IJMS INTERNATIONAL JOURNAL of MEDICAL STUDENTS

Experience

Experiences of a London Medical Student in the COVID-19 Pandemic

Alin-Ioan Suseanu.[1]

Introduction

On the 12th of March 2020, World Health Organisation declared the coronavirus disease 2019 (COVID-19) outbreak a pandemic.[1] At this point, there were 596 confirmed cases of COVID-19 in the United Kingdom a figure that seemed alarmingly high at the time.[2] I had just finished a rotation in Emergency Medicine and Critical Care during my fourth year at medical school and was eagerly awaiting my final rotation in Women's Health. The concern regarding coronavirus was palpable in the hospital but there were still no signs of a lockdown from the government and our placement was scheduled to go ahead as planned.[3] In fact, the only change to our timetable was an hour earlier start to our first induction day to allow for a talk on coronavirus. This day never came.

As precautions were taken to curb the spread of COVID-19, clinical rotations were cancelled and medical students around the world had to adapt to a new norm.[4-6] In my country, the National Health Service (NHS) moved into major-incident mode forcing the university to quickly mobilise to deliver an unprecedented online curriculum.[7] Overhauling the delivery of the curriculum is no easy feat as our fourth year is entirely clinical with very few lectures scattered throughout the year. Our time in surgical theatres and outpatient clinics was replaced by laparoscopic videos with detailed voiceovers and interactive lectures; clerking patients in the emergency department was replaced by interactive case-based discussion. All key content was to be provided via videoconference for the foreseeable future. The university has already been using Zoom video-conferencing for occasional teaching sessions so the transition was not as jarring as one would expect. However, I encountered several problems with the transition.

One problem is the sheer size of the year's cohort with some sessions having as many as 250 students in attendance, meaning only the clinician leading the session could interact audio-visually. The students were instructed to interact using an embedded chat tool. I experienced first-hand how overwhelming this could be in case-based teaching. While the quality of the discussions was excellent, and they remain some of the best teaching sessions I have ever had, I quickly became intimidated despite the fact that I had scored well on my previous exams and felt confident with my learning. It will always be more difficult to interrupt and ask questions in front of such a large group of people, compared to the 5-6 students we would normally have in hospital teaching. Additionally, the speed at which some students were able to answer obscure and challenging questions left me and my colleagues impressed by our fellow students, but also anxious and self-doubting. At times I would struggle to even read the question before answers started filling the chat. It became the perfect environment to compare ourselves to each other, where some students were negatively impacted and others were positively motivated.

I am writing down my experiences one week after finishing my final year-four exam. The exam was quickly changed to an online format, with extra time being granted. The exam was then made open-book, pushing me into uncharted territory. I stopped memorising obscure paediatric milestones or side effects of rarely used diabetes drugs, and instead focused on improving my ability to generate differential diagnoses. Imperial College London was the first to make this change claiming it would not be possible to complete the exam by looking things up online.[8] I personally found this to be true. Case-based questions, which made up most of the exam, worked best in this format. Just as with a real patient, these questions challenged us to figure out the diagnosis, consider the patient's history, and make decisions regarding management. The questions rely on our diagnostic acumen and cannot be answered by two minutes of internet searching. I think we will see a shift in the direction of online and/or open book exams over time. COVID-19 seems to have only pushed forward the inevitable in terms of incorporating technology into our medical exams. My impression is that the university has recognized the need to train doctors who are able to competently use online resources. For example, in our Objective Structured Clinical Examinations (OSCEs) we have access to both paper copies of our drug dictionary, the British National Formulary, and virtual copies on tablet devices. This is reflective of actual clinical practice, as it only takes one day on the wards to see how often clinicians will use their phones to look up drug dosages, national guidelines or peer-reviewed articles concerning less common conditions.

We also decided as a cohort to scale up our previous exams, essentially making our final year-four exam pass or fail. Changing our exams in this fashion was immensely stress-relieving, allowing us to focus on our own wellbeing and the wellbeing of our loved ones during the pandemic without the guilt that we should be studying more. Additionally, it allowed those who wished to contribute to the effort against the pandemic to do so without it affecting their academic ranking. The Medical Schools Council was very quick to provide us with guidance and the opportunity to work up to 16 weeks in paid volunteer roles in the NHS.[9] I noticed that interest in volunteering was particularly strong as we were inspired by the fifth years graduating early to work in the NHS.[10]

Two months into lockdown and with three months of online learning ahead of us, I find myself thinking of a news article headline I read early in January about 44 confirmed cases of "a mysterious viral

[1] Undertaking MBBS. King's College London, UK.

About the Author: *Alin is a 4th year medical student of King's College London, United Kingdom undertaking a 5-year programme. He has been awarded Merit in "From Science to Clinical Practice".*

Correspondence:

Alin-Ioan Suseanu

Address: Strand, London WC2R 2LS, United Kingdom, UK.

Email: suseanua@yahoo.com

Editor: Francisco Javier Bonilla-Escobar
Student Editors: Nate Hayward
Submission: May 20, 2020
Revisions required: Jun 19, 2020; Jul 9, 2020
Received in revised form: Jun 20, 2020
Acceptance: Jul 10, 2020
Publication: Jul 10, 2020
Process: Reviewed by Student Editors

pneumonia" spreading in Wuhan.[11] I immediately showed some friends a 2015 TED talk from Bill Gates titled 'The next outbreak? We're not ready'.[12] Whether our country was ready remains to be seen. What I can say is that our medical school, my fellow medical students, and our clinical teachers were more than ready to ensure we could continue our education. I believe this public health crisis has demonstrated the importance of resilience and adaptability in 21st century educational institutions and the need for them to instil these same values in our generation of doctors.

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Acknowledgments

None.

Conflict of Interest Statement & Funding

The Authors have no funding, financial relationships or conflicts of interest to disclose.

Author Contributions

Conceptualization, Writing – Original Draft Preparation, Writing – Review & Editing: AIS.

Cite as:

Suseanu AI. Experiences of a London Medical Student in the COVID-19 Pandemic. Int J Med Students. 2020 May-Aug;8(2):183-5.

ISSN 2076-6327

This journal is published by the University Library System, University of Pittsburgh **as part of the** Digital Publishing Program **and is co-sponsored by the** University of Pittsburgh Press.