PRE-PUBLICATION FINAL DRAFT

"Excuse the cat…" Reflections on online mentoring during the COVID-19 pandemic

Julie Browne, Cardiff University School of Medicine

During the pandemic, first year students in particular have seemed even more lonely, sad and stressed than usual without a network of friends and social activities to support them (1). These concerns are often expressed during online personal tutoring, individual supervision and one-to-one meetings. There do, however, appear to be some unanticipated positives to mentoring students online. Meetings are easy to arrange, and travel and room bookings are unnecessary, allowing faculty to meet with students more frequently to respond more quickly to a worried student's email requesting a meeting (2).

Additionally, in contrast to the well-documented engagement challenges of remote learning (3), one-to-one online meetings often seem relaxed and open. Students appear more willing to express their feelings and thoughts as they rest comfortably in familiar rooms, wearing casual clothes, chatting over their laptops or phones in a way that seems natural to them. Likewise, many faculty members are lucky enough to be working from home within close reach of a kettle; rooms are snugly fitted out with soft furnishings, family photos and children's drawings. Pets wander past; family members make brief appearances in the background. Thoughts and feelings flow more easily in these domestic settings.

What a contrast to mentoring meetings pre-COVID, where students had to arrive at the campus on time, present themselves to security, make their way to a pokey office in an anonymous building, wait until they were called in, and sit uncomfortably while the teacher stopped what they were doing, rapidly squirreled away papers, and put the screensaver on along with their standard smile of welcome. The student was always on foreign ground. Their first words were invariably: "I'm sorry to bother you."

Physical spaces are important; they have a hidden curriculum all of their own. In 2011, Bleakley et al argued that much hospital architecture reflects outdated attitudes towards healthcare, with the traditional monolithic factory-like structures of the late 19th and early 20th century indicating a 'mass-production' approach to large scale, one size fits all delivery of treatment (4). These massive edifices themselves require both those who are treated and those who work in them to conform to the architecture's unspoken imperatives: throughput, uniformity and economic efficiency. The clinician is part of a standardized system, the patient becomes objectified as a production output; and students and trainees, who are perceived as inhibiting clinical efficiency, represent irritants and glitches within the machine rather than essential to its continued running.

That it is still possible for doctors to innovate, for patients to receive humane care, and for students and trainees to feel part of a community of practice in such depressing, alienating and brutalising buildings is something to be celebrated. Moreover, there is hope that as

these ancient industrial-style buildings begin to fail, they will in future be replaced by healthcare centres that reflect a more humane and individualised approach to education and practice (4).

But what of medical schools? Again, many of our older medical schools reflect the strongly hierarchical attitudes prevalent a century or more ago. The architecture is designed more to impress than to welcome visitors. The Dean's office is often large and forbidding, remote from the main thoroughfares; faculty are tucked away in corners and backrooms. In the first weeks of every semester, it's normal to encounter first year students, lost and disorientated in the maze of corridors.

A classic example of how medical school architecture affects behaviour is the traditional lecture theatre. Learners must sit a minimum of several feet away from the lecturer, who is raised on a dais behind a lectern. Few sit in the front rows; most prefer to be raised at the back near to the exits. Everyone faces towards the lecturer; and, as anyone who has taught in such as space knows, the architecture, lighting and décor simultaneously flatter lecturers with a sense of their own importance and conspire to make it almost impossible to engage learners in meaningful interchange. There is an unspoken but clear sense that in this setting the lecturer is there to lecture, and the learners are there to silently receive information.

Medical schools underwent some structural changes in the later part of the 20th century as regulatory pressures, informed by a better understanding of how people learn, called for a more student-focussed approach to medical education (5, 6). A more democratic and interactive educational style, emphasising student choice and active learning mandated the construction of small group teaching and seminar rooms. As older, less flexible estates started to become obsolete they were replaced with new teaching blocks with social learning spaces, simulation suites, self-study rooms and computer suites.

But power imbalances are not so easily swept aside as all that; many medical school buildings stubbornly perpetuate traditional hierarchies, and the gap between educators and students persists (7). In surveys, students continue to report high levels of anxiety and stress and low levels of help-seeking behaviour (8,9). But despite all the thought, resources and energy devoted to student support, the chief warning signs that a student is unhappy are failure to communicate, lack of engagement with tutors and unwillingness to acknowledge mental distress (10). If the message built into the very fabric of the buildings remains one of teacher-centredness and privilege, it is unsurprising if students are unwilling to reach out for help.

During the worst of the pandemic we met our students in neutral cyberspace from the comfort of our own homes and they seemed happier to contact us and to talk more openly. When we return to post-COVID-19 teaching, will we return to how things were in early 2020? Will our students still be at our beck and call; when they come to see us, will they continue to feel that they are unwelcome visitors? Despite our impressive new buildings and teaching rooms, will the architecture and the way we use it convey that the students are just passing through while staff are the legitimate residents? And when students return to our medical schools, will the first things they see continue to be signs and notices, architecturally impressive but cold facades, hard chairs, security guards and locked doors?

Or will we use our experiences of supporting students from within our own domestic settings to develop our medical schools into more welcoming, democratic places where students can feel at home?

While COVID-19 has been a terrible catastrophe, bringing chaos and tragedy across the world, it has taught us some valuable lessons. One of these is the need to rethink our working spaces and practices in order to reach out to students on a more human, democratic level. If and when we return to something like normality, we will need to take a long hard look at the hidden curriculum of our physical spaces in medical education; for if we do not make more effort to reach out and welcome students as co-producers in the task of learning, we can hardly expect them to carry attitudes of fairness and democracy into their clinical lives (11).

(1) Hodgson JC, Hagan P. Medical education adaptations during a pandemic: Transitioning to virtual student support. *Medical Education.* 2020;54(7):662-3.
(2) Lee ICJ, Koh H, Lai SH, Hwang NC. Academic coaching of medical students during the COVID-19 pandemic. *Medical Education*. 2020;54(12):1184-5.
(3) Dost S, Hossain A, Shehab M, Abdelwahed A, Al-Nusair L. Perceptions of medical students towards online teaching during the COVID-19 pandemic: a national cross-sectional survey of 2721 UK medical students. *BMJ Open.* 2020;10(11):e042378-e
(4) Bleakley A, Bligh J, Browne J. *Medical Education for the Future: Identity, Power and Location.* Dordrecht: Springer; 2011.
(5) General Medical Council Education Committee. *Tomorrow's doctors: recommendations on undergraduate medical education*. General Medical Council London; 1993.
(6) Physicians for the twenty-first century. Report of the Project Panel on the General Professional Education of the Physician and College Preparation for Medicine. Academic Medicine. 1984;59(11):1-208.
(7) Abruzzo D, Sklar DP, McMahon GT. Improving Trust Between Learners and Teachers in Medicine. *Academic Medicine.* 2019;94(2):147-50.
(8) Moir F, Yielder J, Sanson J, Chen Y. Depression in medical students: current insights. *Adv Med Educ Pract*. 2018;9:323-33.
(9) Wilkinson TJ, Gill DJ, Fitzjohn J, Palmer CL, Mulder RT. The impact on students of adverse experiences during medical school. ^2006;28(2):129-35.
(10) Benbassat J. Undesirable features of the medical learning environment: a narrative review of the literature. *Adv Health Sci Educ Theory Pract*. 2013;18(3):527-36.
(11) Kincheloe, JL. *Critical Pedagogy Primer* (2nd edn). New York; Peter Lang

Pullouts

- In contrast to the well-documented engagement challenges of remote learning, one-to-one online meetings often seem relaxed and open

- Many medical school buildings stubbornly perpetuate traditional hierarchies
- A classic example of how medical school architecture affects behaviour is the traditional lecture theatre
- In the first weeks of every semester, it’s normal to encounter first year students, lost and disorientated
- the underlying message built into the very fabric of the buildings is still one of teacher privilege