COVID-19 crisis. On the one hand, it was a cognitive coping mechanism, that helped us to deal with a complex, stressful and challenging situation. On the other hand, bioethics was a part of the medical socialization process.[20–22] According to Bryon Good, medicine creates its own object by focusing only on human body, understood as a preparation, and does not have proper instruments to capture human life-experience and ethical values. [22] According to Good, medicine explains living experience and existential fears in medical terms. Good's observations seem to support this claim; however, our experiences demonstrate that the COVID-19 pandemic reveals another dimension of medical identity, also described and analyzed in the literature, which is associated with a set of certain ethical and cognitive values: beneficence, justice and rationality. Bioethics education does not question or take these values for granted and helps to inculcate them in students.

Ethics of collective autoethnography

The initial idea of this paper, prompted by J, was to write a qualitative, autoethnography study of individual experience with studying and teaching bioethics online, during the COVID-19 pandemic. J thought that the focus of the study will be online tools user experience, and impact of online teaching on perception of bioethical issues. However, during the discussions, and then later when all of us were writing our memoirs, the focus of the research shifted towards personal impact during the pandemic. Having in mind privacy and confidentiality issues, we discussed how much private information should be disclosed in memoirs, and then reported in the paper. We discussed an option of anonymity. We were given an individual choice to anonymize his/her quotes, or not to be quoted at all. However, we usually chose to witness our experience and struggles. We were cautious not to disclose any information that could be damaging for third persons, who are characters in our personal stories.[15, 16]

Initially, J offered to be the first author of the paper, since he thought that writing a first draft of manuscript can be too cumbersome for students, who would already be involved in writing their memoirs. However, everyone wanted to be an author of a draft, and all students declared their willingness to contribute to the paper. During the discussion a consensus was reached, stating that the order of authors will be alphabetical, with the exception of J, who will be the last corresponding author, and that everyone will have similar contribution to the manuscript. J was tasked with dividing work into packages, then the work packages were allocated in a consensus reaching discussion to pairs and trio of authors. The final version of the manuscript was commented and edited by all authors. All authors accepted the final version of the manuscript. Therefore, each author has equal contribution into the research project and to the process of manuscript writing.

Limitations of the study

This study has its limitations. The results of our research should not be overgeneralized and requires further enquiry. The authors are not a representative sample of medical students and teachers either in general or in respect to the X University Medical College. However, the group of students is very diverse in terms of gender, country of origin, and mother tongue, which probably gave a wide spectrum of individual experience.

Conclusion

In the paper we have shown that there were some common patterns in experiencing the public health, social and political consequences of the COVID-19 pandemic. As individuals we experienced shock, and we had an impression that our lives were falling apart. We had an impression that also the institutions around us were falling apart. But after this first phase of shock, we managed to bounce back and adjust studying and teaching to the changed pandemic circumstances. Our analysis suggested that the key factor of adjustment to changed situation was taking personal responsibility not only for the studying process, but also self-care, and one's psychological and social needs. Reflection and critical thinking that allowed us to filter information in the flood of infodemic was shown to be an important factor in this process. Bioethics, as it was demonstrated, played an important role in the process of critical reflection that allowed us to understand and morally judge the social and political dynamic of the pandemic. It allowed us to see the value of bioethical education and, on the teacher's side, set goals for its future development.

It is worth to mention that the experience of 'emergency remote teaching' exposed the need of incorporating online teaching techniques into professional repertoires of individual teachers and into the infrastructure of universities to a greater extent. The psychological struggles experienced by students drew our attention to the importance of professional psychological care offered to students at university X, which should be more visible and accessible to students, especially during times of crises.

Although the COVID-19 disorganized our life and turned on the 'emergency remote teaching' mode and confronted us with the fragility of human life, it did not make us re-evaluate our lives. On the contrary,

both teachers and students did not change their life goals but tried to adapt to the changed circumstances and took responsibility for their professional life (studying medicine and teaching bioethics). Bioethics became a part of physician professional identity, adding to scientific knowledge and technical skills a set of ideological values. Students learned to adopt and to study medicine without the stiff structure of a medical college.

Declarations

We have no conflict of interest to declare. We declare that the research project did not involve human or animal subjects and was a not subject of ethics review.

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