Don't Let a Good Educational Crisis (or Three) Go to Waste

Amanda Calhoun, MD, MPH, and Andrés Martin, MD, MPH

What if 2020 isn't cancelled?
What if 2020 is the year we've been waiting for?
A year so uncomfortable, so painful, so scary,
so raw —
that it finally forces us to grow.

— Leslie Dwight

The Zoom Where It Happens (Or Not)

With over 400,000 COVID-related deaths in the United States alone at the time of this writing, it may come across as insensitive to consider the *positive* sides of the pandemic. And yet, an appraisal of the educational opportunities unleashed by the coronavirus reveals objective opportunities we would not have seized otherwise.

Two sets of examples are indicative: the first taken from our own research. "*Sex Ed 201:* Sexual Health for Child and Adolescent Psychiatrists" was initially developed as a session for trainees at Yale University. The pandemic forced our group to rethink our delivery approach, and in so doing, led us to increase our sample size ten-fold (from one site to 16, and from 12 trainees to 125). We were able to share hard-to-come-by knowledge well beyond the physical confines of New Haven, Connecticut. Through synchronized videoconferencing we were able to recruit from as far afield as California and Brazil.[1] Using a similar method of information dissemination and real-time, face-to-face exchange, we have completed studies about the role of shared living experience with medical students in Israel,[2,3] and with physician assistant students across the United States.[4] We have been able to test the efficacy of a didactic module on electroconvulsive therapy that incorporates videos using standardized patient depictions.[5] None of this could have been possible (let alone in a four-month interval) were it not for communication platforms like Zoom, which have become ubiquitous as a result of the pandemic.

The second set of examples will be easier to relate to, as they affected so many of us: large in-person professional meetings. The 24th World Congress of the International Association of Child and Adolescent Psychiatry and Allied Professions (IACAPAP), and AACAP's 67th Annual Meeting had been respectively scheduled to take place in Singapore in July, and in San Francisco in October. Both were moved to virtual platforms. This was not exactly good news, and certainly not for those of us who look forward to the deep social immersion that these gatherings provide. Still, one cannot but think of the positive effect such changes had on carbon footprints—and on reaching those who would have otherwise not attended due to prohibitive costs or competing professional or personal responsibilities. I remain optimistic that one of the upsides of such virtual e-meetings will be their ability to reach many more participants. The pilot experience from this fall has certainly been promising.

Time will tell more about the opportunities and shortcomings of practicing virtually. When it comes to clinical practice, we are by now rather fatigued of virtual visits. We miss the immediacy of clinical contact. We miss our patients and their families, with screens and pixels able to communicate only so much of their humanity. We celebrate the shot-in-the arm that the pandemic has given to telepsychiatry; we revel in our new set of skills; we even feel proud of our doctorly screen-side manner. And yet, despite our learning curve and fully booked e-schedules, we cannot but think of those we are *not* seeing, the many we are unable to see. For one thing that the pandemic has revealed all too painfully is the digital divide across this vast land of ours: so let's please not *aZoom*.

An Older Virus

The pandemic has also shed light on an even older divide in the US, one that existed long before the digital age: the racial divide. We are in the midst of a syndemic, the double pandemic of COVID-19 and racism, the former just an infant, the latter well over 400 years old. The disproportionate number of deaths in the Black community only serves to highlight the racial inequities in the US when it comes to underlying health conditions, socioeconomics, and access to healthcare. But this is not the entire story. Experts have encouraged us to look deeper, beyond and separate from socioeconomics, and to begin treating racism as the social determinant of health that it is. The American Academy of Pediatrics released a policy statement in 2019 naming racism a major driver of health inequities in children,[6] and a growing evidence base documents the effects of chronic stress due to racism on the mental and physical health of Black Americans.

And then came COVID-19. Then came the murders of George Floyd, Breonna Taylor, Ahmaud Arbery, and countless other Black Americans. The protests that ensued are reminiscent of the Civil Rights movement and make one wonder: was this really 2020? Why must Black Americans and their allies protest to protect the dignity and humanity of Black lives? And what can we, as psychiatrists, and academic physicians do to push an antiracist agenda in our country?

For starters, one thing we can do is re-define the language we use to discuss racism. As academics, we are guilty, like so much of society, of using euphemisms to make hard truths more palatable. But is it right to sugarcoat the experience and trauma of Black Americans for the comfort of others? And even beyond that, is it effective at truly promoting change? As psychiatrists, we believe in the power of language and its ability to convey meaning – to heal and to soothe, or to be wielded like a weapon. To this end, we must be sure that the vocabulary we use around race is targeted, direct, and clear.

The language we use to discuss racism should focus on identifying it and on protecting those targeted by it. In essence: we should call a spade a spade and normalize the R word. If we cannot even name racism, how can we expect to promote an antiracist agenda? Let us use this pandemic as a time to learn, adapt, and move forward. Let us move beyond implicit bias, beyond colorblindness, beyond microaggressions, and beyond race relations. Let us instead confront and stand up to structural racism, coded racism, everyday racism, and White supremacy. Let us embrace antiracism and remember that the opposite of 'racist' is not 'not racist': it is antiracist. Let us move from the assumed 'implicit' or unconscious intentions of the aggressor and instead start focusing on the impact that racist behavior has on those on its receiving end. We have brought this ambitious and overdue set of priorities to our everyday clinical practice, to our teaching and supervising interactions, and to our university-wide policies. Moreover, we have started to explore empirically the impact of race, racism, and the development of antiracist attitudes and behaviors. We are actively doing so through a range of research efforts that, at their core, rely on the *quality* of meaningful conversations, in a way that checklists or close-ended interviews would not be able to capture.

Hearing Voices

For all of our professional experience in disentangling what hearing voices signifies clinically, we would argue that as a discipline we could do better at listening to our patients' voices. This is neither a cheap shot nor professional self-loathing; instead, it is an invitation to enrich and broaden our research efforts.

A few introductory definitions and reminder are in order. Epistemology, that five-dollar word, refers to the branch of philosophy concerned with the nature of knowledge. Simplified to its core, it posits that there is an objective or positivist approach to knowledge: one in which reality is 'out there' in the world, and our task as researchers is to go find, describe, and measure it. By contrast, there is the alternative approach of interpretivism or constructivism, in which we recognize that as social actors we are part of the reality we seek to describe. Rather than considering our own views as noise or bias, we incorporate them fully as part of an exercise in reflexivism.

Let us translate these arcane concepts into the realities of child and adolescent psychiatry today. They can be summarized into a bumper sticker of sorts: 'Keep the baby's bathwater: embrace qualitative methods.'

The realist approach to science is readily recognizable to all in the quantitative approach that dominates our field: numbers, statistics, sample sizes, error measures, power, objectivity, controls, *p* values. Sadly, patients' voices are often lost in this quantitative shuffle. On those few occasions when we recognize a legitimate voice come across the written page, it often is under the case vignette or the psychoanalytic literature. But these two approaches don't take full advantage of the qualitative and mixed methods approach that our colleagues in sociology, anthropology and psychology have been fruitfully using for decades. Methods in which voices, recorded verbatim, become the data themselves. Voices that can include those of patients, families, care providers, and other stakeholders. Voices of those who are often silenced or unheard.

We hope that the pandemic will encourage new research efforts that move from numbers alone, to ones in which voices (through qualitative methods), or voices and numbers (through mixed methods) can further enrich our work. Let's complement our large-n quantitative science with the opportunities and unique vantage points of the small sample, of the lived experience of unique individuals. We hope that more investigators in our field will come to appreciate this approach and join us in using the pandemic crisis as an opportunity to embrace qualitative methods.[7]

The qualitative approach incorporates human stories and personal narrative. As such, it can feel particularly familiar in the field of psychiatry. Many of us were first drawn to the field as a way of making sense of behaviors and emotions, of disentangling people's complexity, of sounding the depths of interpersonal experience. In this way, the qualitative approach offers more than machinery toward the publication of empirical research: it is a means to enrich our everyday clinical, supervisory, and teaching experiences.

Words attributed to Einstein come to mind: "Not everything that can be counted counts, and not everything that counts can be counted." More painfully relevant to these days of pandemic heartache are words from a poem[8] by Pádraig Ó Tuama: "When I was a child,/ I learnt to count to five/ one, two, three, four, five./ But these days, I've been counting lives, so I count // one life/ one life/ one life/ one life/ one life// because each time/ is the first time/ that that life/ has been taken./"

Embracing 2020: Overcoming Hegemonies

What a year of reckoning this was. If we ever had, we can no longer claim ignorance: we cannot sit by the sidelines, blissfully unaware.

By embracing virtual possibilities, we are committed to moving away from a hegemony of place. But by realizing the inherent limitations of our e-reach and the stark reality of a digital divide, we will not capitulate to a hegemony of the virtual. We will meet patients and families where they are, even it means leaving the comfort of our own spaces.

By embracing antiracist policies in all that we stand for and do, and by opening our eyes (and those of our colleagues and field more generally) to the toxic effects of racism on health, we will fight the hegemony of race. And by realizing that numbers can say only so much, and that we can do better at listening and sharing the voices of those under our care, especially of those who have been unheard or disenfranchised for far too long, we can brave the tide against a hegemony of the numerical.

We are recommitting our professional lives, our clinical and our research endeavors to move away from hegemonies that have at best led us astray, at worst limited our reach from where it is most needed. Will the field of child and adolescent psychiatry follow us? Will you?

Take Home Summary

The COVID-19 pandemic has brought a reckoning to the health professions. We explore 3 ways in which this has played out in the case of child and adolescent psychiatry: 1) the ascendance of virtual clinical care; 2) by confronting the realities of racism; and 3) by incorporating patients' and clinicians' voices into teaching and research.

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About the Authors

Amanda Calhoun MD, MPH, is a resident at the Albert J. Solnit Integrated Program at the Yale Child Study Center. Dr. Calhoun serves as the resident representative to the Diversity, Equity and Inclusion committee of the Office of Graduate Medical Education at Yale School of Medicine.

Andrés Martin, MD, MPH, is the Riva Ariella Ritvo Professor at the Yale Child Study Center and medical director of the Children's Psychiatric Inpatient Service at Yale New Haven Health. Dr. Martin is Editor Emeritus of *JAACAP* (2008-2017) and serves as an advisor to *JAACAP Connect*.

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Correspondence to Amanda Calhoun, MD, MPH; e-mail: **amanda.calhoun@yale.edu**