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Commentary and Opinions

Challenges facing medical education in psychiatry during the COVID-19 pandemic

Les défis de la formation médicale en psychiatrie pendant la pandémie de la COVID-19

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Medical education has been drastically affected by the COVID-19 pandemic. Medical students were removed from clinical duties for upwards of 16 weeks at Canadian medical schools, while postgraduate trainees were required to quickly adapt to new forms of learning to conform with infection control requirements.[1] Virtual medical education (i.e. lectures and small group sessions via videoconferencing) became the new and reasonable norm, while the resumption of clinical duties came with significant modifications.[1] Surgical training programs described challenges with providing traditional surgical skills training during the pandemic, but have attempted to implement adaptations such as virtual clinical skills training.[2] Nonsurgical specialties that rely heavily on physical examination skills also described similar challenges, again adapting with virtual learning modalities (i.e. videoconferencing at the bedside).[3] Many medical fields have also shifted to virtual patient care when feasible using videoconferencing tools, altering the process of traditional clinical learning.

In the field of psychiatry, where patient assessments and mental status examinations can often be accomplished indirectly, how has the COVID-19 pandemic impacted psychiatric medical education, if at all?

The field of psychiatry is arguably the most interpersonally intensive medical specialty. It deals with the inner workings of the mind, emotions, and resulting behaviours. Although clinical understanding can be derived from reviewing DSM diagnoses and treatment guidelines, or by viewing online lectures, the nuances of practicing psychiatry are best realized through face-to-face assessments. For psychiatric practice to thrive, a meaningful therapeutic relationship is required to connect with patients at a level that creates trust and a willingness to share personal thoughts and emotions that allows for reflection and ultimately clinical improvement. Notably, the quality of the therapeutic relationship is also a strong predictor of outcomes in psychotherapy.[4] The cultivation of this relationship, therefore, is not trivial. Face-to-face assessments allow psychiatrists and their trainees to better understand patients by identifying nuanced aspects of the patient that are not appreciable during voice and/or video assessments alone. For example, noticing a patient uncontrollably shaking their foot when discussing an anxiety-provoking thought can be a crucial mental status finding. However, with the challenges of the COVID-19 pandemic, clinical care and teaching have been altered, notably by way of virtual patient assessments. For example, when videoconferencing with a patient that only visualizes their head, many mental status signs may be lost. And even with current modified in-person assessments, wearing PPE adds a physical barrier between trainees and patients that often obstructs facial expressions that can be crucial to better understanding and connecting with patients. Unfortunately, the in-person aspect of psychiatry is crucial

to a trainees' ability to fully appreciate the intricate nature of patient interactions and can make or break clinical encounters and the subsequent strength of therapeutic relationships.

Psychiatry trainees often rely on direct clinical observation and supervision to develop their clinical skills.[5] For trainees, observing clinical interactions between staff psychiatrists and patients can be an important tool to understanding the complexities of the clinical psychiatric interaction. However, this has been limited or lost altogether during the pandemic, and it is currently unclear if virtual means of observation are as effective. Similarly, direct supervision of trainees by psychiatrists is also crucial to trainee development.[5] Trainees seek constructive feedback regarding their interview style, approach, and execution, as well as regarding clinical decision making and thought processes, that supervisor-led coaching and clinical articulation provide.[5] However, due to COVID-19, trainee supervision is either reduced, limited to virtual mediums, or with modified in-person settings, and the effectiveness of these changes is questionable.

Psychiatry is often viewed as the medical field of people. It is humanistic, compassionate, and seeks to cultivate therapeutic relationships with patients. For psychiatry trainees, the various intricacies of the patient assessment are crucial to psychiatric medical education and subsequent patient care. We understand that during the COVID-19 pandemic, public health must be the priority compared to medical education. With the flattening of the curve across Canada, public health restrictions are cautiously being lifted, allowing for the resumption of modified in-person clinical activities for residents and medical students. However, with the threat of a second wave ever present, we must re-consider our contingency plan for psychiatric medical education in the coming months and possibly even years. We must determine how to provide effective, pedagogically-sound modified psychiatric medical education during another future pandemic, in a way that minimizes the negative educational effects that such changes may have on the clinical abilities of psychiatry trainees.

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