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Training Military Psychiatrists to Adapt and Overcome: How COVID-19 Highlighted the Unique Flexibility of Military Psychiatry in Training and in the Fleet

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Abstract

Purpose of Review Born out of necessity, military medicine continues to find itself at the forefront of medical innovation. This generation of military physicians has never previously been challenged with continuing to provide top notch medical support to servicemembers in a variety of operational settings in the midst of a global pandemic. While military medicine has always been able to uniquely meet the educational goals of residency training, COVID-19 brought new challenges to the forefront.

Recent Findings While the threat presented by COVID-19 was different from the historical battlefield threats and challenges that have given birth to military medicine, it was nevertheless ready to pivot and adjust course, focusing on how to best meet the medical needs of the military patient population in an ever-changing geopolitical environment while continuing to meet and exceed the educational standards that training programs are held to. Historically and currently, mental health remains one of the most common reasons that servicemembers are evacuated from combat zones.

Summary The COVID-19 pandemic provided an opportunity for modern military psychiatry to showcase its ability to adjust the educational focus in certain areas of residency training to prepare the next generation of military psychiatrists to be able to face the newest threat to force wellness.

Keywords COVID-19 · Psychiatry · Residency · Military · Graduate Medical Education (GME)

Introduction

Often at the forefront of trauma and emergency medicine, the military continues to be synonymous with innovation driven by necessity. As such, the military trains its physicians to adapt and overcome challenges that arise—both in the hospital and on the battlefield. The 2020 coronavirus pandemic (COVID-19) highlighted many unprecedented concerns, one of those being the mental health of a world pushed into isolation. In the military, as in the civilian sector, the provision of mental health and the training of psychiatrists pivoted overnight to adjust to a new practice environment with new constraints and limitations. This article examines how the pre-COVID-19 training methods used in one American military psychiatry residency program fostered the skill set necessary to adapt to and overcome significant operational challenges and how that program was able to adapt and continue to meet educational objectives during a global pandemic. We further look at the impact of military psychiatry residency on the provision of mental health care in the operational setting before COVID, and how the military was uniquely positioned to continue to carry out its mental healthcare mission in light of a global pandemic.

Training Practices Before COVID-19

While American military residencies are held to the same standards as civilian residencies with respect to core rotations and clinical competencies, the day-to-day experience can vary significantly. Some offer the opportunity to work in both civilian and military hospital systems and interact with a variety of patient populations, while others spend

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more time in military hospitals. There are benefits and drawbacks to both training environments [1]. Most patients in the military setting are otherwise healthy young adults and their families. When the system is taxed, those family members are deferred to the insurance network for care. As a result, it is not common to see chronically mentally ill patients in most military clinics. To remedy this, our residency has partnered with hospitals in the community to offer residents the necessary exposure to this patient population. In addition, there are multiple elective opportunities that allow residents to care for a wide variety of patients.

A benefit of this rather insular healthcare system is that we frequently have access to extensive past medical and psychiatric history, both inpatient and outpatient records. Based on the funding of the military health system, residents are less likely to have their patient care limited by cost concerns. However, it also can result in challenges when after residency they are faced with a shortage of supplies, geographic isolation, or budget limitations.

Additional challenges may arise when trainees spend more time in civilian settings, resulting in decreased exposure to unique aspects of military medicine with which residents may be tasked routinely after graduation. In the military setting, there are administrative factors that must be considered at each visit. Residents must consider if their patient is fit for ongoing active duty service, if there are duty limitations, if the command needs to be involved, and if the patient can safely retain their security clearance and weapons access. Early career psychiatrists may find themselves at a significant occupational disadvantage at the beginning of their career if they have not been routinely exposed to military administrative concerns during training [2, 3•].

Prior to COVID-19, our residents spent half of their clinical rotations at military hospitals and a quarter of their clinical rotations outside of the military healthcare system. The remaining rotations were electives and could be spent in either setting, depending on the interests of the individual resident. All of the outpatient rotations occurred in military psychiatric clinics. While our residency consists of mostly Army and Navy trainees, the geographic location of the program provides a fertile ground for routinely seeing patients from the Army, Navy, Air Force, Space Force, and Marine Corps. Foreign military officers, government officials, and members of the Coast Guard, Public Health Service, and National Oceanic and Atmospheric Administration Corps are also eligible for care in the system. Each branch of service has its own unique language, suitability standards, paperwork, culture, and internal systems and processes that must be learned and then followed by residents [4]. The mission statement of the residency is "to develop and transform a diverse group of medical students into military officers and physician-scholars who are equipped with knowledge, skills, and attitudes as experts in psychiatry, prepared to serve the military, veterans, and the community as healers, and to enable medical readiness of their commanders and military units" [5]. Developing the preparedness and skills necessary to serve as a military medical officer is a necessary part of the development of psychiatry residents into competent, capable staff psychiatrists.

In addition to becoming competent in psychiatry, military professional education is also included in residency training [6]. Military disposition is a frequent topic of conversation during twice weekly noon conferences and quarterly training focuses on military competencies such as initiating temporary or permanent duty limitations, or understanding the fitness for duty evaluation and standards for medical retention in military service. Military education is incorporated into the didactic schedule each year, with lectures that include the management of military behavioral health clinics, combat operational stress control, management of a military career, specialty military behavioral health evaluations, and working with operational military units—all of which are crucial to ensuring that the residency graduates competent officer-psychiatrists.

Military psychiatry emphasizes multi-dimensional assessments that require a significant bit of cultural competency. Early career military psychiatrists may be adapting to this new culture themselves throughout training. Military residency programs directly expose trainees to the same culture of their patients from the very first day of their internship and residency, fostering a level of empathy that can be difficult to otherwise instill and match. The repeated, indirect exposure to the military culture (both inside and outside of their clinic or hospital) also reinforces the importance of cultural competency when it comes to the assessments and treatment planning. Military psychiatrists have to learn this culture in order to make effective clinical assessments to help their patients. This fact is profoundly important as all of our patients have unique cultural backgrounds that are often a significant influence in their outcomes. As access to care continues to become more and more of an issue irrespective of military or not, the time crunch to see and take care of these people in need becomes greater. Therefore, the ability to efficiently conceptualize clinical encounters will only serve to help the treatment plan. While none of this is to say that the military has a monopoly on communication skills or cultural competency, it highlights a key aspect of training that produces quality psychiatrists. It also highlights how COVID-19 created a critical gap in training that was closed through key adaptations and that supported the ongoing training of psychiatrists.

Prior to COVID-19, the military recognized the need to use telehealth to increase access to mental health care. Before the pandemic, all of our third year residents had a weekly telehealth clinic to provide care for patients at outlying military clinics, obviating the need for travel and

expanding access to psychiatric care. This meant that some of the underlying structure and system was already in place when it became necessary to rapidly expand telehealth capabilities. Residents had been learning how to balance command communication, ensuring safety and emergency room evaluation if necessary, and confidentiality in telehealth when COVID-19 came onto the scene.

Operational Psychiatry Before COVID

Historically, the operational setting pulled military physicians away from a treatment-only mindset and pushed them toward also developing effective leadership and strong communication skills in both clinical and non-clinical settings. The Embedded Mental Health Provider (EMHP), typically a recent residency graduate, is expected to fully understand the mission of the unit in which they are embedded and be able to advise and support their Commander's decision-making process, which can be likened to the delicate balance of communication and shared decision-making when caring for adolescent patients. As a special staff officer, the EMHP is more than just a physician, they are an officer in an operational military setting [7]. They advise the commander and make recommendations to ensure that the service members are fit for duty. This highlights the evolving skillset required of a psychiatrist in today's healthcare and military [8]. Even under ideal circumstances, balancing these roles is incredibly challenging.

Here, we can see the unique challenges that are faced by military psychiatrists. While civilian psychiatry training incorporates previously mentioned standards of clinical practice such as internships, fellowships, clinical rotations to different specialties within a hospital, and safety evaluations of appropriateness for care (a civilian correlate to Fitness for Duty evals), military psychiatrists are asked to take these skills and apply them in settings with limited support and guidance, often in austere environments where superior officers with zero medical training are imposing uninformed expectations on novice providers. In operational settings where newly licensed military psychiatrists are expected to be autonomous subject matter experts, strong residency training helps guide clinical practice in the face of uncertain, novel situations. Under all of this, military mental health providers must incorporate cultural competency into their clinical practice at a foundational level (i.e., establishing therapeutic rapport) in order to maximize the impacts of targeted interventions. Each military job exposes the individual service member to a unique combination of stressors and barriers within their fields and their branch of service. With a shared language and experiential empathy with the patient, military providers do not just help make patients feel "heard" but they also gain the ability to see the world through their patient's eyes. This aids providers in not just helping their patients heal but also helping determine the patient's fitness for duty (especially if in a time of war) in austere environments—with the latter being key to closing critical gaps and expectations with superior officers and the former being absolutely instrumental to the latter.

Indeed, the entire purpose of operational settings is to train military service members for the unexpected—to rehearse for combat deployments in settings that are unpredictable, laden with hazards, and in which resources are scarce, making the delivery of healthcare complex at baseline [9•, 10, 11]. Soldiers, Marines, Sailors, Airmen, and Guardians often undergo years of training to be able to physically adapt to such environments, but little can be done to prepare for the mental toll that such settings impart on the warfighter. A primary duty of Medical Officers is to maximize the resiliency of their patients, to enable them "to perform with a high level of well-being and resilience and with minimal risk and stress, despite the challenges of the operational environment" [12••]. Treatment remains at the forefront of this challenge. In response to the evolving operational landscape, EMHPs overseas extended telehealth services across large bodies of water (as previously mentioned) and consolidated effective psychotherapeutic interventions into group-based interventions to maximize reach prior to the pandemic [13•]. The ability to effectively communicate with military patients is paramount to improving individual and unit outcomes [14]. Graduates must operationalize their knowledge of military policy to communicate the appropriate information to commanders without violating the military command exception in privacy laws [15]. They are expected to routinely communicate with command about the psychiatric concerns that are relevant to the unit, which can be challenging when the commander outranks them and has the ability to override their treatment recommendations, not unlike family members [16].

COVID-19 Prompted Innovations in Residency Training

In the wake of COVID-19, communication and assessment skills, along with use of telehealth platforms, became more important when addressing situations involving acute safety concerns [17]. While service members might have previously been able to stay with a roommate in the barracks for safety, infection control policies made this impossible. Additional methods of ensuring patient safety became more important during this time, e.g., having service members place personal weapons in their unit armory or in the temporary possession of unit command.

The residency was able to expand its curriculum by reaching out to military psychiatrists stationed around the world

to increase the understanding of the current occupational challenges faced by military medicine in a variety of settings. These lecturers connected with the residency over a virtual learning platform to close training gaps that existed prior to COVID-19, when the residency lacked the robust capability for remote learning [18]. This expanded the educational opportunities available to the residents, as lecturers and grand rounds presenters were no longer limited by time and geography. The residency even invited program graduates who were actively deployed to share their lessons and experiences in real time. This encouraged development of strong inter-professional relationships across both disciplines and time zones, as residents will later practice in the same system in which they are training [16]. Furthering the development of these inter-professional relationships, we have been able to collaborate with other military residency programs and share didactics with others who might benefit from introduction to the material. COVID-19 has truly helped expand our professional networks and has supported ongoing collaboration that will continue to benefit both the profession at large, our individual patients, and each individual military psychiatrist.

Expanding access to care while maintaining mission readiness remained at the forefront even during COVID-19. Since residents were already familiar with telehealth, it was not as challenging as it might have been to move appointments to the virtual environment. Patients and providers grew comfortable with telehealth platforms and resources. It is impossible to imagine a world where military medicine will entirely discontinue the use of telemedicine, as this capability has demonstrated increased engagement with services across a broad geographic and demographic spectrum. COVID-19 has allowed us to provide care to more patients in more locations than ever before.

Reflections From Overseas: How COVID-19 Changed Operational Psychiatry

Working as embedded Navy mental health providers, COVID-19 made the responsibilities of EMHPs more difficult—but, it also facilitated innovation by necessity, and in this way served as a boon to our military's operational readiness. COVID-19 manufactured many of the psychological difficulties inherent in deployments, forcing EMHPs to respond accordingly and ensure that the service continues to effectively take care of its members [19]. Operations continued during the pandemic, despite being impacted by COVID-19. Service members on deployed operations were able to speak with mental health providers on a secure platform, both to aid their mental health and to determine their continued fitness for duty, which allowed their Commanding Officers to have an accurate sense of the health of their forces. These innovations were seen across every military branch and were employed by providers (like ourselves) on Operational Stress Control and Readiness (OSCAR) Teams in the Navy, and refined utilization of the National Emergency Telecritical Care Network in the Army, for example. Remote clinics, EMHPs, and forward-deployed providers were able to learn from each other and share knowledge on best practices in tele-mental health care as the pandemic raged on.

What was once a simple walk-in visit to the mental health clinic became a complex series of emails and phone calls to schedule remote telehealth sessions. Telehealth over great distances required closer command collaboration to ensure appropriate care in the absence of the physical presence of military psychiatrists [20]. This close coordination with a patient's Command was made more difficult by a Medical Officer's clinical duty to protect patient confidentiality while balancing often complex obligations to the patient's command structure, including orders from the actual Commander. With more patients to screen and discuss with the operational chain of command, administrative and staff medical officers had the opportunity to hone their ability to navigate the challenging duality inherent in their role as practitioner and officer, affording them greater competence as a result of the circumstances created by COVID-19.

Since a primary focus in an operational setting is the well-being and preservation (i.e., operational readiness) of the fighting force, a series of measures collectively known as Force Health Protection (FHP) aim to prevent stress-related casualties and ensure the unit is always ready to perform. FHP considers the entire force (regiment, battalion, etc.) to be the "patient," necessitating a multi-faceted, systems-based approach to practice for psychiatrists, psychologists, and social workers embedded with these units. COVID-19 facilitated innovation by highlighting the need for effective crisis leadership and providing an opportunity for Medical Staff Officers to initiate new services in support of preserving unit-wide mental health [21]. Physical distance and isolation helped prevent disease spread, but it also created fertile ground in which symptoms of anxiety and depression could grow [22, 23•]. Resiliency working groups (consisting of the chaplain, EMHPs, medical providers, command staff, and even other line officers for example) developed multi-disciplinary strategies aimed at maximizing the operational readiness and overall outcomes of the entire unit [24]. These new programs met regularly to create ways to preserve and protect the unit's mental health– adhering to the FHP principle of considering an entire unit as a single patient. Historically, the implementation of similar interventions reduced the number of service members lost to Disease and Non-Battle Injury (DNBI), which includes operational stress reactions and mental disorders [25]. This is of the utmost

importance, as DNBI have a more significant impact on military outcome than combat injuries [12••]. Innovative leadership, especially in an operational setting, remains an important competency for residency graduates to exercise adaptive responses.

As previously mentioned, operational psychiatry at baseline requires psychiatrists to practice in settings that are uniquely volatile and fluid, to a much greater degree than the typical day-to-day uncertainty of practicing in a hospital setting. In response to COVID-19, our training helped guide the complex orchestration required to provide care to infected patients in isolated quarantine, while developing previously established constructs such as FHP and telehealth medicine, and simultaneously facilitating the creation of new components of operational practice such as Resiliency Working Groups. The successful response of operational military psychiatrists to the pandemic highlights the effectiveness of military residency training in clinical practice and demonstrates our unique ability to adapt to unforeseen hazards.

Conclusion

Serving as a military medical officer is a calling for some young medical professionals, whether they have family members who previously served or are first-generation service members. However, a military physician is also an officer. That role adds a host of expectations and skills in which any young military physician must be competent. These reflect the dual agency challenges faced by military clinicians, who are working for the good of both the units they support and the individual patients they care for. When psychiatrists begin their first military assignment after the completion of years of medical training, they have passed the medical standards to be considered competent in their field. The needs of the military, however, continue to evolve in response to ever-changing geopolitical landscapes. Developing a competent skill set is only effective if it can be properly utilized. That is where the current training practices that highlight these fundamental values not only develop medical competence, but they also develop military competence. For a successful military career, one must be capable of performing their duties in novel dynamic situations. COVID-19 highlighted this concept, and also underscored the levels to which our military psychiatrists and psychiatrists-in-training are adapting and overcoming.

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Compliance with Ethical Standards

Conflict of Interest The views expressed in this article are those of the authors and do not necessarily reflect the official policy of the Department of the Army/Navy/Air Force, Department of Defense, Defense Health Agency, or the U.S. Government.

Human and Animal Rights and Informed Consent This article does not contain any studies with human or animal subjects performed by any of the authors.

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