CORR Insights®: Has the COVID-19 Pandemic Changed the Daily Practices and Psychological State of Orthopaedic Residents?

David Ring MD, PhD

Where Are We Now?

After arriving at medical school, I recall a growing sense that I needed to be all-knowing, unerring, and resilient under any crisis. Looking back, no one specifically told me this was expected. In fact, some of the instructors might have told me specifically that it was not expected. Nevertheless, the so-called silent or shadow curriculum (the unspoken lessons I picked up from my environment) gave me the impression that I needed to be more than human. Some have associated this culture of omniscience, infallibility, and superhuman resilience with decreased joy in medicine, substance misuse, relationship troubles, and suicide [2, 6].

Clinicians put themselves in stressful situations. We immerse ourselves in the suffering of others. Surgeons cut people. We use strategic harm in an attempt to heal [7]. We may experience what is increasingly referred to as moral injury (the distress associated with acting against our values and ethics) when a patient invests hope in tests or treatments that we think have more potential for harm than benefit. The moral injury might be experienced in the difficulty communicating our expertise and opinions, which are often unexpected or unbelievable, for instance, when a new symptom is interpreted by a patient as new pathology and our examination and diagnostic tests confirm that the problem is longstanding. Incongruity of our expertise and a patient’s lived experience threatens the relationship. A clinician might be tempted to avoid attempting to reorient such misconceptions and then feel the moral distress associated with allowing a person to continue in misinterpretation of their symptoms. The moral injury is even worse—at least for me—when we capitulate to the patient’s view of the best path even when it feels wrong to us. For instance, patients may falsely regard surgery as their only hope. And surgeons may set up an algorithm with a direction toward surgery (for example, “failed nonoperative treatment”) as if surgery was, indeed, their only hope [7]. We can lose sight of the fact that many people with a similar problem successfully accommodate it, and that limited accommodation is often a sign of important misinterpretation and misunderstanding of symptoms. Notable somatic symptoms are also often the first sign of important levels of stress and distress. We might get in the habit of ignoring these important aspects of the human condition. When we do so, we may be correspondingly dehumanized and can experience moral distress [5].

Given the daily stress in our life’s work, it seems possible we might have relatively less in reserve for when personal or societal crises occur. Surgeons and trainees give so much of ourselves that we may have less resilience to take care of ourselves and our families when a problem lands closer to home. The worldwide COVID-19 crisis is unprecedented in my lifetime. It’s no surprise that orthopaedic trainees are feeling the associated stress of the pandemic. In any case, since we are...
human, we should anticipate greater psychological distress in times of crisis, and not be surprised by it.

Enter Castioni and colleagues [1], surveyed the Italian Association of Orthopedic and Traumatology Residents and found that greater median symptoms of depression and anxiety at the end compared to the beginning of the first Italian COVID-19 lockdown. They suggested evaluating residents using standardized questionnaires to identify people who might benefit from counseling.

Where Do We Need To Go?

In my view, anticipation of mental health opportunities among surgeons, trainees, and patients does not lead to screening questionnaires. The use of strategies to identify people with a certain threshold of distress might reinforce stigma associated with mental health. And it strikes me more as crisis management, particularly when the call to action is for strategies that acknowledge that everyone-trainees, educators, and the patients they care for—experiences levels of distress at times. We know that patients don’t always answer mental health questionnaires honestly [4]. It’s possible that trainees might be even more likely to be less-than-candid on mental health questionnaires given that most medical licensure and organizational credentialing forms require doctors to declare diagnosed mental illness [3]. How do we eliminate the social stigma associated with cognitive bias (misconception), psychological distress, and stress? How do we organize care and training for the best support possible? How do we recognize the impact of personal, professional, or societal stress, and help address it before it reaches crisis level?

How Do We Get There?

We don’t need more evidence that mental health is important for both clinicians and patients. Instead, I suggest we design strategies for improved mental health and support of trainees, test them either as quality improvement or research or both, learn, strategize anew, and continue repeating the cycle. For instance, what if we designed training programs to anticipate times of stress and distress in trainees and attendings? What is the impact of incorporating regular events that address clinician mental health and team functioning such as Schwartz rounds or Balint groups? And what if, for each topic of instruction, we spent dedicated time talking about the non-technical aspects of our work, and never limited ourselves only to the technical? While we may not find the best approach, these actions can demonstrate our awareness, sensitivity, prioritization, and commitment to mental health. That would be a major step forward.

References

1. Castioni D, Galasso O, Rava A, Massè A, Gasparini G, Mercurio M. Has the COVID-19 pandemic changed the daily practices and psychological state of orthopaedic residents? Clin Orthop Relat Res. 2021;479:1947-1954.
2. Dzau VJ, Kirch D, Nasca T. Preventing a parallel pandemic - a national strategy to protect clinicians’ well-being. N Engl J Med. 2020;383:513-515.
3. Fu WW, Gauger PG, Newman EA. Mental illness and stigma in surgical residencies—an unspoken truth. JAMA Surg. 2021;156:117-118.
4. Guattery JM, Dardas AZ, Kelly M, Chamberlain A, McAndrew C, Calfee RP. Floor effect of PROMIS depression CAT associated with hasty completion in orthopaedic surgery patients. Clin Orthop Relat Res. 2018;476:696-703.
5. Humbyrd CJ. Virtue ethics in a value-driven world: Medical training and moral distress. Clin Orthop Relat Res. 2019;477:1991-1993.
6. Lu DW. Factors associated with trainee physician burnout—where should the focus be? JAMA Netw Open. 2020;3:e2014345.
7. Ring D, Leopold SS. Editorial: The sacredness of surgery. Clin Orthop Relat Res. 2019;477:1257-1261.