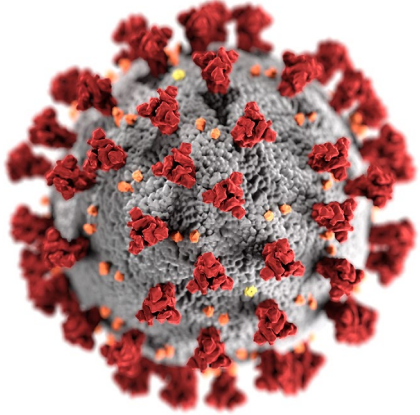

Editorial

Global perspectives on Covid-19 from the editorial board

'May you live in interesting times': although the provenance of this saying is unknown, it has been described as a curse.[1] Globally, we are in a period of disruption and tremendous change during this Covid-19 pandemic. Believing the world is cursed is obviously not helpful and many people are instead rising to the challenges of keeping safe, working collaboratively, changing approaches to education and communication, and rethinking social and political processes. In this article the editorial board of *The Clinical Teacher* reflect on living in the time of Covid-19 from their personal perspectives, influenced by their local and national contexts and experiences.

The journal's senior associate editor, Rachel Locke, shares that in response to Covid-19 the University of Winchester in the UK has closed for the rest of the academic year (to June 2020), with the vast majority of students having gone home. 'In order for teaching and learning to continue, course tutors have been adapting rapidly, getting the rest of the semester's content ready for online delivery. So that lectures and seminars can still run, tutors are busy learning to be agile on different digital platforms to meet learners' needs. Faculty members have been collaborating online with those already running digital courses, who have been very helpful in sharing their expertise. One postgraduate course that I teach on medical education has always placed importance on providing face-to-face, small group-based discussions; however, this philosophy has now been challenged. The learners on this course are primarily health professionals currently working on the front line who study part-time and are trying to make time for their studies. Having now run successful teaching sessions with these cohorts via Zoom and Microsoft Teams, I wonder whether, when we no longer have to stay at home, there may be advantages for students in not travelling but rather engaging in learning from the comfort of their homes. Staff have developed skills as they create content for virtual delivery for the first time and I have found shorter, more frequent sessions work well online. These are early days, but I question whether we will, or even should, go back to the way we were for future cohorts of some students. Online delivery may continue to be the new normal.'

Sharon Buckley works in Birmingham, UK, where, as elsewhere, many health professions students are volunteering in hospitals or other care settings. She and her colleagues are witnessing the importance of teamwork and collaboration for high-quality patient care. 'Qualified health professionals are taking on new roles, giving greater insight into the responsibilities and priorities of their fellow professionals, and policymakers are making changes at a scale and pace that would have been considered impossible only a few months ago. The success of efforts to control the spread of the virus depends on large numbers of potential and actual patients adhering to social distancing and self-isolation requirements, illustrating that patients are integral members of the health care team. Referencing data is a feature of UK government daily press conferences, bringing evidence-based medicine into the public consciousness. The need for teamwork and collaboration at all levels, from individuals meeting on the street, who cooperate in order to maintain the required 2-metre gap, to the international sharing of data, information and resources, is evident. When "normal" times return, individuals who have experienced these events will take into their practice a heightened respect for the power of interprofessional learning and working, with a consequent heightened priority accorded to interprofessional education (IPE) in educational policy and practice. Covid-19 may turn out to have advocated for IPE in ways that no amount of lobbying, theoretical learning or evaluation of educational interventions could ever do.'

In the USA, Gail Jensen concurs that enhanced working together is a feature of these interesting times. 'We are seeing many examples of idea and resource sharing across health professions and professional groups. Collaboration is actually happening. There are expanded roles for telehealth in urban and rural areas, which in turn means more targeted education for all health professionals in this area. Nurses who have long performed physical assessment via telehealth are now working with other health professions and sharing their expertise. Although there are challenging times for outpatient services, which have decreased significantly across all health care systems, there is optimism that the pandemic will result in innovative enhancements for practice and education. In their iCollaborative, the American Association of Medical Colleges (AAMC) has identified a collection of "Clinical teaching and learning experiences without physical patient contact".[2] The National Center for Interprofessional Practice and Education at the University of Minnesota is hosting webinars and discussions on alternative roles for students participating in IPE via online models.[3] Many of the specialised accrediting agencies for the health professions are sharing examples of adaptations being put in place to ensure learner progression in a timely manner.'

Susan van Schalkwyk shares her thoughts on liminal spaces from Stellenbosch. 'South Africa was, to the best of my knowledge, the first country in the world to announce a lockdown before a single Covid-19-related death had been recorded. The reason for this was straightforward. In a country where upwards of 300 people can die every day from HIV/Aids and tuberculosis (TB), the potential of this virus – a third infectious enemy – to inflict devastation in our country was not up for negotiation. The resolve of the government was undoubtedly strengthened by what we saw happening in Europe, and in countries far better resourced than our own. After 2 weeks of lockdown, the numbers look a lot less scary than many had expected, but our politicians talk about the 'calm before the storm' and entreat us to stay at home. As a result, education (primary, secondary and tertiary) finds itself in a liminal space, betwixt and between, uncertain about what lies ahead.'

Susan continues: 'Students who choose one of the health professions as a career in South Africa do so knowing that exposure to HIV and TB will be part of their clinical training. Early on, health professional students have to learn to be vigilant and to take responsibility for protecting themselves and avoiding needle-stick injuries. Medical students at our institution are fitted with N95 masks as part of their preclinical training. In many ways our students can be regarded as fortunate in terms of the opportunities that they have for clinical training in authentic workplace-based contexts, often making meaningful contributions to health care, working directly with patients, including in remote and underserved contexts. Perhaps we have taken this for granted as the virus has now taken them out of the clinical space. Final-year students hoping to graduate at the end of the year (December) – graduates who are desperately needed to swell the numbers in our under-resourced health system – have been sent home for an early Easter break, waiting for the next episode in this human drama, as educators and administrators work around the clock to set up emergency online teaching and learning. Many students have returned to become part of a growing volunteer corps, tracing contacts and working in call centres, as have their fellow students across the world. Concerns about students who do not have access to the internet,

who may share a device with many others in the home, or who may not have any device beyond a mobile phone, weigh heavily on those in the faculty who must make decisions about "where to now" and "what next". Time will be our teacher.'

From Sri Lanka, Madawa Chandratilake reports that the early lockdown of the entire country was the strategy adopted. 'The aim was to reduce the number of Covid-19 cases to within the manageable limits of the country's health resources. Sri Lanka is well known for its strong public health system. It was further strengthened by police and military involvement from the beginning. The military helped to trace contacts of patients with Covid-19 and accommodated them in quarantine facilities set up to meet international standards. These measures have given positive results by flattening the curve, with a low number of cases and deaths; however, the long-term repercussions of this strategy on a developing economy like Sri Lanka's in an era where the global economy is at a stake is yet to be determined.'

In relation to education, Madawa continues: 'Conventionally, the teaching–learning process in undergraduate and postgraduate health education programmes in Sri Lanka was largely face to face and hospital based. Online learning was a complementary rather than supplementary component in almost all medical schools; however, the lockdown came with a directive to continue university programmes online. The government provided several incentives, such as undergraduates being provided with free internet to access learning management systems. In my institution, teachers and students are now engaged more in online learning. The feedback from students and teachers, who are involved in developing and delivering e-learning, has been highly positive. For some teachers, using online platforms appeared to be a steep learning curve. Therefore, the main focus of staff development has been developing their skills in e-education. Medical students are demonstrating a high level of social responsibility during the pandemic. A collaboration between all eight medical schools was formed early and is engaged in various activities: providing health education to the public; assisting health care teams in hospitals; and helping with delivering groceries to families of health professionals, who provide care for patients over long shifts. Health care practitioners are being challenged by peoples' beliefs on health and illness, health seeking, death, dying and post-death. Religion, culture and the collectivist behaviour of community groups appears to influence these aspects. Social media have made such challenges more complex. Although cultural competence and professionalism are part of our programme, adapting these skills to an emotionally tense environment with a predominance of uncertainties, fear psychosis and aggravating factors has appeared to be overwhelming for many. As a medical educator, I have observed a dire need of deepening the dimension of cultural competence in professionalism education to enhance such skills among health professionals.'

Observing the responses across educational institutions to COVID-19 has been fascinating, reflects Jennifer Weller-Newton. She reports that one Australia institution began moving courses online in January as the epidemic unfolded in China. 'Educators delayed starting the first semester to ensure that the infrastructure was in place to support the many international students in social isolation/lock down in China. So, by the time the Australian government had tightened up movement and restrictions, the institution seemed to be well ahead of other universities that seem to have been scrambling, leaving teaching staff overloaded with the extra work of shifting teaching and assessments to online delivery. Yet, the innovation that will emerge from this shift to the virtual classroom is likely to forge new pathways for health professional education, particularly in the delivery of clinical practice/skill classes: e.g. a colleague shared her teaching of listening to heart sounds, asking students to place coloured post-it notes on their bodies so that she could view them all via Zoom to ensure that they had the right locations! This certainly is a time of creativity.'

Reading these perspectives, I was struck by the recurrence of several words and phrases: adaptation, agile working, sharing, collaboration, teamwork, rapid changes and new ways of working. In this issue, three UK-based medical students also reflect on the Covid-19 era and share the opportunities that it provides as their traditional education is transformed,[4] and a medical educator in Australia considers the role of educational research and its uptake to inform practice in this evolving situation.[5] We are accustomed to a slower pace of change but are now experiencing shifts in working practices almost daily. Evidence-based advice is being continually updated to help us to distinguish fact from misinformation and conjecture. The overall aim of what we are doing is to reduce the human costs of this pandemic, not only for those who become infected but for the millions whose lives are affected by economic and

social hardships. Interesting times indeed, which will have positive and negative repercussions for many years to come.

Jill Thistlethwaite
Rachel Locke
Sharon Buckley
Madawa Chandratilake
Gail Jensen
Susan van Schalkwyk
Jennifer Weller-Newton

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