“The World Upside Down”: Clinical Encounters with the First Cohort of a New Pain-Focused Post-Professional Clinical Master’s Degree Program in the COVID-19 Era

Zoe A. Leyland, MPEd, PhD,* and David M. Walton, PT, PhD†

*Department of Health Rehabilitation Sciences, Faculty of Health Sciences, and †School of Physical Therapy, Faculty of Health Sciences, Western University, London, Ontario, Canada

Correspondence to: Zoe A. Leyland, MPEd, PhD, Department of Health Rehabilitation Sciences, Faculty of Health Sciences, Western University, Elborn College, Rm. 1448, 1201 Western Road, London, Ontario, N6E 1H1, Canada. Tel: 519-661-2111; E-Mail: zletwin@uwo.ca.

Funding source: Funding was received via a Teaching Fellowship Award, Centre for Teaching and Learning, Western University, London, Ontario, Canada.

Conflicts of interest: The authors have no conflicts of interest to declare.

Introduction

It has become increasingly recognized that current pain education for health care providers is inadequate [1]. This is evidenced by current public health crises such as the epidemic of chronic pain and the “opioid crisis” [2]. In September 2019, the Master of Clinical Science Program (MCiSc) in Advanced Healthcare Practice at Western University (London, Ontario, Canada) introduced a new “Interprofessional Pain Management” (IPM) field. The program is open to practicing health care providers with a special interest in pain. As an online and competency-based program, learners have full access to numerous resources, academic and clinical mentorship, and content experts in various fields, all connected via video calls. The program is built on a collaborative team integrated competencies framework. Learners participate through group meetings and proceed at their own individualized paces, guided and facilitated by their mentors, as they learn with as well as from the personal and professional views of other learners. The program has been designed such that most learners can maintain 80% of a normal clinical workload while acquiring adequate evidence of competence to complete the program in 12 months. This is facilitated by an ethos of “the clinic is the classroom,” which allows much of the evidence of actual competence to be accrued by capturing aspects of the learners’ routine daily practice completed by the end of the 1-year course of study.

There are five core competencies for the program, each with a set of entrustable professional activities (EPAs) that, when considered together, indicate evidence of adequate mastery (Table 1). The program also has several required milestones, including a clinical mentorship. Achieving the clinical mentorship milestone requires engagement with approved clinical mentors, submission of an engagement log at the end of each term demonstrating the hours completed and the nature of the mentorship, and a minimum of 5 hours/term (15 hours total) of direct interaction between the student and the clinical mentor. Mentored clinical practice demonstrates educational standards by using a framework of clinical reasoning and integrating new knowledge and skills [3]. Effective mentoring has been defined as an important component of academic success [4]. The critical clinical interactions are required to be captured throughout the student’s ePortfolio as reflective practice.

In the program’s first year on offer, the coronavirus disease 2019 (COVID-19) pandemic forced a rapid shift in the student experience. It has been argued that COVID-19 is reviving the need to explore online teaching and learning opportunities, as they are playing a crucial role during this pandemic [5]. This program is completely online, which gave learners flexibility, but problems still occurred. The main objective of this commentary is to demonstrate how learners of the first cohort of the IPM field experienced the phenomenon of a sudden change to the required clinical mentor exchange during COVID-19.
Two research questions were explored: 1) What was the experience of students enrolled in the IPM program with clinical mentoring during COVID-19? 2) What was the experience as a practicing clinician in a clinical role while enrolled in the IPM program during a global pandemic? Four themes emerged, which are explored more deeply in the “Findings” section.

Methods
After ethics approval was received from Western University’s Research Ethics Board, a study took place during October to November 2020 to explore the lived experiences of the first cohort of learners in the new IPM program. There were four learners in total in the first cohort: one naturopathic doctor, two physiotherapists, and one chiropractor. Participants were each given a code (P001–P004) to protect their identities. In conducting interviews via the Zoom (Zoom Video Communications, Inc., San Jose, CA, USA) platform, the primary researcher and lead author (ZAL) followed a semi-structured interview guide that did not follow a formalized list of questions, which created a more conversational interaction [5] with each participant on their experience of completing the program during the COVID-19 pandemic. It is important to state the positionality of ZAL, as she has been involved with the IPM program since its inception. Creating and implementing it were part of her degree requirements as a PhD candidate. ZAL held an administrative role and serves as a committee member to determine policies, but she has not engaged in delivering content and has no power over the progression of the first cohort of the program.

The present study followed an interpretivist research design, also described as a hermeneutic method, meaning that reflecting on experience must aim for discursive language and sensitive interpretation [6]. ZAL engaged deeply with the lived experience of the learners and worked to identify rich descriptions characterized by the qualities of vividness, accuracy, and elegance. In addition, the participants were asked in the informed consent agreement to provide ZAL access to their ePortfolios, and all four agreed, which added richness and detail to the study. The interviews were transcribed verbatim before analysis.

Analysis
The analysis followed van Manen’s selective reading approach, which included reviewing the transcripts,
Theme 1: Importance of Mentorship
Participants emphasized the meaningfulness of the clinical mentorship. As one participant stated, “When I first made the decision to apply to this program, one of the main aspects that attracted me was the opportunity to mentor under an actively practicing health care professional from another discipline who was experienced in pain management” (P003). P003 also described their mentorship experience during the pandemic. “[Clinical mentor] adapted, pulled some strings, and reached out to me to see if I wouldn’t mind continuing the mentorship through Telehealth. After weeks in isolation, I was elated to get back to … clinical work” (P003). Another participant commented that the program offered “something that I haven’t had the opportunity to really like take advantage of in my career like actually having a good mentor, so both that with [academic mentor] and also with … clinical mentor” (P001). When asked what it was like having a clinical mentor, one participant stated, “I think it was probably … one of the key pieces in the program because it was sort of this chance for someone to [see] as an equal, but just sort of check in with where you’re at … and talk through some of those things both from a clinical standpoint and I had the opportunity to be mentored by someone within my profession” (P001). These statements appeared to highlight the importance of mentorship and the benefits of learning from experts, either in the same field or in different ones.

Theme 2: Body Language
Participants acknowledged the shift in clinical dynamics imposed by the need for physical distancing or the donning of face coverings as personal protective equipment. One participant described their clinical mentorship experience as an opportunity to see both the benefits and drawbacks of using a new platform: “The bonus of observing telemedicine demonstrated additional emphasis on communication, as [clinical mentor] couldn’t read the patient’s body language” (P002). When describing moving back to in-person treatment as local distancing measures eased, one participant indicated in a written reflection: “wearing a mask all day was challenging for reasons beyond just comfort. I didn’t realize just how much I gauged my patients’ feelings by looking at their mouths. I found myself having to ask how they were doing much more often because I had a harder time sensing it from their facial expressions” (P004). Another participant described their profession as being critically hands-on: “human interaction is one aspect … which drew me to the profession. I love the ability to sit down, really try to get to know to know somebody, and make them feel comfortable enough to relax … now, instead of being greeted by a welcoming smile and handshake, the first thing that any patient is going to see is an empty waiting room full of hygiene and … me wearing a surgical mask sitting behind a layer of plexiglass” (P003). Another stated that “reading patients over virtual care is challenging. Every few patients, the lag in technology means that I am missing body language or facial expression. I’m realizing that much of my ability to ‘read a room’ and navigate a visit comes from body language” (P002). Collectively, this theme was interpreted as describing the lived experience of forced reflection about what could be considered praxis in clinic—that participants became more aware of what had become an intuitive use of body language and facial expressions in gauging their patients’ well-being. This led some to reflect upon the relative value of alternative communication strategies when engaging with others about their health.

Theme 3: Isolation
One participant’s clinical mentoring experience significantly changed as they went from in-person clinical observership with a physical medicine rehabilitation physician to attending a single interfaculty pain session between occupational therapy and physical therapy on communication skills to promote physical activity. This participant indicated, “it was interesting, but it wasn’t the same and you know I think everyone was going through a lot of stuff for COVID … I imagine[d] being part of the community therapy [on campus]” (P004). Through the IPM program, an academic mentor arranged biweekly meetings with each student to discuss challenges, including this disruption in mastering a competency, and worked to support them by critically thinking of alternative options due to COVID-19. Emerging evidence indicates that partnering with multiple mentors significantly benefits mentees [4]. Another participant described during their interview spending a lot of time...
worrying about their patients’ well-being while maintaining their own self-care. They questioned, “Is it getting potentially … worse without their access to all of their health care providers? It wasn’t just me it was everybody that they see to some extent as well … being worried about people I already know are isolated right now and limited in sort of what they can access. Having more restrictions and … more limitations in their social circles. It was hard” (P002). Throughout the IPM program, there were special topic sessions on living with chronic pain and mental health, which can be applied to this particular case. “This lockdown has presented us all with a unique opportunity to reflect and be thankful for all the good in our lives and make time to connect” (P003). However, all participants expressed fear and anxiety about the unknown for their practices. Knowledge of the detriments of social isolation for all has become more widespread by this point in the pandemic, but it is still important to acknowledge that social isolation measures have had a profound impact on the psychological and mental well-being of individuals across society [7]. With reflexivity and interprofessional collaboration as major components of the program, the restrictions were expressed via reflective journals and within the IPM community.

**Theme 4: Adaptation and Acceptance**

It has been suggested that managing expectations of both patients and health care providers is valuable in maintaining a mutual appreciation for changes in organizational and care structures while managing the COVID-19 crisis [8]. One participant stated, “my plans were dashed when this little thing call ‘COVID-19’ decided to show up and flip the whole world upside down. In spite of this, [clinical mentor] adapted, pulled some strings, and reached out to me to see if I wouldn’t mind continuing the mentorship experience through Telehealth” (P003). Another participant described observing the challenging decisions their clinical mentor faced, particularly with regard to the complexity of opioids in pain management: “During my time observing, [clinical mentor] also saw people who were already taking opioids and had to make a judgment call over the phone about to communicate to both the patient and the provider when the patient was at high-risk for complications from opioids” (P002). The changes in clinical mentorship and adaptations made for the pandemic are also demonstrated in Figure 1, which shows a clinical mentor log from a participant who stated in a reflective post on teamwork and collaboration that they “jumped on the opportunity to receive mentorship from a professional who I respect from a discipline different from my own” (P001). The log (Figure 1) shows that the response to COVID-19 interrupted the flow of topics of discussion, with a 2-hour-long reflection on COVID-19, followed by a shift to adaptation in the work environment, and then a move toward virtual care, grief, and acceptance. This participant was accepting of the online mentorship, as they shared the success story of working with their clinical mentor in a reflective entry on their clinical mentor experience: “Working with [clinical mentor] has helped
me to develop a wealth of skills and knowledge that are both essential and yet also transcend the outer ranges of my competencies... these ‘soft skills’ that were not emphasized in my professional training are in fact the ‘hard skills,’ and they are complete game changers for me and my patients” (P001).

**Lessons Learned**

The goal of the program is for students to undergo a truly transformative change in the ways they see themselves as “providers of pain management,” as this educational field has not been rigorously explored. There are some limitations. One is the small sample size. Additionally, the data are from the first cohort only, and although the positionality of ZAL is clearly stated in the “Methods” section, the responses from the participants might have been different if the interviewer had had no knowledge of the participants. However, each participant adapted and continued their role as a pain care provider. The pandemic has certainly shown the resilience of health care workers, many of whom have sacrificed their lives in the line of duty, and has shown the health care system’s ability to adapt during adversity [9]. The data from the present study describe adaptability, flexible online education programs, and strong mentorship from both academic and clinical advisors, which may suggest that these components in pain education help to lead pain care providers to success. Each participant demonstrated the need for the self-awareness & reflexivity competency to develop a deeper understanding of the patient experience while simultaneously encouraging reflection on the impact of the pandemic. While learners were mastering these competencies, COVID-19 produced additional stress, including social isolation, uncertainty, and more, for the IPM learners. At the same time, all of the learners successfully completed the MCIsC IPM program in August 2020 and highlighted several times throughout the interviews how rewarding the entire educational experience had been. As participant P002 stated, “the harder or difficult moments, they really make an impact on us, but I think those are the ones that almost forced change, right?... Part of the reason I wanted to do this program was that extra chance to be mentored and come through the competencies through that growth.”

**References**

1. Bond M. A decade of improvement in pain education and clinical practice in developing countries: IASP initiatives. Br J Pain 2012;6 (2):81–4.
2. Cohen JL. “That’s not treating you as a professional”; teachers constructing complex professional identities through talk. Teach Teach Theory Pract 2008;14(2):79–93.
3. Heneghan NR, Nazareth M, Johnson WJ, et al. Experiences of telehealth e-mentoring within postgraduate musculoskeletal physical therapy education in the UK and Canada: A protocol for parallel mixed-methods studies and cross-cultural comparison. BMJ Open 2021;11(2):e042602.
4. Tsen LC, Borus JF, Nadelson CC, et al. The development, implementation, and assessment of an innovative faculty mentoring leadership program. Acad Med 2012;87(12):1757–61.
5. Almahia MA, Al-Khasawneh A, Althunibat A. Exploring the critical challenges and factors influencing the E-learning system usage during COVID-19 pandemic. Educ Inf Technol 2020;25 (6):5261–80.
6. van Manen M. *Phenomenology of Practice*. New York: Routledge; 2016.
7. Alradhawi M, Shubber N, Sheppard J, Ali Y. Effects of the COVID-19 pandemic on mental well-being amongst individuals in society: A letter to the editor on “The socio-economic implications of the coronavirus and COVID-19 pandemic: A review.” Int J Surg 2020;78:147–8.
8. Kohan L, Sobey C, Wahezi S, et al. Maintaining high-quality multidisciplinary pain medicine fellowship programs: Part II: Innovations in clinical care workflow, clinical supervision, job satisfaction, and postgraduation mentorship for pain fellows during the COVID-19 pandemic. Pain Med 2020;21(8):1718–28.
9. Dhillon J, Salimi A, ElHawary H. Impact of COVID-19 on Canadian Medical Education: Pre-clerkship and clerkship students affected differently. J Med Educ Curric Dev 2020;7: 2382120320965247.