college or apply to medical school and/or who hail from socioeconomically disadvantaged backgrounds, often referred to as first-generation and/or low-income students, this unsettling disruption to the admissions cycle may amplify already intimidating barriers to educational mobility.

With only 5% of medical students coming from the bottom 20% of U.S. family incomes, a significant disparity already exists in the representation of lower-socioeconomic status (SES) students in medical school.1 Aside from the obvious financial obstacles, these students’ on-paper achievements are potentially limited by opportunity costs, time constraints, and poor social capital. We are concerned that, with research projects suspended through the summer, limited clinical shadowing opportunities available, and the conversion of transcripts to pass/fail, there lies the potential for Medical College Admission Test scores, the prestige of undergraduate institutions, and/or the prominence of recommendation letter writers to fill the void in making admissions decisions. Furthermore, with university campuses closing and the consequent inability to pursue other paid opportunities, socioeconomically disadvantaged applicants may lack the financial capability to apply broadly to medical schools during this upcoming cycle.

In anticipation of these challenges, the Association of American Medical Colleges increased the upper limit of its Fee Assistance Program to 400% of the U.S. poverty level.2 To further the impact of this effort, lower-SES students may benefit from individual institutions waiving secondary fees and using virtual interviews. While these solutions may mitigate the financial impacts that lower-SES applicants face, they likely will not ameliorate the lost opportunities during this time. Therefore, we also propose that admissions committees acknowledge all applicants’ invitations to research conferences and summer programs even if they were financially or logistically unable to attend. Finally, the barriers overcome by lower-SES students, now more than ever, highlight their resilience and resourcefulness. Admissions committees can continue to increase equity for this group by valuing each applicant’s “distance traveled” when forming admissions criteria.

We believe the COVID-19 pandemic brought to the forefront issues that negatively affect socioeconomically disadvantaged applicants’ success in medical school admissions. Only a joint commitment across medical schools to maintain a holistic review of applications will shield these applicants from being further marginalized in upcoming admissions cycles and excluded from a workforce that desperately needs them.

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References


Students’ Experiences With Racism During the COVID-19 Pandemic

To the Editor: Reports of racism against Asian individuals have been documented during the COVID-19 pandemic, but little is known about the implications for student well-being and support.1 We conducted a cross-sectional survey to identify instances of racism associated with the COVID–19 pandemic toward undergraduate pharmacy students (n = 370) in New Zealand. The survey, which was administered via email over 2 periods, included questions exploring experiences with direct and indirect racism and racism-related implications for overall well-being.

The first survey period (March 1–14, 2020) occurred after New Zealand reported its first COVID-19 case but before Level 4 lockdown was instated. At this time, COVID-19 cases were primarily located in China, South Korea, the Middle East, and Europe. The second survey period (March 31–April 13, 2020) occurred one week after Level 4 lockdown was instated. During Level 4 lockdown, only essential services and businesses are allowed to remain open, primarily supermarkets, pharmacies, service stations, and health centers. Individuals are meant to stay at home and to limit any exposure to those not living within the same dwelling.

A total of 86 students (50% Asian) responded to the pre-lockdown survey. Of the respondents, 13% reported experiencing direct racism (defined as a direct physical, verbal, or written act perceived to be targeted at the individual), 35% reported experiencing indirect racism (defined as an act directed at a greater population or community that resonated with the individual), and 37% indicated racism associated with COVID-19 affected their well-being. Reported sources of racism included social media, verbal abuse, and physical contact or gestures. A total of 183 students (50% Asian) responded to the post-lockdown survey. Approximately 7% of the respondents reported experiencing direct racism in this period, 18% reported experiencing indirect racism, and 28% indicated racism associated with COVID-19 affected their well-being. Reported sources of racism were similar to the pre-lockdown survey. In both periods, direct racism was said to occur at the grocery store, on the street, or in other public establishments.

Our findings suggest that racism experienced during the COVID-19 pandemic has impacted students and has negatively affected their well-being. Our findings support the notion that student support services and pathways must be reviewed and modernized to better serve the needs of students affected by racism during international health crises. Future
research should focus on developing proactive prevention strategies, rapid response services, and student resilience training.

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Reference

Certify Medical Students to Respond to National Crises

To the Editor: The COVID-19 pandemic has stretched health systems to their breaking point. And yet, many advanced medical students have been kept away from hospitals, underused in a time of critical need, and unable to take advantage of invaluable learning opportunities. Now is the time to rethink the current structure of the health care system and to implement a national, formalized structure that incorporates medical students into future health care responses to disasters, pandemics, acts of terror, and the like.

Despite the amount of training and the formal examinations that students undergo, fourth-year medical students are technically only as qualified as entering first-year students. Medical students take and must pass 3 different licensing examinations during their schooling. Supplementing preclinical learning with practical skills training, such as airway management, IV placement, and wound stabilization, could equip medical students to serve an important new role in the response to disasters. As students progress through their training, they should gradually accumulate skills and corresponding certifications to perform vital health care functions, in contrast to the current all-or-nothing model of medical licensing.

At a small number of medical schools, first-year medical students already train and become certified as emergency medical technicians to supplement their preclinical years with experience in the field.1 We propose adapting such a model to develop a new disaster response certification for medical students to help meet the needs of the country during times of strain on the health care system. The skills held under this medical student certification should be determined by a panel of experts, including experienced disaster relief and public health officials, to maximize utility during a wide range of national crises. A national registry of medical students with disaster certification could be maintained and updated (e.g., clerkship and board examination completion, current location) so that they are easily called to action. Participation in any relief efforts could be kept voluntary, but certification would ease the process of deploying willing medical students.

Pandemics and other disasters are exactly the problems we signed up to tackle when we committed our professional lives to medicine. This is a critical time for our generation to contribute to the relief effort and gain the skills to lead the way in the future.

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Physician–Scientists in the Era of COVID-19: Gone but Not Forgotten

To the Editor: The COVID-19 pandemic has resulted in the redeployment of many physician–scientists and physician–scientist trainees to full-time clinical services, with their scientific research and academic training put on hold. Physician–scientists are provided with protected time, alongside their clinical duties to perform scientific research and receive academic training. Historically, they have contributed seminal scientific discoveries, and recent Nobel laureates are counted among their number. Yet in many countries an extraordinary proportion of these trainee posts have been postponed due to the pandemic. In England alone, over 1,500 trainees—90% of the physician–scientist trainee workforce—were redeployed to clinical duties during the first wave of the pandemic.1 The resultant drain on the global academic medicine community has been profound. The rationale is clear, but the long-term consequences for research and medical practice are grave.

Physician–scientists are vital contributors to global biomedical research efforts.2 Bridging the divide between scientific research and care at the patient’s bedside, they have led some of the most significant breakthroughs during this pandemic, including findings relating to corticosteroids and hydroxychloroquine. But the stagnation of many of their research projects on high-impact diseases may contribute to the hidden mortality of COVID-19 for years to come. For example, the largest independent funder of cancer research globally announced a reduction in grants of up to 20% for the foreseeable future due to loss of revenue during the pandemic.3 The Association of Medical Research Charities estimated that 70% of clinical trials and studies in the United Kingdom were stopped during the initial stages of the pandemic, and that it will take 4.5 years for medical research spending to reach prepandemic levels.4

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