



## Psychiatry Education Amid COVID-19 Pandemic in Iran

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Recently, the coronavirus disease 2019 (COVID-19) has affected the healthcare system with its unpredictable duration and diversity. Medical education was one of the issues strongly affected by the pandemic, and major reforms were necessitated in many fields (1).

In 2020, in response to the COVID-19 pandemic, the best way seemed to be to remove medical students from the clinical setting (2, 3). Like many other universities in the country, psychiatry education continued in the psychiatry department of Mazandaran University of Medical Sciences in northern Iran, but face-to-face training sessions were restricted. Many traditional clinical and in-person training were terminated, and there was a rapid shift towards online education. Courses related to "psychiatric disorders" were conducted almost entirely virtually for medical students who were training on a psychiatric education rotation. An online mourning counseling session was also held for each group of students to improve the necessary skills in dealing with grieving people.

Psychiatric residency training also faced new challenges in providing patients' care, and there were fewer opportunities for learning compared to the usual traditional training. For psychiatric assistants, as for other medical students, the conflict between learning along with providing care and staying healthy was a serious challenge (4, 5). Another important point was to avoid excesses, including absenteeism (unnecessary avoidance of work and education) and presenteeism (going to work despite feeling sick or ill). Attention to the latter case, which is less valued under normal circumstances, stems from the fact that the presence of employees with presenteeism in the workplace not only reduces productivity (6) but also can endanger the patient's safety (7); this issue was doubly important in the COVID-19 pandemic. Presenteeism had many negative consequences, including reduced levels of individual performance, impaired collective functioning (8), and the

spread of the virus.

In various specialized fields of medicine, education was best achieved virtually to establish a "social distance" (9-11). In the psychiatric department, most of the training was done in cyberspace using Skype software. Unfortunately, the information technology (IT) infrastructure of the university for e-learning was not used due to its poor quality. Meanwhile, in many reports from other parts of the world, virtual training was done through Zoom software (4, 5). However, due to the sanctions on the country, it was not possible to use this software in Iran.

Case report, journal clubs, and morning report sessions were held using Skype software. Because of the risk of the virus spreading, we could not interview the real patients at the case report sessions; thus, the format of the case report sessions changed. In each session, the instructor developed a scenario related to a psychiatric disorder. Two residents, one as the standardized patient and the other as the interviewer, performed the scenario. Standardized patient simulated a real patient. There is ample evidence that simulations in virtual reality are effective in medical education and health care (12). After the interview, differential diagnoses and appropriate treatments were discussed between residents and the faculty in cyberspace. For better online interaction, it was suggested that all the cameras be turned on, but this was not always possible due to the low speed of the internet and lack of access to suitable platforms such as Zoom. In addition to adhering to the special health protocols of the COVID-19 era, practicing interviews and psychiatric examinations, and providing communication skills training, other benefits of these sessions include the possibility of raising rare psychiatric disorders, as well as possible comorbidities and co-occurring conditions that assistants are less likely to face during their residency program. In addition, role-playing practice by assistants enabled them to better empathize

with psychiatric patients.

In addition, a virtual group was formed on WhatsApp to upload educational content and conduct scientific discussions. There was an appropriate, scientifically interactive relationship between the faculty and psychiatric residents in this virtual group. There was also a monthly webinar on psychiatric innovations aimed at retraining graduate psychiatrists. Participation in the webinar was possible from all over the country, and there was no limit in terms of distance. Some of these webinars were also attended by people from abroad.

At the time of COVID-19 peaks, hospitalization of psychiatric patients was limited and performed only in severe cases. However, despite all the limitations, inpatient and outpatient psychiatric training continued in person, albeit to a lesser extent than normal.

In the psychotherapy department, theoretical sessions and peer-group supervision were held virtually, but residents performed psychotherapy face to face. Compared to the pre-COVID-19 period, some changes were necessary, such as physical distance, proper ventilation of the room, and wearing a mask during a psychotherapy session. In one of the virtual peer-supervision sessions, three out of five residents were infected with COVID-19, but they attended the meeting and interacted with others. More flexibility was required in these sessions, so the supervisor allowed the participants to turn off the cameras and lie on the bed.

Increased depression and burnout among psychiatric residents were reported during the COVID-19 pandemic (13). We tried not to allow physical distance to lead to emotional distance, so, for psychological support and emotion sharing, online Balint group sessions were held for psychiatric residents. It should be mentioned that psychiatric residents were already familiar with these sessions because in-person sessions were held at the psychiatric hospital before the pandemic (14).

Face-to-face education is an important issue in psychiatry (1). At the time of writing this article, we have not seen the faces of some psychiatric assistants who have entered the psychiatric ward in the past two years, and we do not know some of them by face because mask has been on their face for two years.

All these limitations have affected our teaching methods, and we are unlikely to return to the same methods after the epidemic ends. However, this allows us to think about how we can change our training and improve the educational methods. One important issue is to revise the curricula and continue the use of cyberspace-despite all its limitations, along with traditional methods in education. Simulation is becoming the cornerstone of clinical education, though it requires financial, equipment, and human

resources. Virtual reality offers a powerful profitable educational tool to trainees and instructors, as well as cost-effective and repeatable clinical training (12).

## Footnotes

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