Possible Ethical Issues of Digital Mental Health Education During and After the COVID-19 Pandemic and How to Prevent Them

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"I am always ready to learn although I do not always like being taught."[1]

Winston Churchill

There is a great need within the limiting context of the coronavirus disease 2019 (COVID-19) pandemic to resume educational activities. However, they will need to be modified for the foreseeable future following the pandemic, as certain measures such as social distancing will be applied or at least recommended for a long time.[2–8]

Given the restrictions almost uniformly mandated across different nations and educational systems and levels, digitalization seems to be an obvious choice, and various parts of the medical school curriculum have already been "uploaded and shared." However, digitalization comes with inherent limitations, as especially during clinical subjects and rotations it seems necessary at some point to expose trainees to living individuals seeking help for various illnesses and health problems.[9,10] Such an exposure, with that word carrying important connotations in the time of pandemics, despite all possible risks is necessary since arguably most important aspects of medicine cannot be learned otherwise.[9] Additionally, encounters with patients during medical education might be some of the most important formative experiences for future physicians, necessary for development of a genuine ego-syntonic professional identity—ready to think, act, and feel as a physician.[9,10] During the COVID-19 pandemic, and given its postulated importance for professional and ethical development, contact with patients might possibly be even more vital for future physicians (and indeed health care workers in general). Isolating them from the clinical context at such a time, and for prolonged periods, might create not only educational gaps but also unwanted dissociations (or at best lags) in the nascent professional identity, as well as serious disruptions of learning trajectories.[11,12] Additionally, disruption of the medical education system in the context of the COVID-19 pandemic may cause significant stress to students, making them vulnerable to various physical and mental health disturbances.[12] In mental health and psychiatry, such privileged encounters may be particularly necessary, as they allow students to experience authentic psychopathology and develop critical clinical skills in the direct contact and clinical context, while sensitizing them to mental health–related issues.[3,5,6,8,13,14] This may be particularly important currently, as the pandemic setting may contribute to the worsening of mental health—to a similar extent in those with prior mental health disorders and in previously unaffected populations—with unpredictable presentations and dynamics.[15–18] The same is true not only during the pandemic but also in the post-pandemic, recovery-oriented reality that awaits us as well. Nonetheless, educational activities that include patients are universally important across medical specialties and specific educational programs.

Despite that such an educational gap calls for an immediate (re)action, there should be no room for lowering educational and ethical standards or for challenging previously well-established learning objectives.[19] In other words, in the educational setting, similarly as in a clinical one, the patients' safety and well-being should be of primary importance. One needs not be particularly insightful to foresee many possible ethical issues when, leaving all other issues aside (eg, organizational, technical), trying to present a patient with mental health disorders in such a digital setting.[14] The weighing of risks and benefits of such encounters should be thoroughly discussed before engaging in such educational activities. That is even truer when the imperative of acting quickly in the best interest of our students potentially clouds many of our judgments. The need to apply certain standards when approaching especially vulnerable individuals in such an educational context may seem more obvious. However, let us not forget that every patient is vulnerable, and, therefore, these standards (or at least underlying principles) should be used in most digital patient encounters occurring within the medical education system. To minimize risk from such encounters, certain considerations should be taken into account (Box 1).

In conclusion, specific and intense major external pressures can force changes in all aspects of our lives and

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Box 1. Key Ethical Considerations for Real Digital Mental Health Patient Encounters

- Such "encounters" should be provided only for the necessary parts of the curriculum, parts for which it is reasonable to believe no other method of knowledge transfer would be appropriate or optimal, and only while it is necessary to employ such methods, with that need being constantly reevaluated in the context of the external limiting factor (pandemics in this case). As such, digital encounters should be used only as the last resource after careful discussion on risks and benefits involving all relevant teaching staff and stakeholders. In that sense, some other innovative possibilities, such as including (professional) actors or various simulation tools may be applied to minimize patients' exposure.
- As there are currently many high-quality educational digital platforms and technologies (such as various repositories, including those of recorded patient encounters) widely available, they should be used prior to real patient presentations. In that sense, following the individualized learning trajectory, students could be required to reliably demonstrate a certain level of knowledge and clinical skills proficiency prior to being allowed to apply them in working with a real patient. Additionally, limitations in utilization of such educational methods need to be assessed and tackled. Students who may have difficulties regarding those issues should be offered institutional resources to access necessary digital technologies.
- Disclosure of patient information and patient exposure should be strictly minimized only to the matter that has been designated as necessary for the topic at hand and curriculum objective.
- Digital interactions should be organized in such a way that examination of a patient by students is always supervised (or only conducted by teaching staff). Supervision of the encounter between students and patients by teaching staff is necessary, as there should be a fine balance between (possible unguarded) unnecessary disclosure and the need to present psychopathological phenomena in their natural context.
- Only 1 specific link between a patient and students should be established and should be provided by a safe software platform, meeting stringent safety and encryption standards. Industry should be involved in making sure those standards are met.
- Digital educational interactions involving psychiatric patients, respecting the sensitive nature of those activities, should be planned in accordance with the guidance and oversight of ethics committees of the responsible clinical institution/university, as well as committees tasked with overseeing possible infringements of the rights of people with mental illness as per specific national or local regional frameworks.
- Informed consent from participating patients should be obtained after a detailed discussion of all possible risks of such an exposure and only after assessing the patient's capacity to understand those risks. Although individuals with mental health disorders may have difficulties representing their own interests, the decisional capacity benchmark should be high, and no surrogate (proxy) consent should be allowed. However, this does not mean that a patient's family or confidants should not be involved in the discussion. Both the treating clinician and a member of the teaching staff should be part of this process.
- Although it is usually assumed that medical trainees will uphold the professional principles of confidentiality and patient privacy, given the nature of the encounter, the importance of those principles should be thoroughly reemphasized (with special emphasis on those issues in digital and virtual spaces, such as "web manners") before the digital encounter with the patient.
- After the encounter, the patient and the students should be separately debriefed to adequately conceptualize their experience and identify any possible issues that emerged during or afterward. This debriefing is of vital importance, as such novel teaching methods should be carefully and reliably assessed. There is a need for continuous research and evaluation of this emerging field by using qualitative and quantitative approaches as well as to share our experiences.
- All of the activities undertaken and their results should be shared with the wider academic and research community, within the limits set by ethical considerations, with the important aim of cross-fertilization and resulting modification of individual practices based on the feedback. The creation of such a wider tele-education framework will have the capacity to ideally result in shared standards and common practices based on accumulated evidence from individual efforts and experiences.

functioning, including the educational process, leaving us with the imperative of overcoming imposed limitations quickly, with digitalization of teaching seeming like the low-hanging fruit in the process.[3,4,14] Despite that such context requires flexibility and creativity when trying to nurture educational continuity and quality, future medical education may benefit, as adoption of such methods may facilitate transformation from more traditional, didactic-based learning to more individualized, adaptive learning with the possibilities of providing guidance and multisource feedback and evaluation while fostering students' self-learning.[3,5,13,19] However, while some things can only be learned in direct (even if digital) contact with real patients, and while that contact might be a vital part of developing a coherent professional identity, one should be mindful of all the pitfalls of such an approach and employ a clear set of standards and principles (of which we outlined a few). And, finally, if considering the development of mature professional identities of future physicians and mental health professionals, we should also immediately start asking the question of when such a digital approach reaches its limits. When we get to those limits, mindful of all the risks and employing extra epidemiologic safety measures, we will be forced to accept that, at some point, the place of medical students might be next to the bedside of those we are teaching them to care for.

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