power supply has made students miss tests being administered virtually.

Despite these challenges, remote learning has benefits and can contribute to improving medical education. Remote learning has been shown to be convenient and effective, and it will help medical schools meet their commitment to produce high-quality doctors during—and despite—the pandemic. Adoption of a hybrid model, where small in-person group discussions are allowed and lectures are held online, should be encouraged. Technology companies should offer discounted Internet services to students and facilitate the implementation of EMR systems. This would help students participate in virtual ward rounds. Students should also be provided opportunities to be involved in research and attend virtual conferences.

During this period, it is important that we embrace remote learning and find new ways to integrate it into medical education and health care delivery. We must also keep our hope alive: Just like a small but frightfully painful kidney stone, this difficult period will surely pass.

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References

Do-It-Yourself Surgical Simulation Kits: One Academic Medical Center’s Response to the COVID-19 Pandemic in Malaysia

To the Editor: The rapidly evolving nature of the COVID-19 pandemic has negatively impacted surgical training by reducing trainees’ operative exposure and curtailing traditional teaching methods. At the University of Malaya, we used easily available materials to construct do-it-yourself (DIY) training and evaluation surgical skill simulation models during a federally mandated lockdown. This effort was spurred by the following:

- Our historical reliance on hands-on operative exposure as a key part of training meant that we did not have simulation sets/modules readily available on site.
- Offices of device companies that would typically provide training models were closed, and their staff were working from home.
- The sudden nature of the lockdown in tandem with rapid hospital-level changes meant that we did not have time to prepare by bringing in simulation models.

Forced to think on our feet, we devised DIY simulation models using the following materials obtained from hardware shops, which were allowed to remain open during the lockdown:

- Foam mat with silver foil covering
- Child-safety corner and edge protector foam
- Plywood cut to 12 inches × 12 inches (edges sanded using an angle grinder)
  - Covered with clingwrap/ cellophane tape to allow reuse
  - Rubberized nonslip surface
- Plastic water bottles
- Nails
- Wall cable organizer
- Wall hanger
- Felt cloth
- Gloves (nonsterile)
- Expired sutures
- Basic running instrument suture and instrument ties
- Bowel Anastomosis (with simulation of anatomy of third part of duodenum)
- Vascular anastomosis (with simulation of a vein)

We created vignettes to provide context for each task to assess the trainees’ understanding of types of suture materials required, choice of needles, and understanding of anatomical structures and tissues at risk. For work simulating bowel and vascular anastomosis, trainees were required to use magnifying loupes, as they would for live surgery. Two sessions were held—one for training (pitched according to trainee seniority) and one for evaluation (convened 10 days after training to allow practice).

We believe these practical suggestions would be easy for others to implement in settings similar to ours. Even programs in resource-abundant settings may find our ideas useful as they may have to deal with diversion of funds to support COVID-19 initiatives.

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“Holistic Admissions” During a Pandemic: The Effects of COVID-19 on Socioeconomically Disadvantaged Medical School Applicants

To the Editor: The COVID-19 pandemic has upended nearly every aspect of undergraduate medical education, including the traditionally yearlong admissions cycle. For those who are first in their family to graduate...