Medical education challenges and innovations during COVID-19 pandemic

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ABSTRACT
COVID-19 pandemic has undoubtedly disrupted the well-established, traditional structure of medical education. The new limitations of physical presence have accelerated the development of an online learning environment, comprising both of asynchronous and synchronous distance education, and the introduction of novel ways of student assessment. At the same time, this prolonged crisis had serious implications on the lives of medical students including their psychological well-being and the impact on their academic trajectories. The new reality has, on many occasions, triggered the ‘acting up’ of medical students as frontline healthcare staff, which has been perceived by many of them as a positive learning and contributing experience, and has led to a variety of responses from the educational institutions. All things considered, the urgency for rapid and novel adaptations to the new circumstances has functioned as a springboard for remarkable innovations in medical education, including the promotion of a more “evidence-based” approach.

INTRODUCTION
As of the beginning of 2021, the COVID-19 pandemic continues to unfold. Several countries have responded to the autumnal/winter second wave of the pandemic by imposing curfews or complete lockdown measures in an effort to limit the viral transmission. However, and despite the spark of hope that the newly introduced vaccines have brought, there have been vast repercussions on the economy and education; one of the fields that the pandemic has substantially affected is the education of future medical professionals.

At the onset of the pandemic, the Association of American Medical Colleges proceeded to the unprecedented decision to suspend clinical rotations, and issued guidance for medical students to avoid activities involving direct patient contact, with many countries adopting similar strategies.1 From that point on, the dynamic everyday changes brought on by the COVID-19 pandemic and the subsequent social distancing measures have resulted in continuous disruption of the routines of medical students, schools and institutions that have been copiously testing the medical educational systems’ adaptability worldwide.

In this review, we explore the impact of the COVID-19 pandemic on the education and assessment of undergraduate medical students, the repercussions on their mental health and future career plans, while exploring their experience as ‘frontline workers’, along with the institutional responses to these challenges. We also focus on how this unique period could act as a catalyst for substantial changes and further implementation of the ‘evidence-based’ approach in medical education.

ONLINE VERSUS FACE-TO-FACE EDUCATION
COVID-19 has already triggered the introduction of new methods of learning in medical education. In an effort not to distract the educational process, the academic institutions worldwide have accelerated the development of online learning environment.2 Online distance education (ODE) can be generally delivered to medical students in two main formats: asynchronous distance education, such as recorded videos and podcasts, and synchronous (live) distance education (SDE), such as video conferences and virtual classrooms.3 One of the new models is the ‘flipped classroom’, which is a blended type of learning mode with an asynchronous component that could allow medical students for more schedule flexibility, and a synchronous component that offers interaction between medical students and faculty members.2

In recent years, SDE has been widely used for educational purposes in health science students. A recent meta-analysis of randomised clinical trials demonstrated a higher overall satisfaction (standardised mean difference 0.60, 95%CI 0.38 to 0.83; p<0.001) for SDE compared with traditional education, showing that SDE was quite acceptable by medical students.3 The adoption of online learning in medical education can have several benefits: one of the most positive aspects of ODE is the flexibility of time and location and the subsequent increased convenience,4 which means medical students are able to adapt their schedule in an easier way. Besides schedule flexibility, ODE can also be much more cost-effective than classroom-based learning, as it does not require educators to move, while more individuals across different institutions (or even countries) can participate in virtual courses.5 In addition, e-learning assists medical students to better adapt to a web-based medical world that increasingly uses digital health services.

On the other hand, ODE can potentially hinder interpersonal contact and interaction between medical students and the faculty members, while
at the same time it limits the students’ opportunities to prac-
tise interviewing and thus cultivate the necessary communica-
tion and empathy skills for interacting with patients and their
colleagues. Indeed, restricted access to clinical environment is a
main obstacle to students’ preparation for clinical practice, thus
lowering their self-confidence. Although the lack of hands-on
training in the preclinical years may have serious implications on
the training of students, which might result in difficulties in the
following clinical years, preclinical medical students may experi-
ence a lower impact on their education compared with those in
the clinical years because preclinical activities are mainly lecture
based. During the last year, there have been also serious
implications in anatomy education including cadaveric edu-
cation; medical students are given limited chances to handle basic
surgical instruments and thus develop manual dexterity, while
having less opportunities to deal with the three-dimensional
relationship of anatomical structures. Online attempts to
substitute hands-on education as much as possible have been
made, including demonstrations of practical procedures, remote
patient consultation programmes and simulated cases. More
such solutions are described in online supplemental table 1.

Furthermore, it is important to consider the technical chal-
lenches that online teaching and learning in medical students can
pose, which include problems with audio and video, downloading
or streaming errors, login problems, poor internet quality, secu-

EXAMINATIONS
Another aspect of medical education that has been disrupted by
the outbreak of the SARS-CoV-2 is the examinations of medical
students. In many countries, clinical and written examinations
have been postponed, cancelled or delayed or have been replaced
by online examinations or new methods of assessment. For
example, for objective structured clinical examinations (OSCEs),
approximately one-third of medical schools in the UK had these
clinical examinations cancelled. Four medical schools in the UK
adjusted by using actors rather than real patients. According
to a structured qualitative survey including medical students
from 32 UK medical schools, the effect of examination disrup-
tions for both OSCEs and written examinations indicated a
significant negative impact on preparedness (p = 0.0005). On the
contrary, the examination disturbances were not significant
regarding confidence (written examinations p = 0.369, OSCEs
p = 0.738). With universities and educators having to adapt to
the new reality of this pandemic, a debate between open book
examinations (OBEs) and closed book examinations (CBEs)
has arisen. Due to the incapacity for organising examinations in person, OBE has been suggested as an alternative tool
of rigorous assessments in medical schools. For example, at
Imperial College London, the online assessment consists of an
OBE of 150 questions. Randomising the order of questions for
each student was necessary in order to prevent cheating. Medical
students were presented with simulated patients and had to
answer the requested questions through provided history and
findings from clinical examination. On the one hand, OBE has
several advantages, especially in the time of the pandemic. First
of all, the use of OBEs discourages medical students to solely
memorise information and enhances their critical thinking, their
analytical skills, as well as their conceptual understanding of
medicine. OBEs as an assessment for deep learning are more
authentic to clinical practice and real-life expectations, rein-
forcing at the same time evidence-based medicine. Integration
of knowledge from multiple sources and the use of internet,
as an invaluable learning tool for medical students, could help
medical students to be more self-directed learners, while OBEs
may foster deeper processing more effectively and strengthen
their long-term memory. This type of assessment also reduces
the anxiety surrounding the examination in medical students,
who feel less pressured when sitting on a familiar and comfort-
able location, such as their room in their own home. On the
other hand, traditional CBEs are more familiar to both medical
students and professors, and the adaptation to the new reality
of OBEs during pandemic could be significantly stressful for
them. According to Euroboonyanun et al, medical students prefer
a traditional CBE over an online OBE.

Grading is also an important factor for medical students
during their studies. Comparing fourth-year medical students’
scores in the online surgery clerkship assessments with the tradi-
tional written examinations shows that mean scores are signifi-
cantly different which has important implications regarding
grading among medical students. Medical students who partic-
ipated in the online OBE had a significantly higher mean score
in both multiple choice questions (p < 0.001) and essay examina-
tions (p < 0.001), but a significantly lower mean score in short
answer examination (p < 0.001) compared with the traditional
written examinations. The contrary, the online OBE group
had a significantly lower correlation between the essay score
(p = 0.005) and their grade point average (GPA) (p = 0.029)
than the traditional groups. Such data are essential in order
to provide information about the comparison between the two
methods of examinations with a view towards the reliable and
fair medical students’ assessment in the incoming online era.

In summary, OBEs and CBEs can both contribute to a blended
assessment programme due to their complementary advantages.
Changes enforced by this pandemic offer a vital opportunity to
evaluate alternative modes of medical education and assessment.

MENTAL HEALTH
The challenge of going through medical school and medical
education in general may contribute to the development of
psychological distress such as anxiety, depression and stress
among medical students; medical students are recognised as
an at-risk group for developing anxiety disorders, with signifi-
cantly larger rates than the general population, even under
normal circumstance. Medical students typically encounter
stressful situations including high workload, many evaluations
and assessments, the pressure of clinical environment, numerous
responsibilities, anxiety regarding their grades, long hours of
studying as well as concerns about their future career. A large
systematic review and meta-analysis of 129 123 medical students
in 47 countries estimated that the prevalence of depression or

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more, during this new challenging COVID-19 landscape, the countries like Malta57–61 showed that the prevalence of depression and anxiety in medical students was significantly high, while other predisposing factors like programme directors may rely on less reliable characteristics such as school reputation.

MEDICAL STUDENTS AS ‘FRONTLINE WORKERS’
Conflicting views have been expressed on the role of medical students in the frontline of this pandemic.42 73–78 should they have an active role by assisting the management of infected patients, thus gaining valuable clinical experience in times of health crisis, yet with the increased risk of exposure? Should students be assigned responsibilities for patients other than the ones infected, in order to somewhat alleviate their senior colleagues’ burden by simultaneously continuing their bedside education, though still not minimising their chances of infection? Should they be entirely kept far from hospitals due to potential inadeguacy of personal protective equipment (PPE), training, experience or emotional resilience and focus instead on reinforcing, for instance, their institutions or local communities? It seems that there is no universal commonly accepted view, especially given the variety of student characteristics (eg, pre-clerkship or clerkship, with or without health morbidities) and institutional settings. However, and despite the lack of consensus, the primary aim remains the establishment of a mutually beneficial situation for both students’ and health systems’ needs, local and governmental policies.

In addition, before medical students undertake roles as ‘frontline workers’, it is essential to first examine their willingness, motives or competence for undertaking such a role. In the Netherlands, students were eager to priorly arrange all necessary insurance issues and receive basic training in acute care principles, in order to assist their university or even regional health institutions.79 In the UK, more than 5500 final-year students have been brought into the workforce, considering this kind of ‘volunteerism’ as a brand-new opportunity for self-directed clinical and research learning.80 81
A structured qualitative survey including students from a single institution in the UK found that their basic motivations to voluntarily support the National Health System were to ‘contribute’, ‘learn’, ‘benefit from remuneration’ and ‘do something active during national lockdown’.82 According to a similar single-institution cross-sectional study conducted in Denmark, 80% of 486 student-participants had decided to join the pandemic workforce, with ‘care’, ‘learning’ and ‘pride’ constituting their top motivations.83 Students also highlighted institutional support, especially in terms of provision of PPE and clarification of study plans, as a matter of top priority.84 In King Saud University of Saudi Arabia, 34.3% and 23.1% of final-year students stated that they were ‘willing’ or ‘somewhat willing’, respectively, to contribute to the pandemic workforce.85 The same study also demonstrated a positive correlation between willingness and self-perceived student competence in essential clinical skills. Similarly, students of Duke-NUS Medical School
in Singapore who were more willing to return to a clinical environment during the pandemic, exhibited greater internal motivation and sense of professional responsibility, and lower self-perception of harbouring risk to the patients. Interestingly, one-third of participants in this survey were not in favour of recommencement of clinical rotations.

With regard to students’ competence, surveys from Turkey and Iran displayed moderate to high levels of student knowledge on pandemic-related subjects, with the two studies using different testing strategies, yet the same quantitative cut-offs when defining these levels. A recent systematic review also revealed that the implementation of ‘pandemic and disaster-themed training programmes’ can be an effective intervention in boosting students’ knowledge, attitude and skills and enhancing their pandemic preparedness. Although this would be an ideal scenario, the aforementioned Iranian study interestingly displayed a significant difference in perception of COVID-19-related risks between students being trained in emergency and those trained in non-emergency wards, as well as a significant negative association of risk perception with preventive behaviour. Haque et al further showed that adherence to preventive measures increased with age and educational attainment. The latter indicate that in spite of knowledge and skills remaining a prerequisite, readiness to respond to pandemic-related duties varies between students and depends on their age, stimuli and experience.

In summary, although the usefulness of medical students acting as frontline workers during COVID-19 has not been universally agreed on, the emerging literature shows that a significant number of students have seen this as an opportunity to learn, volunteer and contribute. Online supplemental table 2 presents several illustrative actions and initiatives of students acting as ‘frontliners’ during the pandemic, which were organised either at a student, institutional or nationwide level.

INSTITUTIONAL ADAPTATIONS AND INNOVATIONS

The need for substitution of the daily live and hands-on education during this pandemic has cultivated the incorporation of a variety of innovative ideas into medical education across the world, that have involved the introduction of new technological concepts, and also novel ways for medical educators to interact with their students. All these innovative methods should be carefully examined, as they could constitute a source of future inspiration for medical educators. These encompass social media initiatives, virtual core clerkships and digital clinical placements, new teaching models, sessions of remote patient consultation, even the use of patient simulators. Online supplemental table 1 describes in detail such adaptive ideas, designed and executed by different institutions, groups or organisations during the COVID-19 pandemic.

A ‘CRASH TEST’ FOR EDUCATION IN THE FUTURE?

It appears that the urgency of the current predicament has forced a rapid transition from the conventional more ‘analogous’ approach to a more ‘digital’ model, even in settings in which the utilisation of digital tools was far less extensive. There are two ways of examining future implications of this unparalleled period, at least as far as medical education is concerned. First and foremost, this pandemic has forced us to realise that medical education can become an extremely vulnerable asset in times of health crises and should not always be taken for granted in its traditional form, especially in the context of future COVID-19 waves and future pandemics. In Singapore, medical educators were driven by the past H1N1 pandemic to prepare a contingency plan for similar future crises. Creating a hybrid environment of fundamental traditional methods with novel technological tools could solidify the provision of medical education even in times in which its integrity is threatened. As illustrated by the responsiveness of medical educators across the world, used technological means may range from feasible, everyday and easy-to-acquire applications to more complex systems of patient simulators or virtual-reality technologies and holographic representation of three-dimensional objects (online supplemental table 1). Such advanced technologies, however, may not be promptly and broadly incorporated into medical education, especially when considering the negative financial impact of the pandemic on institutions and states. As Keegan and Bannister highlight, the...
Self assessment questions

1. Medical students during the COVID-19 pandemic:
   a. Have been assigned the same responsibilities across different countries.
   b. Have totally avoided frontline roles.
   c. Have reacted in a variety of ways, depending on their personal, institutional and even national needs.
   d. Have only undertaken roles inside their institutional environment.

2. During the COVID-19 pandemic:
   a. Student–faculty partnership has been severely and universally undermined.
   b. Student-centred social media initiatives have been organised.
   c. Several medical educators have implemented a develop, test and apply model to promote innovative educational programmes.
   d. An opportunity to reinforce the concept of evidence-based medical education has emerged.

3. The adoption of online learning in medical education can have several benefits:
   a. One benefit is the flexibility of time and location.
   b. Online learning can also be much more cost-effective than classroom-based learning.
   c. Online learning can potentially enhance interpersonal contact and interaction between medical students and the faculty members.
   d. Restricted access to clinical environment is a main benefit of online learning.

4. During COVID-19 pandemic:
   a. The disruption of clinical exposure had an indirect negative impact on the selection of residency for many medical students.
   b. Clinical exposure to positive role models may not help some students to pursue a specialty that they had not previously considered.
   c. A major concern about residency selection involves disruption of away rotations.
   d. Implementation of pass/fail grading system, devaluation of US Medical Licensing Examination (USMLE) Step 1 scores and limited access to USMLE 2 will affect students’ application for residency selection.

5. During COVID-19 pandemic:
   a. In many medical schools, clinical and written examinations have been postponed, cancelled or delayed.
   b. Sleep quality of medical students appears not to have deteriorated.
   c. Open book examination has been suggested as an alternative tool of rigorous assessments in medical schools.
   d. E-learning assists medical students to better adapt to a web-based medical world that increasingly uses digital health services.

CONCLUSIONS

In conclusion, the outbreak of COVID-19 pandemic has forced a rapid transition to online teaching of medicine and introduction of alternative student assessment methods, while it has created challenges in residency selection and future career plans of students, as well as having a significant psychological impact on them. Medical students have undertaken a variety of ‘frontline’ roles, with their actions being adapted to institutional and national healthcare needs, as well as their own knowledge, experiences and preparedness, which has been viewed by many students as an important learning experience. The urgency of the pandemic has rapidly brought on the development of many innovative educational strategies across the world, the majority of which encompass the use of a variety of digital tools. Such initiatives must act as a stepping stone for evidence-based medical education to thrive even more in the future. More large-scale studies from all over the globe are required to accurately depict how this unparalleled period has affected all aspects of medical education. Along with all the difficulties it brought, this pandemic reminded us that human collaboration through science is one of the greatest tools of humanity to deal with threats. Applying the same collaborative science in education, and specifically in medical education, could raise our optimism for the future of medicine. Education is our future, or in the words of Christine Gregoire: ‘Education is the foundation upon which we build our future’.

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Answers
1. (a) false; (b) false; (c) true; (d) false
2. (a) false; (b) true; (c) true; (d) true
3. (a) true; (b) true; (c) false; (d) false
4. (a) true; (b) false; (c) true; (d) true
5. (a) false; (b) false; (c) true; (d) true


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