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Medical Student Government Breaks COVID-19 Communication Barrier Between U.K. Students and Administrators

To the Editor: As U.K. medical students whose clinical placements were suspended in March 2020, the views expressed by Schuiteman and colleagues1 on the importance of bridging communication barriers particularly resonated with us.

COVID-19 lockdown measures brought a halt to in-person teaching and clinical placements for medical students across the United Kingdom. Summative examinations for the academic year at our medical school were also postponed and later moved to online proctoring systems. Having been suspended from placement and isolated—not only from medical school but from our peers, too—there was much concern surrounding online examinations. Bridging the communication gap between medical students and medical school administrators was key in easing increasing worry among students and to provide a more manageable workload for the university in a time of great uncertainty.

To this end, our medical school made use of an online forum to facilitate the dissemination of information to students; this included updates on changes to lockdown measures, examination updates, and directions to well-being services. This forum helped ensure we were kept up-to-date on current guidance, and it alleviated much unrest among students. Effective communication, however, also involved sharing the student opinion in a manageable way. To address this, the Student–Staff Liaison Committee (SSLC) was employed to gather and communicate the medical student opinion. SSLC representatives were able to share the views and concerns of students with the medical school, providing an effective and manageable means of communication.

The importance of a student representatives council has been previously discussed.2 Here, we demonstrate its importance in facilitating the communication of the medical student opinion in unprecedented times and its role in addressing student concerns. Like the authors, we agree that the value of an effective working relationship between the student government and medical school administration has been demonstrated during the COVID-19 pandemic, and we recommend the use of online forums and SSLC representatives in all future crises’ events involving medical schools.

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The COVID-19 Pandemic Is an Opportunity to Enhance Research on Remote Digital Anatomy Teaching Platforms

To the Editor: It was our pleasure to read Pearson’s comments,1 which raise important issues about the restriction of cadaver-based anatomy education due to the COVID-19 pandemic. We agree that disruption of cadaveric dissection could be accompanied by negative consequences because it has proven valuable for medical students regarding acquisition of anatomical knowledge.2 We also agree that this method could lead to development of compassion and empathy,1,3 because medical students can encounter death and consider the cadaver as their first patient. Pearson implies that future patients’ care by physicians could be compromised if cadaveric dissection diminishes. However, despite the aforementioned value of cadaveric dissection, we note that, to the best of our knowledge, there is lack of evidence that patients’ care declines if physicians have not received cadaver-based education.

We believe that recent findings of anatomy education research, concerning 3-dimensional (3D) digital visualization technologies, should be taken into account. Until recently, cadaveric dissection had not been found inferior to any digital anatomy teaching method. Nevertheless, Ruthberg and colleagues4 have recently demonstrated that the examination performances of a group of students taught anatomy via a 3D visualization technology (mixed reality) did not significantly differ from those of a group of students taught anatomy via dissection. Moreover, mixed reality was found to be more time-efficient than dissection.4 Zibis and colleagues5 compared the performances of 4 groups of students, each of which were taught anatomy via 4 different methods: a 3D digital platform, plastic models, cadaveric dissection, and prospection, respectively. The participants in each of the 4 groups were asked to identify anatomical structures in projected images. The students who received teaching via the 3D digital platform performed significantly better than did those who learned anatomy with the remaining 3 methods.

Thus, although cadaveric dissection has a high educational value,2 this method should not be considered as definitely superior to digital technologies in terms of knowledge gain. It seems that, due to the COVID-19 pandemic and the shift to remote digital anatomy teaching platforms,1 a remarkable opportunity arises for enhancement of research concerning these platforms. Continuously evolving 3D digital visualization technologies have shown remarkable potential to enable acquisition of anatomical knowledge.4,6 This knowledge could be the basis for high-quality care to future patients.

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Letters to the Editor

COVID-19’s Impact on Residency Applicants

To the Editor: In March 2020, medical students were pulled from clinical rotations in response to COVID-19. Although medical education was significantly impacted throughout the United States, each school enacted a unique COVID-19 pandemic response. Nearly three-quarters of students agree that their education was significantly disrupted, with a majority of students reporting that the pandemic interfered with their ability to develop skills needed for residency. These changes and their impact on the upcoming residency application cycle weigh on us and our peers as we consider our future careers.

At our institution, existing plans for clinical rotations were heavily modified. With United States Medical Licensing Examination (USMLE) Step 1 testing center closures and widespread appointment cancelations, our administration lifted the requirement to test before beginning our third year. Curriculum leaders placed students into compressed 4-week clerkships scheduled on a monthly rolling basis to accommodate decreased clinical capacity. Thus, each student had a unique timeline for taking their first board exam and completing required clerkships.

These scheduling heroics and structural changes supported the continuation of our clinical education. However, the consequences uniquely impacted each student. One peer had their USMLE Step 1 exam rescheduled weeks earlier than anticipated due to test center availability. Now they question their candidacy for a competitive specialty because of a suboptimal score. Another peer started clerkships months later than expected and, when struck by illness, found that only 2 options were available: either take a research year or continue the rotation, despite their condition, to graduate as planned. These anecdotes highlight the heterogeneity of experience within our institution, but the diversity of experiences across the United States is immeasurable. Students are collectively struggling but face unique and individual challenges.

Residency programs should allow space in the residency application process for us rising physicians to provide context as to how COVID-19-related changes have affected our medical education. Such an inclusion would provide an opportunity for us to expound on the structural challenges and resilience unique to our class. Additionally, this would offer residencies a more holistic applicant review, a goal toward which many programs are already working. If offered an opportunity to provide context for our recent educational experiences, we would feel less disadvantaged for our disrupted clinical education and more supported by our current institutions and future residency programs.

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