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Impact of COVID-19 on Mental Health Care Practitioners



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KEYWORDS

• Psychiatrist • Telepsychiatry • Hybrid practice • Burnout • Workforce • Well-being

KEY POINTS

- Many mental health practitioners, including psychiatrists, have suffered multiple social and mental health impacts from COVID-19
- A range of actions are described that health care organizations and individuals can take to mitigate these impacts
- There will likely be substantial positive short- and long-term outcomes for psychiatrists individually and as a profession post-COVID-19

Nothing is permanent in this wicked world – not even our troubles

—Charlie Chaplin

INTRODUCTION

COVID-19 has been described as a forced experiment that has had a major impact on mental health practitioners, including psychiatrists, who even before the pandemic were struggling at best with workforce shortages across most of the mental health disciplines. In 2019 approximately half of all patients with significant mental health problems were either not receiving any form of care, or not being treated by a mental health professional of any description. In 2017 future shortages of psychiatrists by 2025 were estimated at between 14,000 and 31,000 following many years of reduced training activities and residency positions, in the setting of an expanding population and increasing needs.¹

All of these calculations and projections have been changed by COVID-19, which has proven to be a massive disrupter of not just medical and mental health practice, but of the professionals involved in that practice. Future workforce projections are still fluid, but anecdotal reports suggest that it is likely that there will be, and already have been, many more retirements and exits of psychiatrists from psychiatric practice for

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other reasons than previously predicted, making psychiatry, a workforce shortage discipline before COVID-19, even more so in future.

At first glance it may seem that COVID-19 will have a primarily negative impact on psychiatrists and other mental health professionals. However, there are indications that despite the short-term difficulties related to the individual health and circumstances of all mental health professionals, in the setting of what has been called a “mental health pandemic” of increased numbers of patients, this is not necessarily the case. In fact the disruption that COVID-19 has caused to mental health practice may well have dramatically accelerated numerous structural changes to mental health practice that would have otherwise taken a decade or more to occur, leading to significant improvements and positive impacts on the remaining, and future, generations of mental health professionals.

In this article the focus is on the impact of COVID-19 on mental health care workers, with most of the spotlight on psychiatrists, as the profession that is best described, and where the impact of COVID-19 has probably been greatest. Three major questions are discussed:

- What have been the mental health impacts of COVID-19 on psychiatrists and other mental health professionals?
- What actions can health care organizations and individuals take to mitigate these?
- What are the likely positive short- and long-term outcomes for psychiatrists and other mental health workers post-COVID-19?

All of these questions are examined within the wider context of the pandemic and its’ effect on health care workers around the world, many thousands of whom have lost their lives helping their patients often through heroic actions. Although this article, and this issue, focuses mainly on positive outcomes from the pandemic, it is vital to remember that this is occurring on the back of massive sacrifices by many of our colleagues.

WHAT HAVE BEEN THE MENTAL HEALTH IMPACTS OF COVID-19 ON PSYCHIATRISTS AND OTHER MENTAL HEALTH PROFESSIONALS?

COVID-19 has contributed to stress in physicians in many ways.² This includes anxiety about family and friends, and of taking the virus home, which most of the author’s colleagues have reported as being their number one concern. Also of great importance have been changing policies related to patient care standards, biohazards, and lack of personal protective equipment and a fear of general transmission and contamination. For many there has been increased (or sometimes reduced) physical and emotional work demands, and sometimes anxiety around changed work roles, or possible separation from family members and social supports, and significant economic, work, and social changes. In mental health practice this often meant rapidly transitioning to telehealth approaches with patients which, although most mental health professionals found this straightforward, was still in the context of the need for safety for patients and providers, and to maintain a viable clinical practice. Finally, and especially for those involved clinically, was loss and grief, anger, and frustration at the constant change and uncertainty, and in relation to deaths or illnesses of colleagues or friends.

COVID-19 has also led to a range of moral injuries in physicians and other health care workers. These have been extensively discussed in the literature, including by the National Academy of Medicine.³ Moral injuries, which have historically been

primarily associated with wartime and military scenarios, are most easily defined by the severity and type of the stressor,⁴ as in **Box 1**.

Mental health professionals have been affected by several of these moral injury stressors, especially the inability to provide optimal care to patients without COVID in traditional in-person ways via inpatient and outpatient modalities. Certainly, as detailed elsewhere in this issue, the move to telepsychiatry helped, but many patients, especially those with chronic relapsing illnesses, undoubtedly suffered through a relative lack of psychiatric care at times. In the United States the politicization of mask wearing and vaccination has caused great distress among many health care workers because large groups within the country have refused public health measures, putting others including health care workers at risk, and themselves. Whether the incidence of moral injuries has increased the vulnerability of health care workers to burnout and a range of psychiatric disorders, especially depression, anxiety, and substance use, is unknown, but likely.

What about the core pre-COVID-19 mental health of physicians in the United States? In terms of general mental health, physicians, including psychiatrists, have the same level of mental health problems as the rest of the community except in relation to four areas as defined in the following clinical care points.^{5,6}

Clinical Care Points: Physician Mental Health Differences From the General Population

1. Burnout rates in physicians are known to be at twice the level of other professional groups, mainly caused by organizational dysfunction,⁵ because numerous studies have demonstrated that before commencing medical school, physicians are more resilient than equivalent graduate students
2. Female physicians likely have twice the rate of suicide in comparison with community control subjects, and it is possible that male physicians also have increased rates, although the research is not clear^{6,7}
3. Although alcohol use rates are similar, physicians tend to abuse prescribed drugs more commonly, and illicit drugs less commonly, than community control subjects
4. A lower prevalence of schizophrenia, which tends to commence before or during the typical years spent at medical school

The other group of physicians affected by COVID-19 in particular are psychiatric residents and other learners. Few studies have been published on the impact on these groups in particular, but there are studies in internal medicine trainees showing

Box 1

Definitions of moral injuries

Severe moral stressors

- Denial of treatment to patients with COVID because of lack of resources
- Inability to provide optimal care to patients without COVID for many reasons
- Concern about passing COVID to loved ones

Moderate moral stressors

- Preventing visitors, especially to dying patients
- Triageing patients for health care services with inadequate information
- Trying to solve the tension between the need for self-preservation and the need to treat

Lower level but common moral challenges, especially in the community

- Seeing others not protecting the community by hoarding food, partying, not social distancing, or not wearing masks

significantly disrupted training, especially with the forced move to see patients using video visits, often from home, where residents typically have less privacy and financial capacity to set up a study area than do more senior physicians. Anecdotal reports of psychiatric residents being required to work beyond the usual scope of their roles on general medical wards, the reduction in important supportive friendships with other residents, and of increased loneliness and reduced opportunities for relationships at an important developmental stage in their lives are other important stressors on this group.

So if one takes these issues into account, and includes in a calculation the effect of moral injuries and immediate pandemic-related traumas that many physicians have suffered, it is reasonable to hypothesize that the overall mental health impact of COVID-19 on physicians, including psychiatrists and other mental health workers, has been at least the same as for the general population, or possibly slightly greater. Although the research on the general population in the United States is still incomplete it seems clear that at least the mental health impacts in **Box 2** have occurred.^{2,8,9}

One can assume that, taking these epidemiologic variations into account, physicians should have suffered at least the same, or more, mental health consequences from the impact of the pandemic than the general population. As a consequence it is likely that physicians will be part of what is now being called a mental health shadow pandemic following COVID-19.⁸ One cross-sectional study early in the pandemic from Cyprus, a country at the time little affected by COVID-19, showed high rates of depression and post-traumatic stress disorder in physicians and other health care workers, especially nurses,¹⁰ indicating how vulnerable was this group.

Finally, more than 3600 physicians and other health care workers, including several psychiatrists and other mental health care workers, have died from COVID-19 in the United States during the pandemic. “Lost on the Frontline,” a project run for a year from April 2020 by Kaiser Health News and the Guardian, is the most complete accounting of US health care worker deaths.¹¹ The project found that two-thirds of deceased health care workers identified as people of color, revealing the deep inequities tied to race, ethnicity, and economic status in America’s health care workforce. Other findings were:

- Lower-paid workers who handled everyday patient care, including nurses, support staff, and nursing home employees, were far more likely to die in the pandemic than physicians
- The median age of health care workers who died was 59, whereas in the general population, the median age of death from COVID was 78

Box 2

Mental health impacts of COVID-19 on the general population

1. Increased incidence of anxiety, depression, and substance use disorders
2. Increased grief and loss in relation to illnesses, deaths, relationships, and missed important life or transitional events
3. Increased rates of trauma-related disorders, especially intimate partner violence, gambling, excess online activities, and possibly abortions and suicides
4. Increased isolation and loneliness, which lead to chronic medical and psychiatric disorders and impaired work performance
5. Increased levels of social division, extremism, and polarization, especially via social media, leading to interpersonal, family, and community division

- More than a third of the health care workers who died were born outside the United States
- Nurses and support staff members died in far higher numbers than physicians
- Twice as many workers died in nursing homes as in hospitals
- The death rate among health care workers has slowed dramatically since COVID vaccines were made available to them in December 2020

It is obvious that support and treatment services for physicians and other health care workers need to be increased and made more available post-COVID-19, and that organizational interventions to prevent physician burnout and distress are even more important postpandemic than previously. This brings us to the second question.

WHAT ACTIONS CAN HEALTH CARE ORGANIZATIONS AND INDIVIDUALS TAKE TO MITIGATE THE IMPACTS OF COVID-19 ON MENTAL HEALTH CARE WORKERS?

A recent guidance document from the American Psychiatric Association¹² describes a range of practical initiatives that all health care organizations could implement to do exactly this. The guidance covers five major themes, discussed next.

Create an Organizational Leadership Structure to Lead Efforts to Address Wellness in the Physician Health Care Workforce

This includes funding the roles of Chief Wellness Officer and support teams, ensuring that leadership training in well-being occurs and that physicians are entrusted to leadership positions throughout the organization so that their voice is heard, and is influential.

Create a Culture of Wellness and Mutual Support Throughout the Organization

This involves developing policies and actions that create a trustworthy team-based medical culture that takes into account a strong focus on diversity, equity, and inclusion and that regularly measures physician burnout and provides widespread mentoring opportunities, especially for physicians at times of career transition. This cultural change also involves transparent bidirectional communication using many differing approaches.

Improve the Clinical Efficiency and Leadership of Physicians and Encourage Team-Based Practice to Reduce Stress and Burnout

Here physicians with innovative ideas should be involved in a mission-driven manner to become part of the larger health system meaning and focus, especially when improving workflows and reducing documentation requirements from the electronic medical record and developing video visits and other electronic ways of improving health outcomes.

Promote and Educate About Individual Self-Care and Resilience Approaches

A large number of effective evidence-based approaches to helping self-care are available and educational programs about self-care and mental health access, all of which support resilience.

Provide Timely Easy Nonstigmatized Access to Emotional Support and Mental Health Care for All Physicians

This includes multiple differing approaches from buddy systems to peer support networks, and self-assessment tools and easy referral to mental health experts.

One example of this wide range of initiatives needed to support physician well-being is transparent and truthful messaging from the leadership of health organizations, not just about the status of the health system and its capacity to cope and plan for the present and the future, but in particular about how health care workers, including physicians, can best be supported. An example of such messaging on the topic of physician well-being is the “Good Stuff” message¹³ sent weekly by the author to all UC Davis physicians, and monthly to all staff. During 2020 to 2021 these messages covered a wide range of issues from the importance of gratitude, coping with uncertainty, fostering relationships, psychological first aid and family fun at home to living in a bubble, how to embrace change and overcome anxiety, social connecting, and coping with moral injuries, among many other topics. “Good Stuff” also includes weekly celebrations of positive patient comments about physicians and other health care staff and links to relevant well-being resources and programs. This well-being message became part of the culture of UC Davis Health during COVID-19 and will continue in the postpandemic era as a constant reminder about the importance of well-being for all health care staff, especially physicians.

Looking forward following the pandemic, the National Academy of Medicine¹⁴ has published an important discussion paper examining the lessons learned, and compelling needs going forward, from an impact assessment of COVID-19 on clinicians. The paper summarized the impact on clinicians as follows¹⁴:

Pandemic-era stressors spanning dangers to clinicians' personal safety, to isolation from personal and professional support networks, to the persistent burden of working in understaffed and over-booked care delivery settings, to the role of structural racism in contributing to stark inequities in pandemic outcomes, have all exacerbated pre-pandemic trends of rising burnout, moral distress and deteriorating clinician well-being. COVID-19 has exposed existing challenges for the clinician sector, from the instability of fee-for-service reimbursement to the gaps in clinical capacity for specific specialties (eg, critical care) and populations (eg, rural, safety net), to the inequities embedded into health professionals training and clinical care.

This article described five priority areas for clinicians generally, not just physicians, for future development as discussed next:

Investing in clinician well-being

Recommendations here included rebuilding trust of clinicians lost during the pandemic and implementing recommendations of prior reports from the Academy, which described how to mitigate burnout, often driven by moral distress, and improve physician leadership opportunities, and to strengthen protections for clinicians to report safety and ethical concerns without fear of retribution or retaliation.

Advancing innovations in clinician practice

Suggestions here included enabling clinicians to be able to work across state lines, while encouraging retention and recruitment strategies to address workforce shortages and standardizing evidence-based protocols more widely, while also investing in infrastructure to achieve more effective health data sharing.

Promoting financial resilience for clinicians

Given that there were multiple failures of the traditional fee-for-service system, with many physician practices failing during the pandemic, the need to develop payment models that support quality, value, and team-based care, while reducing administrative requirements, was promoted, especially long-term coverage of telehealth services.

Transforming education and training

Here a major focus was on reducing inequities in resources, such as structural racism, while addressing financial barriers to student progression in health professions and using more technology and simulation for continuous learning.

Addressing health disparities

The crucial need to develop fair, equitable, and transparent plans for all health care services that do not disadvantage certain groups, and which are constantly surveilled to ensure that unintended consequences are not arising, was a major focus and learning from the pandemic.

Implementing these constructive recommendations within the mental health workforce, and in particular within the psychiatric profession, could lead to positive changes in the future. It may well be that the pandemic will be a tipping point for the profession, giving it the opportunity to change clinical practices extensively, just as it has been a tipping point for telehealth and has led to the widespread rapid implementation and acceptance of video and audio consultations. This leads to possible positive outcomes.

WHAT ARE THE LIKELY POSITIVE SHORT- AND LONG-TERM OUTCOMES FOR PSYCHIATRISTS AND OTHER MENTAL HEALTH WORKERS POST-COVID-19?

The COVID-19 pandemic has been a period of forced experimentation, where several practice changes have occurred much faster than could have ever been predicted. Many of these changes have already started to lead to likely positive outcomes for psychiatrists and other mental health professionals, especially the increased interest in physician well-being across the United States, and the added resources being devoted to assist physicians to receive care, treatment, and support in many health care systems and environments. Such positive outcomes are discussed next.

The Development of Hybrid Care: How Telepsychiatry Will Change and Improve Psychiatric Practice

Psychiatry, unlike many other specialties, was able to change dramatically and take to telehealth early in the pandemic,^{15,16} leading to less stress on mental health clinicians than other disciplines, and their continuing ability to manage panels of patients, often better than in the past, and with less “no shows,” improved clinical quality, and more continuity of care. A recent report describing the possible future transformation of psychiatry¹⁷ details the history of the use of telepsychiatry and the technological revolution that has affected the profession of psychiatry during the pandemic, noting that digital care is no longer a valuable aid, but an essential need. The authors concluded that psychiatry will: “emerge altered by its new use of technology and by larger societal trends. While this is a time of uncertainty, threat and change, it is also a time of great opportunity to shape and improve access to psychiatric care for the benefit of patients and practitioners.”¹⁷

Before the pandemic new models of hybrid psychiatric care were being developed by blending videoconferencing with other technologies, such as electronic health records, patient portals, and passive data-collection tools on smartphones.¹⁸ Examples of these hybrid approaches included virtual models of integrated care; residential psychiatric care; and asynchronous psychiatry, such as store and forward telepsychiatry e-consultations. This evolution led psychiatrists, and other medical professionals, into a new epoch of “hybrid doctor-patient relationships,”¹⁹ which are now emerging much more commonly postpandemic as groups of patients and psychiatrists start meeting together in person, or continue online, or mix the modalities.

The term “hybrid” describes relationships that are managed through a variety of mediums including in person, videoconferencing, patient portals, telephone, texts, and email. The psychiatrist works to match the most appropriate communication medium based on the patient’s diagnosis and needs and social and personal circumstances, with patients also making choices of communication modality depending on their own circumstances and convenience.^{18,19} Psychiatrists have had to learn the strengths, weaknesses, clinical adaptations, regulations, and parameters for each of these technologies because these hybrid-relationship models have been radically and rapidly advanced during the pandemic out of necessity, but as a profession have done this extremely well. It is impossible to predict how much traditional psychiatric practice will be affected by this change long-term, but the author has been practicing in this hybrid way for several years and has found that at least 50% of his patients have moved to a hybrid relationship with him.

Reduction of Psychiatrist Workforce Shortages, With Increased Work From Home and More Flexible Work Hours

A side effect of the move to hybrid and virtual care during COVID-19 should be, in the long term, a more efficient use of psychiatrist’s time and expertise with more psychiatrists working with increased scheduling and geographic flexibility from home, leading to reduced workforce shortages and reduced burnout levels. This set of outcomes was described in a paper published before the pandemic²⁰ where the authors reviewed national workforce issues and organizational and individual obstacles for implementing a telepsychiatry workforce based primarily in the home, including administrative, logistical, and clinical considerations. They then offered ideas and resources for how to overcome barriers that may arise in implementing a remote workforce of psychiatrists, as has eventuated during COVID-19. They hypothesized that before the pandemic, burnout was likely a key factor contributing to psychiatrists working less, pursuing less acute cases, and leading to worsened outcomes for patients and the psychiatrists themselves, and then demonstrated evidence that telepsychiatry provides comparable patient and provider satisfaction and equal outcomes when compared with in-person encounters. To support their argument they used several examples of psychiatrists demonstrating successful delivery of care from home in a range of clinic settings and workplace configurations while optimizing their quality of life and reducing their risk of burnout.

There is also widespread publicity about the “mental health pandemic”⁸ that is predicted to follow the COVID-19 pandemic. This includes the impact of isolation and loneliness, now viewed as social determinants of disease, and dramatically increased during COVID-19, and the polarization of community views driven by differing perspectives and beliefs about the pandemic and the need, or otherwise, for masking and social distancing public health measures. In this setting it is likely that more attention at a national level will be paid to prior and impending shortages of psychiatrists in future as this second pandemic continues over time, especially in patients with long-haul COVID-19 complications. It is hoped that the need to scale the capacity of the current psychiatric workforce will also include a move away from fee-for-service billing and toward bundled payments models, which should make psychiatrists’ work more efficient because they are increasingly paid for care provided over time. A side effect of this change should be a reduction in administrative workloads for many psychiatrists, who not uncommonly spend 10% to 20% of their week on such tasks, especially in private practice environments, as the administrative and financial workflows are improved and more closely parallel the “care as a journey” perspective that many surveys have shown patients prefer.

Psychiatrists' Well-Being Improved With Less Burnout

The increased use of telepsychiatry and working from home is likely to improve psychiatrists' well-being, as is a greater focus on physician needs, as described in an excellent influential 2019 report²¹ from the United Kingdom that examined how to meet the "ABC" of physician needs: autonomy, belonging, and competency.

However, there are a series of other positive benefits of telepsychiatry and more flexible working arrangements that will likely improve psychiatrists' overall well-being.^{17,18} These include the following:

1. Time saving through seeing patients on video, where it is possible to document notes at the same time as seeing patients, and where there is also time saved with less "no shows" and the lack of time used entering and exiting a physical room during the rooming process. It has been estimated that these time saving elements will average up to 10 minutes of saved time per hour through the average work day, making more than an hour per day available for telephone calls, inbox management, and other administrative matters, which will no longer have to be done after hours.
2. Home visits to patients are cheaper than those in the clinic, especially if the psychiatrist is also working from home. Technology is cheap compared with renting office space, paying for reception staff, and traveling to work. Hybrid relationships are physically and psychologically safer and more intimate, with the extra distance involved in a video visit to a patient in their home enabling the patient to feel more relaxed and confident in their own environment, while at the same time being less intimidated and able to share deeper information with their therapist. Seeing patients at home provides the psychiatrist with more information about their patient, which improves the care they can provide. They get to see the state of the patient's home, a proxy for an extended look at their mental state, and meet other members of the family and pets, and explore the patient's interests and passions via objects and artwork that they can see in the home. The author often asks patients to show him around the house and garden so that he has a better idea of how the patient lives, eats, and relaxes, and looks to connect more closely with his patients by finding mutual interests in art, sport, or cultural events. If privacy does not exist in the home, the car is an excellent alternative therapy room, as long as it is parked in a quiet area and has all the windows shut.
3. Telepsychiatry allows better matching of patients and psychiatrists than is usually possible in a physical clinic. Many psychiatrists like to specialize with the types of patients they see and treat, and this is a significant advantage of using video, where it is possible to see patients with particular disorders who may live far away allowing such psychiatrists to indulge their specific clinical interests in, say, patients with eating disorders or autism. Equally some patients prefer to see particular psychiatrists, perhaps women or those who speak their own language, and this is easier to arrange on video. Equally some patients (**Box 3**) prefer to be seen online than in-person.
4. Language interpretation on video is also highly effective, with several commercial video interpreting groups easily available. The experience for the physician who is talking via the interpreter is often easier online than in-person.
5. Teaching and group work or supervision is often easier on video than in-person. It is possible to bring in larger groups of people or students, and to move people around using breakout video rooms, while taking questions on chat. If seeing patients as part of the teaching, they can be brought in, and then moved to a waiting area while discussion occurs, and then brought back. This can all be done conveniently with a virtual class spread across many different sites.

Box 3**Clinical pearls: patients who prefer being treated online than in-person**

- Children
- VIPs (eg, celebrities, physicians, lawyers)
- Individuals who are paranoid, agoraphobic, or who have post-traumatic stress disorder
- Individuals who prefer to be seen from home for any reason (eg, COVID-19)
- Individuals for whom the stigma of attending an office visit is too much
- Individuals who live at a distance, or who cannot easily travel (eg, from nursing homes or correctional institutions)

6. Group therapy has finally, during COVID-19, emerged as something that can commonly be provided online, with several intensive outpatient programs in particular moving their entire group-related activities online successfully, or taking up hybrid approaches. Groups for six to eight people, in particular, seem to work well online with everyone able to see each other and interact easily, leading to an easier role for facilitators.
7. Recording video interviews with patients is becoming more common, and can allow a psychiatrist to replay parts of an interview, for personal learning or supervision purposes, and asynchronous telepsychiatry for clinical care direct to the home has been trialed during COVID-19.²² With the advent of asynchronous telepsychiatry, where a patient is interviewed and recorded, and the recording sent to a different expert for analysis or a second opinion, a whole new approach to telepsychiatry, asynchronous telepsychiatry, has been developed. Essentially this is a souped-up form of a curbside or e-consultation where, instead of a quick patient summary and a question being sent to an expert, a video of the patient's mental state and a semistructured interview is sent. A recent randomized controlled clinical trial comparing the clinical outcomes of asynchronous and synchronous video consultations in patients with anxiety and depression in primary care showed similar levels of useful clinical improvements in both groups. Although asynchronous telepsychiatry is novel, in future it is likely to become common, and will allow psychiatrists to scale their work more efficiently, doing consultations during clinic "down time."²² Looking further ahead, the use of video as data allows the implementation of artificial intelligence, machine learning, and voice and facial movement recognition technologies, all of which ultimately should help the psychiatrists of the future.
8. Finally much has been written about the cognitive load required to spend hours on videoconferences leading to what is commonly called "zoom fatigue." Although this may affect some people, if breaks are taken between conferences for 5 to 10 minutes each, especially if they involve some simple exercises or stretches, this seems less of a problem. There is now some evidence that the extra efficiency of videoconferences, with a lack of need to travel between meetings, especially when the agendas for meetings are carefully managed, may actually be less stressful than prior days full of in-person meetings running into each other. Many clinicians and regular users of video visits are now making their consultations and meetings much more structured than previously, and are finding that this not only gives them breaks, but is less stressful overall. In reality the jury is still out in terms of the cognitive load of videoconferences versus the cognitive load of in-person meetings or consultations, and there is probably little difference overall,

because it can certainly be tiring to spend an entire day without breaks in either set of meetings.

Acknowledgment of Psychiatrists and other Health Care Workers As Being Essential Workers, and More Overt Demonstration of their Lived Experience in the Workplace

Early in the pandemic there were numerous examples of communities applauding health care workers as they left work after shifts or returned to their homes. These ranged from groups of grateful people waiting outside hospitals to whole communities living in apartments coming out onto their balconies and applauding. The day-to-day work of health care professionals has traditionally been kept secret from the general public, unless they are patients, because of the need to maintain confidentiality, but in COVID-19 there has been a sudden exposure of many health care worker practices by the media, and usually in a positive or admiring way, especially in emergency departments and intensive care units. Suddenly the potential dangers faced by some health care workers have been understood by the public, and there has been much more open discussion about the lived experience of health care workers.

Has this extended to psychiatrists and the mental health workforce? Likely it has to at least a certain extent, although with less emphasis on the potential personal danger from infection. In many hospitals and inpatient units psychiatrists have been continuing to see patients in-person, wearing full personal protective equipment, as part of a multidisciplinary team. Several have died or become seriously ill, and some were required to work as general physicians when staff shortages occurred. Working in an academic medical center myself, I know that it is difficult to connect with a masked patient while personally also masked and wearing a clear plastic facial guard but many psychiatrists have had to work like this routinely during the pandemic. Given the choice, the author would much rather see a patient on video, with no need for any masking by either person, than in-person with both people masked and in protective equipment.

It will be interesting to see if the positive aspects of being essential workers is sustained postpandemic and is not forgotten. Sadly, in the United States as the pandemic continued on into 2021 there were increasing numbers of reports of people who did not believe in the existence of COVID-19 attacking or abusing health care staff. It is hoped this will not continue. The lesson to be learned from COVID-19, however, is the importance of being transparent about the workforce practices in health care, rather than tending to automatically hide behind the privacy excuse, which only leaves the general public ignorant of the real world of health care, and dependent on overly dramatized television shows for their perception of the lived experience of health care workers.

A Greater Focus on Health Disparities and Structural Racism Throughout the Health Care System

COVID-19 has undoubtedly shone a bright light on those in our society who are underserved and disadvantaged, and on the long-term previously poorly acknowledged structural racism that exists within the health care environment, never mind more broadly throughout society, especially in the United States. Much has been written about the increased morbidity and mortality affecting the African American, Hispanic, and Native American communities generally, and which is also seen among the more than 3600 health care workers who have died of COVID-19.¹¹ Unfortunately, this same problem is seen even when implementing telepsychiatry¹⁸ where such populations as the homeless, the poor, and racially and linguistically diverse groups are less able to

receive telepsychiatry services because they cannot afford smartphones with connection plans, or cannot keep them safely, are not technologically literate, or live in inaccessible situations.

A positive bright spot during COVID-19 has been the ability of psychiatrists to do audio-only consultations with patients, which has been shown to be a good way of connecting with patients who have serious mental illness in New York,²³ and in some respects was shown to be a more effective approach than even in-person visits. It is to be hoped that the regulations that were relaxed during the pandemic to allow these consultations will continue permanently. Some states, such as California, are heading in that direction, but at the time of writing it is unclear what will be the federal response to paying for telephony. Returning to the prior regulations restricting geographic use of telehealth and telephony, which have been described as examples of structural racism within the health care system, would seem to be a retrograde step.²⁴

SUMMARY

Despite the generally disruptive adverse impact of COVID-19 on the mental health workforce, there are constructive plans being proposed to improve the well-being of clinicians, and several likely positive outcomes from the forced experiment that has been the pandemic. The practice of psychiatry and mental health care has changed significantly and rapidly, and a hybrid approach to care involving the integration of multiple technologies and novel asynchronous approaches into mental health practice is a likely positive consequence. This approach to care should improve the well-being of the mental health workforce, giving practitioners more flexibility and more control over their schedules and their lives, hence reducing the likelihood of burnout and other mental health disorders. It is hoped that the exposure of the lived experience of many practitioners will lead to improved understanding from patients and that in future much more emphasis within mental health care will be placed on providing access and services to those members of society adversely affected by disparities and structural racism.

DISCLOSURE

Dr P. Yellowlees has nothing to disclose.

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