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PSYCHIATRY THROUGH A SCREEN: ADAPTING TRAINING FOR A NEW REALITY?

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SUMMARY

The Covid-19 pandemic has had a profound impact on the way psychiatry is taught. Both the formal teaching components and the clinical placements pivoted to run in a virtual world. Students learnt psychiatry through a screen, either through online teaching sessions or remote clinical activity. Two medical students passionate to pursue a career in psychiatry (KB, FR) reflected with an undergraduate department faculty member (SB) upon their experiences of the adapted mental health block, how the delivery may have affected their motivations for psychiatry, as well as considering their learning on psychiatry training for a new, virtual reality.

Key words: *psychiatry in pandemic - virtual reality - psychiatry through a screen*

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INTRODUCTION

The Covid-19 pandemic continues to cause major disruptions to how education is delivered across the world (Sahu 2020, Viner et al. 2020). Social restrictions have led to most institutions switching to teach via online methods, with the majority of undergraduate lectures being delivered virtually (Sun et al. 2020). Changes to medical student placements reflected changes to clinical services, with the adoption of 'blended' models involving limited face to face patient interaction and students joining consultations also through a screen.

Thus, this mental health block course structure and delivery had to be revised. Changes were made with pragmatism e.g using software such as Microsoft Teams or Zoom, instead of in person teaching, as well as with consideration of educational theory. However, in a speciality that has struggled with recruitment (Brown & Ryland, 2019), and with the knowledge that medical students experience of psychiatry exposure is critical for career choice (Seow et al. 2018), the potential consequences of these changes are largely unexplored.

Two final year medical students, already passionate about pursuing careers in this field (KB, FR), reflected with an undergraduate department faculty member (SB) upon our experiences of the mental health block and how completing this 'through a screen' has affected their motivations going forward. We acknowledge this is limited by only providing a particular perspective from psychiatry advocates; we hope that it provokes some interesting discussion.

OVERVIEW OF MENTAL HEALTH BLOCK AND CHANGES MADE DUE TO THE PANDEMIC

The mental health block lasts for seven weeks and has distinct components of clinical placements and taught sessions.

Clinical Placements

The students go into 2 clinical placements, the first for 4 weeks, the second for 3 weeks. There are a mixture of specialities including Child and Adolescent, Old Age, Forensic and Addiction Psychiatry. Every clinical service was affected differently, with many only conducting virtual activities. The placement allocations for students were then adjusted to give a mix of both face to face and virtual activities. Some placements were no longer able to host students leading to last minute changes. Students were also given remote access to the electronic clinical notes system with appropriate governance in place.

Given the reduction of patient contact, effort was made to provide 'sign-up' opportunities. These were remote or face to face clinical activities offering discrete, half day or day sessions a student could select to attend, supplementing their base clinical placements.

Taught sessions

The students have two days of lectures in the first week, largely unchanged in content but switched to online delivery.

The students were split into groups of 10 and attended a full day's small group teaching on Old Age, Forensic and Child and Adolescent Psychiatry. These sessions were adapted to have half a day of online teaching with the rest of the content available for self-directed learning. This allowed new sessions to be developed; students got a full day of on-call psychiatry focusing on common psychiatry presentations they would face as a junior doctor and a half-day session on risk assessment. These also gave students the opportunity to practice key history taking and communication skills with actors employed for role plays.

Furthermore, there was the addition of a weekly, hour-long tutorial, delivered online by a consistent tutor in the same group of 10. The curriculum was spread

over seven weeks with material prepared for the tutor for uniformity. These were taught by a mixture of Consultants employed by the undergraduate department and senior psychiatry trainees as a part of their special interest protected professional development time.

EXPERIENCES OF THE CLINICAL PLACEMENTS

Whilst some students had the opportunity to attend placement in person, they often had to join consultations virtually, from a different clinical room, due to social distancing restrictions. Although unavoidable, as students we often felt that we were not part of the team. This made it difficult to contribute by asking questions and engaging fully. What helped was when the team gave us a role, for example conducting a mental state examination, or to take part of the history. Giving students a job helps them to feel useful, which then allows them to engage and learn more.

We know that building communication relies, in part, on emotional connection (Chichirez & Purcărea 2018). Taking this into account, we as students were concerned about whether the emotional connection we develop with patients would be impacted by virtual consultations, with the screen as a physical barrier. Whilst this was indeed the case, we also noted that as the consultations explored intimate, emotional intricacies of people's lives, an emotional rapport could still be built. That said, this only occured when we were given active roles in consultations, which we could then reflect upon. Reflection helps us as students to enhance our emotional connection to cases, which aids to consolidate our own learning (McConnell & Eva 2012).

The focus on providing 'sign-ups' allowed students to gain access to a range of psychiatric specialties and areas that they otherwise would have missed out on. From the student perspective, this also promoted autonomy and responsibility over our own learning. Establishing a sense of control helped us to manage the last minute placement and timetable changes. That said, we feel that this mostly benefited students who were keen and took up the opportunities. Having more students take advantage of this could be achieved by making it compulsory to do at least one sign-up within the block. Adding this to the mandatory requirements in students' portfolio, whilst also allowing them to choose what they undertake, would be a great way of enriching their experience of psychiatry.

After training, and within an explicit governance structure, students were also given access to the electronic clinical notes system. We found this incredibly useful, especially before meeting patients virtually for the first time. We would often read through a patient's notes before the consultation, which helped in many ways. First, it helped us to identify any gaps in our knowledge to revise before meeting them. Second, it gave us an idea of who the patient is, and the notes allowed us to follow the patient's journey so far. Third, reading patient notes before meeting the patients seemed more lifelike to a doctor's role, helping us to feel part of the medical team whilst on placement. This was especially the case when we could write up our own observations in patient notes.

EXPERIENCES OF TEACHING SESSIONS

From all of our virtual medical education throughout the year, it has been apparent how easy it is for students to disengage. With no one physically present to keep students stimulated, students often become demotivated after staring at a screen for hours. Thus, keeping students engaged is key. Factors that we found which promoted engagement included: ensuring students had their cameras on, utilising the chat box function; explicitly asking students questions; using breakout rooms; having breaks that involved standing up and stretching. Research has suggested that a way of fighting 'Zoom fatigue' in students is by giving regular breaks and encouraging them to relax or get something to eat (Castelli & Sarvary 2021). From our experience, we found that having breaks within sessions increased contributions in discussions from all students, which then enhanced how much we gained from the sessions.

Attendance for sessions also varied significantly throughout the block, in particular the tutorials. One reason could be that students were usually attending placement during the time it was held. Due to the limited clinical space, students were then either not able to find a room to join the tutorials, or were in a communal area where speaking aloud is more challenging. This could be rectified by, where possible, ensuring students have an appropriate environment to attend teaching remotely whilst on placement, or giving protected time for students to be at home for teaching.

Experience of role plays

Performing clinical consultations via role plays offers brilliant opportunities to practice difficult conversations and develop communication skills; applicable in both Objective Structured Clinical Examinations (OSCEs) and the clinical environment. Students get the chance to practice these skills in a non-clinical environment, and receive invaluable feedback from skilled psychiatrists. It was interesting to learn from psychiatrists who were simultaneously learning on the job, in their own newly virtual clinics. For example, they would often speak of their own experiences and struggles of working in this environment.

Generally, role plays help students to learn the history taking structure and to formulate differential diagnoses within a 6-minute window, as allocated in an OSCE station. They also aid in refining the more nuanced aspects of communication that are crucial in

psychiatry, such as; asking difficult questions, conveying empathy and picking up on patient cues. We found learning these skills virtually challenging. Roleplaying through a screen made it harder for us to demonstrate non-verbal communication, so this was usually neglected. This then meant the focus for feedback got shifted away from the delivery of questions to simply the content of the consultation. We observed students making comments such as "Oh I'd have been empathetic in real life, but this is just a role play". This could be improved by having a specific section of feedback for non-verbal communication, or asking students to write down examples that they observe for a discussion afterwards.

Sometimes students in the group were given the role of playing the part of the patient. There are obvious benefits of this, as it allows us to empathise and think from a patient's perspective. We found that this arrangement worked best when groups of 3 were put into breakout rooms, allocated as the patient, doctor or observer who gave feedback. Having breakout rooms have been found to make students more relaxed and likely to interact more (Chandler 2016), so this worked well. The only issue was that the role play was then perceived to be less lifelike, as it involves talking to a peer as opposed to a stranger.

Sometimes actors were used to play the role of the patient or carer. The actors were trained to give cues and challenge us where appropriate, in order to practice having difficult conversations. This made it feel more like a realistic consultation and was a great adjunct to our clinical placements.

HOW HAS THIS AFFECTED OUR DESIRES TO PURSUE PSYCHIATRY?

This rotation was the last exposure in psychiatry before we graduate, so it was a pivotal moment in our medical degree. Although this block was not what we envisaged it would be, it has not negatively impacted our passion for psychiatry. There were challenges yet we found the 'blended' model of education gave us a sufficient experience of psychiatry to feel like we understand, in part, the career we wish to undertake. The course content also focuses on developing the translatable skills of psychiatry that every doctor needs to know, so is beneficial for all students regardless of future specialty. Whilst we feel more confident with these skills, we also found that the extra barriers that come with virtual teaching can make it more challenging to engage, to develop those key skills, and see the wonders that psychiatry has to offer.

As it stands, the uncertainty surrounding the pandemic means it is likely that virtual education will carry on for the foreseeable future (Zalat et al. 2021). Therefore, we suggest some takeaway points that we believe could improve the experience of learning psychiatry through a screen.

For clinical placements:

- Give students a specific role in the team when in virtual clinics, such as taking part of the history or conducting a mental state examination;
- Give students access to the electronic clinical notes system for students to read up on patient's notes before meeting them;
- Consider adding 'sign up' opportunities for students during their block. Having a minimum mandatory amount would ensure all students benefit, whilst giving students the autonomy to choose what they wish to attend.

For taught sessions:

- Explore and overcome the barriers of virtual teaching sessions: asking students whether they have questions, having regular breaks, encouraging cameras to be on;
- Use breakout rooms for roleplays, so that every student gets a role;
- Use trained actors to play the part of patients or carers during role plays;
- Have specific feedback focuses, such as non-verbal communication, during virtual role play sessions;
- Ensure students have an appropriate environment to attend teaching remotely whilst on placement, or give protected time for students to be at home for teaching.

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Faeez Ramjan was involved in all aspects of the manuscript's conception, writing, revision and finding of references.

Kate Baird was involved in all aspects of the manuscript's conception, writing, structure, analysis and revision.

Sophie Butler was involved in all aspects of the course design, conception, writing and revision of this manuscript.

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