

1 **Title:** Two Student Perspectives on Clinical Medical Education During the COVID19 Pandemic

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10 **Acknowledgment:** We would like to acknowledge the help of Anokha Joseph, M.D. and Jannso Joseph, M.D.
11 for their advice, mentorship, and editing suggestions. We would also like to acknowledge Jenifer Fischer for her
12 suggestions as well.

13
14 **Financing:** None

15
16 **Conflict of interest statement by authors:** No conflict of interest.

17
18 **Compliance with ethical standards:** All ethical standards were complied with in the formation of this
19 manuscript.

20
21 **Authors Contribution Statement:** Conceptualization, Writing – Original Draft, & Writing – Review & Editing:
22 APG, ENE.

23
24 **Manuscript word count:** 993

25 **Number of Figures and Tables:** 0

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33 **Discussion Points:**

- 34 1. How do rural vs. urban clerkships differ in third year medical education in light of the COVID-19
35 pandemic?
36 2. What unique challenges are third year medical students facing in their clerkship rotations due to COVID-
37 19?
38 3. Location, individual hospital and private practice policies, and medical school institution infrastructure
39 have varying roles in what clinical experiences third year medical students have had during this time
40 during the COVID-19 pandemic.

- 1 4. How has COVID-19 affected the education of third year medical students and how will this affect their
- 2 future?
- 3 5. Will differing clinical experiences affect residency applications?
- 4

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Accepted, In-press

1 THE EXPERIENCE.

3 Introduction

4 In the age of COVID19, the ultimate question in healthcare became who was essential and who was not.
5 Basically, who could be cut from the roster in patient care? Unfortunately, as medical students, many of us did
6 not make that cut. Third-year clerkships are defined by the direct patient care and hands-on learning, but in the
7 age of COVID19, “hands-on learning” has been a bit hard to come by. Hence, COVID19 has caused many
8 changes in the way medicine is being taught and practiced. This article details the experiences of two medical
9 students from the same institution, working in different locations for their third-year clerkships. We contrast our
10 rural and urban experiences in the time of COVID and attempt to explain the varying experiences students are
11 having during this time. Finally, we touch on the potential ramifications for these wide varieties of experiences
12 from students across the U.S. and how this will affect sub-internships and residency applications.

14 Urban perspective

15 My first rotation impacted by COVID was my outpatient psychology rotation. In-person visits shifted entirely to
16 telemedicine, which many institutions across the U.S. seamlessly transitioned to as they were prepared for this
17 change.¹ This was evident in student experiences at the Methodist Hospital in Houston, Texas, where students
18 were essentially physically present in the room with the physician “via video chat on tablets mounted on rolling
19 stands.”² However, the quality of education received through telemedicine differed from institution to institution,
20 as seen in my rotation site with its inaugural transition to telemedicine. Thus, a significant portion of my time
21 was spent doing clerical and scheduling work rather than taking a history and physical. Patient interaction was
22 limited on this rotation, likely due to the high number of students on this rotation from various schools and the
23 new telemedicine format. Furthermore, while it was certain that students, in both the classroom and the
24 hospitals, felt the effects of online-learning, it also became quickly apparent that many patients also desired to
25 be physically present in the room in order to feel that human connection and trust their provider.⁵⁻⁶

27 My primary care rotations also had many COVID restrictions. During my family medicine rotation, many visits
28 were transitioned to phone visits, and my time was spent listening to the phone conversation between the doctor
29 and patient. Many of the patients who physically visited the clinic were leery of an extra person in the room and
30 would deny requests to have a student observe their appointments or be seen by me prior to the physician.

32 My internal medicine rotation proved to be much more lenient and with fewer limitations in terms of student
33 involvement as it occurred in more prominent hospitals in the area. However, due to the lack of rotation sites
34 allowing for students, there was an increased student to preceptor ratio. In my case, it was 3:1, which forced
35 us to rotate shifts to avoid crowding patient rooms and decreased our total direct patient hours.

37 Rural Perspective

38 My clerkship year consisted of rotations in both a teaching hospital and neighboring outpatient clinics, which,
39 due to COVID screening and policies, were largely unchanged from prior student’s experiences. However,
40 during my OB/GYN rotation, I was dismissed from the hospital and was told not to return until further notice.

1 This no-student policy proved to be problematic moving into my next rotation: surgery. As our school scrambled
2 to find suitable rotations, I was placed last-minute in a surgical clerkship hours away. While the rotation itself
3 was great, it is evident that there was a lack of sites as this rotation had a student to preceptor ratio of 5:1 in per
4 surgery.

5
6 While many institutions practiced this no-student policy in the U.S., most documented accounts are from the
7 spring of 2020 when students were removed from hospital settings according to the American Medical
8 Association guidelines.³ Unlike the students in March 2020, this year's current third-year class is roughly only
9 half-way through our required clinical rotations, meaning that many are still trying to determine their specialty of
10 interest. The current situation, particularly with findings of a new variant of the virus, puts even more uncertainty
11 in when medical students will be able to return to normal rotations, even with the distribution of the vaccine.
12 Most importantly, these current rotation closures are contingent on the individual hospital policies regarding
13 student interaction in the hospital. In this sense, there is a discrepancy across medical education as some
14 facilities have not dismissed students, whereas some institutions have. Student dismissal in March was a
15 consensus felt across all institutions throughout the U.S., but this is not the current case.

16 17 **Conclusion**

18 Our medical education as third-year students during this unique time in history is all about accommodating and
19 making the most of the opportunities we have to learn. Our coordinators and clerkship directors worked to make
20 the best of a difficult situation; however, in researching various other responses to these circumstances, it
21 became apparent that some institutions were better equipped to adapt to the ever-changing situation. Our
22 concern rests mainly on the inequity of clinical opportunities and the resulting disparity in experiences, which
23 has been felt by medical students across the U.S.⁴ We feel this pandemic could prevent us from attaining the
24 clinical foundation necessary to be a fully competent resident and are even more concerned about the inequality
25 of training that might lead to varying levels of preparedness among students. Evaluating different student
26 experiences showed us that individual hospital and private practice policies, location, and medical school
27 institution infrastructure have varying roles in what clinical experiences third-year medical students have had
28 during this time. We are hopeful that with the administration of the vaccine rotation sites will return to normal
29 protocols regarding student participation, but are unsure due to discovering a new variant. The different
30 experiences we have examined make us concerned that this wide variety of experiences may be detrimental to
31 some students when applying for sub-internships and residency programs.

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